

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 12/21/2025
NAME OF PROVIDER OR SUPPLIER Allure of Prophetstown		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>(continued on next page)</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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was free from missing narcotic medication for 1 of 3 residents (R1) reviewed for misappropriation of resident medication in the sample of 3. The past non-compliance occurred from 10/18/25- 10/20/25. The findings include:R1s October Summary Sheet shows she was admitted to the facility on [DATE] and was placed on hospice 10/13/25. The same sheet shows a 10/13/25 physician order for Morphine Sulfate 20 mg/5 ml- give 0.25ml every hour as needed for pain or shortness of breath. The individual controlled substance record shows on 10/14/25 the facility received a 5ml bottle of Morphine Sulfate for R1.The October Medication Administration Record (MAR) shows R1 did not receive any doses of Morphine and had no complaints of pain.On 12/21/25 at 8:53AM, V5, Licensed Practical Nurse (LPN), said R1 had passed away on hospice. She said when R1 was admitted to hospice, they sent a bottle of morphine for her. The bottle stood out to her as weird and the liquid in the bottle was a thick gel and pink in color. When she returned to work a few days later and saw the bottle was missing she began to search what happened to it. She said the medication sheet showed R1 took no doses, and the bottle and count sheet were gone, and it was not signed out on the master count sheet. V5 said she reported the missing bottle to V2, Director of Nursing.On 12/21/25 at 10:45 AM, V2 said V5 reported to her R1 was missing a bottle of Morphine. V2 said she conducted a search and determined the bottle and the count sheet were both missing. She found the count sheet in the shred bin located in the nurse's station, with no doses signed out, and the paper was still intact. V2 said while reviewing the video footage of nurses counting at change of shift, the bottle and count sheet were last seen on 12/18/25 during the morning count between V8, LPN, and V4, Registered Nurse (RN). She said the evening shift change was not conducted in plain view of the camera. But when she interviewed V7, LPN, who counted with V4, she did not recall seeing R1's bottle of Morphine. V2 said based on her findings, she determined V4 had taken the bottle of Morphine.The facility's undated policy for Abuse, Neglect and Exploitation documents it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Definitions: Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.Prior to the survey date of 12/21/25, the facility had taken the following action to correct the noncompliance: During an emergency QAPI Quality Assurance and Performance Improvement meeting on 10/20/25:1. The current policies for Controlled Substances Administration and Accountability and Abuse, Neglect, Exploitation were reviewed.2. A root cause analysis was completed to determine how the Morphine was missing. It was determined the nurses were not doing the narcotic count correctly at the end of shift.3. R1's Morphine was immediately reordered.4. On 10/20/25, education with nursing staff was conducted by the Director of Nursing on 1) Abuse, Neglect and Exploitation policy; 2) Medication Administration; 3) Controlled Substance Administration and Accountability Policy.4. Checklists and monitoring tools were created to determine:1) Were the controlled substances counted correctly and documented at shift change2) Were the controlled substance sheets/papers counted correctly and documented at shift change3) Were there any missing controlled substances</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>(continued on next page)</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure controlled narcotic medications were counted by the nursing staff for 1 of 3 residents (R1) reviewed for narcotic medications in the sample of 3. The past non-compliance occurred from 10/18/25 to 10/20/25. The findings include: R1s October Summary Sheet shows she was admitted to the facility on [DATE] and was placed on hospice 10/13/25. The same sheet shows a 10/13/25 physician order for Morphine Sulfate 20 mg/5 ml- give 0.25ml every hour as needed for pain or shortness of breath. R1's individual controlled substance record shows on 10/14/25 the facility received a 5ml bottle of Morphine Sulfate. On 12/21/25 at 8:53AM, V5, Licensed Practical Nurse (LPN), said R1 had passed away on hospice. She said when R1 was admitted to hospice, they sent a bottle of morphine for her. The bottle stood out to her as weird and the liquid in the bottle was a thick gel and pink in color. When she returned to work a few days later and saw the bottle was missing she began to search what happened to it. She said the medication sheet showed R1 took no doses, and the bottle and count sheet were gone, and it was not signed out on the master count sheet. V5 said she reported the missing bottle to V2, Director of Nursing. V5 said the nurses have 2 medication carts. At each shift change the nurses count the controlled medication. She said the oncoming nurse will follow the count sheets while the outgoing nurse does the control cards, bottles and patches. Then both nurses sign the book showing the count was correct. On 12/21/25 at 9:06 AM, V6, Registered Nurse (RN), said, At each shift change, the nurses count the control cards and number of bottles; they are in a separate drawer. One by one we verify each item in the cart. The count sheet shows the total number of items in the cart. Both nurses sign the book when the count is correct. When we use something, it is subtracted out, and the next shift will reflect that in the count. V6 said when there is any discrepancy with the count, it is reported to V2, Director of Nursing. The October 2025 change of shift control count sheet for the 100 hall shows no count was recorded from the night shift of 10/16/25 until the night shift of 10/18/25. The count sheet was missing the number of cards and count sheets, and the number of miscellaneous items in the cart for 4 shift changes. On 12/21/25 at 10:45 AM, V2 said V5 reported to her on 10/20/25, R1 was missing a bottle of Morphine. V2 said she conducted a search and determined the bottle and the count sheet were both missing. She found the count sheet in the shred bin located in the nurse's station, with no doses signed out, and the paper was still intact. V2 said while reviewing the video footage of nurses counting at change of shift, the bottle and count sheet were last seen on 12/18/25 during the morning count between V8, LPN, and V4, Registered Nurse (RN). She said the evening shift change was not conducted in plain view of the camera. But when she interviewed V7, LPN, who counted with V4, she did not recall seeing R1's bottle of Morphine. V2 said based on her findings, she determined V4 had taken the bottle of Morphine. V2 said she did review the narcotic count sheets and there were some holes in the documentation. The count was not done at shift change as it was supposed to be done. The facility's undated policy for controlled Substance Administration & Accountability documents it is the policy of this facility to promote safe, high-quality patient care, compliant with the state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure. 9. B. For areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift. Prior to the survey date of 12/21/25, the facility had taken the following action to correct the noncompliance: During an emergency QAPI Quality Assurance and Performance Improvement meeting on 10/20/25: 1. The current policy for Controlled Substances Administration and Accountability was reviewed. 2. A root cause analysis was completed to determine how the Morphine was missing. It was determined the nurses were not doing the narcotic count correctly at the end of shift. 3. R1s Morphine was immediately reordered. 4. On 10/20/25, education with nursing staff was conducted by the Director of Nursing on 1) Abuse, Neglect and Exploitation policy; 2) Medication Administration; 3) Controlled Substance Administration and Accountability Policy. 4. Checklists and monitoring tools were created to determine: 1) Were the controlled substances counted correctly and documented at shift change 2) Were the controlled substance sheets/papers counted correctly and documented at shift change 3) Were there any missing controlled substances</p>		