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	12/12/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 31283 Based on interview and record review, the facility failed to ensure call lights were responded to in a timely manner for 8 of 8 residents (R4, R8, R11, R23, R30, R36, R39, and R42) who were in attendance for the Resident Council meeting. Findings include: On 12/10/24 from 09:30 AM - 10:30 AM, a group meeting with the following residents who regularly attend Resident Council Meetings at the facility was conducted: R4, R8, R11, R23, R30, R36, R39, and R42. All eight residents verbalized concerns with staff's response times to call lights. During this meeting, R30 stated the following, There have been a few times I have had to call the receptionist at the back desk to tell her to send someone to help me. I had a bowel movement, and needed changed. I pressed my call light and it was on for 20 minutes. I told the staff that came in to help me, who didn't seem to care. When I reported this, I was told that a call light audit had been completed, and my light was on for 15 minutes, not 20. That is still too long to sit with stool in your pants. R36 then stated, (State Agency) will not see how long the call lights usually take to answer when they're in the building. They (facility staff) act different when (State Agency) is in the building. On 12/10/24, V1 (Administrator) provided copies of Resident Council Minutes (dated 12/2023 - 12/2024). The following Monthly Resident Council Minutes document concerns of repeated resident verbalizations regarding staff responding to call lights/response time to provide assistance: 05/2024 - 12/2024. On 12/11/24, V1 (Administrator) confirmed continued concerns with call light response times has been verbalized by facility residents for seven consecutive months in the past year.

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

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32061 Based on interview and record review, the facility failed to provide a copy of the bed hold policy for residents discharging to the hospital, for four of four residents (R6, R9, R29 and R52), reviewed for bed holds, in the sample of 28. Findings Include: The (undated) facility Bed Hold Notice Upon Transfer Policy, directs staff, At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or resident representative written notice which specifies the duration of the bed- hold policy and addresses information explaining the return of the resident to the next available bed. 1. R9's medical record documents that R9 was hospitalized on [DATE], 8/6/24, 8/19/24 and 10/18/24. R9's medical record does not contain documentation of written notice to R9 or R9's resident representative, of the facility bed hold policy. 2. R29's medical record documents that R29 was hospitalized on [DATE]. R29's medical record does not contain documentation of written notice to R29 or R29's resident representative, of the facility bed hold policy. 38396 3. R6's nursing progress notes, dated 10/27/2024, documents at 1:21 PM, R6 was transferred to the local hospital emergency room and later admitted to the hospital. R6's electronic medical record does not document that R6 was given a bed hold policy at the time of transfer. 4. R52's nursing progress notes dated 11/10/2024, documents at 1:30 AM, R52 was transferred to the local hospital emergency room and later admitted to the hospital. R52's electronic medical record does not document that R52 was given a bed hold policy at the time of transfer. On 12/09/24 1:28 P.M., V4/Regional Nurse verified that facility nurses should document the bed hold policy given to the resident upon transfer to the hospital in the nurse's notes and if its not in the nursing progress notes, then it was not done.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 38396 Based on Observation, Interview and Record Review, the facility failed to develop a comprehensive care plan for Oxygen for one of one resident (R6) reviewed for Oxygen in the sample of 28. Findings include: The facility's Comprehensive Care Plan policy (undated) documents It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The comprehensive care plan will describe, at a minimum the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. Any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment. On 12/9/24 at 10:25 AM, R6 was sitting in the dining room with Oxygen on at two liters per nasal cannula. R6 was leaning forward and sleeping in her wheelchair. R6's current Physician Order Sheet, dated 12/12/24, documents R6 has an order for Oxygen to be administered at two liters per nasal cannula as needed for shortness of breath. R6's current care plan, dated 10/5/24, does not document a plan of care to address R6's Oxygen use. On 12/12/24, V2 (Director of Nursing) confirmed R6 uses Oxygen and that her care plan does not document a plan of care for Oxygen administration. V2 stated Oxygen use should be care planned and isn't for (R6).

