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	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allure of Sterling	612 West St Mary's Street Sterling, IL 61081

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to ensure a registered nurse was scheduled for eight consecutive hours a day, seven days each week. This failure has the potential to affect all residents in the facility. The findings include:The facility's CMS 671 form dated 12/16/25 showed 84 residents reside in the building. The facility's December 2025 nurse schedule was reviewed from 12/1/25 to 12/16/25. The working schedule showed no RN (Registered Nurse) coverage on 12/6 and 12/13. The facility was unable to provide documentation of an RN working either day. On 12/18 25 at 12:19 PM, V2 (Director of Nurses) said. We did not have RN coverage on those days. We need to have a RN here at least eight consecutive hours each day. We missed both of those Saturdays. The facility's undated Nursing Services and Sufficient Staff policy states: 8. Except when waived, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

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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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on interview and record review, the facility failed to post daily nursing staff information and failed to maintain a minimum of 18 months of the daily postings. This failure has the potential to affect all residents in the facility. The findings include: The facility's CMS 671 form dated 12/16/25 showed 84 residents reside in the building. On 12/18/25 at 10:20 AM, the facility's posted direct care staff daily report was dated 12/16/25. At 11:31, V8 (Regional Nurse Consultant) said there are no other daily reports after 7/31/25 (over four months). The prior director of nurses kept copies of the daily posted reports, but the current director of nurses does not. At 12:05 PM, V1 (Administrator) said it is important to post daily staffing numbers, so we know who is working and to ensure there is appropriate staffing for the day. The facility's undated Nursing Services and Sufficient Staff policy states: The facility will supply services by sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans. The personnel types showed licensed nurses and nurse aides.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on interview and record review the facility failed to offer snacks at bedtime. This failure has the potential to affect all residents in the facility. The findings include:The CMS 671 form dated 12/16/25 showed 84 residents residing in the facility. On 12/17/25 at 10:19 AM residents and the facility's ombudsman were present for a group meeting. Residents stated they don't get bedtime snacks unless they ask for one. Staff don't offer them or pass them out room to room. Residents stated bedtime snacks were offered in the past, but it was stopped because staff were sneaking them for themselves. Residents stated it stopped a long time ago. If we want a snack after dinner, we have to bring something back from lunch. Then keep it in our room until the evening time. The facility assessments were reviewed for the residents present at the group meeting. There was no resident with cognitive impairment. On 12/17/25 at 2:00 PM, V10 (Dietary Manager) stated kitchen staff take a snack cart down to the resident units each day. It gets placed in the nutrition room on the long-term care unit. The CNAs (Certified Nurse Aides) are responsible for passing the snacks, not the dietary staff. On 12/18/25 at 12:27 PM the nutrition room on the unit was noted to have a number coded locking system on it. Residents could not access the room to get a snack without staff assistance. On 12/18/25 at 12:30 PM, V2 (Director of Nurses) stated CNAs should be offering bedtime snacks during the water pass. It is important so residents have substance between the evening meal and the next morning meal. The facility's undated Offering/Serving Bedtime Snacks policy states: 1. The nursing staff offers bedtime snacks to all residents in accordance with the resident's needs, preferences and request on a daily basis.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure a resident's (R9, R24) wound care was performed to avoid cross contamination and the risk of wound infection; failed to ensure staff wore appropriate personal protective equipment for a resident on contact isolation (R68) and enhanced barrier precautions (R24, R50). This failure affects 4 of 4 residents reviewed for infection control in the sample size of 34.The findings include: 1.On 12/17/2025 at 09:56 AM, R9's wound care was performed by V4 (Wound Care Nurse) and observed by another surveyor. V4 indicated R9 admitted with wound to her sacrum and has a wound to the coccyx area that is newer and comes and goes. V4 applied wound cleanser to a gauze pad then proceeded to cleanse the sacral wound then the coccyx wound. V4 removed her gloves and performed hand hygiene. V4 applied a new pair of gloves, then proceeded to apply skin prep to the sacral wound then to the coccyx wound. V4 then applied a small piece of mesalt (sodium chloride debridement, dry absorbent wound dressing) to the sacral wound then to the coccyx wound. V4 applied a bordered foam dressing to R9's buttocks that covered both the sacral wound and the coccyx wound. When asked if R9's wounds are considered two separate wounds, V4 said, yes they are now. V4 added that R9's wounds are both measured and assessed separately but she does cleanse and treat both areas at the same time. On 12/18/2025, R9's medical records were reviewed with the following noted: R9's face sheet documented admission date of 12/06/2024 with a past medical history not limited to morbid obesity, type 2 diabetes mellitus, urinary tract infection and hypertension. Minimum Data Set Section M - Skin Conditions dated 09/22/2025 indicated R9 has one or more unhealed