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	12/22/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on interview and record review the facility failed to follow Physician ordered wound treatments and implement Registered Dietician recommendations for wound healing for one (R1) of three residents reviewed for pressure ulcers in a sample of 13. Finding Include:The facility's Physician's Order Policy (not dated) documents, The purpose of this policy is to establish guidelines for the ordering, processing, and management of physician's orders in a long-term care facility, ensuring compliance with State and Federal regulations, and promoting the health and safety of residents. Order implementation, orders must be implemented promptly by licensed nursing staff according to the facility's protocols. The facility's Pressure Ulcer Preventive Measures policy (not dated) documents, Residents at risk for the development of pressure ulcers receive interventions to reduce the risk of pressure ulcers. Procedure: 26. Maintain adequate intake of protein, calories, and fluids by offering support with eating. 27. Provide nutritional support and/or food supplements (protein, calories, vitamin C, and zinc) for nutritionally compromised residents. R1's Wound Physicians note, dated 2/12/2025, documents, Stage three pressure wound of the right, lateral foot. Wound size: 2.5 cm (centimeters) x 4 cm x not measurable, depth is unmeasurable due to presence of nonviable tissue and necrosis. Procedure note, surgically excised 10 cm of devitalized tissue and necrotic subcutaneous level tissues were removed at a depth of 0.3 cm (centimeters). R1's Wound Physicians note, dated 2/19/2025, documents, Stage three pressure wound of the right lateral foot, wound size, 2 cm x 1 cm x not measurable due to presence of nonviable tissue and necrosis. Procedure note, surgically excised 1.4 cm of devitalized tissue and necrotic subcutaneous level tissues were removed at a depth of 0.3 cm. R1's Wound Physicians note, dated 2/26/2025, documents, Stage four pressure wound of the right lateral foot, wound size, 2.2 cm x 1.5 cm x not measurable due to presence of nonviable necrosis. Procedure note, surgically excised 2.31 cm of devitalized tissue and necrotic muscle level tissues were removed at a depth of 0.6 cm. R1's Wound Physicians note, dated 3/12/2025, documents, Stage four pressure wound of the right lateral foot, wound size 2 cm x 1.5 cm x not measurable due to presence of nonviable tissue and necrosis. Procedure note, surgically excised 2.10 cm of devitalized tissue and necrotic muscle level tissue were removed at a depth of 0.7 cm. R1's Registered Dietician note, dated 3/14/2025, documents, Recommendation, 30 ml (milliliters) protein liquid BID (twice daily) x (times) 30 days (wound healing). R1's current medical record no documentation of facility addressing the Registered Dietician's recommendation on 3/14/25 of implementing protein liquid for wound healing. R1's Wound Physicians note, dated 3/19/2025, documents, Stage four pressure wound of the right lateral foot, wound size 2.3 cm x 1.5 cm x not measurable due to presence of nonviable tissue necrosis. Procedure note: surgically excised 2.42 cm of devitalized tissue and necrotic muscle level tissues were removed at a depth of 0.7 cm.R1's Wound Physicians note, dated 3/26/2025, documents, Stage four pressure wound of the right lateral foot, wound size 1.8 cm x 1.5 cm x not measurable due to presence of nonviable tissue and necrosis. Procedure note, surgically excised 1.89 cm of devitalized and necrotic muscle tissues were (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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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	removed at a depth of 0.6 cm.R1's TAR (Treatment Administration Record), dated 3/1/2025-3/31/2025, has no documentation of R1's physician ordered wound care being performed on R1's right lateral foot three out of 31 days (3/9, 3/16, 3/23). R1's Registered Dietician note, dated 4/3/2025, documents, Recommendation, 30 ml protein liquid BID x 30 days (wound healing). R1's current medical record has no documentation of the facility implementing the Registered