STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146098	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharon Health Care Elms	3611 North Rochelle Peoria, IL 61604

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49187 Failures at this level required more than one deficient practice statement. A. Based on observation, interview, and record review the facility failed to conduct a resident assessment to determine the resident's degree of mobility, physical impairment and the proper transfer method needed once a resident experienced increased weakness. The facility also failed to maintain an adequate working electrical supply to adjust an electric bed into the lowest position prior to a transfer for one resident (R9) and failed to implement appropriate fall interventions for one resident (R8.) These failures affect two of three residents (R8, R9) reviewed for falls in the sample of 27. These failures resulted in R9 losing grip of the sit-to-stand mechanical lift handles and falling to the floor, sustaining a coccyx fracture and severe pain that required hospitalization . B. Based on observation, interview, and record review the facility failed to assess the smoking safety yearly for one of five residents (R40) reviewed for smoking in the sample of 27. Findings include: a.) The facility's Job Description for CNA's (Certified Nursing Assistants), undated, documents Illustrative Examples of Work: Care delivery to include, but not limited to: Bathing a minimum of two times weekly, daily oral hygiene, shaving, changing clothes, nail care, toileting feeding, ambulating, transferring, room care, hair care. Recognizing and reporting changes in condition to the nurse (example: health problems, eating problems, changes in skin or incontinence behavioral problems, unstable vital signs.) Maintain a safe environment for the residents and other staff. Follow safety practices (example: keeping resident areas hazard free, follow good body mechanics, wear proper footwear, use lifting devices according to manufacturer's directs, wear gait belt, etcetera.). General Employee Guidelines: Immediately report defective equipment, hazardous conditions, or supply shortages. The facility's Fall Policy and Procedure, dated 1/2/2019, documents It is the Policy of (the facility) to provide an environment conducive to reducing risk for falls. (The facility) provides interventions to reduce risk factors for filling but cannot guarantee or maintain a fall-free environment. The facility's Transfer Between Surfaces policy, dated 3/2000, documents Purpose: To improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices. Procedure: 1. Explain and demonstrate procedure. 5. Bed should be flat and level with wheelchair seat. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility's Fall Prevention Practice, dated 1/10/2016, documents Below is a list of things that can help reduce the risk for falls: 8. Report changes in mental status to nurse immediately. 1. R9's Admission Record documents R9 is a [AGE] year-old male admitted to (the facility) on 5/14/2012 with the following, but not limited to, diagnoses: Chronic Obstructive Pulmonary Disease, Difficulty in walking, Frontotemporal Neurocognitive Disorder, Dementia, Schizoaffective Disorder, Extrapyramidal and Movement Disorder, and Cerebral Infarction. R9's Minimum Data Set (MDS) assessment dated [DATE], documents R9 has severe cognitive impairment, and requires substantial assistance for activities of daily living, toileting, and transfers. R9's current Care Plan documents, (R9) has the potential for falls due to increased weakness. The facility's Maintenance Work Order dated 9/19/24 and signed by V7/CNA, documents R9's room had no electricity. R9's Progress Note, dated 9/19/24 and signed by V15/RN (Registered Nurse), documents (R9) was observed on the floor, lying on right side. Per two aides (Identified as V8/CNA (Certified Nursing Assistant) and (V9/CNA), they were attempting to get (R9) into bed. After a couple minutes, it was indicated that (R9) was to be moved back into chair due to the bed being unavailable for use. Throughout all of this, (R9) was in a mechanical stand lift and was already up at the highest position. Per (V8 and V9), (R9) began to drift down. (V8 and V9) stated that they pulled chair under (R9) but at that point (R9) was too low to get into his chair. Then (V8 and V9) stated that (R9) quickly slid through the straps due to him lifting his arms up, where (R9) then hit the floor at fast and unexpected speed where (V8 and V9) were unable to slowly lower (R9). Different reports of if (R9) hit head or not, so per the physician, we (the facility) called emergency services to send (R9) out to the emergency room to be evaluated due to nature of