

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  12/03/2025
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 - Immediate jeopardy to resident health or safety</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>(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
---	-------	-----------

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  12/03/2025
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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, and record review the facility failed to ensure a resident (R1) was not sexually abused by another resident (R2) for 1 of 3 residents reviewed for sexual abuse in the sample of 5. This failure resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 11/19/25 when facility staff failed to ensure R2 did not enter R1's room and have sexual activity with R1. Both R1 and R2 have cognitive impairment and lack the ability to consent for sexual activity. V1 Administrator was notified of the Immediate Jeopardy on 12/3/25 at 8:15 AM. The surveyor confirmed by observation, record review, interview that the Immediate Jeopardy was removed on 12/3/25, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. The findings include: The Face Sheet dated 11/27/25 for R1 showed diagnoses including dementia, sleep disorder, general anxiety disorder, emphysema, chronic obstructive pulmonary disease, trigeminal neuralgia, hypertension, hyperlipidemia, osteoporosis, and urinary tract infection. The Nurse Practitioner (NP) note dated 11/11/25 for R1 showed she was being seen for a scheduled psychiatric follow up. R1 demonstrated behaviors consistent with her ongoing neurocognitive decline but was attentive and responded appropriately to all inquiries. Alerted and oriented X1 (person). Recent and remote memory: poor. Attention span and concentration: poor. The Minimum Data Set - MDS dated [DATE] for R1 showed severe cognitive impairment. On 11/27/25 at 9:09 AM, V1 Administrator stated R1 and R2 are two residents that are close. They were in R1's room together. V9 CNA (Certified Nursing Assistant) walked into R1's room and R1 and R2 were naked. R2 was standing over R1 with his right hand on the wall and left hand under R1's shoulder. R1 was leaning back. V9 stated she saw R2's buttocks and asked them what they were doing. V9 told R2 to leave the room. V1 stated V9 got V8 the nurse. V1 stated V10 (R1's daughter) was notified when this happened. V1 stated this incident occurred on 11/19/25 and was not reported to the state. V1 stated she did an investigation and since no intercourse happened, she did not report it. V1 stated she asked V9 if R2 had an erection when he turned around and she said he didn't. They were not on top of each other. V1 stated there wasn't any sexual act going on; they were just naked. V1 stated she did an abuse investigation and did not report it because no sexual intercourse happened. On 11/27/25 at 10:10 AM, V1 stated V8 Licensed Practical Nurse - LPN called her the night it happened and V1 directed her to interview R1 and do a skin check. V1 stated it is not documented in R1's chart and she does not know why it wasn't. V1 stated she did not know why V8 did not do a risk assessment and put it into the chart. V1 stated normally a risk assessment is done and entered in the resident's chart so they have all the details. V1 stated it should be documented in the chart that the family was notified. V1 stated she notified R1's family on 11/19/25 so the lack of documentation is on her for that. On 12/1/25 at 9:14 AM, V10 (R1's daughter/Power of Attorney - POA) stated I was called on Wednesday (11/19/25) night when she was sleeping. V10 stated she talked to V1 Administrator Thursday (11/20/25). V1 at first said that there was sexual contact with R2 and R1. V1 said she still needed to talk to the CNA to get more information and then would talk to V10. V1 called V10 back and said both were naked. R1 was sitting on the bed in front of R2 giving him oral sex. R2 wasn't erect but R1 was performing oral sex. V1 had told V11 (R1's son) when she talked to him that R1 was laying down and R2 was leaning over her; R1 was giving R2 oral sex, so the story had changed. V10 stated that bothered them. V10 stated V2 Director of Nursing - DON called and said she would like to get consent for medication for R1 in case she had any anxiety. V10 stated if they need permission for R1 to have the medication, have V10 present to read to R1 what she is signing, and go over the papers, then why do they think R1 can consent to this? V10 stated she did not think R1 has the ability to consent. V10 stated when she went to the facility for a meeting on Tuesday (11/25/25) she was told R2 was leaning over R1, he had her head in his hand and was holding her head there. V10 stated there were so many different stories. V10 stated on Saturday (11/29/25) when she went to see her, R1 told her that R2 raped her. V10 stated she told the facility what R1 said; she told the facility that R1 said R2 raped her. V10 stated R1 doesn't remember exactly what happened but said he raped her. V10 said she dislikes R2 and doesn't have anything good to say about him. V10 stated she did a video/audio recording on her phone of R1 telling her she was raped. On 12/1/25 at 11:14 AM, V10 and R1 were sitting in chairs in the dining room with the door closed and no other residents or staff present for the interview. R1 identified the person at the table with her as V10 her daughter. R1 was asked if anyone there had made any sexual advances and/or touched her in a sexual way. R1 stated, he raped me. R1 stated she couldn't think of the</p>		

