

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057281		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/03/2025	
NAME OF PROVIDER OR SUPPLIER ALLURE OF STERLING				STREET ADDRESS, CITY, STATE, ZIP CODE 612 WEST ST MARY'S STREET , STERLING, Illinois, 61081			
(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		S0000			12/04/2025	
	Complaint Investigation 2511158/2678390						
S9999	Final Observations		S9999			12/04/2025	
	Statement of Licensure Violations:						
	300.610a)						
	300.690a)						
	300.695a)3)						
	300.695b)3)						
	300.1210b)						
	300.3240c)						
	300.3240f)						
	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.						
	Section 300.690 Incidents and Accidents						
	a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 resident shall also be recorded in the progress notes or nurse's notes of that resident. Section 300.695 Contacting Local Law Enforcement a) For the purpose of this Section, the following definitions shall apply: 3) Sexual abuse - sexual penetration, intentional sexual touching or fondling, or sexual exploitation (i.e., use of an individual for another person's sexual gratification, arousal, advantage, or profit). b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations: 3) Sexual abuse of a resident by a staff member, another resident, or a visitor; 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. Section 300.3240 Abuse and Neglect c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act) f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the			S9999			

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S9999	Continued from page 2 perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These requirements were not met as evidenced by: Based on interview, and record review the facility failed to ensure a resident (R1) was not sexually abused by another resident (R2) for 1 of 3 residents reviewed for sexual abuse in the sample of 5. The findings include: The Face Sheet dated 11/27/25 for R1 showed diagnoses including dementia, sleep disorder, general anxiety disorder, emphysema, chronic obstructive pulmonary disease, trigeminal neuralgia, hypertension, hyperlipidemia, osteoporosis, and urinary tract infection. The Nurse Practitioner (NP) note dated 11/11/25 for R1 showed she was being seen for a scheduled psychiatric follow up. R1 demonstrated behaviors consistent with her ongoing neurocognitive decline but was attentive and responded appropriately to all inquiries. Alerted and oriented X1 (person). Recent and remote memory: poor. Attention span and concentration: poor. The Minimum Data Set - MDS dated 10/7/25 for R1 showed severe cognitive impairment. On 11/27/25 at 9:09 AM, V1 Administrator stated R1 and R2 are two residents that are close. They were in R1's room together. V9 CNA (Certified Nursing Assistant) walked into R1's room and R1 and R2 were naked. R2 was standing over R1 with his right hand on the wall and left hand under R1's shoulder. R1 was leaning back. V9 stated she saw R2's buttocks and asked them what they were doing. V9 told R2 to leave the room. V1 stated V9 got V8 the nurse. V1 stated V10 (R1's daughter) was notified when this happened. V1 stated this incident occurred on 11/19/25 and was not reported to the state. V1 stated she did an investigation and since no intercourse happened, she did not report it. V1 stated she asked V9 if R2 had an erection when he turned around and she said he didn't. They were not on top of each other. V1 stated there wasn't any sexual act going on; they were just naked. V1 stated she did an abuse investigation and did not report it because no sexual intercourse happened.			S9999			

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S9999	Continued from page 3 On 11/27/25 at 10:10 AM, V1 stated V8 Licensed Practical Nurse - LPN called her the night it happened and V1 directed her to interview R1 and do a skin check. V1 stated it is not documented in R1's chart and she does not know why it wasn't. V1 stated she did not know why V8 did not do a risk assessment and put it into the chart. V1 stated normally a risk assessment is done and entered in the resident's chart so they have all the details. V1 stated it should be documented in the chart that the family was notified. V1 stated she notified R1's family on 11/19/25 so the lack of documentation is on her for that. On 12/1/25 at 9:14 AM, V10 (R1's daughter/Power of Attorney – POA) stated I was called on Wednesday (11/19/25) night when she was sleeping. V10 stated she talked to V1 Administrator Thursday (11/20/25). V1 at first said that there was sexual contact with R2 and R1. V1 said she still needed to talk to the CNA to get more information and then would talk to V10. V1 called V10 back and said both were naked. R1 was sitting on the bed in front of R2 giving him oral sex. R2 wasn't erect but R1 was performing oral sex. V1 had told V11 (R1's son) when she talked to him that R1 was laying down and R2 was leaning over her; R1 was giving R2 oral sex, so the story had changed. V10 stated that bothered them. V10 stated V2 Director of Nursing – DON called and said she would like to get consent for medication for R1 in case she had any anxiety. V10 stated if they need permission for R1 to have the medication, have V10 present to read to R1 what she is signing, and go over the papers, then why do they think R1 can consent to this? V10 stated she did not think R1 has the ability to consent. V10 stated when she went to the facility for a meeting on Tuesday (11/25/25) she was told R2 was leaning over R1, he had her head in his hand and was holding her head there. V10 stated there were so many different stories. V10 stated on Saturday (11/29/25) when she went to see her, R1 told her that R2 raped her. V10 stated she told the facility what R1 said; she told the facility that R1 said R2 raped her. V10 stated R1 doesn't remember exactly what happened but said he raped her. V10 said she dislikes R2 and doesn't have anything good to say about him. V10 stated she did a video/audio recording on her phone of R1 telling her she was raped. On 12/1/25 at 11:14 AM, V10 and R1 were sitting in chairs in the dining room with the door closed and no other residents or staff present for the interview. R1 identified the person at the table with her as V10 her daughter. R1 was asked if anyone there had made any sexual advances and /or touched her in a sexual way. R1			S9999			

