Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145044	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allure of Peru	1301 21st Street Peru, IL 61354

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on interview and record review, the facility failed to ensure interventions were in place to prevent misappropriation of a medication for one of three residents (R1) reviewed for misappropriation of property in a sample of three. Findings include:The facility's Abuse and Retaliation Policy Prevention Program, dated 01-2026, documents that the facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff, or mistreatment. The Proof of Delivery form, dated 2/7/26, documents that a bottle of Lorazepam (benzodiazepine) 2mg/ml (milligrams per milliliter), 30ml, was delivered and signed in by V4, Registered Nurse. The facility's Final Summary of Investigation, undated, documents that R1 had an order for Lorazepam Oral Concentrate 0.25ml by mouth every two hours as needed for anxiety for 14 days. This form documents that on 2/13/26, V2, Director of Nursing, was notified by V3, Assistant Director of Nursing, that she had been made aware of an incorrect narcotic count for R1. V2 compared the remaining amount of medication in the bottle with the count sheet. V2 confirmed that the count was inaccurate. V2 investigated whether any doses had been administered and not documented; none were identified. R1's Controlled Drug Receipt/Record/Disposition Form, dated 2/7/26, documents that a vial of 30ml was delivered. This form documents that 0.25ml was signed out on 2/12/26 at 5:19pm and at 10:15pm, leaving under 1ml. On 3/18/26 at 12:00pm, V3, Director of Nursing, stated that on 2/13/26, she received a call from V6, Registered Nurse, telling her that R1's Lorazepam was missing. V3 stated that V6 stated that there was less than 1ml in the bottle, which was supposed to be full. V3 stated that V6 sent her a picture of the bottle, which showed less than 1ml of liquid inside. On 3/18/26 at 12:20pm, V2, Director of Nursing, stated that on 2/14/26, she started an investigation and interviewed all staff who had access to R1's Lorazepam. V2 stated that everyone denied giving, spilling, or accessing the bottle. V2 verified that after a very long and thorough investigation, it could not be determined what happened to R1's medication. On 3/18/26 at 2:20pm, V6, Registered Nurse, stated that she went to give R1 a dose of the Lorazepam 0.25ml when she noticed that there was less that 1ml left in the bottle that was supposed to have 30ml. V6 stated that she called V3 to notify her of the missing medication. V6 verified that she did not give or spill any of the medication; it was gone before she even gave the medication.

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: 145044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allure of Peru	1301 21st Street Peru, IL 61354

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 that controlled substances were reconciled and stored appropriately. This has the potential to affect all 82 residents residing in the facility. The facility's Medication Storage policy, undated, documents to ensure all medications housed on the premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperatures, light, ventilation, moisture control, segregation, and security. This form also documents that schedule II drugs and back-up stock of schedule III, IV, and V medications are stored under double-lock and key. This form documents that schedule II controlled medications are to be stored within a separately locked, permanently affixed compartment when other medications are stored in the same area, such as in a refrigerator. The facility's Controlled Substance Administration and Accountability policy, undated, documents that all controlled substances obtained from a non-automated medication cart or cabinet are recorded on the designated usage form. Written documents must be clearly legible with all applicable information provided. This form also documents that for areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift. On 3/17/26 at 10:30am, the west wing medications cart was reconciled with V5, Registered Nurse. V5 removed a taped-up prescription bottle of Hydrocodone-Acetaminophen (Opioid) 7.5mg-325mg belonging to R2. V5 stated that since the bottle is taped up, she does not open it to count the pills left inside. V5 verified that she could not see the number of pills left in the bottle. V5 also stated that the tape could be removed and reapplied with no one even knowing. V5 also stated that it does not matter because R2 is no longer receiving the dose in the bottle. V5 entered the medication room. There were two plastic containers of class II-V medications sitting on the top of a small refrigerator. V5 verified that the containers containing the stock class II-V medications are not in an affixed locked cabinet. The facility's Control Box documents the following medications: 3-Oxycodone/Acetaminophen 5-325mg (milligram), 3-Oxycodone/Acetaminophen 7.5-325mg, 3-Oxycodone/Acetaminophen 10/325mg, Oxycodone 10mg, Oxycodone ER (extended release), Hydromorphone 2mg, Morphine Sulfate IR (immediate release) 15mg, Morphine Sulfate ER 15mg, 2 Fentanyl Patches 25mcg (micrograms), and 15ml (milliliter) of Morphine Oral Solution 20mg/ml. The second Control Box documents 1 of each of the following medications: Hydrocodone/Acetaminophen 5/325mg, Hydrocodone/Acetaminophen 7.5/325mg, Hydrocodone/Acetaminophen 10/325mg, Acetaminophen/Codeine #3 300/30mg, Alprazolam 0.25mg, Diazepam 5mg, Pregabalin 25mg, Lorazepam 0.5mg, Tramadol 50mg, and Clonazepam 0.5mg. On 3/17/26 at 11:00am, the north medication cart was reconciled with V7, Registered Nurse. V7 entered an unlocked storage closet to retrieve R3's bottle of Lorazepam 2mg/ml 30ml bottle. V7 took out the plastic bag of Lorazepam and looked at the box, then placed it back in the refrigerator. V7 did not open the box to check the bottle of Lorazepam. V7 also stated that all staff have access to the refrigerator in the stock room. V7 also stated that the stock room is not visible at all times, so it is possible for someone to walk out with the refrigerator. The facility's Midnight Census Report, dated 3/17/26, documents 82 residents residing in the facility.