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 32061 Based on observation, interview and record review, the facility failed to assess a resident's range of motion quarterly, failed to provide necessary equipment to maintain a resident's range of motion and failed to develop a plan of care for a resident's range of motion for one of three residents (R9) reviewed for range of motion in a sample of 28. FINDINGS INCLUDE: The (undated) facility policy, Prevention of Decline in Range of Motion directs staff, The facility in collaboration with the medical director, director of nurses and as appropriate, physical/occupational consultant shall establish and utilize a systemic approach for prevention of decline in range of motion, including the assessment, appropriate care planning, and preventative care. Licensed nurses will assess resident's range of motion on admission/readmission, quarterly and upon a significant change. Residents who exhibit limitations in range of motion, initially and thereafter, will be referred to the therapy department for a focused assessment of range of motion. Based on the comprehensive assessment, the facility will provide interventions, exercises and/or therapy to maintain or improve range of motion. The facility will provide treatment and care in accordance with professional standards of practice. This includes, but is not limited to: appropriate equipment (braces or splints). Care plan interventions will be developed and delivered. Interventions will be documented on the resident's person centered care plan. R9's electronic Progress Note, dated 9/12/2014 documents, (R9) was admitted to facility at this time from (hospital). (R9) had a fall at home with intercranial subdural hematoma and right cerebral stroke on 9/2/14. (R9) has left sided neglect/droop, contracture of the left arm and little control of left leg. (R9) has numbness at times bilaterally. R9's General Progress Note, dated 6/9/21 documents, (Physician) here to see (R9). Physician ordered: Trim nails left hand. Two washcloth rolls for left hand to prevent progression of contractures. A review of R9's electronic medical record on 12/9/24 includes no documentation of a contracture assessment completed by the facility therapy department or documentation of a splint/brace application by staff, due to R9's long standing history of contractures. A review of R9's electronic Care Plan on 12/9/24 includes no documentation to address R9's contractures or interventions for staff to implement to maintain or improve R9's limitations in her right arm/hand. On 12/09/24 at 10:01 A.M., (R9) was seated in a reclining back wheelchair, in her room. (R9's) left hand was in a tightly contracted position with (R9's) fingertips and nails touching her hand. When questioned if staff places a splint in hand or performs exercises to her hand, (R9) stated, No. On 12/10/24 at 9:23 A.M., (R9) was seated in a reclining chair in her room. (R9) stated she used to have a splint (that staff applied) but it had gotten broke and no one ever replaced it. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/24 at 9:48 A.M., V9/Restorative Aid stated she doesn't apply a splint to R9's contractured left hand. V9 states she wasn't even aware that R9 had a splint. On 12/11/24 at 9:52 A.M., V6/Registered Nurse stated R9 used to have a splint for her left hand, but she hadn't seen staff apply it in many months. On 12/11/24 at 10:46 A.M., V2/Director of Nurses stated the facility does not have a restorative nurse in house. V2 also stated she is unaware of what a contracture assessment is and unsure if anyone in the facility completes them. V2/DON also confirmed that R9's Care Plan does not address R9's contractures. On 12/11/24 at 11:17 A.M., V11/Director Of Rehab confirmed no staff currently complete contracture assessments to monitor a decline in a facility resident's contracture.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 50627 Based on observation, interview, and record review, the facility failed to check placement with venous blood return prior to intravenous (IV) PICC (peripherally inserted central catheter) line medication administration for one of one resident (R47) reviewed for IV medication administration in the sample of 28. Findings include: The (undated) facility policy, Validation Checklist Flushing and Locking a Central Venous Access/Midline/PICC Catheter directs staff, Purpose: To determine if the individual performs flushing and locking of a central venous access catheter/midline/PICC in accordance with professional standards of practice. Attached 10mL (milliliter) normal saline syringe to connector maintaining sterility, Unclamped catheter, if clamp present, aspirated for blood return, slowly injected normal saline into the catheter, and Removed syringe and discarded in sharps container. On 12/10/2024, at 9:15 AM, V6/Registered Nurse (RN) attached a 10mL (milliliter) normal saline syringe to R47's PICC (peripherally inserted central catheter) connecter. Without aspirating for blood, V6 administered all 10mLs of Normal Saline, disconnected the 10mL syringe, connected the IV (intravenous) medication, and started R47's infusion. On 12/10/2024, at 9:18 AM, V6 (RN) stated I never check for a blood return on a single lumen PICC line, only a double lumen I will check for a blood return. On 12/11/2024, at 11:45 AM, V2 (DON/Director of Nursing) stated Yes, (V6) should have checked for a blood return on (R47) prior to starting the IV infusion.