

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2026
NAME OF PROVIDER OR SUPPLIER Allure of Mendota		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 First Avenue Mendota, IL 61342	
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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure money paid to the facility was refunded to the resident or the resident's representative/resident's estate within 30 days following the resident's discharge from the facility. This applies to 3 of 3 residents (R1, R5 and R6) reviewed for discharge in the sample of 7. The findings include: R1's EMR (Electronic Medical Record) shows that she was admitted to the facility on [DATE] and discharged on [DATE] when she expired at the facility. On [DATE] at 10:25AM V4 (Business Office Manager) stated, If someone comes in before the 20th of the month then they just pay for the remainder of the month. If they come in after the 20th then they pay for the remainder of the month plus the next month. If they leave before the month is over, then they have to wait until 10th of the next month for them (corporate) to close out the month. I send a check request to corporate, they cut a check and send it to me and then I call the family and they can either pick up the check, or I can mail it to them. For (R1) I was told that the person that processes the checks was busy with some sort of Medicare Audit and they were not able to cut the check. I don't have any control over what happens after I send the check request. (R1's Spouse) came in here several times and called me everything but a white woman- but he didn't cuss. He said he had bills to pay at the (local hospital) and I offered to call them and explain the situation. I sided with him. I called corporate multiple times. R1 was here 2/2- 2/6, (R1's spouse) would have had to wait until after 3/10 and I would have sent the check request then.V4 provided a copy of Check Request Form for R1 dated [DATE] and a second Check Request Form dated [DATE].V4 stated, I emailed corporate on 5/6 and 5/12, and I got the check on 5/15 (98 days). (R1's spouse) came and picked it up on 5/15. V4 provided a copy of the check in the amount of \$6520.00 and a document showing R1's spouse's signature dated [DATE]. R5's EMR shows that she was admitted to the facility on [DATE] and expired on [DATE].R5's Check request is dated [DATE]. A check for \$4860.00 shows an issue date of [DATE] and a mailing date to R5's Power of Attorney in Arizona on [DATE] (89 days). R6's EMR shows he was discharged from the facility on [DATE].R6's Check Request Form was sent on [DATE] and a check for \$5940.00 was received on [DATE] (68 days).On [DATE] at 11:00AM V4 stated, (R6) is a current resident at the facility and the family wanted the money applied for his stay this time. The facility admission Contract states, Conveyance upon discharge, eviction, or death. Upon discharge, eviction or death of a resident with a resident with a personal fund deposited with the facility must convey within 30 days of the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law.		

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
--	-------	-----------