

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145615	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER Allure of Sterling		STREET ADDRESS, CITY, STATE, ZIP CODE 612 West St Mary's Street Sterling, IL 61081	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34491</p> <p>Based on interview and record review, the facility failed to notify a resident's representative after a fall with injury, and failed to notify the representative that the resident was sent out to a local hospital for 1 of 3 residents (R1) reviewed for resident injury in the sample of 8.</p> <p>The findings include:</p> <p>R1's Admission Record, provided by the facility on 5/14/2025, showed he was admitted to the facility on [DATE] with diagnoses including unspecified dementia, malignant neoplasm of head, face and neck, and hypertension. R1's 5/8/2025 Clinical Admission assessment showed R1 was confused and had severe cognitive impairment affecting all areas of judgement. The assessment showed R1 had wandering behaviors, was occasionally incontinent of urine and frequently incontinent of bowel.</p> <p>On 5/13/2025 at 9:06 AM, V1 (Administrator) said R1 had 2 falls in the facility on 5/8/2025. V1 said the first fall was earlier, while R1's family was in the building. V1 said R1 had another fall later that night after being put in bed.</p> <p>On 5/13/2025 at 1:57 PM, V4 (Licensed Practical Nurse-LPN) said she was working when R1 fell on [DATE]. V4 said it was around 10:30 PM. V4 said she could not recall which Certified Nursing Assistant (CNA) told her that R1 was found on the floor. V4 said she assessed R1, and he did not complain of pain at first. V4 said after they got him back into bed, R1 complained of left hip and knee pain. V4 said she thinks she just sent R1 out to the emergency room after he complained of pain. V4 said she left a message for R1's doctor and then notified his family. V4 was asked who the family member was she spoke to. V4 said she did not remember. V4 was informed this surveyor had just spoken with R1's family and they were not aware that he had a second fall in the facility. V4 said she thought she called them to let them know he was being sent to the hospital. V4 said, I sure thought I did. I don't know. I will be honest with you, and I hate to admit it, but my memory isn't the best.</p> <p>(continued on next page)</p>

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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/13/2025 at 1:25 PM, V13 (R1's daughter and POA) said R1 was admitted to the facility Thursday night. R1 was sent out to the hospital later and no one from the facility called the family to let them know that he was sent out. V13 said R1 had a fall earlier that night while V14 (R1's other daughter and POA) was still at the facility. V13 was asked if R1 had another fall and that is why he was sent out. V13 said no, he only had the one fall in the facility. V14 was on the phone call and agreed R1 had only had the one fall in the facility, and that neither of them was notified that R1 had been sent out to the hospital. V13 said at 12:55 AM they received a call from the emergency room doctor asking if they wanted R1 to have surgery due to a fractured hip. V13 said that is how they found out that R1 had been sent to the hospital.</p> <p>R1's 5/8/2025 progress notes do not show R1's daughters/POAs were notified of the fall, or that he was sent out to the hospital. R1's 5/8/2025 incident reports showed a fall at 4:45 PM, and another fall at 10:30 PM.</p> <p>The facility's 2024 policy and procedure titled Notification of Changes showed the purpose of the policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies consistent with his or her authority, the resident's representative when there is a change requiring notification. The policy showed circumstances requiring notification include accidents resulting in injury and the potential to require physician intervention. The policy also lists a transfer or discharge of the resident from the facility as a circumstance requiring notification.</p>		