

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 04/25/2025
NAME OF PROVIDER OR SUPPLIER Allure of Peru		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>33973</p> <p>Based on observation, interview, and record review, the facility failed to maintain the privacy of residents' health information for two (R12 and R174) of 18 residents reviewed for confidentiality/privacy in a sample of 31.</p> <p>Findings include:</p> <p>The undated Residents' Rights for People in Long-Term Care Facilities documents Your rights to privacy and confidentiality - You have a right to privacy and confidentiality of your personal and medical records. Your medical and personal care are private.</p> <p>On 4/23/25, between 8:29am and 8:45am, V4 Registered Nurse/RN administered medications to R12 and R174 in the dining room. V4's medication cart sat in a high traffic hallway between two dining rooms in the front portion of the facility.</p> <p>On 4/23/25, at 8:29am, V4 RN stood at the medication cart, opened R12's electronic medical record on the lap top computer sitting on top of the medication cart, and prepared R12's medications. V4 then left the medication cart with the computer screen unlocked and open showing a view of R12's clinical record. While V4 was away from the medication cart administering medications to R12, staff brought several residents out of the dining room passing by the medication cart.</p> <p>On 4/23/25, at 8:35am, V4 RN changed the computer screen to R174's clinical record and prepared R174's medications. At 8:37am V4 left the medication cart to retrieve water for R174. The computer screen on top of the medication cart was unlocked and open showing a view of R174's clinical record. At 8:38am V4 RN returned to the dining room and administered R174's medications to R174. During this time staff continued to bring residents out of the dining room passing by the medication cart.</p> <p>On 4/23/25, at 12:08pm, V4 RN confirmed she should not have left the computer screen unlocked and open to residents' clinical records on top of the medication cart.</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145044
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>33973</p> <p>Based on interview and record review, the facility failed to ensure fingernail care was added to a resident's Care plan for one (R40) of 18 residents reviewed for Care plans in a sample of 31.</p> <p>Findings include:</p> <p>The facility's undated Comprehensive Care Plans policy documents Policy: 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 and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. Policy Explanation and Compliance Guidelines: 1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the Resident's personal and cultural preferences in developing goals of care.</p> <p>The facility's undated Nail Care policy documents Policy: The purpose of this procedure is to provide guidelines for the provision of care to a resident's nails for good grooming and health. Policy Explanation and Compliance Guidelines: 5. The resident's plan of care will identify: a. The frequency of nail care to be provided. b. The type of nail care to be provided. c. The person(s) responsible for providing nail care (e.g., licensed nurse, nurse aide, podiatrist, activity professional).</p> <p>R40's current Care plan does not include fingernail care.</p> <p>On 4/24/25, at 1:13pm, V10 Care plan Coordinator confirmed R40's current care plan does not include fingernail care. V10 stated they do not routinely add nail care to residents' care plans.</p> <p>On 4/24/25, at 1:16pm, V2 Director of Nursing/DON confirmed that according to the facility's Nail Care policy nail care should be on all residents' care plans.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33970</p> <p>Based on observation, interview and record review the facility failed to perform nail care for two residents (R19) and (R40) of 18 reviewed for assistance with daily living in a total sample of 31.</p> <p>Findings Include:</p> <p>The facility's undated Nail Care policy documents Policy: The purpose of this procedure is to provide guidelines for the provision of care to a resident's nails for good grooming and health. Policy Explanation and Compliance Guidelines: 3. Routine cleaning and inspection of nails will be provided during ADL (Activities of Daily Living) care on an ongoing basis. 4. Routine nail care, to include trimming and filing, will be provided on a regular schedule (such as weekly on Wednesday 3-11 shift). Nail care will be provided between scheduled occasions as the need arises. 5. The Resident's plan of care will identify: a. The frequency of nail care to be provided. b. The type of nail care to be provided. c. The person(s) responsible for providing nail care (e.g., licensed nurse, nurse aide, podiatrist, activity professional). 6. Principles of nail care: a. Nails should be kept smooth to avoid skin injury. 7. Procedure: a. perform hand hygiene and don gloves. b. fill wash basin(s) with warm water. Soak hands/feet in wash basin for 10-20 minutes, unless resident has diabetes or circulation problems. c. Gently clean underneath nails with 'orange stick'. d. If trimming is allowed, clip nails using nail clippers straight across and even with tops of fingers/toes. e. Shape nails straight across using nail file, emery board, or the like. f. Dry hands/feet well with towel. g. Apply lotion to hands/feet h. Remove gloves and perform hand hygiene. i. Document completion of task, any complications, or if resident refuses.