STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055640	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLURE OF PROPHETSTOWN	**310 MOSHER DRIVE , PROPHETSTOWN, Illinois, 61277**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Facility Reported Incident of October 31, 2025 2663403	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)6) 300.1220 b)7) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 7) Coordinating the care and services provided to residents in the nursing facility. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to provide a safe transfer for R1and failed to notify the nurse when a laceration was found to a resident’s leg. This failure resulted in a laceration to R1’s leg on 10/31/25 requiring 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 8/25/25, 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	S9999		

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S9999	Continued from page 2 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	S9999		

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S9999	Continued from page 3 laceration. 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. 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. 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	S9999		

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S9999	Continued from page 4 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 V3 found blood on the pegs of R1's wheelchair where the footrests attach to the wheelchair. They think R1 received the laceration from that during a transfer. V2 stated what happened was an unsafe transfer. V2 stated what should have happened is they should have had a gait belt on R1. They should have made sure to go slow and steady with the transfer to prevent injury during a transfer.V2 stated V7 should have immediately notified the nurse so it could have been addressed right away. On 11/13/25 at 12:04 PM, V8, CNA, stated R1 was already like that when she went into her room. V8 said she just took the stand lift into the room and then left because she had her own people to take care of. V8 said she went into the room with V7 because R1 wanted to go to the bathroom. R1 said she could not be moved without the sit to stand, so that is why she got the sit to stand and then she left the room. V8 stated they did not transfer R1, she wouldn't let them, she refused to transfer with the gait belt. V8 stated V7 used the sit to stand lift by herself to take R1 to the bathroom. On 11/13/25 at 12:09 PM, V7, CNA, stated R1 was in her recliner with her call light on and she wanted to go to the bathroom. V7 said R1 told her to use the sit to stand on her. V7 stated she pulled R1's covers off and saw a wound to her leg. V7 took R1 to the bathroom and then put her in recliner. V7 stated she put a towel on her leg. V7 stated she was on her way to tell the nurse, but other call lights were going off. V7 stated she answered them and forgot to tell the nurse. V7 stated R1 already had that (laceration) when she came in. V7 stated she took R1 to the bathroom by herself using the sit to stand lift. On 11/13/25 at 12:29 PM, R1 stated it was around 8:00 PM and she had to go to the bathroom before going to bed. R1 stated she put her call light on and 2 ladies from and agency came in to help her. R1 stated she had never seen them before. R1 stated she told them she uses the chair lift to transfer. R1 stated the ladies told her no. R1 stated her wheelchair was quite a bit away from her, and they told her she could walk to her wheelchair. R1 stated she told them she couldn't walk that far, and they laughed at her. R1 stated they had her stand. One of them was behind her having her move	S9999		

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S9999	Continued from page 5 forward and the other one was by the wheelchair. R1 stated she missed part of the seat of the wheelchair; she was half in and half out of the chair. R1 stated that is when she hurt her leg but did not know it was bleeding at the time. R1 said she hit her leg on the chair because of how she landed in the chair. R1 stated they did not have a gait belt around her and did not help her. R1 stated one of the ladies put a towel around her leg and told her it was bandaged and left the room. R1 stated she went to the hospital and had 9-10 stitches put in her leg. R1 stated she felt absolutely not safe during the incident. R1 stated she had never met them before but thinks they are a danger to frail people and any patients anywhere. 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. V9 stated any type of fall or gliding into the wheelchair should be looked into and reported for the resident safety. The resident care plan should be followed for transfers and if staff are unable to transfer the resident as stated in the care plan, then the nurse should be notified. A gait belt should be used for a two person transfer every single time especially if the resident has any weakness; they need to use it for the safety of the resident. The facility's Safe Resident handling/Transfers policy (2024) showed, "all residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and employees that assist them. While manual lifting techniques may be utilized dependent upon the resident's condition and mobility, the use of mechanical lifts are safer alternative and should be used. The interdisciplinary team or designee will evaluate and assess each resident's individual mobility needs, taking into account other factors as well, such as weight and cognitive status. Handling aids may include gait belts, transfer boards, and other devices. Two staff members must be utilized when transferring residents with a mechanical lift. Staff will be educated during transfers, to avoid contact with wheelchair, wheelchair foot pedals, or transfer devices, to prevent injury. Staff must ensure that there is appropriate clearance between the resident and the wheelchair, wheelchair foot pedals, or transfer devices, to avoid such contact." The facility's Notification of Changes policy (2024)	S9999		

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S9999	Continued from page 6 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 date of 11/13/25, the facility had taken the following action to correct the noncompliance: The facility ensures resident's safety during transfers. I. Corrective action for residents identified in the deficiency. A. Resident was sent to the hospital for evaluation and received sutures for laceration to the leg. B. Padded leg sleeves were added to the resident's plan of care to protect legs from further injury. C. Agency CNAs involved will not be returning to the facility. II. Identifying other residents with potential for being affected and corrective action. Any resident that is care planned for transfers needing assistance and any resident that has a change in condition have the potential to be affected, but none have been identified. III. Systemic changes to reasonably assure deficiency does not recur. A. In-service was conducted by the DON with nursing staff on November 3.2025 which includedreporting changes in condition and safe resident handling. IV. How corrective actions will be monitored. DON or designee will conduct QA study to determine: 1. Does the resident require assistance with transfers? 2. Did the staff complete transfer safely? 3. Was there a change in condition? 4. Did staff notify all pertinent parties immediately?	S9999		

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S9999	Continued from page 7 The QA study will be completed 5 days a week for two weeks, twice weekly for 2 months, and weekly for 1 month. Audit results will be forwarded to the facility Quarterly QAPI committee for review. Any concerns identified will be immediately corrected. The Administrator is responsible for compliance. (B)	S9999		