STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145920	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allure of Prophetstown	310 Mosher Drive Prophetstown, IL 61277

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 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 31615

Based on observation, interview, and record review the facility failed to document a resident fall and assessment for 1 of 3 residents (R2) reviewed for falls in the sample of 3.

The findings include:

R2's admission record shows she was admitted to the facility on [DATE] with multiple diagnoses including unspecified dementia, unspecified severity with psychotic disturbance, and expressive language disorder. The facility's 5/22/24 quarterly assessment shows R2 to have severe cognitive impairment and is rarely/never understood. The same assessment shows she is dependant upon staff for all of her ADL' (activities of daily living).

The facility accident and incident log for June 2024 documents on 6/15/24, R2 had a fall and sustained a laceration to her head, was sent to the emergency room and admitted for observation.

The progress notes for R2 were reviewed for 6/15/24 and show a note at 2:46 PM of behaviors such as yelling out and shouting from her room. The next progress note at 5:42 PM, the local hospital was called for an update on R2's condition. The notes do not show any incident, assessment, or when R2 was sent out to the hospital.

A 6/15/24 neurological flow sheet shows vital signs and neuro checks were initiated at 2:45 PM.

The history and physical reports from the emergency room documents R2 was seen on 6/15/24 at 3:41 PM following a fall out of her wheelchair. She was dizzy and fell striking her left forehead. She was assessed for head trauma.

On 6/20/24 at 10:40 AM, V9 RN (Registered Nurse) said when a resident falls it should be documented in the progress notes what happened, and if/when an ambulance is called. An incident report is completed. She said when R2 fell , she had a skin tear to her right eye. She was working when the fall occurred and recalls someone yelling out for help. She found R2 lying on the floor with blood around her face. She had fallen out of the geriatric chair. V9 said she recalls initiating neuro checks because R2 had hit her head, and everything happened so fast, she did not document in the progress notes. V9 reviewed the progress notes and stated she should have made a note about the fall and her assessment.

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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: 145920	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2024
NAME OF PROVIDER OR SUPPLIER: Allure of Prophetstown		STREET ADDRESS, CITY, STATE, ZIP CODE: 310 Mosher Drive Prophetstown, IL 61277	

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/20/24 at 930 AM, V7 RN said when a resident falls, it is documented in the progress notes of what happened, and any notifications such as the DON (Director of Nursing), NP (Nurse Practitioner), and POA (Power of Attorney). In addition if the resident is sent out, it should be noted when 911 was called and when they were transported to the emergency room . On 6/20/24 at 11:00 AM, V2 DON said if a fall occurs it is documented in the progress notes how they found the resident, if any injuries noted, what they think may have happened, and if the fall is witnessed or un-witnessed. They should be notifying the physician or NP and the POA. If a resident is sent out it should be in the progress notes. This is necessary because then the rest of the staff know what happened. V2 reviewed R2's progress notes and said the fall information should be in the notes. On 6/20/24, R2 was observed in the common area by the nurses station in a geriatric chair. She was laid back, and appears to be sleeping. She was observed to have a skin tear to her forehead and another to her left eyebrow. The facility's undated policy for incident and accidents documents an accident refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident. Compliance Guidelines: 5. The following incident/accidents require an incident/accident report but are not limited to: Falls 13. Documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions notifications and orders obtained or follow-up interventions.

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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 0689

Level of Harm - Actual harm

Residents Affected - Few

Note: The nursing home is disputing this citation.

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 31615

Based on observation, interview and record review the facility failed to transfer a resident in a safe manner, failed to follow facilty's policy and procedures for 1 of 3 residents (R1) in the sample of 3. This failure resulted in (R1) falling during a transfer, sustaining a laceration to head and transferred to hospital.

The findings include:

R1's admission record documents she was admitted to the facility on [DATE] with multiple diagnoses including Alzheimer's disease and cognitive communication deficit. The 5/23/24 quarterly assessment of R1 shows she has severe cognitive impairment and is dependant on staff for chair/bed to chair transfers. The 6/19/24 300 hall resident information lists R1 as a transfer with a mechanical lift with 2 assist.

On 6/20/24 at 9:50 AM, R1 was observed sitting up in her chair. She was alert, but non verbal. She had a mechanical lift sling underneath her. V5 and V6 CNA's (Certified Nursing Assistants) said a beige sling is used for R1, and the sling is crossed under her legs. V5 and V6 attached the sling hooks to the mechanical lift, and began to transfer R1. V6 was guiding R1 out of her chair and said there should always be 2 staff present for R1 as she tends to lean forward during transfers.

In a written statement on 6/11/24, V3 CNA stated she hooked R1 up to the mechanical lift, her chair was between her bed and her room mates bed so when R1 was lifted her head would be right where it should lay in the bed. V3 lifted her up and everything was fine until she moved the lift over top of R1's chair, and R1 started to lean forward and V3 tried to grab her, and R1 went back into the sling but did not go back into position. She went to the left and head first out of the sling. V3 stated she tried to catch her but it all happened too fast, and R1 hit her head on the floor.

On 6/20/24 at 10:00 AM, V8 CNA said she was working on the hallway with V3, and was not aware V3 was laying people down and did not ask her for assistance. She said R1 is a mechanical lift and requires 2 staff for a transfer. She said R1 is dangerous to transfer with 1 staff because she tends to lean forward in the sling.

On 6/20/24 at 8:30 AM, V4 CNA said R1 is a mechanical lift, and will attempt to sit up during transfers with the mechanical lift, and there should always be 2 staff present during the transfer.

On 6/20/24 at 9:30 AM, V7 RN (Registered Nurse) said V3 was yelling for assistance with R1. She found V3 holding a bloody rag to the back of R1's head. V7 said she immediately called 911. She said R1 says very little and is not able to follow commands. She said V3 was the only staff in the room at the time of her initial assessment, and V8 came in afterwards.

The 6/11/24 emergency room nursing note document R1 arrived with reports of being dropped from a mechanical lift injuring back of head. R1 noted to have a small abrasion to the back of her head.

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Printed: 08/28/2024
Form Approved OMB
No. 0938-0391

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allure of Prophetstown	310 Mosher Drive Prophetstown, IL 61277

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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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 6/20/24 at 8:50 AM, V2 DON (Director of Nursing) stated V3 was assigned to R1 on 6/11/24, and was putting her to bed. V3 was transferring R1 by herself when R1 fell . The facility's undated policy for safe resident handling/transfers documents 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 guideline. All residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. Compliance Guidelines: 10. Two staff member must be utilized when transferring residents with a mechanical lift.