

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 09/26/2024
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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31615</p> <p>Based on interview and record review the facility failed to provide privacy for a resident during physician appointments for 1 of 1 residents (R13) reviewed for privacy in the sample of 19.</p> <p>The findings include:</p> <p>R13's admission record shows she was admitted to the facility on [DATE] with multiple diagnoses including spinal stenosis, difficulty walking and lack of coordination. The 8/26/24 annual resident assessment shows she is cognitively intact.</p> <p>On 9/25/24 at 11:00 AM, R13 said V5 (transportation coordinator) takes me to my doctor appointments but goes back into the office to see the doctor with her. R13 said she has asked (V5) to stay in the lobby as she can go see the doctor by herself, and V5 told her that was not possible, and was responsible for her and not able to let her out of her sight. R13 said she has requested privacy for her appointments, and V5 will not listen.</p> <p>On 9/25/24 at 2:00 PM, V5 said she transports residents to their appointments. She takes the paperwork with her and gives it to the nurses at the office. She also goes back into appointments with the resident so she can hear what is going on with them. She said no one has ever requested she not go in with them.</p> <p>On 9/26/24 at 10:25 AM V1 (Administrator) said, it depends on a residents cognition level, and the doctor's office whether V5 should be going into a residents appointment. Some residents are completely alert and oriented, and able to go alone if they choose. V1 said R13 is alert and able to make that decision for herself. V1 said, it would be their right, and a right to privacy.</p> <p>The facility's 2024 policy for resident right to privacy in communication shows it is the policy of this facility to support and facilitate a resident's right to privacy in communications with individuals and entities within and external to the facility.</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 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35175</p> <p>Based on observation, interview, and record review, the facility failed to identify a pressure injury prior to becoming a Stage 3, failed to assess a new pressure injury, and failed to implement pressure relieving interventions after a new wound was found for 1 of 6 of residents (R82) reviewed for pressure in the sample of 19.</p> <p>These failures resulted in R82 having a Stage 3 pressure injury for a week before an assessment was done, pressure relieving interventions were put into place and the pressure care plan interventions were updated.</p> <p>The findings include:</p> <p>R82's face sheet showed a [AGE] year-old female with diagnosis of mild protein calorie malnutrition, conversion disorder with seizures, intellectual disabilities, hypertension, dysphagia, malignant neoplasm of the uterus, and cognitive communication deficit.</p> <p>On 9/24/24 at 10:23 AM, R82 was in the hallway in a wheelchair. R82 was self-propelling the chair and leaned to the left.</p> <p>On 9/24/24 and 9/25/24, R82 was seen in her wheelchair and consistently leaned to the left.</p> <p>On 9/26/24 at 7:41 AM, V8 (Wound Doctor) said he expects a wound to be assessed by the nurse at the time it is found. V8 said, They shouldn't wait a week for me to look at it. The wound could deteriorate. [R82's] left mid back wound is a Stage 3 pressure injury. V8 measured the back wound as 3.0 centimeters (cm) X 2.5 cm X 0.1 cm. The wound had a reddened circumference, darkened center, and was circular in shape. V8 ran his finger on R82's back to show the staff present the wound was over the posterior rib cage. V8 told the staff, You don't want it to get any worse. It's right over the chest. V8 debrided the wound at the bedside. V6 (Licensed Practical Nurse) showed V8 R82's wheelchair and said she believed R82's back rubbed on the metal bar on the left side of the wheelchair as she usually leans that way. V8 asked V6 to have therapy apply a pad to the back of the chair to pad the area and alleviate pressure from the bar. V8 said the facility definitely should have implemented interventions to relive pressure to R82's back. V8 said, A cushion or something to provide pressure relief. An initial assessment is important to know if the treatment is doing the job or not. Is it getting better or worse? It helps you decide on the treatment.