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  12/03/2025
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 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>(continued on next page)</p>

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  12/03/2025
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 0609</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 interview, and record review the facility failed to report an allegation of sexual abuse for 1 of 3 residents (R1) reviewed for abuse in the sample of 5. The findings include: 1) A statement dated 11/19/25 by V9 Certified Nursing Assistant - CNA showed she went to R1's room around 8:30 PM to assist her to bed. V9 knocked on the door, stated who she was and walked in. V9 observed R1 on her bed. R1's right foot was on the floor; her left leg was half on the bed and half on the floor. R2 had his right hand on the wall, and his left hand was under R1's right shoulder. R2 was standing with his back to V9; she saw his butt. R2 was not laying on top of R1. A written statement (no date) by V8 Licensed Practical Nurse showed, R1 stated to her that she did not know who wanted the information and stated they had sex. The facility did not have any paperwork to show Illinois Department of Public Health was contacted with an initial allegation of abuse or a final investigation. On 11/27/25 at 9:09 AM, V1 Administrator was interviewed regarding any allegations of sexual abuse at the facility. V1 stated R1 and R2 are two residents that are close. They were in R1's room together. V9 CNA walked into R1's room and R1 and R2 were naked. R2 was standing over R1 with his right hand on the wall and left hand under R1's shoulder. R1 was leaning back. V9 stated she saw R2's butt and asked them what they were doing. V9 told R2 to leave the room. V1 stated V9 got V8 the nurse. V1 stated this incident occurred on 11/19/25 and was not reported to the state. V1 stated she did an investigation and since no intercourse happened, she did not report it. V1 stated it was a team decision. V1 stated she should have reported it. V1 stated it 'ate at her' to not report it. V1 stated any allegation is to be reported and then investigated. The Face Sheet dated 11/27/25 for R1 showed diagnoses including dementia, sleep disorder, general anxiety disorder, emphysema, chronic obstructive pulmonary disease, trigeminal neuralgia, hypertension, hyperlipidemia, osteoporosis, and urinary tract infection. The Nurse Practitioner note dated 11/11/25 for R1 showed she was being seen for a scheduled psychiatric follow up. R1 demonstrated behaviors consistent with her ongoing neurocognitive decline but was attentive and responded appropriately to all inquiries. Alerted and oriented X1 (person). Recent and remote memory: poor. Attention span and concentration: poor. The Minimum Data Set - MDS dated [DATE] for R1 showed severe cognitive impairment. The MDS dated [DATE] for R2 showed moderate cognitive impairment. The Face Sheet dated 11/27/25 for R2 showed diagnoses including dementia, adjustment disorder with mixed anxiety and depressed mood, type 2 diabetes mellitus, and hypertension. The Nurse Practitioner Note dated 11/25/25 for R2 showed he is alert and oriented x 2; he is able to explain why he is here and what his current health status is like. R2's recent and remote memory: fair. Attention span and concentration: fair. The facility's Abuse, Neglect, and Exploitation policy (2025) showed, reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. 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, or b. not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies. 2) The Social Service Note dated 6/9/25 at 4:08 PM for R1 showed, this writer was informed by CNA that resident was interested romantically in another resident in the memory care unit. This writer spoke with both R1 and the other resident (R3) and educated them to utilize public spaces to spend time together. This writer asked them not to spend any time together in each other's rooms. R1 and peer both agreed and stated they want to take it slow. Medical Director in facility and notified. No new orders. Voicemail left for V10 to notify. Requested call back. On 12/1/25 at 9:14 AM, V10 (R1's daughter/power of attorney - POA) stated there was an incident in June 2025 with R1 and R3 but there wasn't any documentation about what happened. V10 stated she found out recently from a CNA that R1 was in R3's bed and R3 had his pants down. V10 stated they were split up before anything happened. On 12/1/25 at 1:18 PM, V3 Assistant Director of Nursing -ADON stated the only thing she knew about the incident in June 2025 between R1 and R3 is that there was an episode reported by V15 CNA. V3 stated V16 previous Social Services and V17 previous Administrator handled the situation. V3 stated she heard R1 and R3 were found in bed together naked. V3 stated V18 LPN was the nurse for the June incident. V3 stated she assumed the incident was reported because with the RIMS (Brief Interview of Mental Status) that the residents involved</p>		

