STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145615	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allure of Sterling	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to notify a resident's physician regarding an injury sustained when a mechanical sling lift tipped and hit the resident on the top of the head for 1 of 4 residents (R4) reviewed for improper nursing care in the sample of 8. The findings include:R4's face sheet, provided by the facility on 4/21/26, showed she had diagnoses including, but not limited to ulcerative colitis, fracture of right clavicle, pain in right shoulder, low back pain, pain in unspecified right knee, benign neoplasms of ascending, descending and transverse colon, post-hemorrhagic anemia, complete intestinal obstruction, colostomy, restless legs syndrome, muscle weakness, lack of coordination, unilateral primary osteoarthritis left hip, and gastrointestinal hemorrhage.R4's facility assessment dated [DATE] showed she was cognitively intact, had no behaviors, used a wheelchair for mobility, and was dependent on staff for toileting, bathing, dressing, bed mobility and transfers. R4's ADL (activities of daily living) care plan, initiated on 9/2/25, showed she had an ADL self-care performance deficit related to activity intolerance, fatigue, impaired balance, and limited mobility. The care plan showed that R4 requires a Mechanical Lift with two staff assistance for transfers.On 4/16/26 at 9:00 AM, R4 said a newer CNA (Certified Nursing Assistant) (V14) transferred her with a mechanical sling lift and the mechanical sling lift hit her on top of the head when she was being lowered into her wheelchair. R4 said her head was bleeding and it hurt a lot at first. R4 said she was crying when it happened. R4 lowered her head, so this surveyor could see the injury. R4 had about an inch long, dark, purplish-colored scab on the top of her head. On 4/21/26 at 9:48 AM, V3 (Licensed Practical Nurse-LPN/Wound Nurse) said she does not know if the nurse called R4's doctor to inform him about the incident on 3/10/26. V3 said she did not update R4's doctor. On 4/21/26 at 10:45 AM V8 said she did not notify R4's doctor after the incident occurred on 3/10/26. V8 stated, I was just supposed to be passing meds that day. Of course, you want to deal with any resident issue that comes up. (V9) and (V10) (LPNs) took over because she was leaving at 10:00 AM. V8 said she documented in the incident report that V21 (R4's doctor) was updated but she does not know who updated the doctor.On 4/21/26 at 12:19 PM, V9 (LPN) said she did not notify R4's doctor or assist in any way for the incident involving R4.On 4/21/26 at 12:34 PM, V10 (LPN) said she is not aware who updated the doctor regarding R4's incident on 3/10/26, adding it was not her (V10). On 4/21/26 at 11:59 am, V21 (R4's previous physician and the facility's medical director at the time of the incident) said he does not recall the facility notifying him about the mechanical sling lift hitting R4 on the head.On 4/21/26 at 1:55 PM, V2 (Director of Nursing/DON) said she asked V3 (Wound Nurse) to assist V8 (RN) with the assessment and documentation. V2 said she believed V21 was R4's doctor at that time. V2 said V21 did not have a nurse practitioner. V2 said she was not sure which nurse would have notified the doctor. V2 said she just said R4's wound looks like it does not need to be treated. V2 said she was not implying that she did not need to be sent out, just that it did not look like she needed stitches.R4's initial incident report dated 3/10/26 showed during transfer the top of (R4's) scalp was scraped by the mechanical lift. Pressure applied to scalp. Neuro checks initiated. Wound care provided. Skin check completed. The incident report showed injuries observed at the time of the (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.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	report were an abrasion to the top of the scalp. Level of pain 10. The report showed injuries report post incident: No injuries observed post incident. The report showed V8 was the one that documented the report. V8 documented that V21 was notified of the incident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to do a thorough assessment of a resident's injury, failed to document an assessment of the injury in the resident's electronic medical record, and failed to initiate a treatment for 1 of 4 residents (R4) reviewed for improper nursing care in the sample of 8.The findings include:R4's face sheet, provided by the facility on 4/21/26, showed she had diagnoses including, but not limited to ulcerative