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 31283 Based on interview and record review, the facility failed to ensure a Registered Nurse was scheduled to work eight consecutive hours, seven days a week. This failure has the potential to affect all 44 residents residing in the facility. Findings include: On 12/10/24, V1 (Administrator) provided copies of the facility's Daily Staffing Assignment Sheets (dated 11/26/24 - 12/10/24), which document which staff members worked, and the duration of the shift that was worked. Based on the facility's census for each day, the facility exceeded their minimum staffing requirements. On 12/10/24, V1 (Administrator) provided copies of the facility's daily staffing assignment sheets (dated 11/26/24 - 12/10/24), which document which staff members worked, and the duration of the shift that was worked. The facility did not have a Registered Nurse scheduled to work for eight consecutive hours on the following days: 11/26/24, 12/02/24, and 12/07/24. On 12/11/24 at 09:29 AM, V4 (Regional Nurse) verified the facility did not have eight consecutive hours of RN coverage on 11/26/24, 12/02/24 and 12/07/24. The facility's Long-Term Care Facility Application for Medicare and Medicaid (CMS Form 671), dated 12/09/24 and signed by V1 (Administrator), documents 44 residents currently reside in the facility.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 50627 Based on observation, interview and record review, the facility failed to address a resident's symptoms of depression and develop a care plan with interventions to recognize and treat symptoms of depression for one of two residents (R47) reviewed for mood in the sample of 28. Findings include: The Facility's Behavioral Health Services Policy (undated) states, It is the policy of this facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental psychosocial functioning. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders, psychosocial adjustment difficulty, and trauma or post-trauma stress disorders. The facility will ensure that a resident who, upon admission was not assessed or diagnosed with a mental or psychosocial adjustment difficulty or a documented history of trauma and/or PTSD (post traumatic stress disorder) does not develop patterns of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors while residing in the facility. The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial stats and providing person-centered care. The assessment and care plan will include goals that are person-centered and individualized to reflect and maximize the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. Staff will monitor the resident closely for expressions or indications of distress. Evaluate whether the resident's distress was attributable to their clinical condition and demonstrate that the change in behavior was unavoidable. Assess and develop a person-centered care plan for concerns identified in the resident's assessment. Share concerns with the interdisciplinary team (IDT) to determine underlying causes of mood and behavior changes, including differential diagnosis. Accurately document the changes, including the frequency of occurrence and potential triggers in the resident's record. Ensure appropriate follow-up assessment, if needed. The care plan shall have interventions that are person-centered, evidence-based, culturally competent, trauma-informed, and in accordance with professional standards of practice. Provide for meaningful activities which promote engagement and positive, meaningful relationships. R47's Mood Assessment completed by V8 (Social Services), documents on 10/16/2024, R47's total severity score was eleven (moderate depression). This same assessment documents on 12/6/2024 R47's total severity score was nine (mild depression). On 12/09/24 at 10:00 AM, R47 was lying in bed on her right side, R47 was withdrawn and did not move after being approached. R47 stated, it is terrible here, I want to go home, I hate it here and I hate the food. R47's current physician order sheet, documents R47 has no diagnoses of any mental health conditions. R47's Social Service progress notes, dated 10/16/24, and 12/6/24 does not document R47's mood assessment score or address R47's symptoms of depression. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/24 at 10:00 AM, V8 (Social Services) confirmed that she did not notify the Director of Nursing (V2/ DON) or R47's Physician with R47's assessment results. At this time, V8 stated I do not deal with correspondence with the physicians that is the DON's job. I did not make notes. Her depression/mood score was not addressed. On 12/11/24 at 10:20 AM, V2 (Director of Nursing) stated I did not speak to the physician at any time during correspondence relating to R47's mood and behavior. On 12/11/24 at 2:26 PM, V10 (LPN) stated R47 is always in bed, never wants to get up, never wants to eat unless her boyfriend comes in and brings her food. R47 does not participate in any activities and never leaves her bed or room.