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	06/10/2026

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 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. Based on interview, and record review the facility failed to ensure the services of a full-time Director of Nursing who is a Registered Nurse, as identified in the facility's staffing plan. This failure affects all 59 residents who reside at the facility.Findings include: The Facility Assessment revised 4/13/26 documents under the facility's staffing plan that the facility will have a Director of Nursing who is a Registered Nurse full time on dayshift. The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 6/8/26 and signed by V10 (Director of Operations), documents 59 residents reside within the facility.On 5/8/26 at 9:30 AM, V3 (ADON/Infection Preventionist) stated that V2, Director of Nursing, was not at the facility because V2 was completing a contract with another employer. V3 stated that V2 began employment with the facility in April 2026 but was not consistently present due to obligations associated with an outside contract. V3 further stated that she attempted to cover responsibilities when V2 was absent but acknowledged she is a Licensed Practical Nurse and not a Registered Nurse.On 5/9/26 at 9:15 AM, V2 (Director of Nursing) stated V2 accepted the Director of Nursing position on April 1, 2026, but continued to fulfill a contractual obligation with a local hospital. V2 stated he was present at the facility approximately three days per week and, at times, worked direct care assignments on the nursing unit, limiting V2's ability to perform Director of Nursing responsibilities.On 5/10/26 at 9:00 AM, V18 (Regional Nurse Consultant) stated that V2 and V3 were responsible for oversight of the facility and that V3 assumed Director of Nursing responsibilities when V2 was unavailable. V18 stated Regional Nurse Consultants were not present in the facility on a daily basis.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on observation, interview, and record review the facility failed to ensure the quaternary sanitation buckets contained an adequate level of chemical to sanitize kitchen surfaces and ensure all foods located within the refrigerator were labeled with the date opened or prepared. These failures have the potential to affect all 59 residents residing in the facility.Findings include:The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 6/8/26 and signed by V10 (Director of Operations), documents 59 residents reside within the facility. The facility's Date Marking for Food Safety, undated, documents, The facility adheres to date marking system to ensure the safety of ready-to-eat, time/temperatures control for safety food. The individual opening or preparing food shall be responsible for date marking the food at the time the food is opened or prepared. The marking system shall consist of a color-coded label, the day/date of opening, and the day/date the item must be consumed or discarded.The facility's Wiping Cloths policy, undated, documents, All dietary department employees are responsible for complying with this policy. Supervisords and managers are responsible for monitoring compliance and providing correction action and retraining when necessary. All sanitizer rags used in the dietary department shall be stored in an approved sanitizing solution when not in use. Sanitizer rags shall be maintained in a manner that prevents contamination of food, food-contact surfaces, equipment, utensils, linens, and single-service items. 2.Storage Requirements. a. Between uses, all damp sanitizer rags shall be completely submerged in a labeled container of approved sanitizing solution. b. Sanitizer buckets shall be maintained at the proper concentration according to manufacturer instructions and verified with appropriate test strips. The Sanitizing Manufacturer's Directions dated 2021 documents, Testing solution should be at room temperature. Dip paper for 10 seconds. Compare colors immediately with colors on the test strip package to determine ppm (parts per million). Always compare against package scale. Testing solutions should be between 200-400 ppm.On 6/8/26 at 9:10 AM, a kitchen tour was conducted with V4 (Cook). Observation of the two-door refrigerator revealed multiple opened food items, including a protein shake, chocolate syrup, grape jelly, lemon juice, a partially used onion, and a partially used tomato, that were not labeled with the date opened. Additionally, five bowls of ham salad lacked preparation date labels. Five sanitizer buckets containing water and washcloths were observed in the kitchen. V4 identified the buckets as sanitizer solutions used for cleaning food preparation surfaces. V4 tested all five buckets with sanitizer test strips which revealed all five buckets sanitizer concentrations at zero ppm , indicating no detectable sanitizer was present. V4 confirmed that opened and prepared food items should be covered and dated, and that sanitizer buckets should maintain a sanitizer concentration of 200 ppm.

