Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007637	A. BUILDING: ______ B. WING ______	C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLURE OF PROPHETSTOWN	310 MOSHER DRIVE PROPHETSTOWN, IL 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) COMPLETE DATE
S 000	Initial Comments Complaint Survey: 2315528/IL161692	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 300.1210b) 300.1210d)3 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. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These requirements were not met as evidenced by:	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1	S9999		

Based on observation, interview and record review, the facility failed to assess, monitor, and document the assessments on 1 of 3 residents (R1) reviewed for improper nursing care in the sample of 9.

This failure resulted in R1 being sent out to a local emergency room the next morning, and being admitted to the hospital with diagnoses of urinary tract infection (UTI), pneumonia, and weakness.

The findings include:

R1's Admission Record. printed by the facility on 7/11/23, showed she had diagnoses including anemia in chronic kidney disease, hypertension, edema, major depressive disorder, weakness, and chronic, peripheral venous insufficiency. R1's facility assessment dated 7/2/23 showed she is cognitively intact and requires extensive assist of staff for activities of daily living.

On 7/11/23 at 9:28 AM, R1 was in the dining room, finishing her breakfast meal. A staff member backed R1's wheelchair up and started propelling her back to her room. On the way to R1's room, two staff members told R1 that they were glad to see her back in the facility. R1 thanked them and said she was glad to be back. At 9:33 AM, R1 said she had been at the hospital. R1 said she was told that she had been having high blood pressure. R1 said she was also told that she was coming down with pneumonia. R1 said she does not remember the high blood pressures or if the nurses assessed her the night before she was sent out to the hospital.

On 7/10/23 at 3:44 PM, V4 (CNA-former

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S9999	Continued From page 2	S9999		

employee of the facility) said she worked the overnight shift on 7/4/23, from 6:00 PM-6:00 AM, the morning of 7/5/23. V4 said at the start of her shift, during the shift report, she was told that R1's blood pressure had been high. V4 said that night she was concerned about R1 because she had checked R1's blood pressure and it was high. V4 said she asked V17 (Licensed Practical Nurse-LPN) to check R1's blood pressure and V17 came in and tried to check R1's blood pressure, but was not able to get it. V4 said V17 threw the blood pressure cuff (wrist type) at her and said none of the blood pressure devices in the facility are working correctly. V4 said she checked R1's blood pressure after V17 threw the monitor at her and was able to obtain a reading. V4 said the first blood pressure reading obtained from R1 was 211/91 and R1's pulse was 41. V4 said that was using the wrist cuff. V4 said the second reading was 230/94, and was obtained manually using a blood pressure cuff and a sphygmomometer. V4 said she asked V17 if they should still give R1 her shower, because it was her scheduled shower night. V4 said V17 told her to give R1 her scheduled shower. V4 said R1's third blood pressure reading was 258/94 using the wrist blood pressure monitor, after R1's shower. V4 said she checked R1's blood pressure again right after getting that reading to compare it using the manual method, with a blood pressure cuff and sphygmomometer and it was 252/77. V4 said R1's pulse was 45 at that time. V4 said she checked R1's blood pressure again around midnight and it was 239/101 using the manual method. V4 said she could not get V17 to do an assessment on R1 and she was really concerned about her. V4 said she tried calling and texting V2 (Director of Nursing-DON), however, V2 did not answer. V4 said she was so upset and worried about R1 because she was not

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S9999	Continued From page 3	S9999		

well. V4 said R1 was kind of delusional on her shift on 7/4/23, adding that she was talking to someone in her room and there was no one there. V4 said R1's speech was slowed. V4 said during the shift report at the beginning of her shift, she was informed that R1 had not been acting like herself recently and she may have had a mini stroke. V4 said when V17 was in R1's room attempting to get a blood pressure on her, she did not do any other assessment on R1, she just tried to get the blood pressure reading, and was not able to get it. V4 said neither one of the nurses were in R1's room after 10:00 PM on 7/4/23. V4 said she could not get either nurse to do an assessment on R1.

On 7/11/23 at 10:16 AM, V5 (CNA) said she worked on 7/4/23 from 6:00 PM-6:00 AM shift. V5 said she was working a different hall, but all of the CNAs were kind of working together that night. V5 said V4 (CNA) was asking the other CNAs what to do. V5 said R1's blood pressure readings had been high all night. V5 said she was not in the room when V17 was trying to check R1's blood pressure. V5 identified V18 as the other CNA assigned to the hall R1 was on. V5 said after R1 had her shower, V16 (Licensed Practical Nurse-LPN, Agency Nurse) went into R1's room to check on R1, however she does not know if she assessed R1 or not. V5 said she did hear V16 tell V4 that she did not go to school for nursing and she did not know what she was talking about. V5 said both of the nurses that night were in and out of the building quite a bit that night. V5 said the nurses on duty were either outside or in the nurses station with the lights off a lot of the night.

On 7/11/23 at 2:03 PM, V8 (LPN) said she worked the morning of 7/5/23. V4 said the Nurse

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S9999	Continued From page 4	S9999		

Continued From page 4

giving shift report did not voice any concerns regarding R1 to her. V8 said the nurse did say that she was not able to obtain a blood pressure reading on R1. V8 said she went in to see R1 and she did not seem like herself. V8 said R1 was still alert, but slower to think. V8 said she had the CNAs get R1 up and bring her to the dining room. V8 said in the dining room, when R1 was brought down for breakfast, she noticed that something was not right with R1. V8 said R1 was definitely different and had a change in condition from 7/4/23-7/5/23. V8 said when monitoring a resident closely, she would expect to see some assessment documented in the resident's progress notes. V8 said by documenting an assessment, the Nurses working after that can get an idea of what the resident was like on the previous shifts versus what they are seeing at that time.

