

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0032789		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/22/2025	
NAME OF PROVIDER OR SUPPLIER SHARON HEALTH CARE ELMS				STREET ADDRESS, CITY, STATE, ZIP CODE 3611 NORTH ROCHELLE , PEORIA, Illinois, 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) COMPLETION DATE	
S0000	Initial Comments		S0000			01/08/2026	
	Investigation of Facility Reported Incident of 10-15-2025/2653153						
S9999	Final Observations		S9999			01/20/2026	
	Statement of Licensure Violations						
	300.610a)						
	300.1210a)						
	300.1210b)						
	300.1210c)						
	300.1210d)6)						
	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						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 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. These requirements were not met as evidenced by: 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. 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 7/23/2025.			S9999			

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S9999	Continued from page 2 R2's Minimum Data Set (MDS) dated 7/30/2025 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 Helmick 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			S9999			

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S9999	Continued from page 3 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 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		S9999				

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S9999	Continued from page 4 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. "A"		S9999				