Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007306	A. BUILDING: _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE ELMS	3611 NORTH ROCHELLE PEORIA, IL 61604

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)
b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:

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S9999	Continued From page 2	S9999		

Based on interview and record review the facility failed to follow a care plan for fall prevention measures, and failed to follow a Fall Procedure policy for one of three residents (R2) reviewed for falls in a sample of six. These failures resulted in R2 falling ,sustaining a laceration, a fractured right orbit (eye socket), and a subarachnoid hemorrhage.

Findings include:

A Fall Procedure policy dated 6/08/15 states, "It is the Policy (of the facility) to provide an environment conducive to reducing risk for falls....Following an observed or suspected fall event...Do not move the resident until the nurse has assessed the resident."

R2's fall risk assessment dated 11/09/15 documents R2 is at high risk for falling.

R2's care plan dated 8/17/14 documents R2 is at risk for falls related to confusion and being legally blind. The care plan also documents for staff to ensure R2's bed is kept in the lowest position as a fall prevention measure.

R2's Minimum Data Set assessment dated 11/13/15 documents R2 is severely cognitively impaired with moderate hearing difficulty, has highly impaired vision, and sometimes understands when spoken too. R2's MDS also documents R2 requires extensive assistance for bed mobility, transfers, and incontinence care.

R2's fall investigation dated 12/11/15 documents that on 12/11/15 at 7:50a.m. E6 (Certified Nurse Aide/CNA) was assisting R2 with care. E6 had raised R2's bed from the low position in order to provide R2's care. The investigation documents

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that E6 became distracted by another staff member outside of R2's room at which time E6 turned away from R2 to pull back R2's privacy curtain. The investigation documents that while E6 was turned away, R2 then fell off the bed onto the floor sustaining a laceration. The investigation also documents that R2 was admitted to the hospital, "...for right orbital fracture and subarachnoid hemorrhage." R2's fall investigation documents E4 and E6 lifted R2 back into bed after the fall but prior to being assessed by a nurse.

An emergency room history and physical of present illness dated 12/11/15 states, "The CNA was cleaning the patient when she stepped away from the bed, the patient fell on the floor hitting her head."

A hospital Computed Tomography scan result dated 12/11/15 states R2 was diagnosed with, "Fracture in the floor of the right orbit (eye socket) with hemorrhage into the right maxillary sinus....Subarachnoid hemorrhage on the...frontal lobe."

On 12/16/15 at 2:05p.m. E6 verified that on 12/11/15 while providing care to R2, E6 left R2's bed in the high position while E6 turned away to talk with E4 (CNA Supervisor). E6 stated that while E6 was providing care to R2, E4 called into R2's room multiple times asking to speak to E6. E6 stated, "I told E4 just a minute and E4 said E4 needed me to step out." E6 verified leaving R2 unattended with the bed in the high position so E6 could look around R2's privacy curtain to speak with E4. E6 stated that E6 heard a loud sound, turned back toward R2's bed, and saw R2 on the floor. E6 stated R2's head was bleeding around the right eye.

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S9999	Continued From page 4 On 12/16/15 at 11:20a.m. E4 verified talking to E6 from the hallway on 12/11/15 while E4 was caring for R2. E4 stated that E6 looked around R2's privacy curtain to talk with E4. E4 stated, "...then there was a thump and R2 was on the floor." E4 verified that E4 and E6 lifted R2 back into bed before R2 was assessed by a nurse. E4 verified R2 was bleeding from a cut around R2's right eye. E4 stated, "I know I shouldn't have picked up R2 off the floor." On 12/17/15 at 8:50a.m. Z1 (R2's Hospital Physician) verified R2's fracture to the right eye socket and subarachnoid hemorrhage were new injuries consistent with the trauma R2 sustained when R2 fell from the bed at the facility 12/11/15. (A)	S9999		

IMPOSED PLAN OF CORRECTION

Sharon Health Care Elms
Complaint Investigation 1526817/IL82146 & IRI of 12/09/2015/IL82152
DATE OF SURVEY: December 17, 2015

300.610a)
300.1210a)
300.1210b)
300.1210c)
300.1210d)6)
300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

a) *Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.* (Section 3-202.2a of the Act)

Attachment B
Imposed Plan of Correction

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) *An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.* (Section 2-107 of the Act)

This will be accomplished by the following:

1. Conduct an in-service on following a resident's Plan of Care, Resident's Safety, Resident falls, etc.

2. The facility will conduct an investigation of needed training. Take appropriate actions to see that employees involved will receive education and training as needed regarding the above topic.

3. Each employee whose duties might include direct care of residents who are at risk for falls shall provide a return demonstration of the skills covered in the above in-services not more than ten days after the in-service. These demonstrations shall be monitored by the facility's Director of Nursing Services who shall maintain documentation of staff performance.

4. Any new facility employee will be required to review the in-service and demonstrate competency prior to being allowed to care for residents who are at risk for falls without direct supervision.

5. The DON shall be responsible for making periodic observations of resident direct care, re-in servicing staff as necessary, and documenting any problems observed and corrective action taken.

Attachment B
Imposed Plan of Correction

The Administrator and Director of Nurses will monitor Items I through VII to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Within ten (10) days of receipt of this plan of correction.

1/26/2016/LJK

Attachment B
Imposed Plan of Correction