pressure ulcers/injuries that both require the application of ointments/medications and nonsurgical dressings. Review of R9's care plan on 12/18/2025 reads in part: resident has a history of requiring antibiotic therapy related to urinary tract infection (UTI) and wound infection last revised on 01/06/2025; has potential/actual impairment to skin integrity related to fragile skin, impaired mobility, type 2 diabetes mellitus, obesity, weakness, deconditioning. Resident has a stage four pressure wound to sacrum, and stage two pressure wound to coccyx last revised on 12/02/2025. R9's care plan interventions included but not limited to follow facility protocols for treatment of injury. Date Initiated 12/09/2024. R9's active orders as of 12/18/2025 showed treatments to cleanse coccyx with wound cleanser, apply skin prep to peri wound, apply mesalt sheet and cover with border foam once daily and as needed (PRN) if saturated, soiled, dislodged; cleanse sacrum cleanse with wound cleanser, apply skin prep to peri wound, apply mesalt sheet and cover with border foam once daily and PRN every day shift for wound care. Review of R9's December 2025 treatment administration record (TAR) showed individual treatment orders to sacrum and coccyx, both with start dates of 12/10/2025. R9's most recent wound evaluation and management summary dated 12/16/2025 reads in part: focused wound exam (site 1) indicated a stage four pressure wound to sacrum with wound size of 2.7 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	x 0.5 x 0.3 (cm) centimeters (length x width x depth) and focused wound exam (site 8) stage three pressure wound to coccyx with wound size of 0.9 x 0.4 x 0.2 cm (length x width x depth). On 12/18/2025 at 08:40 AM, V3 (Assistant Director of Nursing & Infection Preventionist) said when providing wound care to a resident with multiple wounds, each wound should be cleansed, treated and covered individually, starting with the cleanest to the dirtiest wound to avoid cross contamination and prevent infection. Undated Wound Treatment Management Policy reads in part; to promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. The facility will follow specific physician orders for providing wound care. **On 12/18/2025, healthcare worker background check was conducted, and it was noted that V4 (Wound Nurse) did not have a current nursing license. Look up detail view provided by facility and dated 12/18/2025 08:57 AM showed V4's license status as not renewed. First effective date showed 06/08/2024 with expiration date pf 02/28/2025. (See citation 300.661) ** 2. On 12/18/2025 at 10:47 AM, V13 LPN gathered the supplies to perform R24s wound dressing changes. He entered the room, donned gloves, no gown, and moved R24s catheter bag to the opposite side of the bed. He removed the blankets and then removed the soiled dressing from R24s left leg. Without changing gloves, he cleansed the wound and applied skin prep to the skin surrounding the wound. V13 then applied her treatment and covered the wound with a new bandage. He did not change his gloves at any time during the treatment. V13 removed his gloves and gathered supplies for R24s next dressing. He stated he made a mistake and should have had a gown on during the dressing change. He put on a gown and gloves for her next wound care treatment. After rolling R24 onto her left side, he removed the dressing from the right upper back. The dressing had dark tan drainage. Without changing gloves, he cleansed the wound and applied skin prep to the wound edges. R24 needed repositioning and he moved her legs and rolled her back over before removing his soiled gloves. With clean gloves, V13 removed the packing from a wound on R24s lower buttocks, and without changing gloves he cleansed the wound and applies skin prep around the wound bed. He opened packages and used his scissors with the same soiled gloves and re-packed the wound before removing his gloves. V13 said he thought he only had to change his gloves between wounds. The facility's undated policy for Personal Protective Equipment documents this facility promotes appropriate use of personal protective equipment to prevent the transmission of pathogens to residents, visitor, and other staff. Definitions: Personal Protective Equipment (PPE) refers to a variety of barriers used alone or in combination to protect mucous membranes, skin, and clothing from contact with infectious agents. It includes gloves, gowns, face protection (facemasks, goggles, and face shields), and respiratory protection. Gloves: iv. Change gloves and perform hand hygiene between clean and dirty tasks, when moving from one body part to another, when heavily contaminated, or when torn. B. Gowns. Wear gowns to protect arms, exposed body areas, and clothing from contamination with blood, body fluids, and other potentially infectious material. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 12/17/2025 at 8:46 AM, V4 Wound Nurse put on gloves, went into R50's room, provided a dressing change and treatment to his diabetic foot ulcer. V4 was not wearing a gown. After the dressing change was completed, V4 stated R50 was on enhanced barrier precautions – EBP and she should have worn a gown. The EBP sign on R50's door showed, enhanced barrier precautions; everyone must: wear gown and gloves for the following high contact care activities - dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting. device care or use: central line, urinary catheter, feeding tube, tracheostomy, wound care: any skin opening requiring a dressing. On 12/17/25 at 1:45 PM, V2 Director of Nursing stated enhanced barrier precautions are followed whenever care is given. Gowns and gloves should be worn to stop the transmission of everything. The Face Sheet dated 12/17/25 for R50 showed diagnoses including type 2 diabetes mellitus with foot ulcer, hypertension, benign prostatic hyperplasia, obstructive sleep apnea, adjustment disorder with mixed anxiety, and vascular dementia. The Physician Order Summary Report dated 12/17/25 for R50 showed an order dated 5/1/25 for enhanced barrier precautions. The Care Plan dated 9/16/25 for R50 showed resident is on enhanced barrier precautions related to skin integrity issues. PPE is for enhanced barrier precaution-only necessary when performing contact care activities. The facility's Enhanced Barrier precautions policy (2025) showed, Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown, and gloves use during high contact resident care activities. 