On 7/11/23 at 1:19 PM, V2 (Director of Nursing-DON) said V4 (CNA) had sent her a text message around midnight on 7/4/23-7/5/23 saying she was concerned about R1's increased blood pressure. V2 said V4 also called her around 12:30-1:00 AM. V2 said she did not hear the call or the text. V2 said V16 and V17 called her later and they were both upset with V4, saying V4 was yelling at them and slamming the nurse's door. V2 said V16 and V17 told her that they checked on R1 and were assessing R1.

On 7/11/23 at 4:48 PM, V9 (CNA) said she worked on 7/4/23 during the 6:00 PM-6:00 AM shift. V9 said she had checked R1's blood pressure before her shower and it was 211/91. V9 said V4 and V18 (CNA) asked V17 to assess R1 due to the high blood pressure. V9 said she was sitting out by R1's room when V17 went in to R1's room. V9 said V17 was not in R1's room very

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S9999	Continued From page 5	S9999		

long at all. V9 said V17 came out of R1's room and said none of the blood pressure monitors in the facility were working. V9 said she asked V16 later to assess R1 and V16 did go down to R1's room, however, she did not assess R1. V9 said V16 just looked at R1 and said something to her, then left the room. V9 said V16 did not assess R1's blood pressure, hand grips, pupils, or any of the other assessments to assess for stroke. V9 said V16 just said something to R1 and then left the room. V9 said neither V16 or V17 went back in to check on R1 after that. V9 said V4 could have handled it better, but she thinks V4 was upset because she was concerned about R1 and her high blood pressure and she did not feel like the nurses were assessing R1. V9 said V4 wrote down all of the blood pressure readings she obtained during her shift that night and showed the readings to V13, one of the nurses that came in on the morning of 7/5/23.

On 7/12/23 at 1:08 PM, V13 (LPN) said she arrived to work about 6:00 AM on the morning of 7/5/23. V13 said V4 told her about the concerns she had regarding R1's high blood pressures. V13 said she saw the paper that V4 had written R1's blood pressure readings on and R1's blood pressures were abnormally high and low. V13 said when she came in to work that day, V17 (LPN) was upset and said the CNA was trying to be a nurse and said the CNA was talking about increased blood pressures for R1. V13 said she asked V17 if she took R1's blood pressure reading and V17 told her that she was not able to obtain a blood pressure reading on R1. V13 said V17 did not mention any other assessment, she just said R1 was alright. V13 said she asked V17 if she went in and assessed R1 and V17 just ignored her question. V13 said if she were the nurse on duty the previous night, she would have

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S9999	Continued From page 6	S9999		

done a full assessment on R1 and rechecked her blood pressure. V13 said she would have documented the assessment. V13 said it is important to do an assessment and document the assessment, so the facility nurses have a history of what is going on and to get a current picture of what is going on with the resident and see if further medical treatment is needed. V13 said with increased blood pressures like those that V4 (CNA) showed her, she (V13) would have assessed the resident and then notified the Nurse Practitioner or R1's Doctor.

On 7/12/23 at 1:26 PM, V3 (Nurse Practitioner) said if there are alarming blood pressures, like 200/100, she would expect the nurse to notify her so they can try to figure out what may be the cause and adjust her medications if needed to bring the blood pressure down, or send her out to the emergency room if needed. V3 said she was not notified of any increased blood pressures for R1 on 7/4/23, or of any other symptoms.

R1's 7/3/23 notes from V3 (FNP-Family Nurse Practitioner) showed R1 was seen by V3 on 7/3/23 due to R1 being very lethargic that morning, not being able to move her left side, right facial drooping, leaning to her right side, and her words were slurred. V3's notes showed she assessed R1 and staff reported that R1 was 100 % better at that time versus earlier that day. The notes show, "Will hold off on ER as they will most likely send her back. Nurses to monitor closely..."

On 7/13/23 at 7:40 AM, V18 (CNA) returned this surveyor's call from 7/11/23 and 7/12/23. V18 said she worked on 7/4/23 during the 6:00 PM-6:00 AM shift. V18 said she was working the same hall as V4 that night. V18 said R1 was slow

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S9999	Continued From page 7	S9999		

to respond and not her normal self that night. V18 said V17 came in and put the wrist type blood pressure monitor on R1's upper arm, instead of her wrist area, the first time she went to check it. V18 said then she put it down by R1's wrist but had the monitor turned around and it was not in the correct position, where you would check the pulse. V18 said she wanted to say something to V17, but V17 had already snapped at V4 and she was afraid to say anything to her. V18 said V17 was not able to obtain a blood pressure reading on R1 and did not do any further assessment on her. V18 said R1's blood pressure kept going up and she and V4 were concerned. V18 said V17 did not do any other checks/assessments on R1 that shift. V18 said V4 did get aggressive with V16 and V17 that night, but it was because she was concerned about R1. V18 said V16 had gone in one time to R1's room to check on her, after the CNAs asked her to. V18 said V16 went in and asked R1 how she was feeling. V18 said V16 did not do an assessment on R1, and did not check her blood pressure. V18 said V16 told her and V4 that if R1's blood pressure was that high, then she would be complaining about a headache. V18 said her and V4 were checking R1's blood pressure using both the wrist monitor and doing it manually. V18 said she worked on a cardiology unit for two years previously and she knows how to obtain a blood pressure. V18 said at one point, it looked like R1's mouth was sagging to the right. V18 said V16 told them R1 was okay.

On 7/12/23 at 2:03 PM, V16 (LPN-Agency) said she worked on 7/4/23 on the night shift. V16 said one of the CNAs had concerns with a resident's blood pressures. V16 said she does not know the name of the CNA, or the name of the other nurse that was on duty on 7/4/23, or the resident's name that the CNA was concerned about. V16

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S9999	Continued From page 8	S9999		

said R1 was not her patient. V16 said the CNA complained that the resident's blood pressure was high. V16 said the other nurse was on break so she went and checked the resident's blood pressure. When asked what R1's blood pressure was, V16 said she was not sure what her blood pressure was, but she was not in distress. V16 said she is not sure if V17 assessed R1 or not because she had her own patients.