Dietician's recommendation on 4/3/25 of implementing protein liquid for wound healingR1's Wound Physicians note, dated 4/9/2025, documents, Stage four pressure wound of the right lateral foot, wound size 1.8 cm x 1.5 cm x not measurable due to presence of nonviable tissue and necrosis. Procedure note, surgically excised 1.62 cm of devitalized tissue and necrotic muscle level tissues were removed at a depth of 0.7 cm. R1's Treatment Administration Record, dated 4/1/2025-4/30/2025, has no documentation of R1's physician ordered wound care being performed on R1's right lateral foot two out of 30 days (4/2, 4/3).On 12/18/2025 at 2:01 PM, V2 (Director of Nursing) confirmed there was no documentation of R1's wound care being done on 3/9, 3/16, 3/23, 4/2, and 4/3/25. On 12/18/2025 at 2:00 PM, V1 (Administrator) confirmed days were missing on R1's TAR and stated, If it wasn't documented, it didn't happen. On 12/17/2025 at 2:00 PM, V14 (Wound Doctor) stated not following the Registered Dietician recommendation to give liquid protein, and not following the physician ordered wound treatments would most definitely contribute to R1's wounds worsening.

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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 - Immediate jeopardy to resident health or safety 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** Based on interview and record review the facility failed to ensure that a resident received adequate supervision and dietary management to prevent a choking incident for one of three residents (R2) reviewed for choking in the sample of six. These failures resulted in the resident (R2) consuming food inconsistent with his prescribed mechanical soft diet, leading to a fatal choking event at the facility.These failures resulted in an Immediate Jeopardy that began on 7/23/25. While the Immediate Jeopardy was removed on 12/17/25, the facility remains out of compliance at a severity level two. Additional time is needed to monitor the effectiveness of the implementation of protocols and oversight visits.Findings include: The facility's undated policy titled Food Brought in by Visitors documents that visitors must notify nursing staff prior to providing outside food to a resident. The policy further documents that nursing staff are responsible for confirming whether the food complies with the resident's prescribed diet, allergies, and swallowing precautions.R2's census record documents R2 was admitted to the facility on [DATE].R2's Minimum Data Set (MDS) dated [DATE] documents R2 was cognitively impaired.R2's Hospital After Visit Summary dated 7/23/2025 documents diet instructions of soft-to-digest foods, one-on-one feeding assistance, and aspiration precautions.R2's Physician Orders dated 7/23/2025 documents R2 was admitted with a general diet with regular texture and consistency. This diet order remained unchanged through 10/15/25, the date of R2's death.R2's Care Plan dated 7/23/2025 (R2's Admission) through 10/15/2025 (R2's Death) revealed no documentation identifying R2 as an aspiration risk. The Care Plan did not include documentation that R2 was on a mechanical soft diet or that R2 required staff observation while eating. Additionally, the Care Plan lacked documentation R2 was non-compliant with dietary restrictions and that education had been provided to R2 or family members regarding R2's diet restrictions.R2's Nurse Progress Notes dated 7/23/2025 (R2's Admission) through 10/15/25 (R2's Death) revealed no documentation that staff educated R2's family regarding R2's dietary needs, including permitted or prohibited food items related to swallowing precautions.R2's Nurse Progress Note dated 10/15/2025 by V5 (Wound Nurse) documents, At approx. (approximately) 1840 (6:40 PM) CNA (Certified Nursing Assistant) yelled out that the resident (R2) was choking. All nursing staff present to initiate [NAME] maneuver process. Resident(R2) was sitting in his wheelchair, when nursing staff arrived, the resident appeared bent down, cyanotic, unresponsive with his mouth full of food. 911 called, resident (R2) assisted to the ground; faint pulse verified; CPR (Cardio-Pulmonary Resuscitation) measures initiated by nursing staff. (POA/Power of Attorney/V4) present and stated she had brought the resident a roast beef sandwich from (brand name food chain restaurant.) POA (V4) stated she knows the resident (R2) is on a mechanical soft diet. AMT (Advanced Medical Transport) on scene at approx. 