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	11/14/2025

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. (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

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the Certified Nursing Assistant/CNA failed to notify the nurse when she saw a laceration to a resident's leg, which was a change in condition for 1 of 3 residents (R1) reviewed for change in condition in the sample of four. This past noncompliance occurred from 10/31/25 to 11/3/25. The findings include:R1's Face Sheet, dated 11/13/25, showed diagnoses including metabolic encephalopathy, gastrointestinal hemorrhage, asthma, atrial fibrillation, pneumonia, bacteremia, bullous pemphigoid, gastroesophageal reflux disease, hypertension, and tinea unguium.R1's Minimum Data Set (MDS), dated [DATE], showed no cognitive impairment; chair/bed transfer - dependent; toilet transfer - dependent.R1's Nurses Note, dated 11/1/25 at 2:41 AM, showed, Resident sitting in recliner and tells this nurse she has a cut on her leg. This nurse sees a washcloth taped over affected area, when washcloth removed there is a large, deep laceration below knee on upper part of lower leg. No active bleeding at this time, subcutaneous tissue showing, resident denies any pain to area. At 4:10 AM, Resident has returned from emergency room, 9 stitches to right lower extremity, dressing clean, dry, and intact.R1's Incident Investigation Final Report, dated 11/6/25, showed on 10/31/25, R1 was interviewed and she stated that two aides came in to get her ready for bed. R1 reports they transferred her into a wheelchair around 9:00 PM and at that time she complained of her leg hurting but was not aware of any injury to her leg. The night shift agency CNA (Certified Nursing Assistant) V7 was interviewed. V7's stated when she entered R1's room, R1 said she had to use the bathroom and that she transferred R1 with the sit to stand because R1's leg hurt. V7 stated she saw R1's leg was bleeding so she covered the wound with a towel so she could continue toileting R1. V7 stated she forgot to notify the nurse because she had answered another light.On 11/13/25 at 9:34 AM, V1, Administrator, stated the investigation into R1's incident was done by V2, Director of Nursing, and V10, Regional Nurse. R1 was interviewed and said two girls transferred her and then her leg started to hurt, and she did not realize she had a laceration. V7, Certified Nursing Assistant/ CNA, said she wrapped the towel around the laceration, took R1 to the bathroom, left the room after toileting R1, answered call lights, and forgot to tell the nurse. V1 stated it was after that another CNA (V5) answered R1's call light and saw the laceration to her leg. V7 should have immediately reported it to the nurse.On 11/13/25 at 9:43 AM, V2, Director of Nursing/DON, stated she did the investigation for the laceration to R1's leg. V2 stated she watched the facility cameras to see if she could figure out what happened. V2 stated on 10/31/25 in the evening, she saw V7 go into R1's room and then she came out, and V8 followed V7 back into R1's room. V2 stated on the camera she could see V7 grab a washcloth and go back into the room. V2 stated she then saw V8 take the stand lift into the room; a few minutes later they both left the room. V2 stated she saw V7 grab a roll of tape, go into R1's room and a few minutes later, V7 left the room. V2 stated she called V7, and she said R1 was sitting in her recliner in just a brief when she went into the room and the wound was already there. V2 stated V7 told her she covered the laceration to stop the bleeding and then continued to transfer R1 to take her to the toilet. V2 stated V7 told her she got distracted answering call lights and forgot to tell the nurse. V2 stated after completion of the investigation, she feels the injury to R1's leg occurred when V7 was caring for R1, that it occurred during a transfer, and she taped a washcloth over the top of it because she was afraid of getting in trouble. V2 stated V7 should have immediately notified the nurse so it could have been addressed right away.On 11/13/25 at 12:09 PM, V7, CNA, stated when she pulled the cover from R1 she saw a wound to her leg. V7 stated she took R1 to the bathroom, put her back in her recliner, put a towel on the laceration, and left R1's room. V7 stated she was going to tell the nurse but started answering call lights and forgot to tell her.On 11/13/25 at 2:17 PM, V9, Nurse Practitioner, stated she was notified R1 had a fall with laceration, so she was sent out for sutures. V9 stated the laceration should be reported right away as well as any complaints of pain. V9 stated staff should look and see why there are complaints of pain and follow up on it. The facility's Notification of Changes policy (2024) showed the purpose of the policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Circumstances requiring notification include: 1. Accidents: a. resulting in injury; b. potential to require physician intervention.Prior to the survey date of 11/13/25, the facility had taken the following action to correct the noncompliance:The facility ensures proper notification with resident condition changes.I. Corrective action for residents identified in the deficiency A. Resident was sent to the hospital for evaluation

