

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 06/11/2025
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on observation, interview, and record review the facility failed to prevent resident to resident physical abuse for one resident (R3) of three residents reviewed for abuse in the sample of 3.</p> <p>The Findings include:</p> <p>Comprehensive Cognitive Assessment indicates R3 is moderately impaired and has diagnosis of Mild Intellectual Disabilities.</p> <p>Incident Investigation Report dated 6/6/25 at 2:45pm indicates R3 was asked if someone hit her and R3 responded, Yes. My Roommate.</p> <p>Incident Investigation Report dated 6/6/25 at 2:45pm indicates R2 denied hitting R3 and stated that if she did, she didn't mean to.</p> <p>On 6/6/25 at 2pm, R3 was lying in bed and when asked if her previous roommate (R2) had ever hit her. R3 responded Yes. When asked where she was hit, R3 made eye contact and stated, All over. R3 denied being physically hurt.</p> <p>According to resident Census/Room assignments, both R2 and R3 were roommates until 5/28/25 when R2 was moved to another room on the same hall. R3 did not have another roommate after 5/28/25.</p> <p>Current Comprehensive Assessment indicates R2 is independent with mobility.</p> <p>Current Care Plan indicates R2 prefers to have a private room and has been manipulative and rude to past roommates (Revised 10/4/24).</p> <p>Current Comprehensive Assessment indicates R3 is total assist with transfers via mechanical lift and only has limited use of her right arm; Hemiplegia/Hemiparesis affecting left side.</p> <p>Social Service Progress Note dated 5/28/25 at 9:38am indicates R2 and guardian were notified and in agreement with the room move due to roommate preferences.</p> <p>Progress Note dated 5/29/25 at 2:48pm indicates R2 was noted to have behaviors of delusional thinking regarding their roommate. Intervention added of room move.</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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Social Service Progress Note dated 5/28/25 at 9:41am indicates R3 and POA (Power of Attorney) notified of room move due to resident preference for window side of room.</p> <p>On 6/10/25 at 3pm V7, LPN (Licensed Practical Nurse) stated I don't remember who told me. I did hear (R2) was on (R3's) bed and that (R2) hit (R3). V7 stated she heard it as gossip and stated she didn't know if it was true or not. V7 stated, I heard in passing that's why (R3) was moved.</p> <p>On 6/10/25 at 2:45pm V2, ADON (Assistant Director of Nursing) stated she heard R2 was on R3's side of the room before they were moved.</p> <p>On 6/11/25 at 7:15pm V8, LPN stated R2 was found on R3's side of the room insisting it was R2's side.</p> <p>On 6/6/25 at 3:25pm V3, SSD (Social Service Director) denied R2 was moved to another room due to the alleged altercation of R2 and R3.</p> <p>Progress Notes did not include any documentation regarding a potential physical altercation between R2 and R3 or that R2 was insisting R3 was on the wrong side of the room.</p> <p>Facility Policy/Abuse, Neglect and Exploitation dated 2025 documents:</p> <p>It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation resident property. Physical Abuse includes, but is not limited to hitting, slapping, punching, biting and kicking.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview and record review the facility failed to report allegations of abuse to the Abuse Coordinator for three residents (R1, R2, R3) of three residents reviewed for abuse in the sample of 3.</p> <p>Findings include:</p> <p>Comprehensive Cognitive Assessment indicates R1 is moderately impaired and has diagnosis of Mild Intellectual Disabilities.</p> <p>On 6/5/25 at 1:15pm R1 stated (with V1, Administrator present) that [female staff member name] threw her up against the wall and she hit the left side of her head. R1 stated it hurt, but she didn't cry and there was no bump or anything. R1 identified [female staff member name] as a night shift CNA (Certified Nurse Assistant). R1 was unable to state the day/date of this incident.</p> <p>On 6/6/25 at 11:30am R1 stated (with V5, Hospice RN/Registered Nurse present) that [female staff member name] got her dressed for bed one night and then threw her against the wall getting her into bed. R1 stated that she hit the left side of her head It didn't hurt, I didn't cry but it made me mad. R1 stated that [female staff member name] does not have the temperament for the job and has a bad attitude. R1 stated that she told V7, LPN (Licensed Practical Nurse) the nurse who comes in the morning and stated V7 told R1 she would report her concerns.