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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. Based on observation, interview, and record review the facility failed to establish and maintain an effective infection prevention and control program by failing to perform surveillance to track and monitor resident and staff illnesses and failed to implement appropriate PPE (Personal Protective Equipment) while handling soiled linens. These failures have the potential to affect all 59 residents residing in the facility. Findings include:The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 6/8/26 and signed by V10 (Director of Operations), documents 59 residents reside within the facility.The Infection Prevention and Control Program policy, undated, documents, This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. The designated Infection Preventionist is responsible for oversight of the program and services as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposes, surveillance, and epidemiological investigations of exposures of infectious diseases. All staff are responsible for following all policies and procedures related to the program. Surveillance: A system of surveillance is utilized for prevention, identifying, reporting, investigation, 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. Linens: Laundry and direct care staff shall handle, store, process, and transport linens to prevent spread of infection.The facility's Handling Soiled Linens, undated, documents, It is the policy of this facility to handle, store, process, and transport linen in a safe and sanitary method to prevent the spread of infection. The policy pertains to soiled linen. Linen can become contaminated with pathogens from contact with intact skin, body substances, or from environmental contaminants. Transmission of pathogens can occur through direct contact with linens or aerosols generated from sorting and handling contaminated linen. All used linen should be handled using standard precautions and treated as potentially contaminated. Other protective equipment may be required. Examples of linen that may require special handling include but are not limited to: Visibly soiled with blood or large amounts of body fluids. Residents with infection transmitted by contact.The Environmental Services Laundry Worker Job Description dated 2023 documents, The facility's infection control surveillance logs were all reviewed from 1/1/26 through 6/9/26 and do not contain a tracking log of resident illnesses (that did not require antibiotic use) or employee illnesses.The facility's Infection Control Contact Isolation List documents R62 is currently placed in contact isolation due to ESBL (Extended-Spectrum Beta-Lactamase) of a surgical wound.On 6/8/26 at 9:20 AM V6 (Laundry Aide) was handling and putting soiled linen in the washer. V6 was not wearing a gown while handling the linen. V6 stated soiled linens that are transported to laundry from contact isolation rooms are not in any different containers or bags and V6 stated she never wears a gown or goggles when handling any soiled linens, including linen brought from contact isolation rooms.On 6/9/26 at 1:30 PM V3 (Infection Preventionist) stated she has not been tracking employee illness since she has started the position. V3 stated, I was told to no longer track employee illnesses because we (the facility) are not allowed to ask why the staff called in. We (the facility) do not use special bags or special barrels for isolation linens. Laundry staff should be using a gown and gloves when handling all linens. V3 verified antibiotic tracking logs are maintained for each residents every month, however these do not include a comprehensive record of all resident illnesses other than infections that are being treated with an antibiotic.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, Interview and Record Review, the facility failed to ensure residents had an appropriate diagnosis, timely and accurate consent and targeted behaviors to warrant the use of antipsychotic medications and for four of four residents (R4, R7, R17, R53) reviewed for antipsychotic medications in the sample of 33.Findings include: The facility's Use of Psychotropic Medications policy, dated 2026, documents It is the intent of this policy to ensure that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. Additionally, these medications should be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint. Chemical restraint refers to any drug used for discipline or that makes it more convenient (example; less effort) for staff to care for a resident and not required to treat medical symptoms. This includes when a psychotropic medication may be approved to treat certain symptoms, however, nonpharmacological interventions should be used or attempted, unless clinically contraindicated, because they are less dangerous to a resident's health and safety. Psychotropic medications are to be used only when a practitioner determines that the medication(s) is appropriate to treat a resident's specific, diagnosed, and documented condition and the medication(s) is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). The indications for initiating, maintaining, or discontinuing medication(s) as well as the use of non-pharmacological approaches, will be determined by evaluating the resident's physical, behavioral, mental, and psychosocial signs and symptoms in order to identify and rule out any underlying medical conditions, including the assessment of relative benefits and risks, and the preferences and goals for treatment. The facility will document that the resident or residents 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 (example; written consent form, narrative note, etcetera.) 