

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  01/07/2026
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)		
F 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to supervise residents in a manner that prevented resident injury for one of six residents (R1) reviewed for safety/supervision in the sample of six. This failure resulted in R1 obtaining a large skin tear that required sutures at the local hospital emergency room and increased pain. This past noncompliance occurred from January 1, 2026-January 2, 2026. The findings include: R1's admission Record dated January 7, 2026 shows that she was admitted to the facility on [DATE] with diagnoses including heart disease, long term use of anticoagulants, diabetes mellitus, major depressive disorder, anxiety disorder, morbid obesity, need for assistance with personal care, history of falling, and muscle wasting. R1's Care Plan initiated September 29, 2021 shows, The resident has potential/actual impairment to skin integrity related to fragile skin, long term use of anticoagulants, diabetes mellitus, major depressive disorder, impaired mobility, and weakness. R1's Care Plan revised on March 18, 2022 shows, The resident needs assistance/escort to activity functions. R1's Progress Notes dated January 1, 2026 shows, This nurse was called to the 400 hallway. [R1] was bleeding all over the floor and on her hand. Cleansed with normal saline and observed skin tear/laceration. Unable to approximate some edges with steri strips and some areas on the right hand were deeper than others. The laceration/skin tear goes from the middle finger at the knuckles all the way up in between 2nd and middle finger to her wrist. Resident transported to local emergency room via ambulance. R1's hospital records dated January 1, 2026 shows, Right hand with significant multilayer laceration exposing extensor tendons over the second metacarpal and phalange as well as the third metacarpal. Assessment and plan: Upon evaluation she had a pretty extensive deep laceration that measured proximately 12 cm X 6 cm. She was dressed with a nonstick dressing and put in a splint to promote adequate healing and to prevent disruption of the sutures to the back of her hand. R1's Progress Notes dated January 2, 2026 at 1:36 AM shows that R1 received 19 sutures and is on an antibiotic for infection prevention. R1's Progress Notes dated January 2, 2026 at 5:34 PM shows that R1 received a new order for narcotic pain medications due to right hand injury. R1's Progress Notes dated January 3, 2026 at 2:17 PM shows it was apparent during the breakfast meal that R1 needed increased assistance for meal and obtaining items that may or may not be too heavy. R1 voiced complaints of pain to her hand. R1's Progress Note dated January 4, 2026 at 2:50 AM shows R1 was three days post right hand injury. R1 was having a hard time with day-to-day function, including self-feeding. R1's Progress Note dated January 6, 2026 at 6:23 AM shows R1 has a right-hand laceration and is in pain frequently which is being controlled with scheduled pain medication. R1's Progress Note dated January 7, 2026 at 3:44 AM shows R1 was in pain and rating her pain at seven out of ten scale. The facility's Root Cause Analysis shows R1 received a laceration on top of her right hand when she became entangled in the food cart. R6 (who utilizes an electric wheelchair) went to help R1 by moving the food cart out of the way when he accidentally bumped his controller causing his wheelchair to move. R1's</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  145615	Facility ID:  145615  If continuation sheet Page 1 of 2

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>hand got caught under R6's wheelchair controller causing the laceration. On January 7, 2026 at 11:00 AM, R1 was in her recliner in her room. R1's right hand was covered in an ace bandage. R1 said she had pain to her right hand. R1 said that staff put her at the nurses' station and left her there. R1 said she was tired and decided to take herself back to her room when she became caught on a food tray. R1 said she cut her hand on the meal cart when she got tangled in it. R1 said she is having a hard time feeding herself now because she is right-handed. At 11:33 AM, R6 was sitting in a motorized wheelchair in his room. R6 said R1 got stuck in the metal tray cart and he did not want the metal tray cart to tip onto R1, so he tried to help R1 get unstuck. R6 said there was no staff in the hallway. R6 said he must have bumped the controller on his wheelchair and his chair moved and scratched R1's hand. R6 said he felt horrible it happened. On January 7, 2026 at 11:14 AM, V4 Licensed Practical Nurse (LPN) said R1 was pretty good with her activities of daily living prior to her injury to her hand. V4 said R1 now has difficulties with eating because she is right-handed. V4 said she had to write something down for R1 because R1 couldn't write since she is right-handed. V4 said R1 also experiences more pain than she did before. On January 7, 2026 at 1:07 PM, V2 Director of Nursing (DON) said she believed staff were in the process of picking up meal trays during the incident with R1's hand and R6. V2 said no staff saw that R1 was stuck in the tray cart. V2 said staff usually push R1 in her wheelchair back to her room after meals. V2 said staff placed R1 at the nurses' station and got called in a different direction. V2 said she expects staff to transport residents back to their rooms when they are done eating and their call lights are given to them. The facility's Accidents and Supervision policy dated 2025 shows, The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. All staff are to be involved in observing and identifying potential hazards in the environment. The facility will provide adequate supervision to prevent accidents. Prior to the survey date of January 7, 2026, the facility had taken the following action to correct the noncompliance: On January 2, 2026, the facility held an emergency quality assurance performance meeting to discuss the facility's incident and accident policy and come up with a plan of correction. On January 2, 2026, R6's motorized wheelchair was evaluation for any safety concerns- none were found. On January 2, 2026, all food trays were evaluated with no concerns identified. R6 was re-evaluated for his motorized wheelchair safety. On January 2, 2026, all staff were in serviced on accidents/supervision and placement of meal carts. The administrator or designee will ensure the food tray cart is placed in the nutrition room to avoid further incidents.</p>		