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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>145615 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing   | (X3) DATE SURVEY COMPLETED<br><br>08/09/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Allure of Sterling |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>612 West St Mary's Street<br>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.

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| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                             |
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review the facility failed to ensure a resident at risk for elopement was supervised for 1 of 3 residents (R3) reviewed for safety and supervision in the sample of 3. The findings include: R3's admission record documents he was admitted on [DATE] with a diabetic foot ulcer and cellulitis. R3's elopement evaluation of 8/5/25 shows he had a history of elopement or attempted elopement while at home. Scoring a 1 for risk of elopement. No risk factors for elopement were identified, and no clinical suggestions or interventions were checked on the form. On 8/9/25 at 8:50 AM, V6 Licensed Practical Nurse (LPN) said on 8/5/25 R3 was observed going to the front door asking for family members to give him a ride. V6 said V8 Registered Nurse placed a wander guard bracelet on him so if he was attempting to go outside the alarm would sound. V6 did not recall where the wander guard came from or who gave it to V8 to put it on him. V6 said the next day on 8/6/25, R3 went to the front door in his wheelchair and had removed the wander guard so the alarm would not sound, and he left the facility. V6 said he was located at the gas station down the road. On 8/9/25, a message was left for V8, but no return call was received. On 8/9/25 at 8:55 AM, R3 said he was admitted to the facility for an infection to his foot, and he was on the other side of the facility for therapy. R3 stated the following: R3 can walk on his own but uses his wheelchair for longer distances. R3 was not happy his kids put him in the facility, so he left and was going to his friend's house. R3 did not tell anyone he was leaving; he just took off. R3 removed the wander guard because it would have made the door squeal when he left. R3 headed towards route 40 and made it to the gas station. R3 said he waited at the crosswalk to go across the highway. R3 said at the gas station he was put into a car and returned to the facility. R3 denied any falls, or injury and walked the entire distance without any issues. During the interview R3 was ambulating without assistance in his room. R3 had no visible injuries and spoke clearly of the event. On 8/9/25 at 1:00 PM, V9 LPN said R3 resided on the 200 wing and did not have any exit seeking behaviors. V9 said V12 CNA came to inform her R3 was asking family members to give him a ride. V9 said she completed the task she was doing and went to speak with R3, but he was not in his room or in the lobby. She said his wheelchair was by the front door and his wander guard was on the floor. V9 said she informed V6 to announce a missing resident, and all staff began to search for him. V9 said she left out the front door and went towards the east and the rest of the staff went west. Once she turned, she could see him down the road. R3 had a sack with him and was talking to a couple that were on the road. V9 said the couple assisted R3 across the highway to the gas station. Once at the gas station, V10 CNA arrived with the facility van, and V12 arrived with her mother in a private vehicle to assist with getting R3 back to the facility. V9 said R3 refused to get into the facility van but would get into the car. V9 said R3 was out of the facility for about 10 minutes total and had no injury noted upon assessment. On 8/9/25 at 2:25 PM, V1 Administrator said she was notified of the elopement around 6:00 PM, it was shift change. V1 was advised R3's wheelchair was found by the front door, and he had removed a wander guard. V1 said she was not aware R3 had a wander guard and could not determine who ordered it or placed it on R3. V1 said there is a process for placing a resident on such a device. It should have an assessment, care planning and orders. The facility's 4/16/21 policy for elopements and wandering residents the facility ensures that residents who exhibit wandering behavior and or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk.</p> |  |  |