1. On 6/8/26 at 11:40 AM, R4 was observed sitting in a wheelchair near the facility's dining room. R4 was not displaying any behaviors. R4's Medication Administration Record, dated 6/10/26, documents R4 was started on Risperidone 0.25 milligrams (mg) (antipsychotic medication) two times daily for Dementia with Psychosis on 1/20/26. R4's Care Plan, dated 3/30/26, documents R4 was admitted to the facility on [DATE] and has diagnoses including Dementia without Behavioral Disturbance, Alzheimer's Disease with Late Onset, Depression, Cognitive Communication Deficit and Dementia with Psychotic Disturbance (added 1/28/26). This same care plan documents a plan of care for Behaviors: (R4) has potential for behaviors. Monitor behavior symptoms, at risk for elopement. This care plan also documents I use psychotropic medications with diagnosis of Dementia with Psychosis. I receive Risperdal (risperidone) 0.25 mg two times a day. R4's care plan does not address targeted behaviors for the use of an antipsychotic or what psych behaviors to monitor R4 for. R4's current electronic medical record does not document behaviors of psychosis for R4. On 6/9/26 at 2:30 PM V16 (Registered Nurse) stated (R4's) only behavior is that she will get anxious (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	or want attention right now. She will want things addressed if she needs something. (R4) has never been aggressive though. 6/10/26 at 10:35 AM V2 (Director of Nursing) stated (R4) doesn't ambulate much. She gets depressed and will be down in her mood. We planned to have her see Psychiatry when they come in. V2 confirmed R4 is not a harm to herself or others and does not display behaviors that are psychotic in nature. V2 stated (R4) is on the list for psych consult due to depression but she is not aggressive towards others. R4's Psychotropic Medication Consent for Risperidone is dated 4/14/26 and does not document the reason for use, a diagnosis for the use, or any non-pharmacological interventions that were attempted prior to initiating the medication. On 6/10/26 at 11:00 AM, V18 (Regional Nurse Consultant) confirmed R4's Risperidone consent was not filled out completely and was not obtained prior to initiating the medication. V18 stated The risperidone was started in January, and we did not get a consent until 4/14/26. I am not sure why, but it should be filled out completely and it is not correct. Several areas were left blank. 2. On 6/8/26 at 11:30 AM, R53 was seated in the facility's dining room being assisted with eating lunch by facility staff. R53 was positioned in a high-back wheelchair with her feet resting on pedals. R53 did not display any behaviors. On 6/8/26 at 11:50 AM, R53 was reclined in a high-back wheelchair with her feet on pedals and was wheeled to her room by facility staff. R53 was quiet, confused with conversation and was not displaying any behaviors. On 6/9/26 at 2:30 PM, R53 was laying in bed in her room with her eyes closed. R53 was quiet and not displaying any behaviors. R53's current Care Plan, dated 4/6/26, documents R53 was admitted to the facility on [DATE] and has diagnoses including Alzheimer's Disease with late onset, Dementia without behavioral disturbance, Depression, Cognitive Communication Deficit, and Major Depressive Disorder without psychotic features. This same care plan documents R53 experienced falls on 1/3/26, 1/11/26, 1/13/26, 1/22/26, 1/24/26, 1/25/26, and 3/9/26 and a plan of care documenting I receive ABH (Ativan (antianxiety medication), Benadryl (antihistamine medication), and Haldol (antipsychotic medication) topical) cream for restlessness. Original start date 2/23/26. R53's Physician Order Sheet, dated 6/9/26, documents ABH cream, apply one milliliter to wrist or other hairless area three times a day for frequent restlessness and agitation. R53's Consent for Psychotropic Medications, dated 6/4/26, documents consent was obtained on 6/4/26 for ABH cream and is categorized as antianxiety medication. On 6/9/26 at 2:30 PM, V16 (Registered Nurse) and V17 (Certified Nursing Assistant) confirmed R53 has behaviors that are consistent with Dementia and Sundowners (confusion worsening in the evening). V16 stated (R53) has increased agitation and restlessness in the evenings. (R53) can get up and tries but she isn't strong enough to hold herself so she would fall. She just has a lot of confusion when she's anxious too. V16 verified that R53 did have several falls in the winter and now is in a high-back wheelchair with foot pedals when she's not in bed. V16 sated We recline her and that helps (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	calm her down. V17 then stated (R53) is typically fine all day and sleeps late at night. It is the usual Sundowners symptoms, and she becomes more agitated and anxious in the evenings for second shift. (R53) is not aggressive towards other residents. On 6/10/26 at 10:35 AM, V2 (Director of Nursing) confirmed that R53 had several falls in January and stated (R53) gets restless and tries to stand up but she is not safe to stand. She has ABH cream now three times a day, I think just because of her being more restless. V2 then confirmed that behaviors of agitation and restlessness in a resident with dementia are normal for the disease process and are not psychotic in nature. 