On 7/12/23 at 3:06 PM, V17 (LPN-Agency) said the CNA (did not know her name) told her that R1's blood pressure was 300 over something. V17 said she manually checked R1's blood pressure and it was fine. When asked what R1's blood pressure was when she checked it, V17 said she did not recall what R1's blood pressure was, but it was within normal range. V17 said she even had V17 check R1's blood pressure too. V17 said R1 was fine and there was nothing out of the normal for R1. V17 said 7/4/23 was the first or second time she had worked at the facility. V17 said she assessed R1 on 7/4/23. When asked where she documented the assessment, V17 said she did not document an assessment because there was nothing wrong with R1. V17 said it was the CNA that was causing the problem.

R1's electronic medical record was reviewed. No progress note or assessment of R1 was found in her electronic medical record for 7/4/23, except for a wound assessment on the day shift. R1's electronic vitals tab had no entry of blood pressure monitoring on 7/4/23. On 7/11/23 at 1:19 PM, V2 said she spoke with V16 and V17 on the phone during their shift on 7/4/23. V2 said V16 and V17 said they were assessing R1. V2 said there should have been documentation in R1's medical record showing that an assessment was

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S9999	Continued From page 9	S9999		

done for R1. On 7/12/23 at 4:18 PM, V2 (Director of Nursing) said she did not see any assessment documented in R1's electronic medical record for 7/4/23, other than her wound assessment. V2 said she did not see any blood pressure readings documented in R1's medical record for 7/4/23.

On 7/12/23 at 1:26 PM, V3 (FNP-Family Nurse Practitioner) said she saw R1 on 7/3/23. V3 said staff had reported that R1 was lethargic and leaning to the side. V3 said when she saw R1, her symptoms had pretty much resolved. V3 said she wrote in her notes that nursing staff would monitor closely. V3 said that means that they would monitor R1 for any change in condition, any symptoms, monitor her vital signs and blood pressure, and speak with her to see if her speech is clear. V3 said if blood pressure readings were high, like 200/100, she would expect the Nurse to increase the monitoring of R1's vitals and watch for any symptoms. V3 said the assessments should be documented in the resident's medical record. V3 said even if the assessment is normal, the nurse should be documenting the assessment in the resident's medical record.

R1's Shower Assessment Sheet dated 7/4/23 showed a blood pressure reading of 211/91 and a pulse of 41. the shower sheet showed "Couldn't log. No way to log on to point care." was written under R1's vitals on the shower sheet.

R1's Health Status Note dated 7/5/23 at 10:45 AM showed "Resident confused and unable to swallow medications due to confusion. Pocketing food in mouth at breakfast. Redirected to swallow and resident began to cry, upset with self related to the increased confusion. Complained of pain level of 4 out of 10 to left lower extremity, does have scheduled Tramadol however is unable to

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S9999	Continued From page 10	S9999		

swallow medications this morning. Vital signs: Blood pressure 194/96, pulse 80, respirations 16, and temperature 97.6 tympanic. Equal grip with hands. At 9:10 AM, POA (power of attorney) updated on current status and is requesting resident be sent to ER for further evaluation and treatment. DON notified. Nurse Practitioner notified." The note showed 911 was called at 9:13 AM and left via stretcher with emergency medical services at 9:34 AM on 7/5/23. The Health Status Note dated 7/6/23 at 12:21 AM, the nurse on duty called the local hospital and was informed that R1 had been admitted to the hospital for pneumonia, UTI, and weakness.

R1's 7/10/23 Medication Discharge Report from a local hospital showed "Visit Reason: UTI, pneumonia, weakness." The report showed R1 was admitted to the local hospital on 7/5/23.

(B)

2 of 2 Licensure Violations

300.1210b)
300.1210d)6

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.

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S9999	Continued From page 11	S9999		

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.

These requirements were not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure a resident with dementia, wandering and aggressive behaviors, did not exit the building and obtain a metal rod, which he used as a weapon. The facility failed to develop a care plan addressing the resident's aggressive and wandering behaviors and put interventions in place to de-escalate a situation of aggression, and the facility failed to ensure a resident with dementia exhibiting wandering behaviors was supervised for 1 of 2 residents (R3) reviewed for abuse in the sample of 9.

This failure resulted in R3 exiting the building into the back courtyard where he grabbed a metal rod, brandishing it as a weapon, chasing staff around the back courtyard. The police were notified, R3 was tazed, sustaining wounds to his bilateral hands and sent to a local hospital.

R3's Admission Record, printed by the facility on 7/12/23, showed he had a diagnosis of unspecified moderate dementia, with other behavioral disturbance. R3's facility assessment dated 5/3/23 showed he had severe cognitive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007637	A. BUILDING: ______ B. WING ______	C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLURE OF PROPHETSTOWN	310 MOSHER DRIVE PROPHETSTOWN, IL 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) COMPLETE DATE
S9999	Continued From page 12	S9999		

impairment. R3's care plan, initiated on 4/24/23, showed R3 had a history of criminal behavior, including battery in 1982 and domestic violence in 1984. The care plan showed "Visually monitored for any agitation or behavior. Monitor and assess for signs of agitation. Reassure and redirect to quiet place in (R3's) room if agitated. R3's Cognitive deficit care plan, initiated on 4/24/23, showed R3 had impaired decision making. The care plan showed "Offer verbal cues and reminders. Redirect as needed." R3's 4/20/23 Health Status Note showed R3 was admitted to the facility. Upon assessment R3 was moderately hard of hearing and had poor vision in both eyes. R3's Health Status Notes dated 5/5/23 at 5:23 AM, showed R3 was observed in the hallway urinating on the floor. The note showed R3 told staff "Get him out of the bathroom or else I am going to kill him." Directed towards R3's roommate who was using the bathroom at the time. R3's Health Status Note dated 5/5/23 at 5:29 AM, showed R3 was observed in another resident's room, sitting on the bed, taking his shoes off. The note showed R3 was hard to redirect out of the other resident's room. The note showed the other resident was already in the bed. R3's electronic vitals tab showed his was 67 inches tall (5 foot 6 inches) on 4/19/23. The vitals tab showed R3 weighed 126.1 pounds on 5/5/23 and 120.2 pounds on 5/11/23.