colitis, fracture of right clavicle, pain in right shoulder, low back pain, pain in unspecified right knee, benign neoplasms of ascending, descending and transverse colon, post-hemorrhagic anemia, complete intestinal obstruction, colostomy, restless legs syndrome, muscle weakness, lack of coordination, unilateral primary osteoarthritis left hip, and gastrointestinal hemorrhage.R4's facility assessment dated [DATE] showed she was cognitively intact, had no behaviors, used a wheelchair for mobility, and was dependent on staff for toileting, bathing, dressing, bed mobility and transfers. R4's ADL (activities of daily living) care plan, initiated on 9/2/25, showed she had an ADL self-care performance deficit related to activity intolerance, fatigue, impaired balance, and limited mobility. The care plan showed that R4 requires a Mechanical Lift with two staff assistance for transfers.On 4/16/26 at 9:00 AM, R4 said a newer CNA (Certified Nursing Assistant) (V14) transferred her with a mechanical sling lift and the mechanical sling lift hit her on top of the head when she was being lowered into her wheelchair. R4 lowered her head, so this surveyor could see the injury. R4 had about an inch long, dark, purplish-colored scab on the top of her head. R4 said no treatment was started and they did not measure the injury on the top of her head. On 4/21/26 at 9:48 AM, V3 (Licensed Practical Nurse-LPN/Wound Nurse) said did assess R4 the morning that the mechanical sling lift fell on her. V3 said V10 asked her to look at R4. V3 said V10 looked at it too. V3 said she did not do a full assessment of R4's wound. She looked at it and recommended they call the doctor because R4 may need to be sent out. V3 said V2 (Director of Nursing) went down to assess R4 and said it looked fine, and no treatment was needed. V3 said she did not document an assessment for the wound on R4's head. V3 said she measured the wound and wrote it down on paper but did not document an assessment in R4's electronic medical record. V3 said no treatment was initiated for R4's injury. At 9:58 AM V3 went with this surveyor to measure the wound on top of R4's head. It measured 1.9 centimeters (cm) x 0.2 cm x 0.0 cm. R4 was asked by this surveyor how often they measure the wound. R4 said today is the first time they have measured it. At 10:20 AM R4 said V3 would come in and look at it to see how it was doing, but there were no measurements done until today, and no treatment was put in place for it. V3 was asked to provide this surveyor with any documentation that she had regarding the wound on R4's head.On 4/21/26 at 10:45 AM V8 (Registered Nurse/RN) said she was working the day the incident happened with R4. V8 said she looked at R4's injury quickly then went to get the equipment to take her vitals. V8 said V9 and V10 (LPNs) went down to see R4. V8 said V10 said the wound just looked like an abrasion. V8 said V9 and V10 took over the care for R4. V8 said she did not do an assessment of the wound or document an assessment of the wound. V8 said she was not sure what the aftercare treatment was. On 4/21/26 at 12:19 PM, V9 (LPN) said she was working on a different hall the day of the incident. V9 said she did not see R4's wound or do an assessment of the wound or assist in any way. V9 said it looked like they had enough people in R4's room to handle the situation so she went back to her area.On 4/21/26 at 12:34 PM, V10 (LPN) said she was working on a different hall the day R4 got hit by the mechanical lift. V10 said V9 got R4's vitals. V10 said she was up at the desk and V9 asked her to look at R4. V10 said the wound looked superficial from what she could see. V10 said she did not do an assessment of the wound or document any assessment. She said she went back to her hall.On 4/21/26 at 1:55 PM, V2 (Director of Nursing/DON) said she went down to look at R4 that morning after the mechanical lift hit her head. She was up in the chair and there was maybe an inch abrasion on her head that was already starting to form a scab. V2 said the wound was no longer bleeding. V2 said she asked V3 (Wound (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse) to assist V8 (RN) with the assessment and documentation. V2 said she just said it looks like R4's wound does not need to be treated. V2 said she was not implying that R4 did not need to be sent out, just that it did not look like she needed stitches. V2 said R4 was not bleeding at that time. V2 said R4 said she was not going anywhere right then. V2 said she let R4 know if she had any headaches, to let staff know and the doctor could be updated and decide if she needed to be sent out. V2 