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S9999	Continued from page 4 stated, "he raped me." R1 stated she couldn't think of the man's name. R1 stated she was watching TV; the man came into her room and raped her. R1 stated the man got down next to her and was playing with her; he wasn't there long. R1 stated she told her boyfriend what happened because she was crying, and her boyfriend got mad. R1 was asked if the man was R2 or R3. R1 stated R2 was the one that raped her, and she was called into an office and questioned about it. R1 stated R2 had forced her to have oral sex, and she did not want to, but she didn't have a choice. R1 stated R3 is her boyfriend, and they are getting married. R1 stated she has been with R3 for a long time and has not had sex with him. V10 played a recording on her phone of R1 that was done on 11/28/25 at 3:47 PM and in the video R1 stated she was raped. R1 confirmed that R2 was the man's name and stated, "I never want to see that bastard again." On 12/1/25 at 11:38 AM, R2 was sitting in a wheelchair in his room and was interviewed at that time. R2 stated his daughter put him in this place. R2 stated he is not in a relationship with anyone here. R2 stated he knew of R1 but did not really know her. R2 stated he went into R1's room one time. R2 stated he did not know what happened when he went into R1's room. R2 denied having sex with R1. R2 denied having his clothes off in R1's room. R2 stated he was in a room at the end of the hall, and they moved him to this room. R2 stated R1's room is somewhere down there (down the hall). On 12/1/25 at 11:49 AM, R1 and R3 were in the dining room sitting at a table together. R3 was facing across from R1 and they were talking. R2 entered the dining room and R1 looked at him and told him to leave. R1 and R3 were asked who R2 was and R3 stated he (R2) used to be his friend but wasn't anymore. R3 said R1 told him that R2 raped her, and she could not get up. R3 stated he felt so bad that it happened. R3 stated he did not have any part in what R2 was doing and wouldn't do something like that. R3 stated he was beyond mad at what happened and felt bad because there was nothing, he could do to protect R1. R3 stated he has never done anything like that in his life and doesn't know what R2 was thinking. R3 stated they stay away from R2 the best that they can. On 12/1/25 at 12:45 PM, V9 CNA stated on 11/19/25 at around 8:30 PM she went to R1's room, knocked on her door, and was told to wait a minute. V9 stated she entered the room and saw R2 naked with his buttocks facing her and he was thrusting. V9 stated R1 was laying at an angle with her back/torso area on the bed and her bottom half was half on and half off the bed. R2 had his right hand on the wall and his left hand on			S9999			

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S9999	Continued from page 5 R1's shoulder. R2 was leaning in on R1 and was thrusting. V9 stated she couldn't really see R2's penis because it was dark and due to his body shape, she said she couldn't tell if he had an erection or not. V9 stated she couldn't tell if he was in R1's vagina or not and stated R1 and R2 were skin to skin, and he was thrusting. V9 stated when she told R2 to stop it seemed like he did not want to and wanted her to wait until he was finished. V9 stated she separated R1 and R2 and got the nurse right away. V9 stated V8 Licensed Practical Nurse - LPN contacted V1 Administrator and assessed R1. V9 stated she talked to V1 also. V9 stated R1 seemed like she was fine that evening and did not appear distraught. V9 tried to clean R1 up and R1 was giving her a hard time. V9 said, "It was a big protest to get her (R1) dressed". V9 stated R1 acts like that at times normally. V9 stated R1 is confused and has a false reality. R1 thinks she has 8 kids at home that she must take care of and talks about seeing her mother. V9 stated what happened was serious in nature so it had to be reported. V9 stated she was in shock and was not aware of anything like this happening before and she has worked at the facility a total of four years; 2 years in housekeeping and 2 years as a CNA. V9 stated in her opinion she thought this was sexual abuse. V9 stated R2 seems more consciously aware of what he is doing more than R1 does. V9 CNA stated there are 2 CNAs from 6 PM to 10 PM and then she is working alone on the unit. V9 stated if she is in a resident room providing care such as incontinence care she could be in a room for 20 - 30 minutes so there is no one to check/monitor the other residents. V9 stated there needs to be 2 aides on the unit so one can do rounds, and the other one can check and monitor residents. On 12/1/25 at 1:18 PM, V3 Assistant Director of Nursing - ADON stated she was left out of the November 2025 incident between R1 and R2. V3 stated a night shift CNA, and the nurse spoke with V1 about the instance of R2 going into R1's room. V3 stated she has heard a couple of different stories about what happened. V3 stated the next day R1 told V15 CNA that she was raped; and V15 told V13 LPN who then reported it to V2 Director of Nursing and V1 Administrator. V1 went down immediately to talk to R1 and V19 regional Corporate Nurse did some questioning. V3 looked in her phone and stated it was on 11/21/25 that the rape was reported. V3 stated V20 Psychiatrist does not come into the facility; V14 Psychiatric Nurse Practitioner is the one that currently comes in. On 12/1/25 at 1:44 PM, V13 LPN stated she was doing morning medication pass on the dementia unit and V15 CNA told her that R1 went into R3's room and told him			S9999			