R3's Health Status Note dated 5/9/23, showed R3 was in the back courtyard stating, "He is trying to kill us.". The note showed V12 (Licensed Practical Nurse-LPN) was trying to redirect R3 to no avail. R3 grabbed a steel rod from the ground and began chasing V12 and two other CNAs (Certified Nursing Assistants) that were also out in the courtyard, trying to talk R3 into going back inside. R3 was charging at staff with the rod. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007637	A. BUILDING: ______ B. WING ______	C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLURE OF PROPHETSTOWN	310 MOSHER DRIVE PROPHETSTOWN, IL 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) COMPLETE DATE
S9999	Continued From page 13	S9999		

note showed V26 (Maintenance Supervisor) was called because V12 thought having a male present would help calm the situation, which it did not. R3 continued running after staff threatening them with the steel rod. The note showed V12 had also told V15 (LPN) on her walkie talkie to call 911 and V3 (Family Nurse Practitioner-FNP) for an order to send out to a local emergency room for evaluation and treatment. The note showed the police showed up and R3 ran at the police officers with the steel rod. The police officers asked R3 to stop and drop the weapon, R3 continued at them and the police tazed R3. R3 fell forward onto his stomach and immediately jumped up and continued fighting the police. The police told R3 to stop or they would taze him again. The note showed R3 received injuries to both hands. R3 was handcuffed and walked to the front of the building by the two police officers, where an ambulance was waiting.

The police Incident Report #2300015, dated 5/9/23, showed V29 (Prophetstown Police Officer) was starting his shift when he heard dispatch notify V30 (Chief of Police, Prophetstown) that a patient at (the facility) was combative and attacking the staff. V29's report showed he notified dispatch that he was enroute as well. The report showed upon arrival V29 heard commotion coming from the courtyard as he was walking down the hall. "I (V29) heard V30 yell repeatedly to drop the stick etc." The report showed V29 "then "pie'd" the corner of the courtyard and V30 told him that R3 had a metal rod that he was swinging at people." The report showed V29 found R3 chasing after a nurse with the rod and told R3 to drop the rod. R3 refused. V29's report showed, "At this time, I (V29) could see the rod was about 3-4 feet in length and was stout. (R3) was swinging it around his head like a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007637	A. BUILDING: ______ B. WING ______	C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLURE OF PROPHETSTOWN	310 MOSHER DRIVE PROPHETSTOWN, IL 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) COMPLETE DATE
S9999	Continued From page 14	S9999		

sword. He (R3) then took about five steps and began to charge at me (V29). I then drew my taser and pointed it at (R3). I warned him that he was going to be tased. He (R3) still lunged at me. I then deployed my taser center mass at (R3's) chest. The taser locked up all major muscle groups causing him to fall thankfully into a flower bed/landscaping area." The report showed "After taking the rod away, and securing (R3) into handcuffs, he was treated by (the facility's) nursing staff for skin tears incurred during the fall. During this time, (R3) was in an altered state of mind and kept seeing people that weren't there. We kept asking who was there, and he (R3) said the man who was trying to get everyone. We had to reassure him that no one was there. Once his initial injuries were taken care of, we walked (R3) to the ambulance where he was restrained with soft restraints. He was then transported to (a local hospital) without incident."

R3's 5/9/23 Discharge Instructions and Summary of Visit documents showed a CT without contrast was performed on R3 due to decreased level of consciousness and bilateral hand x-rays were performed due to the fall. The Discharge summary showed a 12 lead EKG was also performed due to an altered level of consciousness. The discharge summary showed a urinalysis was collected as well as blood draws for lab work. The emergency department notes dated 5/9/23 showed R3 was noted to have some injury to his bilateral hands that was wrapped with rolled gauze in the field. The notes showed R3 arrived to the emergency department in two-point restraints and was noted to be calm and cooperative, but unable to provide a direct history.

On 7/20/23 at 11:37 AM, V12 (LPN) said one of the CNAs came up to the nurse's room while she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007637	A. BUILDING: ________ B. WING ________	C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLURE OF PROPHETSTOWN	310 MOSHER DRIVE PROPHETSTOWN, IL 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) COMPLETE DATE
S9999	Continued From page 15 was receiving report at 6:15 in the morning on 5/9/23. V12 said she grabbed a shake and R3's medications and as soon as she opened the door to the memory care unit, she saw R3 going out the back door to the courtyard. V12 said herself and V23 (CNA) went out to the courtyard. R3 was heading left towards the 200-300-unit courtyard area. V12 said she told Richard to come talk to her that she had a shake for him. V12 said R3 was frantic to get out and was grabbing the fence and shaking it. V12 said she had not seen R3 like that before. V12 said this was R3's first major behavior outburst. V12 said she does not remember exactly when R3 got the rod, but the rod was sticking in the ground. V12 said once R3 grabbed the rod, the situation turned. He was holding it like like he was going to stick it into us. V12 said R3's vision is not the best. V12 said she called V2 (Director of Nursing) from the cell phone she had on her, and she had her walkie talkie radio in her other hand letting V15 (LPN) to notify V3 (FNP-Family Nurse Practitioner) to get an order to send R3 to the ER for eval and treatment and then to call 911. V12 said she was doing all of this while running from R3 and trying to protect the CNAs that were out there. V12 said she thought if there was a male involved, it would change the situation, so she used the radio to ask V26 (Maintenance Supervisor) to come out. V12 said V26 came out and tried to calm R3 down to no avail. V12 said R3 started chasing V26, and them (herself and the CNAs), if they were around him. V12 said R3 was chasing them for about 12-15 minutes and it was about 45 minutes from the time R3 went out the back door until he left in the ambulance. V12 said the police came and R3 was still chasing them around the courtyard. V12 said R3 came at the police and they told him to drop the weapon or he would get tased. V12 said R3 continued to charge at the police and they	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007637	A. BUILDING: ______ B. WING ______	C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLURE OF PROPHETSTOWN	310 MOSHER DRIVE PROPHETSTOWN, IL 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) COMPLETE DATE
S9999	Continued From page 16	S9999		