fall. Per (V8 and V9) (R9) was lethargic. No signs of lethargy when this nurse assessed (R9). During assessment, (R9) stated that he was in extreme pain on right side of arm. R9's Electronic Medical Record does not include evidence of a nursing assessment being performed when R9 was lethargic prior to be transferred from the wheelchair. R9's Local Emergency Record, dated 9/19/24, documents CT (Computed Tomography) pelvis for bone detail without contrast final result: Impression:1. Acute or subacute mildly displaced comminuted inferior coccyx fracture. This same form documents Clinical Impression: Fall, Urinary Tract Infection, and Hyponatremia (low sodium level.) On 10/06/24 at 9:02 AM R9 was in self-propelling wheelchair around R9's room. R9 had nonskid socks on. R9 was unable to answer questions appropriately at this time. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/7/24 at 12:04 PM V8/CNA stated, (V9/CNA) and I were transferring (R9) from his wheelchair to the bed with a mechanical stand lift machine. (R9) was weak when (V9) and I were lifting him, so (V9) and I tried to get (R9) to the bed quickly. When (V9) and I attempted to transfer (R9) to the bed we realized the bed was too high. I then tried to use the controller to lower the bed while (R9) was trying to hold on and slipping from the sit-to-stand machine at the same time. I realized the controller was not working to the bed, so (V9) and I attempted to turn him back around and put him in the wheelchair. By that time (R9) had let go of the sit-to stand and had fell to the ground. V8 verified at this time, that she should have not attempted to transfer (V8) when she realized he was weak and should have ensured the bed was working and in the proper position prior to transferring R9. On 10/7/24 at 12:14 PM V9/CNA stated, (R9) was not a resident on my group the night of 9/19/24, but I was asked to help lay (R9) down. (R9) had been outside at a party, and when he came inside, (R9) was found lopped over the side of his wheelchair in the television room. (V15/RN) called (V8/CNA) and I up to the nurse's desk and asked for us to lay (R9) down. I pushed (R9) to his room with (V8). I asked (V8) how she wanted to transfer (R9) since (R9) seemed weak and was lopped over. (V8) just stated we would transfer (R9) with the stand mechanical lift and get him to his bed. (V8) and I strapped (R9) to the mechanical stand lift machine and started lifting (V8) up in the air. As (V8) and I were lifting him up, (R9) started slipping and was barely hanging on to the (stand lift machine.) (V8) and I attempted to hurry and put (R9) in bed before (R9) fell just to notice the bed was too high. (V8) and I tried to use the controller to lower the bed and the controller wasn't working. (V8) and I attempted to turn (R9) back around to get (R9) in his wheelchair, but (R9) kept getting lower and lower and then let go of the (hand bars of the mechanical stand lift) machine. When (R9) let go of the (stand lift machine) (R9) fell quickly to the ground. If (R9) was on my group that night, I would have not transferred him to the bed when he was visibly weak. I would have gone and notified (R9's) nurse to have (R9) assessed. I should have done that anyway, but I felt like that was (V8's) responsibility. V9 verified she should have notified R9's nurse prior to transferring R9 when R9 was lethargic and should have ensured the bed was working and in the proper position prior to transferring R9 to the bed. On 10/7/2024 at 12:30 PM V6/Maintenance Assistant stated, I get work orders for no electricity all the time for rooms. The staff will move the resident's beds and hit the plug, which breaks a prong off in the outlet. When the staff went to plug the bed back in, the plug-in hits the prong and blows the circuit breaker. I received the work order for (R9) not having electricity in his room on 9/20/24. The staff laid it on my desk on 9/19/24, but I don't usually get to work orders in the same day, it's always the next day I am at the facility. No staff member got ahold of me to let me know (R9) did not have electricity in his room on 9/19/24. On 10/7/24 at 12:47 PM V7/CNA stated, I filled out a work order on 9/19/24 around 2:30 PM regarding (R9) not having electricity in his room. (R9's) television was not working. I put the work order on (V6/Maintenance Assistance) desk. I did not tell anyone else or try to get ahold of (V6) to fix it right then. On 10/8/24 at 1PM V2/Director of Nursing stated, If any staff notices a change in condition with a resident, they should immediately notify the nurse prior to transferring especially if the resident seems weaker. Also, the staff should have everything positioned correctly prior to transferring any resident. V2 verified no nursing assessment had been performed prior to V8/CNA and V9/CNA transferring R9 from his wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/8/24 at 1:09 PM V3/Assistant Director of Nursing stated Staff should go to the nurse or myself prior to transferring a resident if they notice a change in the resident's condition or if they notice the resident is weaker. They should never transfer someone to a bed with the bed in high position, they should always ensure the bed is at appropriate position prior to transferring. 