</p> <p>1. On 4/22/25 at 1:30 PM, R19's fingernails on both hands were long with dark brown substance under all of them. R19 stated I need to do something about my nails, they are gross, I just haven't had time.</p> <p>On 4/23/25 at 8:30 AM, R19's fingernails on both hands were long with dark brown substance under all of them. R19 stated they are gross (indicating her nails.)</p> <p>R19's MDS (Minimum Data Set) assessment, dated 1/29/25, documents I. Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene): substantial/maximum assistance.</p> <p>R19's CNA (Certified Nursing Assistant) Task section documented nail care as complete on 4/23/25 at 10:12 AM by V9 (CNA).</p> <p>On 4/23/25 at 11:30 AM V7 (Activity Aide) confirmed R19's fingernails on both hands were long and dirty</p> <p>On 4/23/25 at 11:40 AM V8 (Licensed Practical Nurse) confirmed R19's fingernails on both hands were long and dirty.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/23/25 at 1:00 PM V9 (CNA) stated she performed nail care on R19 as best as she could. V9 stated she wiped R19's hands with a washcloth. V9 denied attempting to soak, clip or clean under nails with orange stick.</p> <p>33973</p> <p>2. R40's Minimum Data Set/MDS, dated [DATE], documents R40 is moderately cognitively impaired and requires substantial/maximal assistance with personal hygiene.</p> <p>On 4/22/25, at 10:46am, R40 sat in a chair with long jagged, sharp fingernails. R40 stated I need to get them cut, but I don't know where to get that done. I am new here.</p> <p>On 4/23/25, at 9:53am, R40 sat in a wheelchair in the doorway of her room. R40's fingernails are still long and jagged and R40 stated, Now they are breaking off. R40's right index fingernail is partially broken off, sharp, and jagged with the other half still long.</p> <p>On 4/23/25, at 10:09am, R40 sat in the activity area. At this time V2 Director of Nursing/DON confirmed that R40's nails are long, broken and jagged and should be clipped.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>33973</p> <p>Based on observation, interview, and record review, the facility failed to ensure glove change during pressure ulcer treatment for one (R27) of seven residents reviewed for pressure ulcers in a sample of 31.</p> <p>Findings include:</p> <p>The facility's undated Clean Dressing Change policy documents Policy: It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination. Physician's orders will specify type of dressing and frequency of changes. Policy Explanation and Compliance Guidelines: 7. Wash hands and put on clean gloves. 9. Loosen the tape and remove the existing dressing. If needed to minimize skin stripping or pain, moisten with prescribed cleansing solution or use adhesive remover to remove tape. 10. Remove gloves, pulling inside out over the dressing. Discard into appropriate receptacle. 11. Wash hands and put on clean gloves. 12. Cleanse the wound as ordered, taking care to not contaminate other skin surfaces or other surfaces of the wound (i.e. clean outward from the center of the wound. Pat dry with gauze.</p> <p>R27's Wound Evaluation & Management Summary, dated 4/23/25, documents R27 has a stage III pressure wound to her left heel.</p> <p>On 4/24/25, at 8:20am, R27 sat in a wheelchair in her room. V5 Registered Nurse/RN wearing a mask, donned a gown and gloves and prepared to change the dressing to R27's left heel pressure ulcer. V5 removed R27's old dressing soiled with a small amount of drainage. R27's left heel has an approximately dime sized open area. With the same soiled gloves, V5 cleansed R27's left heel pressure ulcer with gauze wet with normal saline. V5 removed V5's soiled gloves, performed hand hygiene, then completed the rest of the dressing change.</p> <p>On 4/24/25, at 1:30pm, V5 RN stated V5 should have changed her gloves after removing the soiled dressing and before cleansing the wound.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>33973</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were administered according to physician orders and pharmacy medication instructions for two (R12 and R48) of six residents reviewed during Medication Administration in a sample of 31. There were two errors out of 26 medication opportunities observed resulting in a 7.69% medication error rate.</p> <p>Findings include:</p> <p>The facility's Medication Administration policy, dated 2025, documents Policy: 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: 10. Ensure that the six rights of medication administration are followed: a. Right resident. b. Right drug. c. Right dosage. d. Right route. e. Right time. f. Right documentation. 17. Administer medication as ordered in accordance with manufacturer specifications. a. Provide appropriate amount of food and fluid.</p> <p>1. On 4/23/25, at 8:23am, R12 sat in the dining room eating breakfast. V4 Registered Nurse/RN administered Aspirin 81mg (milligrams) one tab, Multivitamin one tab, Metoprolol 50mg one tab, Sertraline 50mg one tab, Vitamin B-12 100 mcg (micrograms) one tab, and Carafate one gram one tab to R12.</p> <p>R12's current Physician Order Sheet/POS documents orders for Aspirin 81mg one tab, Multivitamin one tab, Metoprolol 50mg one tab, Sertraline 50mg one tab, Vitamin B-12 100 mcg (micrograms) one tab, and Carafate one gram one tab all to be given by mouth in the morning.</p> <p>The two pharmacy labels on R12's Carafate multi-dose medication bubble card read Take this product at least two hours before or two hours after your other medications. And Take medicine on an empty stomach- 1 hour before or 2-3 hours after a meal unless otherwise directed by your doctor.