tased him. V12 said when R3 hit the ground, he popped back up, he did not have the rod at that time. V12 said the police told him to stop being combative or they would tase him again. V12 said the officers handcuffed R3 and she attempted to clean the wounds on his hands. V12 said there was quite a bit of blood, mostly on his right hand. At 4:24 PM, V12 said she works for the corporation's float pool. V12 said she had not received any training through the facility and had not received any dementia training through the corporation. V12 said she had worked dementia units prior to working at the facility. V12 said with increased aggression and agitation, 95% of it is approach. Most of the time you can turn a situation around with how you approach the resident. V12 said you do not want to crowd a resident with agitation. You do not want too many people or get too close to the resident or stand over them. V12 said sometimes two to three people may be too much.

On 7/20/23 at 12:15 PM, V1 (Administrator) said she did not report the incident to the Illinois Department of Public Health because R3 was sent to the local hospital due to increased agitation and aggression. V1 said R3 did not receive any stitches or anything for the wounds on his hands.

On 7/20/23 at 12:38 PM, V25 (CNA) said she worked on 5/9/23. V25 said R3 was already outside when she went out. V25 said R3 was holding the steel rod like a rifle. "Anytime we got close or tried to calm him down, he would swing at us." V25 said V26 (Maintenance Supervisor) tried to calm R3 down. V25 said R3 would not put the rod down and nothing they tried was working. V25 said that when the police were called. V25 said V30 (Chief of Police) tried to talk with R3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007637	A. BUILDING: ______ B. WING ______	C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLURE OF PROPHETSTOWN	310 MOSHER DRIVE PROPHETSTOWN, IL 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) COMPLETE DATE
S9999	Continued From page 17 calmly and calm him down. V25 said then V29 (police officer) came out and tried to do the same. V25 said R3 did not calm down. V25 said the police officers warned R3 to put the rod down quite a few times. V25 said she looked away for a second and was not sure if R3 had lunged at the officers. V25 said she turned back around and saw V29 tase R3. V25 said R3 got right back up an kept going. V25 said she thinks it was V29 that told R3 if he does not calm down he will tase him again. V25 said R3 said okay and the behaviors stopped. V25 said she does not know if R3 could have been subdued without being tased, adding, "I know we could not get (R3) to calm down and drop the rod." V25 said R3 was not scared of anyone at that time and he was unpredictable. On 7/20/23 at 11:03 AM, V26 (Maintenance Supervisor) said he was in his shop at the facility when he was asked over the radio to go outside. V26 said he went outside and saw R3 chasing V12 and two other staff. V26 said R3 had a little 3/8-inch rod that was used to hold up tomato plants last summer. V26 said he asked (R3) what he was doing and then R3 turned and started chasing him for about five minutes before the police came. V26 said he ran because he could see himself getting stabbed with the rod if he tried taking it away from R3. V26 said R3 was holding the rod like a spear with a hand near both ends of the rod. V26 said V30 and V29 came out and saw R3 chasing him. They told R3 to put the rod down. They tried quite a few times to get R3 to put the rod down and then R3 lunged at the officer on his (V26's) right side so the officer tased him. V26 said R3 fell face down in the dirt and his hands must have slid across the concrete sidewalk. V26 said the officers got R3 up off the ground and he (V26) grabbed the steel rod off the ground. V26 said V29 and V30 handcuffed R3. At 11:14 AM, V26 showed this surveyor where the	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007637	A. BUILDING: ____ B. WING ____	C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLURE OF PROPHETSTOWN	310 MOSHER DRIVE PROPHETSTOWN, IL 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) COMPLETE DATE
S9999	Continued From page 18	S9999		

Continued From page 18

incident took place in the back courtyard. At 11:16 AM, V26 showed this surveyor the metal rod that R3 had brandished during the incident. The rod was approximately four feet long and 3/8-inch around. The ends of the rod were smooth. V26 said the rod was located in one of the flower boxes by the 200-300 halls courtyard.

On 7/20/23 at 1:20 PM, V23 (CNA) said a little after 6:00 AM on 5/9/23, R3 exited the memory care unit into the courtyard. V23 said She tried to get him to come back in but he would not stop. V23 said R3 kept going towards the unlocked gate. V23 said R3 grabbed a rod out of the ground by the flower beds and started chasing them. V23 said R3 was holding the rod like it was a gun at times. V23 said V12 told V26 (Maintenance Supervisor) to come out. V26 came out and was not able to calm R3 down. V23 said R3 chased V12, her and V26 around for about 20 minutes. V23 said when the police arrived, R3 was still swinging the rod around and the police told him to drop it or he was going to get tased. V23 said R3 was still going towards the officers and they tased him.

On 7/20/23 at 2:28 PM, V28 (CNA) said she has worked at the facility for one year. V28 said she worked on the memory care unit for the first-time last week. V28 said she has not had any in-person training for dementia; however, she has done some computer training for dementia care. V28 said she has not had any specific training on how to deal with a dementia resident exhibiting aggressive behaviors.