</p> <p>On 9/26/24 at 8:07 AM, V2 Director of Nursing (DON) said when a wound is found the nurse should do an assessment and document the assessment. V2 said, Documentation could be done in the progress note. Not every wound has a wound observation tool. There should be a wound note on the date the wound is found, and I don't see one for [R82's] wound. V2 was unable to show any care plan interventions initiated after finding the wound to R82's back. V2 said R82 is only in bed at night.</p> <p>R82's 5/22/24 admission skin assessment showed no open areas.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R82's physician order sheet showed a 9/19/24 order that she may see the wound care services. Another order dated 9/18/24 showed wound treatment orders to the mid back wound to start 9/19/24 (wound present 9/18/24).</p> <p>R82's wound doctor notes showed no mention or assessment of the left mid back wound.</p> <p>R82's pressure care plan interventions have had no updates since 5/2024.</p> <p>R82's 8/23/24 facility assessment showed moderate cognitive impairment.</p> <p>The facility's 1/3/22 Pressure Injury Prevention and Management Policy showed: The facility shall establish and utilize a systemic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; and modifying the interventions as appropriate. Licensed nurses will conduct a full body skin assessment on all residents after any newly identified pressure injury. Assessments of pressure injuries will be performed by a licensed nurse and documented on the _____ (left blank). After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment. Evidence based interventions for prevention will be implemented for all residents who have a pressure injury present. Interventions on a resident's care plan will be modified as needed. Considerations for needed modifications include new onset or recurrent pressure injury development.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>34891</p> <p>Based on observation, interview, and record the review the facility failed to transfer a resident in a safe manner for 1 resident (R343) and failed to ensure hazardous liquids and disposable razors were inaccessible for 1 sampled resident (R56) and 10 residents outside the sample (R43, R60, R34, R28, R22, R86, R75, R85, R33, R41).</p> <p>The findings include:</p> <p>1. On 9/26/24 the facility supplied a list of residents able to ambulate or propel independently on the dementia unit. The list included (R43, R56, R60, R34, R28, R22, R86, R75, R85, R33, R41).</p> <p>On 9/24/24 at 12:02 PM, the dementia unit shower room door was unlocked. The handle had a numbered keypad. This surveyor was able to fully access the room alone. Bins of mouth wash, skin and hair cleanser, hand sanitizer, body lotion, baby powder, and shaving cream were in the room. A spray bottle of glass and surface cleanser was hanging from a wire rack in the room. A bin with multiple disposable razors were in the room.</p> <p>On 9/25/24 at 9:16 AM, the shower room door was still unlocked, and the same items were in the room. The body lotion, skin and hair cleanser, hand sanitizer, and shave cream had caution labels stating: Keep out of reach of children. Instructions to Do not swallow and call the Poison Control Center immediately was on several items.</p> <p>The Safety Data Sheet for the glass and surface cleanser showed under the toxicological information section: Causes eye irritation. May be mildly irritating to sensitive skin. May cause irritation, nausea, vomiting and diarrhea. The sheet showed to keep out of reach of children.</p> <p>On 9/26/24 at 11:15 AM, V13 and V17 (Certified Nurse Aides) stated the door should always be locked. There are several residents that wander around on the unit. Some are known to grab supplies out of the room and take them to their own room. The door has a code to lock it and keep the residents away from the items in the shower room.</p> <p>On 9/26/24 at 10:15 AM, V2 (Director of Nurses) stated the shower room needs to be locked at all times. There are supplies in there that are potentially dangerous to the residents. Residents could open the door and get access to hazardous items when it is unlocked. It should never be left open. The door's keypad should be automatically locking when it closes. It is a safety issue for the confused residents that reside on the dementia unit.</p> <p>The facility's undated Accidents and Supervision policy states: The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents.</p> <p>2. R343's face sheet printed on 9/26/24 showed diagnoses including but not limited to lack of coordination, hypertension, and obesity.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R343's care plan showed a focus area dated 9/18/24 related to risk for falls due to deconditioning and gait/balance problems.