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. High-contact resident care activities include h. Wound care: any skin opening requiring a dressing 4. R68's face sheet dated 12/18/25 showed diagnosis including but not limited to diabetes mellitus foot ulcers, absence of left leg below the knee amputation, chronic ulcer of right foot and ankle, and peripheral vascular disease. R68's December 2025 physician order report showed an order start dated 12/15/25 for contact isolation every shift for ESBL (extended-spectrum beta-lactamases) infection in the right lower extremity wound. On 12/16/25 at 9:45 AM, a yellow sign was posted on the door of R68's room. The sign stated, STOP contact precautions. The sign showed gloves and gowns required before room entry. At 9:50 AM, V9 (CNA) entered the room and dropped off bed sheets inside. V9 was not wearing a gown or gloves. At 2:24 PM, V11 (Social Services) stated gowns and gloves are not necessary unless direct resident care is being provided. At 2:31 PM, R68 was seated in a recliner in his room. R68's right lower leg was wrapped in a white gauze dressing. The dressing did not cover his toes. R68's second toe was visible and had bright red blood fully exposed. At 2:34 PM, V9 (CNA) was observed entering R68's room a second time and not wearing a gown or gloves. At 2:39 PM, V12 (Licensed Practical Nurse) said gowns and gloves are needed regardless if care is being done or not. On 12/17/25 at 2:25 PM V3 (Infection Control Preventionist) stated R68 is on contact isolation (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	because of the infection in his right leg wound. Staff need to wear gowns and gloves before entering the room, just like the sign shows. Proper PPE is needed to keep germs off the staff and reduces the potential for them carrying it to another resident. All staff are educated, including non-nursing personnel like housekeeping, social services, and dietary, about correct PPE use in isolation rooms. The facility's undated Transmission-Based (Isolation) Precautions policy states under the contact precautions section: c. Healthcare personnel caring for resident on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. The policy states: f. Contact precautions will be used .when a resident has wounds, secretions, or excretions that are unable to be covered or contained.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure a female resident (R29) was properly groomed by not removing facial hair from her chin area. This failure affects 1 of 3 residents reviewed for activities of daily living (ADL's) in the sample size of 34.The findings include:On 12/16/2025 at 09:51 AM, R29 was observed in her room in a wheelchair next to bed. Resident was dressed appropriately and appeared clean with course facial hair visible to chin area that was approximately 1-2 inches in length. At 01:10 PM, R9 was observed on the 300 hall and remained unshaved.On 12/17/2025 at 10:03 AM, R29 was observed in her wheelchair near the 300 unit nurse's station. Resident was dressed appropriately and appeared clean with course facial hair visible to chin area that was approximately 1-2 inches in length. At 12:30 PM, R9 was observed in the dining room near the 300 unit and remained unshaved. On 12/17/2025, R29's medical records were reviewed with the following noted:R29's face sheet documented admission date of 01/16/2023 with a past medical history not limited to osteoarthritis, muscle weakness, lack of coordination and hypertension.Minimum Data Set (MDS) Section GG - Functional Abilities dated 11/25/2025 indicated that R29 is dependent on staff to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands.R9's care plan last completed on 11/26/2025 reads in part: resident has an ADL self-care performance deficit related to impaired balance.currently in restorative programming for dressing and grooming and bed mobility. Date initiated 01/18/2023. Last revision on 06/09/2025.Care plan interventions include but not limited to, bathing/showering: R9 requires limited to extensive assistance by one staff with bathing/showering routinely, and as necessary. Date initiated 07/27/2023.Review of progress notes for last 30 days showed no refusal of care notes documented.On 12/18/2025 at 08:40 AM, V3 (Assistant Director of Nursing & Infection Preventionist) said most residents are showered twice weekly, sometimes if requested. V3 added that residents are typically groomed/shaved on their shower days by the aides (provide most of grooming) but should be offered anytime its needed. V3 then said female residents should not have facial/chin hair and if care/grooming/shaving is refused, it should it be charted.Facility provided R29's shower sheets for the last three months on 12/18/2025 that showed resident shower days are on Wednesdays and Sundays and staff are to indicate whether facial hair was removed on the shower sheet. Five shower sheets were received dated 12/03/2025, 11/12/2025, 11/09/2025, 11/02/2025, and 10/26/2025 that showed R29 was not shaved on 11/09/26 and 10/26. No shower sheets were received for R29's scheduled shower days on 12/07, 12/10, 12/14 or 12/17. Undated Grooming a Resident's Facial Hair policy reads in part, it is the practice of this facility to assist residents with grooming facial hair to help maintain proper hygiene as per current standards of practice.