On 7/20/243 at 2:03 PM, V21 (CNA) said she has worked at the facility for about two years. V21 said she has not had any training from the facility for dementia care. No in-service training, and no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007637	A. BUILDING: ______ B. WING ______	C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLURE OF PROPHETSTOWN	310 MOSHER DRIVE PROPHETSTOWN, IL 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) COMPLETE DATE
S9999	Continued From page 19	S9999		

computer training for dementia. V21 said if a resident displays aggressive behaviors, they are supposed to report it to the nurse. V21 said "It is hard because they just walk out the door and don't want to come in. I have never worked at a place with a door that goes outside on the dementia unit." V21 said she thinks it is very important to have dementia training especially for aggressive behaviors because the resident with dementia is confused and does not know wat is going on.

On 7/20 23 at 2:13 PM, V10 (CNA) said she has worked at the facility since October 2022. V10 said she has not had any in-service training on dementia. V10 said she has done some computer training on dementia. V10 said the training covered different types of abuse and there was one on redirection. V10 said she thinks it is important to keep on dementia training, especially training for what to do when residents have behaviors, aggression, and agitation.V10 said she thinks there could be better, clear-cut procedures on how to handle residents with aggression.

On 7/21/23 at 2:23 PM, V22 (LPN) said she is in the float pool and not an employee of the facility. V22 said she receives training through the corporation. It does include dementia training. V22 said you cannot de-escalate if a patient is that aggressive. V22 said she would report it to V2 (Director of Nursing) and stay with the resident, never leave them alone. V22 said she would have another staff member with her. V22 said she would have another nurse on duty call the doctor and see if the resident could be sent out for an evaluation. V22 said she would protect other residents during that time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007637	A. BUILDING: ______ B. WING ______	C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLURE OF PROPHETSTOWN	310 MOSHER DRIVE PROPHETSTOWN, IL 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) COMPLETE DATE
S9999	Continued From page 20	S9999		

Continued From page 20

On 7/20/23 at 1:57 PM, V8 (LPN) said she has done the dementia training online for CEU (continued education). V8 said she has not attended any in-service training for dementia that she can recall. V8 said when a resident with dementia has aggression, staff should diffuse the situation, lower their tone, make eye contact. If aggression increases, "tap out" and get someone else to help.

On 7/20/23 at 3:13 PM, V2 (Director of Nursing) said on 5/9/23 staff tried to redirect , re-approach and use different staff. V2 said they had to have the police come. V2 said staff tried to get R3 to come back into the building and he would not do it. V2 said the facility staff cannot let a resident from the dementia unit be out back by themselves, adding, there is a river out back. V2 said if staff cannot get the resident to calm down, they call the police and send the resident out for a psychiatric evaluation. V2 said maybe there was too much stimulation, adding that it was the perfect storm; R3's brothers had recently visited, he had a roommate and the roommate's wife would come in with their dog. V2 said they let R3 go out back door now and watch him from afar. If he does not want to come back in, staff watch him from afar and let him cool down, and then he will usually come in.

On 7/21/23 at 2:15 PM, V3 (FNP-Family Nurse Practitioner) said R3 needs a locked unit and he is on a locked unit. V3 said a code had to be entered into the back door to the courtyard, or it would not open because it was locked. This surveyor informed V3 that the door would still open, however, the alarm would sound. V3 said she was not aware of that. V3 said there should not be a steel rod, or anything that could endanger R3 or any other resident in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007637	A. BUILDING: ______ B. WING ______	C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLURE OF PROPHETSTOWN	310 MOSHER DRIVE PROPHETSTOWN, IL 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) COMPLETE DATE
S9999	Continued From page 21 courtyard. V3 said it is important to ensure staff are knowledgeable on how to diffuse instances of aggression for residents with dementia. V3 said it is a good idea to develop a care plan that addresses a resident's aggressive and exit-seeking behaviors and list the interventions put in place to address those behaviors. On 7/11/23 at 9:06 AM, R3 was observed in the hallway, outside of his room. R3 was confused and did not know the door he was standing near was his room, even though R3's name was on the door. On 7/20/23 at 2:07 PM, R3 approached this surveyor and V21 (Certified Nursing Assistant-CNA). R3 asked "How do you get out of this place? Someone needs to show me the way out." R3 was able to be redirected to the dining area for a snack without difficulty. R3 still had a wound on his right hand from the incident on 5/9/23. R3's Vohra Initial Wound Evaluation and Management Summary dated 5/16/23 showed a non-pressure wound of the right hand, full-thickness, due to trauma/injury, measuring 12 cm (centimeters) x 8 cm x 0.3 cm with 40% thick adherent devitalized necrotic tissue (non-viable tissue), 25% slough (white or yellow, non-viable tissue), and 35% granulation tissue (red, beefy, viable tissue). The Wound Evaluation showed excisional debridement was performed to remove the non-viable tissue. R3's most recent Wound Evaluation and Management Summary dated 7/18/23 showed a non-pressure wound of the right hand, partial thickness measuring 3.3 cm x 2.2 cm x not measurable due to dried fibrinous exudate (scab). On 7/20/23 at 3:40 PM, V1 (Administrator) was asked about an assessment for R3's left hand.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007637	A. BUILDING: ______ B. WING ______	C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLURE OF PROPHETSTOWN	310 MOSHER DRIVE PROPHETSTOWN, IL 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) COMPLETE DATE
S9999	Continued From page 22	S9999		

V1 said maybe an assessment for R3's left hand was not documented because the right hand was so bad and they were focusing on it. V1 said the wound on R3's left hand was just a small abrasion. V1 said maybe because R3 would not let the nurses remove the bandage and do the dressing change, that by the time they did take the bandage off, the left hand was healed.

R3's care plans were reviewed. As of 7/20/23, the facility had not developed a care plan to address R3's wandering, exit-seeking, or aggressive behaviors.

2. On 7/10/23 at 3:44 PM, V4 (CNA) said she was working on 7/4/23 and was talking with other CNAs when one of them (she did not recall who said it) said R2 and R3 were found laying in bed together and R3's hand was under R2's clothes, in her private area.