1847(6:47 PM) to take over medical care. AMT call to on-call MD (Medical Doctor) advised medical personnel to stop CPR. Coroner notified at 1855 (6:55PM). Coroner arrived at 2050 (10:50PM). POA (V4) present with expired resident (R2) until Funeral Home arrival per Coroner at 2130 (11:30 PM). Coroner stated there will be no autopsy done due to unnatural death and the Funeral Home will sign certificate. On call notified. Administrator (V1) notified. MD notified.On 12/15/2025 at 11:30 AM, V4 (R2's Family Member) stated V4 brought food to R2 weekly, including a roast beef sandwich and a soda. V4 stated facility staff were aware she brought food weekly and never informed her it conflicted with R2's diet. V4 stated that on 10/15/25, an unknown nurse assisted V4 in carrying the food to R2's room and told R2 she would return later to take him outside to smoke. V4 stated the unknown nurse observed V4 placing sauce on the sandwich and told R2, I'll be back. V4 stated R2 took several bites, appeared to struggle, and V4 instructed R2 to slow down and drink. V4 stated R2's (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	eyes became wide, he crushed the cup in his hand, and V4 yelled for help. V4 stated staff immediately responded and initiated emergency interventions. V4 stated staff asked who brought the roast beef sandwich, and V4 informed them she brought food weekly to R2. V4 stated staff then informed her R2 was on a mechanical soft diet and should not have eaten the sandwich. V4 further stated R2 had difficulty communicating as R2 had garbled speech and was confused, so R2 would have not been aware of any dietary restrictions or could communicate that with V4.On 12/15/2025 at 11:00 AM, V3 (Registered Nurse) stated that on 10/15/25 V4 arrived at the facility with a container V3 believed contained soda. She stated V4 had concealed a folded (fast food restaurant) bag inside the container and stated V4 frequently brought food and snacks to R2. V3 stated R2 was a very fast eater and drinker and would consume food and beverages quickly. V3 stated V4 went into R2's room and V3 left the room. V3 stated that approximately five minutes later, an unknown CNA (Certified Nursing assistant) began yelling that R2 was choking. V3 and V5 (Wound Nurse) initiated the Heimlich maneuver. V3 stated R2 began turning blue, at which point staff assisted R2 to the floor and initiated CPR (Cardiopulmonary Resuscitation) until emergency medical services arrived. V3 stated staff performed repeated mouth checks in attempts to clear R2's airway but were unsuccessful.On 12/15/2025 at 11:10 AM, V5 (Wound Nurse) stated that on 10/15/25 V5 arrived at the facility at the start of her shift and heard an unknown CNA yelling that someone was choking. V5 stated she went down the hallway and observed R2 sitting in his wheelchair while staff attempted the Heimlich maneuver. V5 stated R2 turned blue, and staff were unable to locate a pulse, at which time R2 was assisted to the floor and CPR was initiated. V5 stated R2's family member stood in the room during the incident and did not speak. V5 stated an unidentified CNA reported that R2 had choked on a roast beef sandwich.On 12/16/2025 at 11:15 AM, V6 (Dietary Manager) stated that when a resident admits to the facility the nurse fills out a diet slip and gives to V6, so she knows what diet is ordered and then she makes out a diet card for staff to know what meals to serve. V6 stated that R2 was a Mechanical Soft Diet upon admission and during R2's stay at the facility. V6 stated R2 ate in dining room and would eat very fast. V6 verified that R2's Physician orders and Care plan does not match what R2 was being served at the facility and that the only communication V6 was given is that R2 was a mechanical soft diet. On 12/16/2025 at 12:00 PM, V2 (Director of Nursing) stated she never spoke with R2's family during his stay. V2 stated R2 was on a mechanical soft diet and acknowledged it was her error