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 31283 Based on observation, interview, and record review, the facility failed to ensure items in the kitchen were clean. This has the potential to affect all 44 residents residing in the facility. Findings include: The facility's Sanitation Inspection policy (undated) documents the following: All food service areas shall be kept clean, sanitary, free from litter, rubbish and protected from rodents, roaches, flies and other insects. On 12/09/24 at 10:00 AM, the hot water dispenser on the coffee maker in the kitchen contained a large amount of white, crusty build-up around the dispensing spout. V5 (Dietary Manager) verified the presence of the build-up and stated, It needs to be cleaned with lime scale. On 12/06/24 at 10:08 AM, the facility's walk-in cooler had a large amount of dust and debris adhered to the fan covers, as well as the surrounding wall and ceiling. V5 confirmed the presence of dust and debris in the walk-in cooler, and stated, It needs to be cleaned. The facility's Long-Term Care Facility Application for Medicare and Medicaid (CMS Form 671), dated 12/09/24 and signed by V1 (Administrator), documents 44 residents currently reside in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 31283 Based on interview and record review, the facility failed to implement all components of their Infection Prevention Control Program. This failure has the potential to affect all 44 residents currently residing in the facility. Findings include: The facility's Infection Prevention and Control Program policy (undated) documents the following: A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards. This same policy documents, Staff Referral to Treatment Centers: Our staff shall be referred to appropriate medical treatment center/service when she/he: Is feverish and appears to be in the infectious stages of an illness; Experiences occupational exposure to body/blood fluids; Has been exposed to a communicable disease; Exhibits infected skin lesions. This policy also documents, Our Infection Preventionist shall coordinate screening procedures in case of widespread exposure of staff to any infectious disease. On 12/11/24 upon review of the facility's Infection Control Log, no documentation of employee illness tracking and trending could be located. On 12/11/24 at 11:05 AM, V2 (Director of Nursing/Infection Preventionist) stated she is unable to provide an employee illness log or any documentation of employee illness tracking. V2 stated, This isn't being done. The only infection log we are logging is for the residents. The facility's Long-Term Care Facility Application for Medicare and Medicaid (CMS Form 671), dated 12/09/24 and signed by V1 (Administrator), documents 44 residents currently reside in the facility.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 31283 Based on interview and record review, the facility failed to implement their antibiotic stewardship program. This failure has the potential to affect all 44 residents residing in the building. Findings include: The facility's Antibiotic Stewardship Program policy (undated) documents the following: It is the policy of the facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. This same policy documents, Director of Nursing- establish standards for nursing staff to assess, monitor, and communicate changes in a resident's condition that could impact the need for antibiotics, use their influence as nurse leaders to help ensure antibiotics are prescribed only when appropriate, and educate front line nursing staff about the importance of antibiotic stewardship and explain policies in place to improve antibiotic use. This policy also documents, Infection Preventionist- utilizes expertise and data to inform strategies to improve antibiotic to include tracking of antibiotic starts, monitoring adherence to evidence-based published criteria during the evaluation and management of treated infections, and reviewing antibiotic resistance patterns in the facility to understand which infections are caused by resistant organisms. This policy documents, This program includes antibiotic use protocols and a system to monitor antibiotic use. Antibiotic Protocols: Nursing staff shall assess residents who are suspected to have an infection and notify the physician; Laboratory testing shell be in accordance with current standards of practice; The facility uses the (Center for Disease Control National Healthcare Safety Network Surveillance Definitions, updated McGeer criteria, or other surveillance tool) to define infections; The Loeb Minimum Criteria may be used to determine whether to treat an infection with antibiotics; All prescriptions for antibiotics shall specify the dose, duration, and indication for use; Whenever possible, narrow-spectrum antibiotics that are appropriate for the condition being treated shall be utilized. On 12/11/24 at 11:15 AM, V2 (Director of Nursing/Infection Preventionist) stated the facility does not implement any protocols to review clinical signs and symptoms and/or laboratory reports prior to implementation of an antibiotic for a resident. V2 stated the facility does not utilize any assessment tools or management algorithms to determine if an antibiotic is warranted, We do not complete any forms if we suspect an infection. We just call the doctor and get an order for an antibiotic if we believe one is needed. The facility's Long-Term Care Facility Application for Medicare and Medicaid (CMS Form 671), dated 12/09/24 and signed by V1 (Administrator), documents 44 residents currently reside in the facility.