On 7/11/23 at 8:43 AM, V1 (Administrator) said she had not received any reports of sexual abuse. V1 said she had not received any report of R3 touching R2 inappropriately.

On 7/11/23 at 8:55 AM, R2 was in her room, laying in bed. R2 said there had been a male in her room. R2 said the male did not do anything inappropriate to her, and has not touched her inappropriately. R2 said when the male came into her room, he just stood there for a minute and then walked back out. R2 said this has happened two times. R2 said if a male did come in and touch her inappropriately, she would tell staff right away. R2 said she has never been in any of the males rooms in the facility.

On 7/11/23 at 8:48 AM, R3 was observed in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007637	A. BUILDING: ____ B. WING ____	C 07/21/2023

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

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S9999	Continued From page 23	S9999		

dining room, sitting at a table with 2 other males. At 9:06 AM, R3 was observed standing in the hall outside the dining room. R3 was asked by this surveyor if that was his room, and pointed to the room across the hall from the dining room, displaying R3's name on the door. R3 said no, it was not his room and asked this surveyor where his room was. This surveyor asked R3 if his name was (R3's name) and he said yes. This surveyor informed R3 that his name was on the door along with a picture of animals. R3 said well maybe that is my room. Upon entering R3's room, R3 recognized some of his belongings and said yes this is my room, I can tell now that I am in here. When asked if any of the female residents had ever been in his room. He said yes, my daughters come to see me and they have been in here. When asked if any of the women that live in the building have been in his room, R3 again said yes, my daughters have been in here. R3 appeared confused and was not able to comprehend what this surveyor was asking him. When asked if he had gone into any of the females rooms in the building, R3 said he has not been in any other resident's rooms.

On 7/11/23 at 8:50 AM, V19 (Certified Nursing Assistant-CNA) said she has seen R2 and R3 in eachother's rooms and has redirected them. V19 said R2 and R3 hang out, walking down the hall. V19 said she has not seen, or heard about any inappropriate touching involving R3 and any other residents.

On 7/11/23 at 9:00 AM, V7 (Licensed Practical Nurse-LPN) said she was not aware of any incident regarding R3 inappropriately touching any of the female residents. V7 said usually R3's behaviors are aggressive such as verbal aggression and raising his hand at staff. V7 said

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S9999	Continued From page 24	S9999		

R3 has sundowners and tries to get out of the building sometimes, V7 said R2 also wanders and tries to get out of the building. V7 said she has not seen any inappropriate sexual behaviors and no one has reported any regarding R3.

On 7/11/23 10:16 AM, V5 (CNA) said she is not aware of R3 being in R2's room. V5 said she knows that R2 and R3 thought they were husband and wife one day. V5 said V10 (CNA) told her during shift report one day that R2 and R3 were laying in bed together in R3's room, but to her knowledge, they were both fully clothed. V5 said V10 said they were being "touchy-feely" and they were split up. V5 said it only happened one time.

On 7/11/23 at 10:43 AM, V10 (CNA) said she has seen R2 and R3 in R3's room, laying on the bed together a couple of times. V10 said it happened about a month prior. V10 was not able to identify the day it happened. V10 said the first time she saw them, they were both fully-dressed, laying in bed together. V10 said she redirected R2 out of R3's room. V10 said the next time (within two days of the first incident) she saw R2 and R3 laying in bed in R3's room, R3 had his hands down R2's pants. V10 said she redirected R2 out of R3's room and informed V12 (LPN). V10 said she informed V12 what she had seen and asked if residents on the dementia unit were able to give consent for sexual activity. V10 said V12 told her she was going to talk to V2 (Director of Nursing) about it. V10 said she was told to redirect R2 and R3 and to pass the information on to other staff. V10 said she has seen R2 and R3 go into eachother's room after that and staff would redirect them. V10 said R2 and R3 are both confused and seek out eachother. V10 said they thought they were married. On 7/12/23 at 9:50

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S9999	Continued From page 25	S9999		

AM, V10 said she has seen R3 go into other female resident's rooms. He will go in and talk to R7 sometimes. V10 said R3 wanders. He has dementia. V10 said R3 is easily redirected. V10 said she did not report the first time she saw R2 and R3 laying in bed together because she did not see anything inappropriate going on.

On 7/11/23 at 1:31 PM, V12 (LPN) said she does not recall if one of the CNAs ever told her that R2 and R3 were laying in bed together in R3's room and R3 had his hands under R2's clothes. V12 said she cannot say one way or the other without looking at her nursing notes. V12 said she was in another state, on vacation at the time and did not have access to her nursing notes. When asked if that was something that you would probably recall being told, V12 said yes, you would think so, but I cannot say without looking at my notes.

On 7/11/23 at 2:03 PM, V8 (LPN) said she has not been on the dementia unit since December of 2022. V8 said she had not heard anything about R2 and R3 laying in bed together and there being any inappropriate touching.

On 7/12/23 at 9:37 AM, V14 (CNA) said R3 roams around a lot. V14 said R3 is easily redirected. V14 said she has not seen R3 exhibit any sexually inappropriate behaviors towards any residents or staff. V14 said she just heard about the incident involving R2 and R3 yesterday (7/11/23).

On 7/12/23 at 11:55 AM, V11 (LPN) said R3 has general wandering behaviors. He will go in and come right back out. V11 said this past weekend is the first time she has seen a female in R3's room. V11 said her and V13 (LPN) were doing report and one of the CNAs came and said there

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S9999	Continued From page 26	S9999		

was a female resident in R3's room. V11 said the female resident was laying on R3's bed and R3 was on the bed next to her, leaning back, propped up on his elbows. V11 said she did not see any inappropriate touching, or clothing messed up, or anything that would lead me to believe anything happened. V11 said staff intervened and they got R2 out of the bed. V11 said R3 was upset and combative and asked where are you taking her. V11 said they informed R3 that they were taking R2 back to her house. V11 said R3 did not say anything about R2 being his wife during that incident, but he was speaking very lovingly about her, saying don't you hurt her, and that's a good woman there.