that the physician order was entered incorrectly by V2 on admission. V2 stated R2's aspiration risk and diet should have been included in the care plan and V2 was unaware they were not.On 12/16/2025 at 12:20 PM, V7 (Care Plan Coordinator/MDS) stated dietary care plans are entered by V6 Dietary Manager. V7 stated she relied on the diet order entered in the computer and did not review hospital discharge instructions. V7 stated she never spoke with R2's family regarding R2's diet. V7 stated staff informed her that R2's family brought snacks and fast-food weekly.On 12/16/2025 at 12:40 PM, V8 (Certified Nursing Assistant) stated R2's sister typically came to the facility on second shift, so V8 did not see V4 often. V8 stated R2 was on a mechanical soft diet, however R2 had a bin of snacks in his room that included items such as pretzels, prepackaged breakfast pastries, crackers and soda. V1 (Administrator) was notified of the Immediate Jeopardy on 12/17/2025 at 9:05 AM.The surveyor confirmed through observation, interview, and record review that the facility took the following actions to remove the Immediate Jeopardy:1.R2 is no longer at risk for the alleged deficiencies. R2 expired on 10/15/2025. 2.On 12/17/2025 V2 initiated daily Nursing Huddles to review resident diets and any residents requiring one on one supervision during meals. On 12/17/2025 V17 notified all families of residents of the facilities policy on visitors bringing in outside food as well as what the residents diet restrictions are.3.On 12/17/2025 V2 and V6 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	completed an audit of all residents' diet orders.4.All resident dietary cards were reviewed and verified by the Dietary Manager and the Director of Nursing on 12/17/2025. 5. The front desk personnel have been in-serviced regarding food that is delivered, or that comes into the facility from friends or family on 12/17/2025 by ADON. The front desk staff must stop the family member or delivery services and notify the nurse in charge of the resident receiving the food, informing that nurse that outside food had been delivered. The nurse will then review the food and ensure that all the items are consistent with resident dietary orders/restrictions6.The IDT (Inter-Disciplinary Team) reviewed the policy on food brought in by visitors and implemented modifications to the policy to address the new review process on 12/17/20257. A mandatory all-staff training was initiated by V19 (Assistant Director of Nursing) on 12/17/2025 to review the revised Policy on food brought in by visitors and resident diets/ restrictions. All staff members were in serviced before start of next shift.8. On 12/17/2025, a copy of the revised policy on food brought in by visitors was mailed by V18 (Social Services Director) to all resident responsible parties/families.9. The new policy on food brought in by visitors has been added to the new admission pack on 12/17/2025 by V18. Completion Date 12/17/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on interview and record review the facility failed to follow Registered Dietician recommendations to obtain weekly weights to monitor for and prevent further weight loss for one (R1) of four residents reviewed for nutrition in a sample of six. Findings include:R1's Care Plan, dated 12/22/2025 documents, R1 has had a significant weight loss 6.1% (percent) in one month weight 153.3 lbs. (pounds), R1 eats 50% sometimes less. R1 will get up from table before completing his meals. R1's significant weight loss 10.7% (percent) in three out of six months (December 2024-March 2025).R1's Registered Dietician note dated 1/24/2025 documents, Weight on 12/16/2024, 163 lbs. (pounds), weight on 1/10/2025, 153 lbs. Weight change: weight loss of 10 lbs/6.1% (percent) in one month. Recommendation: weekly weight.R1's Weight Summary, dated 1/2025, documents R1's weight was only obtained once during the month of January on 1/10/2025 (153.3lbs (pounds)).R1's Registered Dietician note dated 2/26/2025 documents, Nutritional weight change note, weight 145.8 lbs. (pounds), more than 30-day weight of 1/10/2025: 153.3 lbs. (5% (percent) weight loss), Recommendation: continue weekly weights.R1's Weight