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S9999	Continued from page 6 she was raped by R2. V13 stated she told V15 to tell V1 Administrator now. V15 came back and said she wasn't able to talk to V1 because she was in a meeting. V13 stated she went herself first to V2 DON who asked why she was she reporting this to her (V2) and to go and report it to V1. V13 stated she was going to go to V1's office when V1 walked by so she told V1 and V1 went to the unit to talk to R1. R1 and R2 are confused but R2 is more with it than R1 who is confused and forgetful. V13 stated she doubted that R1 had the ability to consent to sex. They have to call V10 for everything; R1 is not quite with it. On 12/1/25 at 1:59 PM, V14 Psychiatric Nurse Practitioner - NP stated she sees R1 for psychiatric services and R1 has dementia with moments of clarity, but it depends on the day. Some days R1 is more alert than others; there are moments when she is confused and moments when she is with it. V14 stated there is no way to tell if R1 can or can't consent but what she could say is when she has seen R1 she is alert and oriented x 1 (to herself). On 12/1/25 at 2:09 PM, V15 CNA/Activities stated R1 and R3 were walking in the hall and R3 told me that I V15) needed to talk to R1. V15 stated she talked to R1 and R1 said she was raped, R1 did not know his name, and pointed R2 out. V15 stated she reported it to V13 LPN who then reported it to V1. V15 stated V1 talked to them. On 12/1/25 at 4:00 PM V4 Medical Director stated, R1 is on a memory care unit for a reason. R1 cannot consent for herself. R1 and R2 are both in the memory care unit. V4 stated they are not capable of making sound decisions. V4 stated he was notified that there may have been a sexual encounter between R1 and R2. The residents were separated. V4 stated that later R1 accused the other resident of rape. V4 stated he doesn't know if a rape occurred. V4 stated the facility's policies and procedures should be followed. V4 stated what happened should be recorded/documented. V4 stated R1 was not sent out for examination because it probably was not wanted by the family. On 12/2/25 at 7:29 AM, V23 Sexual Assault Nurse Examiner stated R1 was seen at the hospital on 12/1/25 and V10 stated the state was looking into a sexual assault for R1. V23 stated she was just checking so she did not make a duplicate report. V23 stated V10 told her that this was reported at the facility right away, but nothing was done until they were told they had options. V23 stated it was two weeks past when this happened, so there won't be any evidence left but swabs			S9999			

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S9999	Continued from page 7 were completed. V23 stated there wasn't any visible signs of trauma and no discharge was present, but it was hard to tell if anything happened because 2 weeks have elapsed since it happened. V23 stated R1 told her she was watching TV; a guy came into her room looking for her fiancé and raped her. V23 stated V10 was there and said R1 was forced to have oral sex so there were two different stories about what happened. V23 stated R1's clothes could not be collected for any evidence because they did not know what she had been wearing, and her clothes have been washed. V23 stated she documented everything in the hospital record. On 12/2/25 at 10:08 AM V8 LPN stated she did not remember the day the incident happened between R1 and R2. V8 stated the CNA told her she knocked on R1's door, went into the room, and R2 was on top of R1 having sex. V8 stated when she went to R1's room they were no longer having sex. V8 stated she texted V2 DON who told her to contact V1 Administrator who told her to put 15-minute checks in place, make sure room doors were open, and have the aide sit outside of R2's room door. V8 stated she assessed R1 and did not find anything. R1 at first stated she didn't remember what happened then R1 told her she did want sex and wasn't forced. V8 stated R2 would not allow her to assess him. V8 stated she was told not to document anything or notify the families because V1 stated she would do that. V8 stated she knows things have happened in the past, her coworkers have charted them and then the charting disappears, and she doesn't know how that can happen. V8 stated in her opinion R1 and R2 can't consent to sex. V8 stated she reported what happened because she felt it was sexual abuse and is required to report it. V8 stated they put the 15-minute checks in place but there is only one aide and when that aide is providing care there is no way for her to monitor the other residents and do checks and complete her work. V8 stated there needs to be two aides on the hall at all times to watch everyone. The MDS dated 11/5/25 for R2 showed moderate cognitive impairment. The Face Sheet dated 11/27/25 for R2 showed diagnoses including dementia, adjustment disorder with mixed anxiety and depressed mood, type 2 diabetes mellitus, and hypertension. The Nurse Practitioner Note dated 11/25/25 for R2 showed he is alert and oriented x 2; he is able to explain why he is here and what his current health status is like. R2's recent and remote memory: fair. Attention span and concentration: fair.		S9999				

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S9999	Continued from page 8 The facility's Abuse, Neglect, and Exploitation policy (2025) showed sexual abuse is non-consensual sexual contact of any type with a resident. Prevention of Abuse, Neglect and Exploitation: The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. This may include identifying when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship. (A)		S9999				