On 7/12/23 at 1:08 PM, V13 (LPN) said on 7/9/23 V20 (CNA) came up to the nurse's desk and asked if it is okay for R2 to be in R3's room. V13 said she and V11 went to R3's room to see what was happening. R2 was laying on her back in R3's bed and R3 was on his side next to her in the bed. V13 said she did not see any inappropriate touching during the encounter. V13 said she talked to R2 and redirected her out of R3's room. V13 said it took a minute to redirect her out of his room. V13 said R2 sat on R3's bed for a while before they were able to redirect her out of his room. V13 said R2 did not want to leave R3's room at first. V13 said R2 and R3 are both confused and she does not know if R3 realizes who R2 is. He was walking down the hall behind them yelling at staff. V13 said prior to the incident on 7/9/23, she was not aware of any incident involving R3 touching any female residents inappropriately. V13 said R2 has a tendency of migrating towards the new male residents, not sexually, just befriending them.

On 7/12/23 at 1:34 PM, V15 (LPN) said she has

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S9999	Continued From page 27	S9999		

had to redirect R2 out of R3's room before. V15 said she had not seen any inappropriate sexual behavior from R3 before. V15 said R3 has not acted sexually inappropriate with herself or any other staff, that she is aware of. V15 said R3 has not acted sexually inappropriate with any other female residents.

R2's Admission Record, printed by the facility on 7/12/23, showed she had diagnoses including unspecified dementia with agitation, anxiety disorder, and visual hallucinations. R2's facility assessment dated 6/30, 2023 showed she had severe cognitive impairment, disorganized thinking and inattention. R2's care plans were reviewed. R2's Cognitive deficit care plan, with a revision date of 5/10/23, showed she has impaired decision making and a self-care deficit. The interventions in place were to encourage activity participation, remind and direct her to activity, and offer verbal cues, reminders and redirection as needed. Redirect when wandering or rummaging. R2's cognitive function/dementia care plan, with a revision date of 5/10/23, showed she has impaired cognitive function/dementia or impaired thought processes. The interventions include cue, reorient and supervise as needed. R2's care plan, with a revision date of 6/28/23 showed R2 uses anti-anxiety medications related to adjustment issues, anxiety disorder. Interventions include "Monitor/record occurrence of for target behavior symptoms of pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, etc., and document per facility protocol." The care plans do not address wandering into male resident's rooms, being found in a male resident's bed, inappropriate touching, or redirecting out of male resident's rooms. R2's progress notes from 4/8/23 - present

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S9999	Continued From page 28	S9999		

do not document R2 being found laying in bed with a male resident or inappropriate touching.

R3's Admission Record, printed by the facility on 7/12/23, showed he had diagnoses including unspecified dementia, moderate with other behavioral disturbance, and adjustment insomnia. R3's facility assessment dated 5/3/23 showed he had severe cognitive impairment. R3's cognitive deficit care plan, with a revision date of 5/15/23, showed he had impaired decision making, and a self-care deficit. The interventions in place included encourage activity participation, invite to group activities, Offer verbal cues and reminders, redirect as needed. R3's care plan, with a revision date of 6/20/23 showed R3 had a history of criminal behavior including batter in 1982 and domestic violence in 1984. The care plan showed R3 was evaluated by the State Police and considered high risk. The care plan showed R3 was placed in a private room, in high visually monitored area, to permit visual monitoring prior to analysis. The care plan interventions showed R3 had been referred to facility psychiatrist for evaluation monthly. R3's care plans do not address being found laying in bed with a female resident or inappropriate touching.

R3's progress note dated 5/4/23 showed a CNA reported to the nurse that R3 had been passing another resident's room and the CNA heard the resident say to R3, come here and give me a kiss R3 went into that resident's room, leaned over, embraced the resident and gave her a kiss. The note showed the residents were redirected and V1 had been notified. R3's progress note dated 5/5/23 showed R3 was observed by a CNA in another resident's room, sitting on the bed, taking his shoes off, getting ready to lay down. The other resident was already in the bed. R3 was hard to

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S9999	Continued From page 29	S9999		

redirect to get him out of the other resident's room. R3's progress note dated 5/9/23 showed R3 was in the back court yard stating "he is trying to kill us." staff were trying to redirect R3 and he grabbed a steel rod from the ground and began chasing the nurse and two CNAs. The notes showed 911 was called and R3 was tazed by police when he started running towards the police with the steel rod in his hand. R3's progress note dated 5/11/23 showed he got into another resident's room across the hall from his and tried keeping the door shut, to keep staff from entering. One of the resident's in the room yelled at R3 to get out. Staff were able to get R3 out and back to his room. Progress note dated 5/17/23 showed res was observed going in and out of other resident rooms. R3 said "I'm getting out of here and you can't stop me." R3's progress note dated 6/28/23 showed R3 was wandering hallway, searching for exit. R3's progress note dated 6/30/23 showed he was anxious and seeing images and people that were not there. Pacing up and down the hallway, going in and out of other rooms. Progress note dated 7/3/23 showed R3 was very agitated and hallucinating. R3's progress note dated 7/9/23 showed resident noted to be wandering in hall and entering other resident rooms at this time. The notes showed the nurse was able to get resident into bed to lay down. Resident then patted the bed and said "Come on right here honey", followed by "Man I sure hope your old man doesn't come home to this." On 7/12/23 at 11:55 AM, V11, the nurse who wrote the note on 7/9/23, said she thinks it may have been the way she worded "Let's get into bed." when she was assisting him into bed. V11 said she did not feel uncomfortable or like he was trying to be sexually inappropriate with her. V11 said she thinks R3 just misunderstood what she was saying.

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S9999	Continued From page 30 (B)	S9999		