3. On 4/8/26 at 9:45 AM, R7 was sitting in a high back wheelchair asleep in the hallway. R7's Face sheet documents R7 admitted to the facility on [DATE]. R7's Physician Orders documents R7 received Aripiprazole 5 mg (milligrams) daily for Schizophrenia beginning 4/25/26, Seroquel 200 mg, two tablets at bedtime for Schizophrenia beginning 4/24/26, and Seroquel 50 mg daily for Schizophrenia. R7's Target Behaviors for use of Psychotropic medications include repetitive and anxious behaviors and complaints in R7s behavioral monitoring records. On 6/9/26 at 9:15 AM, V14 (Certified Nursing Assistant) stated that R7 does not have behaviors that affect himself or others and occasionally repeats things but does not exhibit other behaviors. On 6/9/26 at 9:25 AM, V3 (Assistant Director of Nursing/Infection Preventionist) stated that R7 does not have behaviors that she has observed. On 6/10/26 at 11:00 AM, V18 (Regional Nurse Consultant) stated that R7's documented target behaviors were not appropriate indicators to support the identified interventions or the use of psychotropic medications to treat a diagnosis of Schizophrenia for R7. V18 stated this should have been identified on R7's admission to the facility on 4/24/26. 4. R17's census line documents R7 admitted to the facility on [DATE]. R17's clinical record documents diagnoses Dementia without behavioral disturbance, Psychotic Disturbance, Mood disorder, Anxiety, and Depression. R7's Physician orders included Clonazepam 0.5 mg (Milligrams), two tablets three times daily for anxiety (ordered 10/6/25), and Quetiapine (Seroquel) 50 mg three times daily for dementia (ordered 1/26/26). Prior documentation also referenced use of Celexa and Trazodone for anxiety and depression per PASRR Level I completed 3/28/25. R7's Behavior Tracking records from 5/24/26 through 6/8/26 revealed no documented behavioral episodes. Target behaviors included increased anxiety, resistance to care, and wandering; however, no behaviors were observed or recorded during this period. On 6/9/26 at 10:00 AM, V14 (Certified Nursing Assistant) stated V14 had not observed any behaviors in R17 that were harmful to self or others. V14 reported the only behavior observed with R17 was talking to self. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/10/26 at 11:00 AM, V18 (Regional Nurse Consultant) stated the diagnosis of Dementia for a psychotropic medication is not an appropriate diagnosis and R17's targeted behaviors are not appropriate for the use of psychotropic medications.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interview and Record Review, the facility failed to ensure residents with a new psychiatric diagnosis or significant change in psychiatric status were reevaluated for a level two PASRR (Preadmission Screening and Resident Review) screening, for four of four residents reviewed for PASARR in the sample of 33.Findings include: The facility's Resident Assessment-Coordination with PASARR Program policy revised in 2025 documents The Social Services Director shall be responsible for keeping track of each resident's PASARR (Preadmission screening and resident review) screening status and referring to the appropriate authority. A resident who demonstrates increased behavioral, Psychiatric, or mood-related symptoms or any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level two resident review. Examples include A. a resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where Dementia is not the primary diagnosis). B. a resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR. 1.R4 PASARR level screening, dated 8/11/24, documents at the time of R4's screening her diagnoses of mental health disorders was limited to Anxiety Disorder and the only medication R4 was taking for mental health was Aricept (Alzheimer's medication). This screening documents R4 did not require a level two evaluation at the time of screening and also documents If changes occur or new information refutes these findings, a new screen must be submitted. R4's current electronic medical record Diagnosis Summary documents R4 was diagnosed with Unspecified Dementia with severe Psychotic Disturbance on 1/28/26. R4's Medication Administration Record, dated 6/10/26, documents R4 was started on Risperidone 0.25 milligrams (antipsychotic medication) two times daily for Dementia with Psychosis on 1/20/26. On 6/10/26 at 11:00 AM, V18 (Regional Nurse Consultant) confirmed that R4 does not have a level two PASARR screening and was given a diagnosis that includes Psychosis in January 2026 when Risperidone was also initiated. V18 confirmed this change signifies a change in R4's psych status and a new PASARR screen should have been conducted. 2. R57's PASARR level one screening, dated 1/21/24, documents at the time of screening R57's only mental health diagnosis was Anxiety Disorder and the only medication R57 took for mental health was Lorazepam (anti-anxiety medication). This screening documents R57 did not require a level two evaluation at the time of screening and also documents If changes occur or new information refutes these findings, a new screen must be submitted. R57's current electronic medical record Diagnosis Summary documents R57 was diagnosed with Delusional Disorder on 2/21/24. R57's Consent for Psychotropic Medications, dated 11/3/25, documents that's R57 was started on Abilify 10 milligrams (Antipsychotic medication) on 11/3/25. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/9/26 at 2:30 PM, V16 (Registered Nurse) and V17 (Certified Nursing Assistant) confirmed R57 has had changes in her mental health since living in the facility. V17 stated (R57) does have hallucinations. She sees things not there. (R57's) increased in behaviors since moving her room in the facility. On 6/10/26 at 10:35 AM V2 (Director of Nursing) confirmed R57 had a new psych diagnosis and antipsychotic medication added after admission and stated she should have had a new PASARR screening completed at that time. 3. R7's Face sheet documents R7 admitted to the facility on [DATE]. R7's PASARR documentation revealed a Level I PASARR screening completed on 3/6/23 identified a diagnosis of schizophrenia and documented the use of Ativan for anxiety. A Level II PASARR evaluation was completed on 3/8/23. R7's Physician Orders documents R7 received Aripiprazole 5 mg (milligrams) daily for Schizophrenia beginning 4/25/26, Seroquel 200 mg, two tablets at bedtime for Schizophrenia beginning 4/24/26, and Seroquel 50 mg daily for Schizophrenia. R7's diagnosis list documents a diagnosis of Psychosis dated 1/12/24. R7's Behavioral monitoring records identified target behaviors that included episodes of repetitive and anxious behaviors and complaints. R7's Clinical record did not contain documentation of targeted behaviors for Schizophrenia. R7's clinical record failed to identify evidence that a new PASARR screening or referral for PASARR review was completed following R7's admission on [DATE] or following the identification and treatment of ongoing serious mental illness diagnoses and symptoms. The facility was unable to provide documentation of any PASARR evaluation completed after the Level II PASARR dated 3/8/23. On 6/9/26 at 9:15 AM, V14 (Certified Nursing Assistant) stated that R7 does not have any behaviors that affects himself or others. V14 stated sometimes R7 repeats things but he does not have other behaviors. On 6/8/26 at 9:45 AM, V19 (Social Services Director) confirmed V19 did not initiate a new level two PASARR when R7 admitted to the facility and did not know she needed too. On 6/10/26 at 10:30 AM, V1 (Administrator) confirmed that the facility should have initiated a Level two PASARR upon R7's admission to the facility because R7's last PASARR did not capture medications being used to treat Schizophrenia and did not contain the diagnosis of Psychosis. On 6/10/26 at 11:00 AM, V18 (Regional Nurse Consultant) stated that R7's target behaviors for the use of Seroquel were not appropriate behaviors for the use of this medication. V18 further stated the facility should have initiated a new PASARR on R7's admission to the facility. 4. R17's Census record documented admission to the facility on 4/2/26. R17's Medical Diagnosis List documented diagnoses including dementia with psychotic disturbance, mood disturbance, anxiety, and depression. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R17's PASRR Level I screening, completed on 3/28/25, documented the resident was receiving Celexa for anxiety and depression and Trazodone for anxiety and depression. R17's Physician Orders revealed an order dated 10/6/25 for Clonazepam 0.5 mg, two tablets by mouth three times daily for anxiety. R17's Physician Orders also revealed an order dated 1/26/26 for Seroquel 50 mg by mouth three times daily for dementia. On 6/10/26 at 11:00 AM, V18 (Regional Nurse Consultant) stated that R17's target behaviors for the use of Seroquel were not appropriate behaviors for the use of this medication. V18 further stated the facility should have initiated a new PASARR on R17's admission to the facility.

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	145012	A. Building B. Wing	06/10/2026

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on Observation, Interview and Record Review, the facility failed to ensure residents with indwelling urinary catheters were provided drainage privacy bags for three of three residents (R1, R51, R52) reviewed for dignity in the sample of 33.Findings include: The facility's Catheter Care policy, dated 2025, documents It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. Privacy bags will be available and catheter drainage bags will be covered at all times while in use. Privacy bags will be changed out when soiled, with a catheter change or as needed.1. On 6/8/26 at 10:56 AM, R1 was sitting in his room in wheelchair directly in line with the entry to his room. R1's urinary catheter drainage bag was hanging below the wheelchair with copper-tinged urine draining into bag. R1's wheelchair did not have a privacy bag for the urine to be covered or hidden. R1 stated he has had a urinary catheter for several years and confirmed he eats his meals in the dining room typically.2. On 6/8/26 at 11:30 AM, R52 was eating lunch in the facility's dining room. R52's urinary catheter drainage bag was hanging below his wheelchair and contained a large amount of amber colored urine without any dignity covering or privacy bag.3. On 6/8/26 at 11:46 AM, R51 was self-propelling his wheelchair in the hallway. R5's urinary catheter bag was dangling below his wheelchair. An empty dignity bag was also under the wheelchair but R51's catheter bag was draining yellow urine and was not in a covered dignity bag.On 6/10/26 at 10:35 AM, V2 (Director of Nursing) confirmed that residents who have an indwelling urinary catheter should have their drainage collection bags covered with a privacy/dignity bag. V2 stated It should always be in place, for their own dignity and for other residents who likely do not want to see someone else's urine.