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	04/09/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify R2's Power of Attorney of R2's transfer to the hospital. This failure affects 1 of 1 resident reviewed for transfers. The facility policy, Notification of Changes, document: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. R2's EMR document R2's diagnosis included: Chronic Obstructive Pulmonary Disease, Chronic Bronchitis, Aphasia, Diabetes Mellitus Type II, Chronic Kidney Disease, Neurologic Neglect Syndrome, Hemiplegia Right Dominant Side, Atherosclerotic Heart Disease, Dependance on Supplemental Oxygen, Gastro-Esophageal Reflux Disease, Major Depressive Disorder, Anxiety Disorder, ST Elevation Myocardial Infarction, Hypertension, Hypercholesterolemia, Dysphagia, and Nicotine Dependence. R2's Progress noted document: [DATE] 9:28 p.m., Aide notified this nurse resident was unresponsive upon walking into room. This nurse assessed resident and began sternal rub with no response. VS/vital signs were taken; Manual BP/blood pressure 200/120, P/pulse 70, R/respirations 22, T/temperature 97.9, o2/oxygen 95, BS/blood sugar 138. Awaiting EMT [emergency medical technician]; [DATE] 1:17 a.m., Note Text: The nurse was informed via phone call that the patient has an intracranial hemorrhage (brain bleed) and is intubated for airway protection. He is awaiting transfer by air to Hospital (in adjacent town) for a higher level of care; and [DATE] 1:45 a.m., Note Text: This nurse answered phone and it was POA [power of attorney] of resident. She stated that she had a call from the [doctor] at [local hospital]and was told resident would be going into surgery due to a brain bleed'. She asked if I knew when resident was sent out because no one had informed her. I explained to her that I am unaware of the time this incident occurred, however I will go speak to the nurse who is on that floor. I spoke to the nurse and asked her to call residents POA to inform her of the incident.R2's Death Certificate document R2 died [DATE] From a Massive Intraventricular Hemorrhage due to Cerebrovascular Accident.On [DATE], at 2:40 p.m., V4 confirmed V4 failed to notify R2's POA that R2 was sent to the hospital. V4 stated, It was the end of the shift; I didn't call-it slipped my mind and it was an honest mistake because there was a lot going on.

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