said she did not have any assessments from V4 for the wound on top of R4's head. V2 said V3 said she had one. V2 said an injury assessment should include a description of the wound, a full description of the skin issue, the appearance, including measurements, and any pain associated with the wound. V2 said it should all be in the initial incident report; however, it was not in the initial incident report. V2 said she has not seen any measurements or descriptions of the wound other than the next day on 3/11/26 when V10 (LPN) documented abrasion to top of scalp is closed. No drainage. No redness or swelling. The resident had no complaint of pain or discomfort. V2 said that is not an acceptable assessment of the wound either. V2 said no treatment was initiated. V2 said R4 still has a scab on her head, and it has been over a month.R4's initial incident report dated 3/10/26 showed during transfer the top of (R4's) scalp was scraped by the mechanical lift. Pressure applied to scalp. Neuro checks initiated. Wound care provided. Skin check completed. The incident report showed injuries observed at the time of the report were an abrasion to the top of the scalp. Level of pain 10. The report showed injuries report post incident: No injuries observed post incident. The report showed V8 was the one that documented the report.R4's electronic medical record showed no Weekly Skin Assessment for R4 on the day of the incident (3/10/26). The next Weekly Skin Assessment was dated 3/16/26. The assessment dated [DATE] only showed abrasion to top of scalp. No documentation of the size or appearance of R4's wound to her head was documented in the assessment. R4's progress notes showed R4 was not seen by her facility physician (V21) or the Nurse Practitioner until 4/6/26.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the safety of a resident during a mechanical sling lift transfer for 1 of 4 residents (R4) reviewed for improper nursing care in the sample of 8. The findings include: R4's face sheet, provided by the facility on 4/21/26, showed she had diagnoses including, but not limited to ulcerative colitis, fracture of right clavicle, pain in right shoulder, low back pain, pain in unspecified right knee, benign neoplasms of ascending, descending and transverse colon, post-hemorrhagic anemia, complete intestinal obstruction, colostomy, restless legs syndrome, muscle weakness, lack of coordination, unilateral primary osteoarthritis left hip, and gastrointestinal hemorrhage.R4's facility assessment dated [DATE] showed she was cognitively intact, had no behaviors, used a wheelchair for mobility, and was dependent on staff for toileting, bathing, dressing, bed mobility and transfers. R4's ADL (activities of daily living) care plan, initiated on 9/2/25, showed she had an ADL self-care performance deficit related to activity intolerance, fatigue, impaired balance, and limited mobility. The care plan showed that R4 requires a Mechanical Lift with two staff assistance for transfers.On 4/16/26 at 9:00 AM, R4 said a newer CNA (Certified Nursing Assistant) (V14) transferred her with a mechanical sling lift and the mechanical sling lift hit her on top of the head when she was being lowered into her wheelchair. R4 said V14 could not find anyone to help her, so she transferred her from her bed to her wheelchair by herself. R4 said her head was bleeding and it hurt a lot at first. R4 said she was crying when it happened. R4 lowered her head, so this surveyor could see the injury. R4 had about an inch long, dark, purplish-colored scab on the top of her head. On 4/16/26 at 4:00 PM, V1 (Administrator) was asked about the injury on R4's head. V1 said the injury was caused by the mechanical sling lift during a transfer. V1 said it was a single staff transfer. V1 said there should have been two staff doing the transfer. V1 said she provided staff education on proper transfers, adding, it is in my file. This surveyor requested all assessments and documents V1 had on the incident.On 4/21/26 at 9:48 AM, V3 (Licensed Practical Nurse-LPN/Wound Nurse) said the day the mechanical lift fell on R4's head, V10 asked her to look at R4. V3 said R4's wound was bleeding, but not a lot. V3 said there was a dime-sized amount of blood on the gauze. There was some blood in her hair. V3 said R4 could have already been cleaned up. V3 said R4 was upset when the incident happened and had pain when she (V3) cleaned it. It was very sensitive and sore. V3 said R4 still has a scab on it (over a month later). At 9:58 AM, V3 and this surveyor went to R4's room and measured the wound on top of R4's head. It measured 1.9 cm x 0.2 