</p> <p>On 6/10/25 at 10:45am V9, CNA stated that about two weeks ago she was getting R1 out of bed in the morning and R1 told V9 Thank God it's you, because last night [female staff member name] threw me in the bed. V9 stated she was pretty sure there wasn't any staff by the name of [female staff member name] and (R1) talks all the time. V9 stated while she was still assisting R1 - V5, Hospice Nurse came into the room and V9 asked V5 if she knew who [female staff member name] was and if she had ever heard R1 talk about her. V5 told V9 that (V5) knew about R1's allegations and that (V5) was handling it.</p> <p>V9 stated she did not tell V1, Administrator or any other facility staff about R1's allegations. V9 acknowledged even if someone is cognitively impaired their allegations should be reported to their supervisor or to V1, Administrator.</p> <p>On 6/5/25 at 3:45pm V5, Hospice RN stated that R1 did tell her that a CNA named [female staff member name] had been rough while helping her to bed About 3-4 weeks ago and she reported R1's allegations to V2, ADON (Assistant Director of Nursing) at that time. V5 stated that she believed R1 was referring to V12, CNA who was usually R1's CNA on night shift. V5 stated she was told that R1 sometimes refers to V12 as [female staff member name] although that is not V12's name.</p> <p>On 6/6/25 at 2pm V7, LPN stated she also heard R1 calls V12 by [female staff member name]</p> <p>On 6/5/25 and again on 6/10/25 V2, ADON denied V5 reported any allegations of abuse to her regarding R1 or any other resident.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1 was consistent in her reporting of allegations throughout the investigation. Internal reporting of an allegation of abuse was not implemented until reported to the V1, Administrator by the State Agency surveyor on 6/5/25.</p> <p>2) Current Comprehensive Assessment indicates R2 is independent with mobility.</p> <p>Current Comprehensive Assessment indicates R3 is total assist with transfers via mechanical lift and only has limited use of her right arm; Hemiplegia/Hemiparesis affecting left side.</p> <p>According to resident Census/Room assignments - both R2 and R3 were roommates until 5/28/25 when R2 was moved to another room on the same hall.</p> <p>Social Service Progress Note dated 5/28/25 at 9:38am indicates R2 and guardian notified and in agreement with room move due to roommate preferences.</p> <p>Progress Note dated 5/29/25 at 2:48pm indicates R2 noted to have behaviors of delusional thinking regarding roommate. Intervention added of room move.</p> <p>Social Service Progress Note dated 5/28/25 at 9:41am indicates R3 and POA (Power of Attorney) notified of room move due to resident preference for window side of room.</p> <p>On 6/10/25 at 3pm V7, LPN stated, I don't remember who told me - I did hear (R2) was on (R3's) bed and that (R2) hit (R3). V7 stated she heard it as Gossip and stated she didn't know if it was true or not. V7 stated, I heard in passing, that's why (R3) was moved.</p> <p>On 6/10/25 at 2:45pm V2, ADON stated that she did hear that R2 was on R3's side of the room before they were moved.</p> <p>On 6/6/25 at 2pm, R3 was lying in bed and when asked if her previous roommate (R2) had ever hit her - R3 responded Yes. When asked where she was hit, R3 stated, All over. R3 denied being physically hurt.</p> <p>Progress Notes did not include any documentation regarding a potential physical altercation between R2 and R3.</p> <p>No internal reporting of R2 being physically aggressive with R3 was made until 6/6/25 when State Agency surveyor reported the allegation to V13, Regional Nurse Consultant.</p> <p>Facility Policy/Abuse, Neglect and Exploitation dated 2025 documents:</p> <p>It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation resident property.</p> <p>The facility will have written procedures that include:</p> <p>Reporting of alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframe's:</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.</p> <p>The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on interview and record review the facility failed to protect one resident (R1) from further potential abuse for 1 of three residents reviewed for abuse in the sample of 3.