STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145012	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allure of Knox County	280 East Losey Street Galesburg, IL 61401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31285 Based on interview and record review the facility failed to obtain consent prior to the use of psychotropic medications for two of three residents (R1 and R2) reviewed for psychotropic medications in the sample of three. Findings include: The facility's undated Use of Psychotropic Medication(s) documents the following: 11. The facility will document that the resident or resident representative was informed in advance of the risks and benefits of the proposed care,the treatment alternatives or other options and the preferred option to accept or decline, in a format the facility deems to use (e.g.written consent form, narrative note, etc.). R1's medical record documents R1's diagnoses include: Major Depressive Disorder, Bipolar Disorder Depressive State and Anxiety disorder. R1's medical record includes a MD (Medical Doctor)/Nursing Communication form for R1, dated 02/14/25 by V8 (the facility's Medical Director), documents V8's facility visit with R1 and an order to discontinue R1's Venlafaxine Hydrochloride Extended Release Oral Tablet 24-hour 150 mg/milligrams (an antidepressant medication). This visit note also included an order to initiate administration of Sertraline 50 mg orally once daily (an antidepressant medication). R1's Physicians Orders document R1's Venlafaxine was ordered upon R1's admission to the facility on [DATE], and was discontinued by V8/Medical Director on 2/14/25 and V8 ordered initiation of Sertraline 50 mg, which was started on 2/16/25. As of 3/28/25, R1's medical record did not contain documentation of a consent form for R1's Sertraline medication. On 3/28/25 at approximately 1:35pm V2 DON/Director of Nursing verified she was present with V8 on 02/14/25 and verified she received V8's orders to discontinue R1's Venlafaxine and initiate Sertraline. V2 stated consent for antidepressant medication administration changes should be obtained prior to initiating the medication orders. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/28/25 at approximately 2:35pm V2 stated the facility did not obtain consents from R1's Health Care Power of Attorney (R1's designated representative) prior to initiating the proposed medication changes. V2 stated the facility should have obtained consents for R1's change in medications. 38805 2. R2's Diagnoses include: Major Depressive Disorder, Recurrent, Unspecified. R2's physician orders document: Duloxetine Oral Capsule Delayed Release Sprinkle 30 milligrams/MG at bedtime for depression. Monitor for side effects related to use of Antipsychotic medications: i.e. tremors, Tardive Dyskinesia, dystonia, dry mouth, blurred vision, hypotension, sedation/drowsiness, dizziness, cardiac abnormalities, increased anxiety/agitation, sweating, rashes, urinary retention/hesitancy, weakness, etc. R2's Care Plan documents: (R2) is at risk for adverse effects related to use of antidepressant medication, use of antipsychotic medication. Review of R2's Electronic Health Record indicated there was no Psychotropic Medication Informed Consent form documentation for R2's Duloxetine/Cymbalta. On 3/28/25 at 1:40pm, V5 Regional Nurse Consultant confirmed that R2 had been taking the Duloxetine medication without a signed consent form. V5 stated, We did not have a signed consent form for (R2's) medication; this should have been done on admission. We just got the form signed today by the resident and the doctor (V8 Medical Director). (Documentation indicated that R2 was admitted to the facility on [DATE]).