33975 2. R8's Fall Investigation Worksheet/Worksheet, dated 5/25/24 at 8:56 pm, documents that R8 slid out of the wheelchair in R8's room, while transferring self to bed. The Worksheet documents no injuries and fall interventions for a gripper pad to be placed in R8's wheelchair and to utilize a nightlight. R8's Fall Investigation Worksheet, dated 7/1/24 at 4:00 pm, documents a fall in R8's bathroom. The Worksheet documents that R8's decision making is impaired and has unsteady gait. The Worksheet describes that R8 hit the side of R8's head on R8's bathroom door jamb/frame while trying to get up from the toilet. The Worksheet documents no injuries and fall interventions for staff to intervene when they see her going down the hall and ask her is she needs to go to the bathroom and take her as much as possible. R8's Fall Investigation Worksheet, dated 7/27/24 at 3:00 pm, documents a fall from R8's wheelchair, in R8's room. The Worksheet documents that R8 has impaired memory, impaired decision making and is impaired physically. The Worksheet documents no injuries and fall interventions to educate R8 on the proper use of R8's call light. R8's Fall Investigation Worksheet, dated 9/8/24 at 10:08 am, documents a fall from R8's wheelchair in R8's room. The Worksheet documents no injuries and that R8's gripper pad be replaced in R8's wheelchair. On 10/8/24 at 12:50 pm, V2 (Director of Nursing) stated (R8) is confused and self transfers a lot. (R8) is frequently taking herself to the bathroom and she always slides to the end of R8's wheelchair seat all the time too. On the first fall, we put a gripper pad on (R8's) wheelchair to help to grip (R8) in the wheelchair but (R8) does not like it on there and removes it all the time. R8's MDS (Minimum Data Set) documents that (R8's) cognition score is ten out of fifteen, which is moderately impaired. We have educated (R8) and we just changed (R8's) gripper pad again. Now that I think about it, we probably should use some different interventions since (R8) is confused and keeps removing the gripper pad from (R8's) wheelchair. We do not have (R8) on a toileting schedule. 32875 b.) On 10/7/24 at 9:15 AM, R40 was sitting in front of the facility in his wheelchair with two other residents and had just finished smoking a cigarette. There were no staff present for supervision. On 10/8/24 at 11:55 AM, V4/MDS/Minimum Data Set Coordinator stated that R40 is an independent smoker and does not need to be monitored. On 10/8/24 at 2:20 PM, V2/Director of Nursing stated that the smoking assessments are to be done at least yearly by V14/Activity Director. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R40's Face Sheet documents R40 was admitted to the facility on [DATE] with diagnoses which included Schizoaffective Disorder, Mild Cognitive Impairment, Emphysema, and Chronic Obstructive Pulmonary Disease. R40's Care Plan dated 3/23/22 documents (R40) is an independent smoker. The Resident Smoking List for October 2024 documents that R40 is an independent smoker. R40's facility Smoking -Safety Screen dated 3/1/23 at 3:23 PM, documents that R40 has cognition loss, dexterity problems, is an independent smoker, keeps his own smoking materials, and lights his own cigarettes. The Smoking Safety Policy and Procedure revised 7/18/2019 documents Policy In order to provide the residents of (the facility) the opportunity to use tobacco products and do so in a safe environment and manner, the following procedures/rules/regulations shall be followed by all residents. Procedure Those that wish to use tobacco products will be assessed upon admission, yearly, and as needed as to the resident ability to smoke safely and to ascertain other needs the resident may have in which using tobacco products would be an issue, i.e. (example), ability to manage/ budget tobacco products. Based upon this assessment the resident will be placed in one of three groups as described below (full independence, managed independence, or supervised). A copy of the rules and regulations pertaining to smoking is given to each resident and further discussed with the SSA (Social Service Assistant). A Smoking Contract is then executed indicating the resident's understanding of smoking rules and his/her agree compliance.