</p> <p>On 9/24/24 at 10:43 AM, V9 and V10 (Certified Nurse Aides) were assisting R343 with toileting and peri care. R343 was unsteady and struggled to stand up during peri care. V9 and V10 instructed R343 to hold his walker, stand up, and walk across the room to his wheelchair. R343 needed verbal cues to hold the walker, walk upright, and go to a seated position in his wheelchair. V10 held the back of R343 pants and V9 held his forearm. R343 was weak and slow during the transfer. V9 and V10 did not apply a gait belt around R343 at any time during the peri care or transfer. A gait belt was observed hanging on the back of R343's room door.</p> <p>On 9/26/24 at 10:10 AM, V2 (Director of Nurses) stated gaits belts are needed to keep resident up during transfers. It gives staff more control and safety to steady the resident. It helps with balance. The therapy department determines who needs gait belts while transferring. It is a good indication one is needed if there is one in the room. V2 said staff should be using a gait belt with R343 during transfers.</p> <p>The facility's undated Use of Gait Belt policy states: It is the policy of this facility to use gait belts with residents that cannot independently ambulate or transfer for the purpose of safety.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35175</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident receiving oxygen had a physician order, failed to ensure oxygen and breathing treatment equipment was changed weekly and stored in a manner to prevent cross contamination for 3 of 3 residents (R19, R82, R14) reviewed for respiratory in the sample of 19.</p> <p>The findings include:</p> <p>1. R19's face sheet showed a [AGE] year-old female with diagnosis of acute respiratory failure, chronic obstructive pulmonary disease, obstructive sleep apnea, hypertension, and anxiety disorder.</p> <p>On 9/24/24 at 11:04 AM, R19 was in bed. R19 had oxygen being administered via nasal cannula at 2 liters per minute.</p> <p>At 1:30 PM, V7 Licensed Practical Nurse (LPN) said R19 has been on oxygen for at least six months.</p> <p>On 9/26/24 at 8:00 AM, V2 Director of Nursing (DON) said R19 should have an order for oxygen. It used to be as needed. Oxygen is a treatment which requires a physician order. Oxygen tubing and breathing treatment tubing should be dated when started and changed once a week for infection control purposes. Oxygen and nebulizer treatment tubing should be stored in a plastic bag to keep it clean.</p> <p>R19's physician order sheet (POS) had no current order for oxygen administration.</p> <p>R19 did not have an oxygen administration care plan.</p> <p>The facility's 4/1/24 Oxygen Administration Policy showed oxygen is administered under orders of a physician. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident assessment and orders, such as, but not limited to the type of oxygen delivery, when to administer, such as continuous or intermittent and/or when to discontinue, equipment setting for the flow rates. Change oxygen tubing and mask/cannula weekly and as needed if they become soiled or contaminated. Keep delivery devices covered in plastic bag when not in use.</p> <p>2. R82's face sheet showed a [AGE] year-old female with diagnosis of acute respiratory failure with hypoxia, asthma, atrial fibrillation, conversion disorder with seizures, intellectual disabilities, and pneumonia.</p> <p>On 9/24/24 at 10:23 AM, R82 was in the hallway in a wheelchair. R82 was self-propelling the chair and there was an oxygen tank on the back of the chair. The oxygen tubing attached to the tank had no date to indicate when it was initiated. The oxygen was not in use and the tubing was not stored in a plastic bag. It was wrapped around the top of the tank.</p> <p>On 9/25/24 at 11:01 AM, R82's oxygen concentrator in her room had a nasal cannula attached and lying on the floor. There was no date on the nasal cannula and the tubing was not stored in a plastic bag.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R82's current POS showed an order for oxygen at 2 liters per nasal cannula for saturations (sat) below 90% as needed to maintain oxygen (O2) sat above 90%.</p> <p>3. R14's face sheet showed an [AGE] year-old female with diagnosis of asthma, chronic obstructive pulmonary disease, chronic kidney disease, anxiety disorder, hypertension, bipolar disorder, and diabetes.</p> <p>On 9/24/24 at 11:08 AM, R14 was in bed with her eyes closed. There was a breathing treatment machine on the bedside table. The machine was not in use. The tubing was not stored in a bag and there was not date on the tubing.