cm x 0.0 cm. At 10:04 AM, V3 said for the first three weeks R4's wound on the top of her head was sensitive and painful when touched.On 4/21/26 at 1:22 PM, V14 (CNA) said she started working at the facility in mid-January of 2025. V14 said she tried to get help transferring R4 when she went to bring the mechanical sling lift into R4's room but did not see any other CNAs down the other halls. V14 said she got R4 changed, got her ready to be transferred, and told R4 she would get her hooked up to the mechanical sling lift. V14 said R4 had told her before the day the incident happened that she was terrified of the mechanical sling lift. V14 said she started transferring R4 from her bed to the wheelchair. V14 said she hooked the sling to the mechanical lift and lifted R4 off the bed. V14 said she tried to get R4 aligned with the wheelchair, she (V14) was trying to adjust the sling to line her up with the chair when the mechanical sling lift tipped. V14 said R4 plopped down into the wheelchair and the mechanical lift hit her on top of the head. V14 said she felt terrible. V14 said R4 cried and screamed out that it hurt. V14 said she imagined it did hurt. V14 said she called the nurse to come check on her. V14 said R4's head had blood on it, at least at the site. V14 said she and another CNA cleaned the blood from the side of R1's head. There was blood on R4's shirt, she thinks it may have been from R4 wiping her hand on it. V14 said R4 complained of it hurting when she went back in later to check on R4 during the day. V14 said when the incident happened, she transferred R4 by herself. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V14 said there should be two staff for mechanical sling lift transfers.On 4/21/26, V8 (LPN) said she was the nurse working on 3/10/26 when the mechanical lift hit R4 on the head. V8 said a CNA notified her that while transferring R4 with the mechanical sling lift, something slipped, and the mechanical lift hit R4 on the top of the head. V8 said there was only 1 CNA doing the mechanical lift transfer and she believes, according to the facility policy, there should have been 2 CNAs. V8 said when she went into R4's room R4 was sitting in her wheelchair with a wet cloth to her head. V8 said R4 was actively bleeding on top of her head. V8 said she looked at it quickly then went to get the equipment to take R4's vitals. V8 said V9 and V10 (LPNs) came to look at R4, then V8 and V9 took over the incident. V8 said she documented the incident report. On 4/21/26 at 12:19 PM, V9 (LPN) said she was assigned to a different hall and heard the mechanical lift hit R4's head. V9 said she thought V3, and a CNA were cleaning it up when she went to R4's room to look at her. V9 said she did not see R4's wound. V9 said she does not recall who all was in the room at the time, but it looked like they had enough people in there to take care of the situation, so she went back to her hall.On 4/21/26 at 12:34 PM, V10 (LPN) said she was working another hall the day R4 got hit by the mechanical lift. V10 said V9 got R4's vitals. V10 said she was up at the nurses' desk and V9 asked her to look at R4. V10 said from what she could see, the wound looked superficial. V10 said V9 tried to clean it up and the blood was starting to coagulate. V10 said after looking at R4's wound, she went back to her hall.On 4/21/26 at 1:55 PM, V2 (Director of Nursing/DON) said she went down to look at R4 after the mechanical lift hit her head. R4 was up in the chair and there was maybe an inch abrasion on her head that was already starting to form a scab. V2 said it was that morning that I went in to look at R4. V2 said the wound was no longer bleeding. R4's progress note showed 3/10/2026 10:13 During transfer, top of Resident's scalp scraped by (mechanical sling lift). Pressure applied to scalp; Neuros initiated; wound care provided; skin check completed. MD and POA notified.R4's care plan initiated on 9/2/25 showed R4 requires Mechanical Lift with two staff assistance for transfers.The facility's 2025 policy and procedure titled Safe Resident Handling/Transfers showed It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. The policy showed 3. Mechanical lifting equipment or other approved transferring aids will be used based on the resident's needs to prevent manual lifting except in medical emergencies.10. Two staff members must be utilized when transferring residents with a mechanical lift.12. Staff members are expected to maintain compliance with safe handling/transfer practices.13. Resident lifting and transferring will be performed according to the resident's individual plan of care.