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a safe transfer for R1. This failure resulted in a laceration to R1's leg on 10/31/25 that required 9 stitches at the local emergency room for 1 of 3 residents (R1) reviewed for safe transfers in the sample of four. This past noncompliance occurred from 10/31/25 to 11/3/25. The findings include: R1's Face Sheet, dated 11/13/25, showed diagnoses including metabolic encephalopathy, gastrointestinal hemorrhage, asthma, atrial fibrillation, pneumonia, bacteremia, bullous pemphigoid, gastroesophageal reflux disease, hypertension, and tinea unguium.R1's Minimum Data Set (MDS), dated [DATE], showed no cognitive impairment; chair/bed transfer - dependent; toilet transfer - dependent.R1's Care plan, dated 10/19/25, showed R1 has an activity of daily living self-care performance deficit, activity intolerance, and limited mobility. Transfer: The resident requires assistance of 2 staff members for a pivot transfer using a FWW (front wheeled walker) and gait belt. Restorative-Transfers. I will be able to transfer between surfaces using a 2-person pivot with a FWW and gait belt. Staff will provide gait belt and walker. Staff will also ensure to block my feet during the sit to stand part of my transfers. Staff will also provide verbal cues to assist due to visual deficits. Monitor/document/report as needed any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function.R1's Nurses Note, dated 11/1/25 at 2:41 AM, showed, Resident sitting in recliner and tells this nurse she has a cut on her leg. This nurse sees a washcloth taped over affected area, when washcloth removed there is a large, deep laceration below knee on upper part of lower leg. No active bleeding at this time, subcutaneous tissue showing, resident denies any pain to area. At 4:10 AM, Resident has returned from emergency room, 9 stitches to right lower extremity, dressing clean, dry, and intact.R1's Final Incident Investigation, dated 11/3/25, showed, on 11/1/25, V5, Certified Nursing Assistant, enters the room of R1 and observes a wound to the resident's right lower extremity, to which she immediately reports to the nurse, V6 Licensed Practical Nurse - LPN. Upon V6's assessment she notes a laceration. V6 reports that there was visible subcutaneous tissue, but no active bleed. V9, Nurse Practitioner, was notified of the newly acquired skin condition and gave the orders to send R1 to the emergency department for evaluation. V3, Assistant Director of Nursing - ADON, was notified. Power of attorney was notified. R1 later returned from the hospital with 9 stitches to her right lower extremity. V9 NP was notified of the resident's return and gave orders to monitor the wound for signs or symptom of infection before initiating antibiotic therapy, remove stitches in 10 days, and utilize as needed Tylenol for pain. R1 was interviewed and she stated that two aides came in to get her ready for bed. R1 reports they transferred her into a wheelchair around 9:00 PM and at that time she complained of her leg hurting but was not aware of any injury to her leg at that time. R1 described the staff as two black girls but did not know their names. V7, CNA, was interviewed. V7 stated when she entered R1's room, R1 said she had to use the bathroom and that she transferred with the sit to stand because her leg hurt. V7 stated she saw that R1's leg was bleeding so she covered the wound with a towel so she could continue toileting R1, and she forgot to notify the nurse because she had answered another light. It was also discovered during the investigation that there was blood on the foot pedal pegs on the wheelchair, believed to have caused the skin laceration.On 11/13/25 at 9:34 AM, V1, Administrator, stated the investigation into R1's incident was done by V2, Director of Nursing and V10, Regional Nurse. V3, Assistant Director of Nursing, was on call and was notified about a laceration on R1's leg. V3 looked at R1's wheelchair and found blood on the area where the foot pedals attach to the wheelchair. R1 was interviewed and said two girls transferred her and then her leg started to hurt, and she did not realize she had a laceration. R1 was being transferred to the recliner when the laceration occurred. V7, CNA, and V8, CNA, transferred R1 to her recliner They did not do a safe transfer. On 11/13/25 at 9:43 AM, V2, Director of Nursing/DON, stated she did the investigation for the laceration to R1's leg. V2 stated she watched the facility cameras to see if she could figure out what happened. V2 stated on 10/31/25 in the evening, she saw V7 go into R1's room and then she came out and V8 followed V7 back into R1's room. V2 stated on the camera she could see V7 grab a washcloth and go back into the room. V2 stated she then saw V8 take the stand lift into the room; a few minutes later they both left the room. V2 stated she saw V7 grab a roll of tape, go into R1's room and a few minutes later V7 left the room. V2 stated she called V7, and she said R1 was sitting in her recliner in just a brief when she went into the room and the wound was already there. V2 stated V7 told her she covered the laceration to stop the bleeding and then continued to transfer R1 to take her to the toilet. V2 stated V7 told her she got distracted answering call lights