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure medications were administered in accordance with facility policy and that residents only self-administer medications when a documented assessment and care plan approval were in place for one (R15) of one resident reviewed for self-medication administration in a sample of 33. Findings Include:The facility's Medication Administration policy, not dated, documents. Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines, 19. Observe resident consumption of medication.On 6/8/2026 at 9:00 AM, R15 was in bed, dressed, and awake, having just had staff assist her with her morning cares. R15 had her bedside table over her lap with her morning medications sitting in a clear medication lid on R15's bedside table.On 6/8/2026 at 9:30 AM, V8 (Licensed Practical Nurse) confirmed R15's medications in the clear medication lid was a cranberry tablet, Lyrica (anticonvulsant), Hydrocodone/Acetaminophen (pain medication), Duloxetine (antidepressant/nerve pain medication), Lasix (loop diuretic), Losartan (blood pressure medication), Tizanidine (skeletal muscle relaxant and a central alpha-2 adrenergic agonist), and Spironolactone (potassium sparing diuretic). R15's Medication Administration Record dated 6/10/26 documented that R6 was administered medications that morning. Cranberry 450 mEq (milliequivalent), Lyrica 75 mg (milligrams), Hydrocodone/Acetaminophen 5/325 mg, Duloxetine 30mg, Lasix 40 mg, Losartan 100 mg, Tizanidine 2mg, and Spironolactone 25mg.On 6/8/2026 at 10:00 AM, V1 (Administrator) stated these medications are not to be left in the resident's room, all medications are to be administered by a nurse, and the nurse is responsible for making sure the residents take the medications by watching them take the medications.R15's Electronic Medical Record does not contain documentation of a medication self-administration assessment, and the current care plan did not include documentation indicating R15 was approved to self-administer medications at bedside.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure a written Bed Hold Notice was provided to the resident representative and documented in the medical record at the time of hospitalization for one (R59) of one residents reviewed for transfer and discharge requirements in a sample of 33 residents.Findings include: The facility's Bed Hold Notice policy revised in 2025 documents it is the policy of this facility to provide written information to the resident/resident representative regarding bed hold practices both well in advance, and at the time of a transfer for a hospitalization or a therapeutic leave. R59's Census line documents R59 transferred out of the facility to a local hospital on 5/5/26. On 6/10/26 at 9:45 AM, V1 (Administrator) stated V1 was unable to locate a Bed Hold Notice that had been sent with R59 to the hospital and was unable to find documentation indicating the Bed Hold Notice had been reviewed with the resident's Power of Attorney. During the same interview, the Regional Nurse Consultant (V18) confirmed that a Bed Hold Notice should have been provided and documented in the resident's electronic medical record. On 6/10/26 at 10:30 AM, V19 (Social Services Director) stated V19 does not handle bed hold notifications and did not communicate with R59's Power of Attorney regarding a Bed Hold Notice.

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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. Based on Interview and Record review, the facility failed to ensure a resident with significant weight loss had a plan of care with measurable outcomes and interventions to address and prevent further weight loss for one of one resident (R4) reviewed for weight loss in the sample of 33.Findings include:The facility's Weight Monitoring policy, dated 2025, documents Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. Information gathered from the nutritional assessment and current dietary standards of practice are used to develop an individualized care plan to address the resident's specific nutritional concerns and preferences. The care plan should address the following, to the extent possible: identified causes of impaired nutritional status; reflect the residents personal goals and preferences, identify resident-specific interventions; time frame parameters for monitoring; updated as needed such as when the resident's condition changes, goals are met, interventions are determined to be ineffective or a new cause of nutritional-related problems are identified.R4's current electronic record Weight Summary documents on 3/10/26 R4's weight was 137.2 pounds and on 6/6/26, R4's weight was 123.4 pounds (a 10 percent weight loss in three months).R4's Nutritional Dietary progress note, dated 5/26/26 at 4:09 PM, documents R4's weight on 5/26/26 was 126 pounds. This note documents Noted diagnosis Dementia, Alzheimer's Disease. Will refer to psyche. Recommendation Medication Pass (supplement) 120 milliliters two times a day. Meal intake 51-100 percent. Continue weekly weights.R4's current Care Plan, dated 4/7/26, does not document that R4 has experienced significant weight loss, interventions or measurable goals to address the weight loss or R4's medication pass supplement initiation. On 6/10/26 at 10:35 AM V2 (Director of Nursing) confirmed R4 has suffered a significant weight loss and that her care plan does not reflect interventions or a plan of care to address the weight loss and stated the care plan should include R4's weight loss.