</p> <p>At 1:30 PM, V7 Licensed Practical Nurse (LPN) said she administered R14's two breathing treatments today. V7 said she did not know how old the nebulizer tubing was or when it needed to be changed. V7 confirmed she did not place the tubing in a plastic bag after the treatments.</p> <p>R14's current POS showed an order for albuterol nebulizer solution orally via nebulizer every four hours.</p> <p>R14's medication administration record (MAR) showed R14 was given a treatment 9/24/24 at 8:00 AM and 12:00 PM.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35175</p> <p>Based on interview and record review, the facility failed to administer two doses of an ordered antibiotic to 1 of 3 residents (R32) reviewed for hospitalization in the sample of 19.</p> <p>The findings include:</p> <p>R32's face sheet showed a [AGE] year-old male with diagnosis of urinary tract infection, multiple sclerosis, neuromuscular dysfunction of the bladder, calculus of the kidney and ureter, and chronic obstructive pulmonary disease.</p> <p>R32's 5/20/24 local hospital history and physical showed he had a suprapubic catheter and fever of 102 while at the facility. At the hospital R32 was found to have a urinary tract infection (UTI).</p> <p>R32's local hospital 6/2/24 hospitalist note showed R32 was diagnosed with sepsis likely source UTI, osteomyelitis, and infected decubitus ulcers.</p> <p>R32's facility census showed he returned to the facility on [DATE] after 14 days in the hospital.</p> <p>R32's 6/15/24 local hospital history and physical showed his workup in the emergency room revealed a urinary tract infection with fever, elevated white blood cell count, and early sepsis.</p> <p>R32's local hospital records showed admission on 6/15/24 and discharge back to the facility on [DATE].</p> <p>R32's 6/18/24 hospital discharge report showed to administer amoxicillin 500 milligrams (mg) by mouth three times a day for eight days.</p> <p>R32's census report showed he returned to the facility from a hospital stay on June 18, 2024, at 6:50 PM.</p> <p>The facility's stock drug convenience box list showed amoxicillin 250 mg capsules (six doses) were available on site.</p> <p>R32's June 2024 MAR showed the amoxicillin was not administered June 18, 2024, at 8:00 PM or on June 19, 2024, at 8:00 AM.</p> <p>On 9/26/24 at 7:58 AM, V2 Director of Nursing (DON) said there's no excuse for R32 not receiving his antibiotic doses on 6/18/24 and 6/19/24. If it didn't come from pharmacy both doses could have been taken out of the convenience box in the facility.</p> <p>The facility's 2024 Medication Administration Policy showed medications are administered by licensed nurse as ordered by the physician and in accordance with professional standards of practice.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>31615</p> <p>Based on interview and record review the facility failed to monitor food temperatures and failed to monitor and record dishwasher temperatures. This applies to all 90 residents residing in the facility.</p> <p>The findings include:</p> <p>The facility's 9/24/24 CMS (Centers for Medicare and Medicaid Services) 671 form shows 90 residents reside in the facility.</p> <p>1. On 9/24/24 at 8:53 AM V14 (Dietary Manager) said the dishwasher is a hot water sanitizer, and the temperature gets up to 200 degrees, there is a booster in place. The temperatures are checked before cleaning the dishes from each meal and should be logged and recorded. V14 said it is important to make sure the dishes are sanitized to ensure there is no bacteria that could cause food borne illnesses.</p> <p>The September 2024 dishwasher logs show no monitoring of the temperatures from 9/6/24 until 9/11/24, and no temperature recordings on 9/17/24.</p> <p>The facility's 2024 policy for dishwasher temperatures documents it is the policy of this facility to ensure dishes and utensils are cleaned under sanitary conditions through adequate dishwasher temperatures. 6. Water temperatures shall be measured and recorded prior to each meal and /or after the dishwasher has been emptied or re-filled for cleaning purposes.</p> <p>2. On 9/24/24 at 9:30 AM, V16 (Cook) said the food temperatures are checked prior to serving and are logged into the book. It is the responsibility of the cook to ensure this is done.</p> <p>The food temperature log for the week of 9/22/24 was reviewed and show no dinner temperatures of the food have been logged for the past 2 night meals.</p> <p>On 9/24/24 at 9:45 AM, V14 (Dietary Manager) said it is important to check the food temps before plating the food to make sure all the bacteria are killed to prevent food borne illnesses.