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	08/29/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to assess the pain of a resident who received scheduled medication to control pain for one resident (R4) of three residents reviewed for pain. The Facility's undated Pain Management policy documents The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences. Monitoring, Reassessment and Care Plan Revision a. Facility staff will reassess resident's pain management at established intervals for effectiveness and/or adverse consequences such as: i. tolerance 11. Physical dependence iii. increased sensitivity to pains iv. constipation v. nausea, vomiting, and dry mouth vi. sleepiness, dizziness, and/or confusion vii. depression viii. itching and sweating; b. If re-assessment findings indicate pain is not adequately controlled, the pain management regimen and plan of care will be revised as indicated. c. if the pain has resolved or there is no longer an indication for pain medication, the interdisciplinary team will work to discontinue or taper (as needed to prevent withdrawal symptoms) analgesic's. d. If a resident reports or there are signs of increased pain, the facility should evaluate whether there is a time or day pattern to ensure that the problem is not due drug diversion.R4's Medical Record documents that she was admitted to the facility on [DATE] with diagnosis to include but not limited to left below the knee amputation, spinal stenosis, anxiety and depression. On 8/27/25 at 10:50 AM R4 was alert and answered questions appropriately. R4 was lying bed, appeared pale, her hairline was damp and she seemed to be breathing rapidly. R4 stated she was in pain, stated The nurse knows, she hasn't brought my morning medicine yet. Sometimes it takes these agency nurses longer.R4's Physician Order Sheet dated August 2025 documents R4 receives the following scheduled medications for pain: Hydrocodone (narcotic) 5-325 mg, pregabalin (for pain) 75 mg and Tizanidine (muscle relaxer) 2 mg.R4's Medical Record does not contain any documentation prior to or after the administration of her scheduled pain medications. On 8/29/25 at 9:00 AM V2 (Director of Nursing) confirmed that R4's pain was not assessed prior to or after the administration of R4's scheduled medications for pain. It (pain scale) is not on there and it should be.

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
	145012	A. Building B. Wing	08/29/2025

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

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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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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	08/29/2025

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

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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 0760 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure one resident (R4) was free of significant medication error of three residents reviewed for medications. This failure caused R4 to be visibly uncomfortable and anxious. The Facility's undated Medication Errors policy documents Medications errors, once identified will be evaluated to determine if considered significant or not by utilizing the following three general guidelines: a. Resident's condition: if the resident's condition requires rigid control, such as strict intake and out put measurement, daily weights, or monitoring of lab values. b. Drug category: if the medication is from a category that usually requires the resident to be titrated to a specific blood levels such as a medications with a narrow therapeutic index. c. Frequency of Error: if an error is occurring repeatedly such as an omission of a resident's medication several times. The Facility's undated Medication Errors policy documents the facility will consider factors indicating errors in medication administration, including, but not limited to, the following: a. medication administered not in accordance with the prescriber's order. Examples include but not limited to: 1. Incorrect dose, route of administration, dosage form, time of administration. If a medication error occurs, the following procedure will be initiated: a. The nurse assesses and examines the resident's condition and notifies the physician or health care practitioner as soon as possible. b. Monitor and document the resident's condition, including response to medical treatment or nursing interventions. c. Document actions taken in the medical record. d. Once the resident is stable, the nurse reports the incident to the appropriate supervisor and completes the incident or occurrence report. R4's Medical Record documents that she was admitted to the facility on [DATE] with diagnosis to include but not limited to left below the knee amputation, spinal stenosis, anxiety and depression.On 8/27/25 at 10:50 AM R4 was alert and answered questions appropriately. R4 was lying bed, appeared pale, her hairline was damp and she seemed to be breathing rapidly. R4 stated she was in pain, stated The nurse knows, she hasn't brought my morning medicine yet. Sometimes it takes these agency nurses longer. On 8/27/25 at 10:55 AM V13 (Registered Nurse) confirmed that R4 had not gotten her scheduled 8:00 AM morning medications. V13 stated I'm agency when asked if there was a reasoning or incident causing R4's medications to be late. R4's Medication Administration Record dated August 2025 documents that on 8/27/25, R4's scheduled 8:00 AM medications were administered at 11:22 AM by V13 (Registered Nurse).R4's Medication Administration Record dated August 2025 documents R4's scheduled 8:00 AM medications were: Cranberry (vitamin) 450 mg (milligrams), Duloxetine 30 mg for depression, Lasix (diuretic) 40 mg, Hydrocodone (narcotic) 5-325 mg, Losartan Potassium (anti-hypertensive) 100 mg, Miralax ((laxative)17 Grams, multivitamin 1 tablet, oxybutynin (anticholinergic) 10 mg, Pregabalin (for pain) 75 mg, Spironolactone (diuretic) 25 mg, Tizanidine (muscle relaxer) 2 mg. R4's Medication Administration Record dated August 2025 documents that R4 has a scheduled 12:00 PM dose of Pregabalin (for pain) 75 mg also. R4's noon dose of Pregabalin was not signed out at all. R4's Medication Administration Record dated August 2025 documents that on 8/19/25 R4's scheduled 5:00 PM medications were given at 9:20 PM by V15 (Licensed Practical Nurse).R4's Medication Administration Record dated August 2025 documents R4's scheduled 5:00 PM medications were: Pregabalin (for pain) 75 mg and Tizanidine (muscle relaxer) 2 mg. R4's Medical Record did not contain any documentation regarding why R4's medications were not given at the scheduled time or what R4's condition was on 8/19/25. V15 (Licensed Practical Nurse) was not reachable during the survey to answer questions. R4's Medication Administration Record dated August 2025 documents that on 8/11/25 R4's scheduled 8:00 AM medications were given by V5 (Registered Nurse) at 10:34 AM. R4's Medication Administration Record documents that on 8/18/25 R4's scheduled 8:00 AM medications were given by V5 (RN) at 10:44 AM. Neither date (8/11/25 or 8/18/25) document R4's scheduled 12:00 PM dose of Pregabalin as given. R4's Medical Record did not contain any documentation regarding why R4's medications were not given at the scheduled time or what R4's conditions was on 8/11/25 or 8/18/25.On 8/29/25 at 9:40 AM V5 (RN) stated One of two things happened, either (R4) slept in and I gave the medications late, or I gave (R4)'s medications on time but just did not sign them out until later. V5 stated she did not remember specifically. V5 confirmed that there was no documentation as to which possible reason was what occurred on either date. V5 stated that she did not notify the doctor or any other staff member of what occurred. I might have passed it on verbally to the next shift, I'm not sure. V5 (RN) stated that if she gave R4's Pregabalin late for the 8:00 AM dose she would have waited on giving the scheduled 12:00 PM dose until 1:30 PM or 2:00 PM she