</p> <p>R12's Physician Order Sheet/POS does not indicate other directions for the administration of R12's Carafate.</p> <p>On 4/23/25, at 8:30am, V4 RN confirmed the pharmacy label and stated, It should be given two hours before or two hours after his other meds. V4 stated that R12 did not receive his Carafate on an empty stomach or without other medications and should have.</p> <p>2. On 4/23/25, at 11:45am, R48 sat in the dining room eating breakfast. V4 RN administered Carb/Levo (Carbidopa/Levodopa) (sub for Parcopa) 25-100mg one tab and Acetaminophen 325mg two tabs to R48 whole and mixed in applesauce.</p> <p>R48's current POS documents orders for Carb/Levo (Carbidopa/Levodopa) (sub for Parcopa) 25-100mg one tab and Acetaminophen 325mg two tabs to be given by mouth in the morning.</p> <p>The pharmacy label on R48's Carb/Levo multi-dose medication bubble card reads Place medicine on your tongue and allow it to disintegrate.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/23/25, at 11:48, V4 stated (R48) wants it in his applesauce. I have never given it that way to him before. V4 confirmed the pharmacy label and stated, I guess I should have given it that way.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>33973</p> <p>Based on observation, interview, and record review, the facility failed to keep residents' medications securely stored for two (R12 and R174) of seven residents reviewed for medication storage during medication administration in a sample of 31.</p> <p>Findings include:</p> <p>The facility's undated Medication Storage policy documents Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy Explanation and Compliance Guidelines 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.</p> <p>On 4/23/25, at 8:25am, V4 Registered Nurse's/RN's medication cart sat in a high traffic hallway between two dining rooms in the front portion of the facility.</p> <p>On 4/23/25, at 8:29am, V4 stood at the medication cart and prepared R12's medications. At this time, V4 walked over to R12 with R12's medications in a medicine cup and left two multi-dose medication bubble cards on top of the medication cart consisting of Vitamin B-12 100mcg (micrograms) and Carafate one gram. While V4 was away from the medication cart administering medications to R12, staff brought several residents out of the dining room passing by the medication cart.</p> <p>On 4/23/25, at 8:35am, V4 RN prepared R174's medications at the medication cart. At 8:37am V4 left the medication cart to retrieve water for R174. The medication cart had nine multi-dose medication bubble cards on top including Lipitor 10mg, Apixaban 2.5mg, Lasix 40mg, Zestril 10mg, Toprol XL 25 mg, Potassium Chloride Micro tabs 20mEq (milliequivalents), Hydrodiuril 25mg, Preservision capsules, and Zolof 50mg. At 8:38am, V4 RN returned to the dining room and administered R174's medications to R174. During this time staff continued to bring residents out of the dining room passing by the medication cart.</p> <p>On 4/23/25, at 12:08pm, V4 RN confirmed she should not have left medications on top of the medication cart.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>33973</p> <p>Based on observation, interview and record review, the facility failed to ensure accuracy of resident medical records for two (R40 and R48) of 18 residents reviewed for medical records in a sample of 31.</p> <p>Findings include:</p> <p>The facility's Documentation in Medical Record policy, dated 2024, documents Policy: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Policy Explanation and Compliance Guidelines: 4. Principles of documentation include but are not limited to: a. Documentation shall be factual, objective, and resident centered. I. False information shall not be documented. ii. Record descriptive and objective information based on first-hand knowledge of the assessment, observation, or service provided. b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care.</p> <p>The facility's Certified Nursing Assistant job description, dated 2023, documents Major Duties and Responsibilities: Completes flow sheets daily to indicate that the specified task was done.</p> <p>1. On 4/22/25 at 10:46am and 4/23/25 at 9:53am, R40's fingernails were long, sharp and jagged.</p> <p>R40's Task: Inspect & Clean Fingernails, dated 3/25/25 to 4/23/25, documents on 4/22/25 at 6:07am by V6 Certified Nursing Assistant/CNA that R40's nails were trimmed.</p> <p>On 4/23/25, at 10:41am, V6 CNA confirmed that V6 worked day shift yesterday (4/22/25) and had charted that R40's nails were trimmed even though she didn't know that they had not been.</p> <p>On 4/23/25, at 1:22pm, V2 Director of Nursing/DON stated the Certified Nursing Assistants/CNAs should not chart on a resident who another CNA is taking care of unless they are charting together and knows what cares were done.</p> <p>2. On 4/23/25, at 11:45am, R48 received Carb/Levo (Carbidopa/Levodopa) (sub for Parcopa) 25-100mg (milligrams) one tab with two Tylenol 325mg tabs whole in applesauce by V4 Registered Nurse/RN.</p> <p>The pharmacy label on R48's Carb/Levo multi-dose medication bubble card reads Place medicine on your tongue and allow it to disintegrate.</p> <p>On 4/23/25, at 11:50am, V4 looked up the hospital discharge orders and confirmed that the order for R48's Carb/Levo is for an oral dose, not the dispersing type. V4 stated It was put in wrong.</p> <p>On 4/23/25, at 1:18pm, V2 Director of Nursing/DON stated I put the order for Carb/Levo in wrong. I should have selected the oral route not the dispersing route. I probably took it from the template.</p>		