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  12/03/2025
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 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>(continued on next page)</p>

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  12/03/2025
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 0610</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 interview and record review the facility failed to investigate an allegation of abuse in June 2025 for 1 of 3 residents (R1) reviewed for abuse in the sample of 5. The findings include: The Social Service Note dated 6/9/25 at 4:08 PM for R1 showed, this writer was informed by CNA that resident was interested romantically in another resident in the memory care unit. This writer spoke with both R1 and the other resident (R3) and educated them to utilize public spaces to spend time together. This writer asked them not to spend any time together in each other's rooms. R1 and peer both agreed and stated they want to take it slow. Medical Director in facility and notified. No new orders. Voicemail left for V10 to notify. Requested call back. On 12/1/25 at 9:14 AM, V10 (R1's daughter/power of attorney - POA) stated there was an incident in June 2025 with R1 and R3 but there wasn't any documentation about what happened. V10 stated she found out recently from a CNA that R1 was in R3's bed and R3 had his pants down. V10 stated they were split up before anything happened. On 12/1/25 at 1:18 PM, V3 Assistant Director of Nursing -ADON stated the only thing she knew about the incident in June 2025 between R1 and R3 is that there was an episode reported by V15 CNA. V3 stated V16 previous Social Services and V17 previous Administrator handled the situation. V3 stated she heard R1 and R3 were found in bed together naked. V3 stated V18 LPN was the nurse for the June incident. V3 stated she assumed the incident was reported because with the BIMS (Brief Interview of Mental Status) that the residents involved have, they cannot consent to sex. V3 stated she does not know why it was not reported. On 12/1/25 at 2:58 PM, V16 previous Social Services stated she no longer works at the facility and doesn't remember much without her notes in front of her. V16 stated R1 and R3 were on a memory care unit, and they were close friends. V16 stated R1 and R3 wanted to be boyfriend and girlfriend. V16 stated she spoke to V22 (R3's POA). V16 could not remember if she spoke to V10 (R1's POA) or left a message for her. V16 stated she was not aware of anything else between R1 and R3. V16 stated she was not aware of R1 and R3 being in each other's room, being in each other's beds, or being naked together. On 12/1/25 at 4:00 PM, V4 Medical Director stated R1 is on a memory care unit for a reason. R1 cannot consent for herself. V4 stated the facility's policies and procedures should be followed. On 12/3/25 at 8:15 AM, V1 Administrator stated, V1 stated she does not know anything about what happened in June 2025 between R1 and R3. V1 stated she was not at this facility at that time. V17 was the Administrator, and she is no longer with the company. V1 stated there isn't an investigation for anything in June and there is no abuse investigation in the last six months except now they have one for R1 and R2 because of what happened recently. On 12/3/25 at 8:26 AM, V12 Certified Nursing Assistant - CNA stated in June she was working on the memory care unit and went to do her rounds. V12 went past R3's room and his door was shut, so she knocked on the door, and went into the room. V12 stated R3's bed was the farthest bed and the curtain was drawn. V12 stated she was going to leave but she saw R1's walker in the room. V12 stated R3 was standing up next to the bed, had a white t-shirt on and underwear. R1 was laying on R3's bed but had her clothes on. V12 stated she escorted R1 out of the room and then reported it to the nurse. V12 stated she told the nurse. On 12/3/25 at 8:47 AM, V18 Licensed Practical Nurse - LPN stated on a day at the beginning of June around 5:00 PM a CNA came and told her that R1 and R3 were in bed together but had their clothes on. The CNA said she separated them and then came to get her. V18 stated she reported it to V17 previous Administrator who told her not to put anything in the notes in the resident's charts. V17 told her that V16 previous Social Services would take care of it. V12 stated she thought the nurse contacted the Administrator at the time. V12 stated no one from management talked to her about what happened. V12 stated she was taught that anything like this has to be reported immediately so she reported it. On 11/27/25 the facility did not have any Abuse Investigations in the last 6 months. The Face Sheet dated 11/27/25 for R1 showed diagnoses including dementia, sleep disorder, general anxiety disorder, emphysema, chronic obstructive pulmonary disease, trigeminal neuralgia, hypertension, hyperlipidemia, osteoporosis, and urinary tract infection. The Nurse Practitioner note dated 11/11/25 for R1 showed she was being see for a scheduled psychiatric follow up. R1 demonstrated behaviors consistent with her ongoing neurocognitive decline but was attentive and responded appropriately to all inquiries. Alerted and oriented X1 (person). Recent and remote memory: poor. Attention span and concentration: poor. The Minimum Data Set - MDS dated [DATE] for R1 showed severe cognitive impairment. The Face Sheet dated 11/27/25 for R3 showed diagnoses including dementia without behavioral disturbance, hypertension, morbid obesity, hypokalemia, adjustment disorder, and anxiety.</p>		

