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	07/20/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the Facility failed to complete post-fall documentation and implement appropriate fall interventions for four Residents (R1, R2, R3 and R4) and monitor for post fall injuries for three Residents (R2, R3 and R4) of four Residents reviewed for Falls in a sample of four. Findings include:The Facility Fall Prevention Policy, revised 1/2025, documents: each Resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls; a fall is an event in which an individual unintentionally comes to rest on the ground, floor or other level and may be witnessed, reported or presumed when a Resident is found on the floor or ground; the nurse will indicate on the Care Plan, the Resident's fall risk and initiate interventions on the Resident's baseline Care Plan; provide interventions that address unique risk factors measured by the risk assessment tool, medications, psychological, cognitive status or recent change in functional status; provide additional interventions as directed by the Resident assessment, including assistive devices, increased frequency of rounds, sitter, medication regimen review, low bed, alternative call light system, scheduled ambulation or toileting, family/caregiver/Resident education or therapy services; interventions will be monitored for effectiveness; and when a Resident falls the Facility will assess the Resident, complete post-fall assessment, complete an incident report, notify physician/family, review Resident's Care Plan and update as indicated and document all assessments and actions.The Facility Skin Assessment Policy, revised 5/2025, documents: to perform a full body assessment as part of our systematic approach to pressure injury prevention and management; the assessment may also be performed after a change of condition; note any skin conditions such as redness, bruising, rashes, blisters, skin tears, open areas or lesions; and document the date and time of assessment, observations, type of wound, describe wound (measurements, color, type of tissue in wound bed, drainage, odor or pain) and any other information as appropriate.1) R1's Minimum Data Set/MDS, dated [DATE], documents R1 is dependent on staff for sit-to-lying, sit-to-standing, chair-to- bed transfer and that R1 is unable to ambulate ten feet.The Facility Incidents by Incident Type Report, dated 4/1/25 through 7/17/25, documents falls for R1 (4/16/25 at 12:54 pm, 4/29/25 at 1:50 pm, 5/1/25 at 10:40 pm, 5/13/25 at 4:20 am, 5/17/25 at 8:45 am and 8:15 pm, 5/21/25 at 6:15 pm, 5/27/25 at 4:00 pm, 6/14/25 at 6:00 am, 6/27/25 at 4:33 am, 7/8/25 at 8:40 am, and 7/15/25 at 4:10 am). The Report also documents R1's bruise incidents (4/27/25 at 12:00 am, 6/11/25 at 1:41 am and 6/19/25 at 1:00 pm).R1's current Care Plan documents: impaired cognitive loss (to person, place and time) related to Dementia; impaired vision; and requires staff assistance for Activities of Daily Living. R1's Care Plan also documents fall interventions: bowel and bladder program (4/16/25); keep engaged I activity such as coloring if does not want to go to bed (5/1/25); reorient to time as needed and when gets up during night and thinks it is morning, allow R1to see it is dark outside and if R1 wants to stay up, allow to stay up and assist into wheelchair, night light in room (5/13/25); likes to stay up late, if still up after 9:00 pm, offer to assist to bed, if wishes to stay up later, offer R1 assistance to bed at intervals, monitor and assist for footwear (5/17/25); assist toilet after breakfast and monitor going to room to lie down (5/17/25); provide education to ask for assistance (5/21/25); monitor for R1 in TV room and offer to assist into chair (5/21/2025; lower back of wheelchair to keep from sliding out(7/07/2025); bed in low position (4/07/2025); non-skid pad under wheelchair cushion and on top of wheelchair cushion (6/14/2025); observe for resident showing signs of fatigue and offer to assist to bed (4/30/2025); non-skid pad (dycem) in wheelchair seat (5/27/2025); medication review (Hydroxyzine) at hours of sleep (6/27/2025); monitor for resident trying to propel wheelchair with brakes locked (6/27/2025); have commonly used articles within easy reach (4/07/2025); provide assistance to transfer and ambulate as needed (4/07/2025); Staff education (6/15/2025).R1's Neurological Evaluation Flow Sheets, dated 4/1/25 through 7/18/25, do not document neurological checks for R1's un-witnessed falls on 4/29/25, 5/1/25, 5/13/25and 7/8/25.R1's Un-witnessed Fall Report (#367), dated 4/29/25 at 1:50 pm, documents R1 was noted to be sitting on the floor next to bed and stated, I was trying to get into bed and my foot went out from under me. No injuries were noted. The intervention was to observe for signs/symptoms of fatigue and offer assist to bed. R1's Un-witnessed Fall Report (#370), dated 5/1/25 at 10:40 pm, documents R1 was sitting in wheelchair at end of hallway and self-transferred standing up to walk and states was trying to answer the phone and the kids were calling. No injuries were noted. The intervention was to provide a tray table in corridor and provide activities (coloring books, markers/crayons an puzzles) R1's Un-witnessed Fall Report (#387), dated 5/13/25 at 4:20 am