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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. Based on observation, interview, and record review, the facility failed to ensure restorative services were provided for one (R9) of one resident reviewed for range of motion in a sample of 33. Findings Include:The facility's Restorative Nursing Programs policy, not dated, documents, It is the policy of this facility to provide maintenance and restorative services designated to maintain or improve a resident's abilities to the highest practicable level. Definition: Restorative nursing program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. Policy Explanation and Compliance Guidelines: 6. Residents, as identified during the comprehensive assessment process, will receive services from restorative aides when they are assessed to have a need for restorative nursing services. These services may include a. Passive or active range of motion. 9. The restorative nurse is responsible for maintaining a current list of residents who require restorative nursing services, and for ensuring that all elements of each resident's program are implemented.On 6/8/2025 at 9:15 AM, R9 was in bed, dressed, with an indwelling catheter attached to the right side of the bed. R9 had bilateral contractures in his upper extremities and in his bilateral lower extremities. R9 was not interviewable.R9's Care Plan dated 6/10/2026 documents, Restorative: R9 has a diagnosis of Cerebral Palsy and has contractures to his bilateral upper extremities and bilateral lower extremities. R9 is at risk for further declines in range of motion, discomfort, and skin breakdown. Passive range of motion program initiated to maintain or improve range of motion to bilateral upper extremities and bilateral lower extremities, prevent skin breakdown, and reduce discomfort.R9's MDS (Medical Data Set) section GG dated 4/30/2026 documents R9 has an impairment on bilateral upper extremities and bilateral lower extremities, this same document states R9 is dependent on all cares.On 6/10/2026 at 11:00 AM, V13 (Restorative Nurse) stated R9 had not received passive range of motion (PROM) services since April 29, 2026. V13 indicated that R9 was scheduled to receive PROM services daily; however, these services had not been performed as required.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure oxygen tubing was dated, changed weekly, failed to provide a care for plan oxygen use, and failed to correctly identify oxygen use on MDS (medical data set) for one (R2) of one resident observed with oxygen therapy in the sample list of 33. Findings Include: The facility's Oxygen Administration policy, not dated, documents, Policy, oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and residents' goals and preferences. Policy explanation and compliance guidelines, 4. The resident's care plan shall identify the interventions for oxygen therapy, based upon the residents' assessment and orders, such as, but not limited to: a. The type of oxygen delivery system, b. When to administer, such as continuous or intermittent and/or when to discontinue, c. Equipment setting for prescribed flow rates, d. Monitoring of SpO2 (oxygen saturation) levels and/or vital signs, as ordered e. Monitoring for complications associated with the use of oxygen. 5. b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated.On 6/9/2026 at 11:16 AM, R2 was dressed in her high back wheelchair in the dining room. R2 had a nasal cannula with 3 liters of oxygen flowing. Tubing was not dated.R2's Physician's Orders dated 6/10/2026 documents, O2 (oxygen) 2-6 liters via nasal cannula continuously for SOB (shortness of breath).R2's Care Plan dated 6/10/2026 does not document a care plan for oxygen use.R2's MDS (medical data set) section O (Special Treatments, Procedures, and Programs) dated 4/17/2026 does not document the use of oxygen therapy.On 6/9/2026 at 11:20 AM, V1 (Administrator) confirmed there was no date on R2's oxygen tubing. V1 confirmed oxygen tubing should always be dated.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview and record review the facility failed to provide documentation of communication and collaboration with the dialysis facility regarding dialysis care and services for one (R8) of one resident reviewed for dialysis care in a sample of 33. Findings Include:The facility's Hemodialysis policy, not dated, documents, This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the residents goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis. Purpose, the ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatment received at a certified dialysis facility. Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. Compliance Guidelines, 5. The licensed nurse will communicate to the dialysis facility via telephone communication or written format, such as a dialysis communication form or other form, that will include, but not limit itself to: a. Timely medication administration (initiated, held or discontinued) by the nursing home and/or dialysis facility, b. Physician/treatment orders, laboratory values, and vital signs;, c. Advance Directives and code status; specific directives about treatment choices; and any changes or need for further discussion with the resident/representative, and practitioners; d. Nutritional/ fluid management including documentation of weights, resident compliance with food/fluid restrictions or the provision of meals before, during and/or after dialysis and monitoring intake and output measurements as ordered; e. Dialysis treatment provided and resident's response, including declines in functional status, falls, and identification of systems that may interfere with treatments; f. Dialysis adverse reactions/complications and/or recommendations for follow up observations and monitoring, and/or concerns related to the vascular access site; g. Changes and/or declines in condition related to dialysis; h. The occurrence or risk of falls and any concerns related to transportation to and from dialysis facility.R8's Physician's Order sheet dated 6/10/2026 documents R8 has a diagnosis of End Stage Renal Disease.R8's Care Plan dated 6/10/2026 documents, I have need for hemodialysis related to renal failure at a renal dialysis facility on Monday, Wednesday, and FridayOn 6/10/2026 at 10:05 AM, V1 (Administrator) confirmed R8 does not have any written communication from the hemodialysis facility to communicate and report to facility nurse.