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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, interview and record review the facility failed to have weekly measurements and complete assessments of a resident's diabetic ulcer for 1 of 4 residents (R50) reviewed for wounds in the sample of 34.The findings include: On 12/17/25 at 8:46 AM, R50 was sitting in a chair in his room for wound care to his right foot. V4 Wound Care Nurse removed the dressing to the bottom of R50's foot. R50 had a large, round, dark colored area to the ball of his foot, below his right big toe. The edges of the wound were raised. V4 stated R50 is supposed to have surgery to remove a bone in his foot that is pushing downward. V4 stated the wound was a diabetic ulcer. V4 stated R50 goes out to the podiatrist for wound care. V4 stated she did not have any wound notes/assessments for R50 and if there are any from the podiatrist V3 Assistant Director of Nursing - ADON would know where the notes are located. On 12/17/2025 at 9:55 AM, V3 ADON stated the wound documentation for R50 should be scanned into miscellaneous in the electronic medical record. V3 stated staff should be monitoring the wound; there should be documentation. V3 has a diabetic ulcer and that is to be monitored weekly with the wound observation tool. V3 stated it was probably a mistake that there wasn't any documentation of the assessment and monitoring of the ulcer and there should be documentation. V3 stated she would contact the podiatrist for the assessments of R50's ulcer. The facility Weekly Skin Assessments dated 9/15/25, 9/22/25, 9/29/25, 10/6/25, 10/13/25, 10/20/25, 10/27/25, 11/3/25, 11/10/25, 11/17/25. 11/24/25, 12/1/25, 12/8/25, and 12/15/25 showed R50 is being followed by the doctor for a diabetic wound to the right plantar foot, treatment order in place. The assessment does not include the measurement or description of the wound.On 12/17/2025 at 11:17 AM, V3 ADON brought in notes for R50 from the podiatrist and stated the notes are dated 11/6/25; they are the last notes that they received. V3 stated it is a diabetic ulcer. V3 stated the doctor did measurements and showed them and description of the area on the resident foot. V3 stated that the facility should be doing that as well and doesn't know why it isn't being done.The Podiatrist note dated 11/6/25 that was sent to the facility on [DATE] showed, R50 presented to the doctor's office for evaluation of a foot ulcer. R50 has an ulcer and callus on the bottom of his foot due to the deformity on his right side, where the big toe goes up and the first metatarsal goes down, causing pressure on sesamoid bone. Assessment: diabetic neuropathic ulcer. The note showed a full thickness wound that measured post debridement of nonviable skin slough as 3/5 cm x 4 cm x 0.2 cm. The Face Sheet dated 12/17/25 for R50 showed diagnoses including type 2 diabetes mellitus with foot ulcer, hypertension, benign prostatic hyperplasia, obstructive sleep apnea, adjustment disorder with mixed anxiety, and vascular dementia. The Physician Orders for R50 showed an order dated 11/3/25 to apply betadine to the right plantar foot and cover with gauze daily and as needed. On 8/6/25 an order was placed for a post-op to shoe to be worn when in chair and ambulating as tolerated by resident. The Care Plan dated 11/24/25 for R50 showed the resident has potential/actual impairment to skin integrity related to cellulitis, type 2 diabetes mellitus. Resident has a diabetic wound to right plantar foot. Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs/symptoms of infection, maceration etc. to doctor. Post op shoe per physician order as tolerated by resident. The Minimum Data Set- MDS dated [DATE] for R50 showed moderate cognitive impairment. The facility's Wound Treatment Management policy (2025) showed, the effectiveness of treatments will be monitored through ongoing assessment of wound. Pressure injuries will be differentiated from non-pressure ulcers, such as arterial, venous, diabetic, moisture or incontinence related skin damage. Characteristics of wound: Pressure injury stage (or level of tissue destruction if not pressure injury). Size - including shape, depth, and presence of tunneling and/or undermining. Volume and characteristics of exudate. Presence of pain. Presence of infection or need to address bacterial bioburden. Condition of tissue in the wound bed. Condition of the peri-wound skin. Location of wound. Treatment decisions will be based on etiology of wound.