</p> <p>Findings include:</p> <p>On 6/5/25 at 1:15pm R1 stated (with V1, Administrator present) that [female staff member name] threw her up against the wall and she hit the left side of her head. R1 stated it hurt, but she didn't cry and there was no bump or anything. R1 identified [female staff member name] as a night shift CNA (Certified Nurse Assistant).</p> <p>On 6/6/25 at 11:30am R1 stated (with V5, Hospice RN/Registered Nurse present) that [female staff member name] got her dressed for bed one night and then threw her against the wall getting her into bed. R1 stated that she hit the left side of her head, it didn't hurt, I didn't cry but it made me mad. R1 stated that [female staff member name] does not have the temperament for the job and has a bad attitude. R1 stated that she told V7, LPN (Licensed Practical Nurse) the nurse who comes in the morning and stated V7 told R1 she would report her concerns. R1 never referred to the CNA in question [female staff member name] by any other name. R1 stated she could not recall if [female staff member name] cared for her after the incident or not.</p> <p>On 6/10/25 at 11:45am V7 denied R1 reported being thrown into bed [female staff member name]. V7 stated R1 usually just sits next to her and talks non-stop has a very soft voice and is difficult to understand at times. V7 stated R1 may have thought she told V7, But I might not have really been listening.</p> <p>On 6/10/25 at 10:45am V9, CNA stated that about two weeks ago she was getting R1 out of bed in the morning and R1 told V9 Thank God it's you, because (last night) [female staff member name] threw me in the bed. V9 stated she was pretty sure there wasn't any staff by that name and (R1) talks all the time. V9 stated while she was still assisting R1 - V5, Hospice Nurse came into the room and V9 asked V5 if she knew who [female staff member name] was and if she had ever heard R1 talk about her. V5 told V9 that (V5) knew about R1's allegations and that (V5) was handling it.</p> <p>V9 stated she did not tell V1, Administrator or any other facility staff about R1's allegations. V9 acknowledged even if someone is cognitively impaired their allegations should be reported to their supervisor or to V1, Administrator.</p> <p>On 6/5/25 at 3:45pm V5, Hospice RN stated that R1 did tell her that a CNA named [female staff member name] had been rough while helping her to bed About 3-4 weeks ago and she reported R1's allegations to V2, ADON (Assistant Director of Nursing) at that time. V5 stated she did look at R1's head and did not find any signs of injury. V5 stated that she believed R1 was referring to V12, CNA who was usually R1's CNA on night shift. V5 stated she was told that R1 sometimes refers to V12 as [female staff member name] although that is not V12's name.</p> <p>On 6/6/25 at 2pm V7, LPN stated she also heard R1 calls V12 [female staff member name].</p> <p>Current list of all nursing staff employed at the facility were reviewed and no staff named [female staff member name] was identified.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/5/25 at 1:15pm V1, Administrator stated the facility does not utilize CNA Agency staff.</p> <p>On 6/5/25 at 3:55pm V1 confirmed that V12 had quit yesterday due to an assignment dispute.</p> <p>Human Resources: Change in Status Form indicates V12 Walked out and quit on 6/4/25 and was terminated from employment at that time.</p> <p>Prior to 6/4/25 - Time Card Reports indicate V12 remained working at the facility on Night shift until 6/4/25.</p> <p>V5, Hospice Nurse stated she reported R1's allegation to V2, ADON 3-4 weeks ago, V2 denied receiving the allegation from V5.</p> <p>V9, CNA stated that R1 reported the allegation to her approximately 2 weeks ago and V9 did not report R1's allegation to any facility staff.</p> <p>V12, CNA was not suspended pending investigation and continued to work primarily as R1's CNA until 6/4/25.</p> <p>Facility Policy/Abuse, Neglect and Exploitation dated 2025 documents:</p> <p>It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation resident property.</p> <p>Protection of Resident:</p> <p>The facility will make all efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to:</p> <p>Responding immediately to protect the alleged victim and integrity of the investigation;</p> <p>Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed;</p> <p>Increased supervision of the alleged victim and residents.</p> <p>Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator;</p> <p>Protect from retaliation;</p> <p>Providing emotional support and counseling to the resident during and after the investigation, as needed.</p>		