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure multi-dose injectable insulin pens were labeled with the date when opened for two of 15 residents (R5 and R56) reviewed for storage and labeling of medications in a sample of 33.Findings include:The facility's Labeling of Medications and Biologicals policy, undated, documents, All medications and biologicals used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications. 8. Labels for multi-use vials must include: a. The date the vial was initially opened or accessed.On 6/8/26 at 9:30 AM V7 (LPN/Licensed Practical Nurse) was standing at the Back Hallway medication cart. V7 opened the top drawer of the medication cart where multi-dose insulin injector pens were stored. This drawer contained R5's opened 1/3 full Lispro Insulin100 u/ml (units/milliliter) injector pen that was not labeled with the date when opened. V7 stated, All insulin pens should be labeled with the date opened. V7 verified R5's insulin pen was not labeled with the date opened.On 6/8/26 at 9:35 AM V8 (LPN) was standing at the Middle Hallway medication cart. V8 opened the top drawer of the medication cart where multi-dose insulin injector pens were stored. This drawer contained R56's opened 1/2 full Basaglar Insulin100 u/ml injector pen that was not labeled with the date when opened. V8 verified R56's insulin pen was not labeled with the date opened.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review the facility failed to ensure the State Agency survey results were kept in a location readily accessible to residents and visitors and post a notice that survey results are available for review. This failure has the potential to affect all 59 residents residing in the facility.Findings include:The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 6/8/26 and signed by V10 (Director of Operations), documents 59 residents reside within the facility.The Ombudsman Resident Rights for People in Long Term Care Facilities booklet, dated 11/2018, documents You have the right to see reports of all inspections by the Illinois Department of Public health from the last five years and the most recent review of your facility along with any plan that your facility gave to the surveyors saying how your facility plans to correct the problem.On 6/9/26 at 10:10 AM, during a resident group meeting, R34, R44, and R51 all denied being aware of a (state agency) survey binder or the availability to review those results. R34 confirmed she is the resident council president and stated she would like to know where the state agency survey binder is so that she can review the state inspection results.On 6/9/26 at 10:15 AM V12 (Activity Director) stated, I usually go over rights with the residents in resident council and I am not even aware of where the state survey inspection binder is located.On 6/9/26 at 10:25 AM, the facility's state agency survey inspection's binder was located on top of a four-drawer filing cabinet behind the receptionist desk and not freely accessible for residents to access. The facility's lobby area and hallways do not contain a posting about the state agency survey results being available for review.On 6/9/2026 at 10:30 AM, V12 confirmed the state survey binder was located behind the receptionist desk and stated she was not aware of any signage about the survey results binder location. V12 verified that residents would not be able to reach the state agency survey binder.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review the facility failed to ensure the daily resident census and direct care staff posting was posted in an area accessible to residents and visitors. This failure has the potential to affect all 59 residents residing in the facility.Findings include:The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 6/8/26 and signed by V10 (Director of Operations), documents 59 residents reside within the facility.The facility's Nurse Staff Posting Information policy, undated, documents, It is the policy of this facility to make nurse staffing information readily available in a readable format to residents, staff, and visitors at any given time. 1. The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information: a. Facility name. b. the current date. C. Facility's current resident census. d. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. i. Registered Nurses. ii. Licenses Practical Nurses/Licenses Vocational Nurses. iii. Certified Nursing Aides. 2.The facility will post the Nursing Staffing Sheet at the beginning of each shift.On 6/8/26 at 9:40 AM a tour was done of the facility. During this tour the direct care staffing and census for 6/8/26 was not posted within the facility.On 6/8/26 at 9:45 AM V5 (Receptionist) verified the direct care staffing for 6/8/26 was not posted within the facility. V5 stated, (V1/Administrator) normally posts the staffing and has not gotten around to it yet.