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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 effectively implement a fall intervention and provide a safe mechanical lift transfer for 1 of 5 residents (R13) reviewed for safety in the sample of 34.The findings include: On 12/17/2025 8:37 AM, R13 was sitting at the dining room at table eating breakfast. R13 was dressed and had slipper socks on that were worn on the bottom and the heels appeared to have holes. R13 was sitting forward in her chair and her butt wasn't at the back of her chair. At 8:44 AM, V6 Certified Nursing Assistant - CNA told R13 to scoot back in her chair, that she is too far forward, and can fit her arm behind her. V6 stated R13 can stand and walk but refuses too. V6 stated R13 got mad about something last week and stood up on her own. V6 stated they used to transfer her with a stand lift, and she would raise her arms up. V6 stated it was dangerous, so they use the full mechanical lift to transfer R13. On 12/17/2025 at 9:17 AM the surveyor had V6 check R13's slipper socks. V6 stated the socks used to have grips on the bottom but they were worn off and should probably have different ones on. V6 stated it would be safer for R13 to have socks on with grips. V6 removed R13's slipper socks and they were worn on the bottom with holes forming and very few grip dots left. The Fall Risk assessment dated [DATE] for R13 showed a score of 15 - high risk for falls. On 12/17/25 at 1:45 PM, V2 Director of Nursing - DON stated for fall prevention residents have an assessment completed. The assessment gives a fall risk which determines the resident's location in the building and interventions that need to be put in place. If a resident has a score over 10, that puts them at high risk for falls. V2 stated interventions that are specific to the resident are put in place and are on the care plan. V2 stated the resident's care plan should be followed. The Care Plan dated 12/17/25 for R13 showed, the resident is at risk for falls related to deconditioning, and dementia. Nonslip footwear to be worn as tolerated as residents allows. Follow facility fall protocol. On 12/18/25 the facility did not have a fall prevention policy. The facility had an Incidents and Accidents policy for after an incident has occurred that V1 Administrator submitted as the facility fall protocol. On 12/17/2025 9:27 AM, V5 CNA and V7 CNA took R13 to her room to provide incontinence care. R13 was sitting in her wheelchair and had a mechanical lift sling under her. V5 and V7 attached the sling to the mechanical lift. V7 went into R13's bathroom. V5 transferred R13 from her chair to her bed without any assistance. After the transfer, R7 came out of the bathroom with wet washcloths and a towel for incontinence care. V5 stated it is the policy to have two people transfer a resident with the mechanical lift. V5 stated they use two people for safety. V5 stated she transferred R13 with the lift when V7 was in the bathroom, and she probably shouldn't have done that. On 12/17/2025 at 1:45 PM, V2 DON stated the mechanical lift policy is to have two people for the transfer with the lift for safety. One person to maneuver the lift and the other person to watch the resident and guide them. The Face Sheet dated12/17/25 for R13 showed diagnoses including dementia, lack of coordination, Alzheimer's disease, depression. Anxiety disorder, hyperlipidemia, hypertension, hypothyroidism, and sepsis. The Minimum Data Set, dated [DATE] for R13 showed severe cognitive impairment; substantial/maximal assistance for rolling in bed; dependent for transfers. The Care Plan dated 12/17/25 for R13 showed, R13 has an activity of daily living-ADL self-care performance deficit related to dementia. R13 is a 1-2 assist with ADL's. Transfer: The resident requires assistance by 2 staff to move between surfaces. R13 uses a mechanical lift for transfers. The facility Safe Resident Handling/Transfers policy (2025) 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 provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. Policy Explanation: All residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. While manual lifting techniques may be utilized (continued on next page)

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	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allure of Sterling	612 West St Mary's Street Sterling, IL 61081

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dependent upon the resident's condition and mobility, the use of mechanical lifts are a safer alternative and should be used. Two staff members must be utilized when transferring residents with a mechanical lift.