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  12/03/2025
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on interview and record review the facility failed to ensure resident medical records contained complete and accurate information for 1 of 3 residents (R1) reviewed for medical records in the sample of 5. The findings include: The Social Service Note dated 6/9/25 at 4:08 PM for R1 showed, this writer was informed by CNA that resident was interested romantically in another resident in the memory care unit. This writer spoke with both R1 and the other resident (R3) and educated them to utilize public spaces to spend time together. This writer asked them not to spend any time together in each other's rooms. R1 and peer both agreed and stated they want to take it slow. Medical Director in facility and notified. No new orders. Voicemail left for V10 to notify. Requested call back. On 12/1/25 at 9:14 AM, V10 (R1's daughter/power of attorney - POA) stated there was an incident in June 2025 with R1 and R3 but there wasn't any documentation about what happened. V10 stated she found out recently from a CNA that R1 was in R3's bed and R3 had his pants down. V10 stated they were split up before anything happened. On 12/1/25 at 1:18 PM, V3 Assistant Director of Nursing -ADON stated the only thing she knew about the incident in June 2025 between R1 and R3 is that there was an episode reported by V15 CNA. V3 stated V16 previous Social Services and V17 previous Administrator handled the situation. V3 stated she heard R1 and R3 were found in bed together naked. V3 stated V18 LPN was the nurse for the June incident. V3 stated she assumed the incident was reported because with the BIMS (Brief Interview of Mental Status) that the residents involved have, they cannot consent to sex. V3 stated she does not know why it was not reported. V3 stated the note entered into R1's chart doesn't match the story of what happened. The note states so and so wanted a relationship and not that they were found in bed together. On 12/1/25 at 2:58 PM, V16 previous Social Services stated she no longer works at the facility and doesn't remember much without her notes in front of her. V16 stated R1 and R3 were on a memory care unit, and they were close friends. V16 stated R1 and R3 wanted to be boyfriend and girlfriend. V16 stated she spoke to V22 (R3's POA). V16 could not remember if she spoke to V10 (R1's POA) or left a message for her. V16 stated she was not aware of anything else between R1 and R3. On 12/1/25 at 4:00 PM, V4 Medical Director stated R1 is on a memory care unit for a reason. R1 cannot consent for herself. V4 stated the facility's policies and procedures should be followed. V4 stated what happens should be recorded/documented. On 12/3/25 at 8:47 AM, V18 Licensed Practical Nurse - LPN stated on a day at the beginning of June around 5:00 PM a CNA came and told her that R1 and R3 were in bed together but had their clothes on. The CNA said she separated them and then came to get her. V18 stated she reported it to V17 previous Administrator who told her not to put anything in the notes in the resident's charts. V17 told her that V16 previous Social Services would take care of it. The facility's Documentation in Medical Record policy (2025) showed, licensed staff and interdisciplinary team members shall document all assessments, observations, provided in the resident's medical record in accordance with state law and facility policy. Documentation shall be factual, objective, and resident centered. False information shall not be documented. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care.</p>		