</p> <p>The food temperature log shows the temperatures should be checked prior to serving the food, and again after half of the meals have been served.</p> <p>The facility's 2024 policy for record of food temperatures documents it is the policy of this facility to record food temperatures daily to ensure food is at the proper serving temperatures before trays are assembled.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>34891</p> <p>Based on observation, interview, and record review the facility failed to ensure PPE (personal protective equipment) was worn in a manner to prevent cross contamination for 2 residents (R71, R84) in the sample and 1 resident (R72) outside the sample.</p> <p>The findings include:</p> <p>1. R71's September 2024 order summary report showed an order for modified droplet/precautions with face/eye protection. Verify signage is on outside of door to identify the isolation every shift. R72's September 2024 order summary report showed an order for modified droplet precautions with face/eye protection. Verify signage is on outside of room to identify the isolation every shift.</p> <p>On 9/24/24 at 8:53 AM, V1 (Administrator/Infection Control Preventionist) stated R72 is in a COVID positive room. V1 said her roommate (R71) is also a COVID positive resident.</p> <p>On 9/24/24 at 10:24 AM, R71 and R72 had signage on the door indicating the room was on special droplet/contact isolation precautions. The sign showed everyone must, including visitors, doctors, and staff, wear an N-95 mask, eye protection, gown and gloves. A bin of the required PPE was located directly next to the door. At 10:26 AM, V11 (CNA-Certified Nurse Aide) entered the room wearing only a surgical mask. R71 was observed from the hallway seated in a wheelchair. V11 leaned in close to R71 and asked if she wanted anything to drink. V11 continued conversing with R71 for several minutes before exiting the room. R72 (roommate) was observed from the hallway and was lying in bed. V11 returned five minutes later and went into the room to deliver a cup of juice to R71. V11 wore only the surgical mask.</p> <p>On 9/24/24 at 12:32 PM, V13 (CNA) entered the room wearing only a surgical mask and delivered a lunch tray to R71. V13 remained in the room and assisted R71 with the lunch meal. At 12:35 PM, V11 (CNA) entered the room wearing only a surgical mask and delivered a lunch tray to R72. At no time were gowns, eye protection or N-95 masks worn.</p> <p>On 9/25/24 at 1:15 PM, V1 (Administrator/Infection Control Preventionist) stated anyone entering a COVID positive room needs eye protection, N-95 mask, gowns, and gloves on. The PPE should be donned at the door and removed before exiting. The sign clearly shows what needs to be worn in the room. The PPE stops the spread of germs to other residents and other areas. Staff are educated at multiple times during the year and should be aware of what to wear in that room.</p> <p>The facility's Infection Control Policy and Procedure For COVID-19 states under the universal PPE for healthcare providers' section: If a resident is suspected or confirmed to have COVID-19, HCP (healthcare providers) must wear an N95 respirator, eye protection, gown and gloves.</p> <p>(continued on next page)</p>		

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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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. On 9/25/24 at 9:15 AM, a sign was on the door to R84's room showing he was on enhanced barrier precautions. The sign stated staff must wear gloves and a gown for high contact resident care activities. Examples of high contact activities included transfers, changing briefs, toileting, and wounds. At 9:25 AM, V11 and V12 (CNAs) transferred R84 from his wheelchair to the toilet using a stand lift. The aides changed his brief and provided peri care then transferred R84 back to his wheelchair. The aides wore gloves but at no time did the aides wear a gown.</p> <p>On 9/25/24 at 1:24 PM, V1 (Administrator/Infection Control Preventionist) stated R84 has a wound to his left foot and is on enhanced barrier precautions. Staff need to wear gloves and gowns during care which includes transfers and toileting. Germs and infection can spread when the correct PPE is not worn.</p> <p>The facility's undated Enhanced Barrier Precaution policy states: PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. The policy listed several high-contact care activities including transferring, providing hygiene and wounds.</p>		