Summary, dated 2/2025, documents R1's weight was only obtained once during the month of February on 2/19/2025 (145.8lbs).R1's Registered Dietician note dated 3/14/2025 documents, Nutritional weight change, recommendation: continue weekly weights X (times) four weeks.R1's Weight Summary, dated 3/2025, documents R1's weight was only obtained twice during the month of March on 3/13/2025 (156 lbs.) and 3/21/2025 (155 lbs.).R1's Registered Dietician note dated 4/3/2025 documents, Nutritional wound note, recommend continuing recording weekly weights X four weeks.R1's Weight Summary, dated 4/2025, documents R1's weight was only obtained once during the month of April on 4/5/2025 (153 lbs.).On 12/17/2025 at 1 PM, both V8 and V16 (Certified Nurse Assistants) stated they thought R1 was only monthly weights. They have not obtained weekly weights on R1 because they were not aware R1 was on weekly weights.On 12/17/2025 at 1:15 PM, V11 (Registered Nurse) confirmed weekly weights were not performed on R1. V11 stated she was not aware he needed them weekly.On 12/17/2025 at 11:38 AM, V12 (Registered Dietician) confirmed she puts her recommendations in dietary notes, nursing staff is to refer to notes and place orders per medical doctor. V12 stated she recommended R1 to be on weekly weights due to his significant weight loss to monitor his weight loss or gain.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to date multi-use medications upon opening, discard expired medications, and double lock controlled substances for seven residents (R7, R8, R9, R10, R11, R12, R13) reviewed for medication storage in a sample of 13. Findings Include:The facility's Storage of Medications policy (not dated) documents, No discontinued, outdated, or deteriorated drugs or biologicals may be retained for use. All such drugs must be returned to the issuing pharmacy or destroyed in accordance with our established procedures governing the destruction of medication. 14. All controlled substances must be stored under double lock and key.The facility's Labeling of Drugs and Medications policy (not dated) documents, All drugs and biologicals must be properly labeled and legible at all times. 11. f. Other as appropriate or necessary.On 12/15/2025 at 11:00 AM, a facility medication cart contained: R7's opened Lantus vial with no documented date of when it was opened; R8's opened insulin garlgine vial with no documented date of when it was opened. R8's insulin garlgine had also expired on 12/12/2025; R8's Latanoprost Ophthalmic eye solution that expired on 10/28/2025; R8's opened insulin aspart vial with no documented date of when it was opened; R9's Breo Ellipta inhaler that expired on 10/28/2025. On 12/15/2025 at 11:15 AM, a facility's medication room contained an unlocked refrigerator. The refrigerator contained drawers to store controlled substances. Each of the drawers were not locked. R9's lorazepam 0.5 mg (milligrams) IM (intramuscular) (Schedule IV) was in the unlocked drawer. On 12/15/2025 at 11:15 AM, V3(Registered Nurse) confirmed the refrigerator drawers were unlocked and contained R9's lorazepam. V3 also confirmed R7 and R8's medications in the medication cart were opened without a documented opened date, and they should have been labeled with an opened date. V3 also confirmed R8 and R9's expired medications should have been discarded.On 12/15/2025 at 11:30 AM, a facility medication cart contained: R10's opened bottle of levetiracetam liquid with no documented date of when it was opened; R11's Anro Ellipta inhaler that expired on 10/25/2025; R12's Anro Ellipta inhaler that expired on 10/25/2025; R13's Breo Ellipta inhaler that expired on 11/22/2025; R8's Basaglar KwikPen that expired on 10/3/2025.On 12/15/2025 at 11:45 AM, V11 (Registered Nurse) confirmed R10's medication was opened without an opened date documented. V11 also confirmed R8, R11, R12, and R13's medications were expired medications, and they should have been discarded.On 12/22/2025 at 1:30 PM, V2 (Director of Nursing) confirmed all multi use medications need to be labeled with a date they were opened, and all expired medications need to be discarded correctly. V2 also confirmed all controlled substances should be double locked.