STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145619	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allure of Lake Storey	1250 West Carl Sandburg Drive 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30678 Based on interview and record review the facility failed to prevent drug diversion of Oxycodone from occurring for one (R1) of three residents reviewed for narcotic medications in the sample of 12. Findings include: The facility's Abuse, Neglect, and Exploitation policy and procedure policy, dated 8/11/22, documents, It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. This policy defines willful as the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. This policy also defines misappropriation of Resident property as the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent. The facility's Medication Administration policy and procedure, dated 2024, documents, Sign MAR (medication administration record) after administered and If medication is a controlled substance, sign narcotic book. The Controlled Drug Receipt/Record/Disposition Form, for R1, documents a bubble pack card of 60 Oxycodone-APAP (Tylenol) 5-325 mg (milligrams) tablets was delivered to the facility on [DATE]. This form documents R1 received Oxycodone two tablets on the following dates: 2/7/24 at 12:00 pm; 2/8/24 at 7:30 am; 2/9/24 at 8:30 pm; 2/20/24 at 8:00 am; and on 2/20/24 at 8:30 pm. All other days R1 received only one tablet with the last dose of one tablet being administered on 2/19/24 at 11:12 am. There is no Oxycodone signed out for R1 between 2/19/24 and 3/5/24. This form documents V4 Former RN/Registered Nurse signed out Oxycodone on the following dates and times: 3/6/24 at 7:05 pm two tablets; 3/6/24 at 11:45 pm one tablet; and 3/7/24 at 5:00 am two tablets. (continued on next page)

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's final report submitted to the state agency on 3/11/24, documents R1 was admitted to the facility on [DATE] and has a physician order for Oxycodone-APAP 5-325 mg (milligrams) one to two tablets every four hours as needed for pain. R1 is alert and oriented to person, place, and time. R1 as cognitively intact on 1/22/24. It was noted on 3/8/24 that the narcotic count sheet from 3/6/24 at 7:15 pm to 3/7/24 at 5:00 am 5 tablets were signed out by an agency nurse (V4 Former RN). Resident had not taken this medication since 2/19/24 prior to this shift. The Oxycodone was not signed out on the resident's medication administration records. (R1's) scheduled Tylenol was signed out by (V4 Former RN) with zero reported pain from (R1). (R1) was questioned by the Administrator (V1) and DON/Director of Nursing (V2) and reports she has not taken any Oxycodone for several weeks and that she has had no pain. Physician and Family have been notified of incident. (Local) Police Department was notified of incident and report was taken by V20 Police Officer with complaint #24-8835. (V4 Former RN) has not been back into facility since incident and has been placed on Do Not Rehire/Allow to work in facility and the agency, (Company) that (V4 Former RN) works for has suspended her pending the investigation. A complete narcotic count has been completed by the Administrator and DON with no further discrepancies noted. The DON and/or Administrator will monitor the narcotic count sheets for two nurse signatures daily. Pharmacy to replace the medication as soon as Physician can write a script for the replacement medication. The facility's investigation includes V20's (local) Police Officer business card with a complaint number 24-8835 having been filed by the facility. The EMAR, dated March 2024, documents R1 with no complaints of pain 3/6/24 through 3/7/24 and no Oxycodone being administered to R1. On 4/2/24 at 3:00 pm, V7 LPN/Licensed Practical Nurse stated V4 Former RN was his relief at shift change for two days and the narcotic count was spot on both times. V7 LPN stated, Because the count was correct, I didn't notice anything. V7 LPN stated (V4 Former RN) was a bit odd, I thought. I love my job but (V4 Former RN) was beyond happy and excited to be here. On 4/2/24 at 1:07 pm, V2 DON stated on 3/8/24 V19 LPN/Licensed Practical Nurse, discovered R1 was administered five doses of Oxycodone in two days when R1 had not been taking any of it since February and V19 LPN thought it was suspicious and contacted V2 DON. V19 LPN knew R1 and due to having worked with her for some time. V2 DON stated she and V1 Administrator started the investigation and did notice that R1 hadn't taken any Oxycodone since 2/19/24 and then received five doses within two days. V4 Former RN/Registered Nurse signed the Oxycodone out on R1's paper narcotic sheet but did not sign the medication out in the EMAR (electronic Medication Administration Record) and scored R1 as having no pain on the pain assessment and did not administer any Tylenol to R1. V2 DON stated she spoke to R1, who is alert and oriented and R1 stated she had not received any of Oxycodone for a while and was trying not to take Tylenol anymore. V2 DON stated she contacted the facility float pool agency where V4 Former RN worked, and V4 Former RN was suspended pending the investigation and was made a DNR (do not return) from the facility. V2 DON stated everyone was notified and a report was filed with the police and a few days later the float pool agency informed the facility they had terminated V4 Former RN's position and V4 would no longer be working in any of the company's facilities. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/24 at 1:25 PM, V1 Administrator stated she and V2 DON did the investigation and completed narcotic counts on all of the facility medication carts and the counts were all correct. V1 Administrator stated all residents receiving narcotic medications were interviewed and they all said they received their medications except for R1. R1 said she had not taken the Oxycodone for some time and was even trying not to take Tylenol. R1 said no nurse came in to give her the Oxycodone during the past few weeks. V1 Administrator stated V4 Former RN was made a DNR (do not rehire) to the facility and the float pool suspended V4 and a few days later terminated her from the company. V4 Former RN was new to the facility and only worked those few days and due to the narcotic count being correct at shift change no one noticed anything out of the ordinary. V19 LPN was familiar with R1 and noticed that after not taking the Oxycodone for some time, R1 was randomly given five doses in two days, thought it odd and reported it right away. V1 Administrator stated, Because the narcotic count was correct during shift change, no one noticed anything out of the ordinary. V4 Former RN literally signed the medications off on the narcotic sheet and noticed that V4 did not sign them off in the electronic charting and documented R1 not having pain. V1 said, (R1) was alert and oriented and did not appear to be medicated at all and so it was pretty obvious what had happened. The police were called, a report filed, and the narcotic count sign off forms were changed from three shifts to two shifts due to the nurses working 12-hour shifts.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 30678 Based on interview and record review the facility failed to ensure safe positioning in bed was maintained during incontinence care and failed to obtain an air mattress and safety devices for one of three residents (R4) reviewed for falls in the sample of 12. These failures resulted in R4 falling from bed, hitting head on floor, and obtaining a hematoma to her forehead. Findings include: The facility's Fall Prevention Program, dated 2023, documents, Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. A fall is an event in which an individual unintentionally comes to rest on the ground, floor or other level, but not as a result of an overwhelming external force (e.g., resident pushes another resident). The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere. The facility's Safe Resident Handling/Transfers policy and procedure, dated 2023, documents, It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. The facility's Turning and Repositioning policy and procedure, dated 2023, documents, It is our policy to implement turning and repositioning as part of our systematic approach to pressure injury prevention and management. This policy establishes responsibilities and protocols for turning and repositioning. Turning and repositioning is a primary responsibility of nursing assistants. However, all nursing staff are expected to assist with turning and repositioning. Use the appropriate number of staff to perform the tasks safely. Utilize positioning devices as needed to maintain posture. The facility's Use of Support Surfaces dated 2/1/23, documents, Support surfaces will be used in accordance with evidence-based practice for residents with or at risk for pressure injuries. Support surface refers to a specialized mattress, mattress overlay, or a chair cushion designed to manage pressure, shear, microclimate, or friction forces on tissue. Support surfaces will be chosen by matching the potential therapeutic benefit with the resident's specific situation. Considerations for utilizing specialized support surfaces: a. Medical condition; b. Size and weight; c. Mobility and activity levels. d. Due to unique needs and situations of individuals, the guidelines may not be appropriate for use in all circumstances. The facility's fall log, documents R4 had two un-witnessed falls on 3/10/24 and 3/11/24 and a witnessed fall on 3/25/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The current Care Plan for R4, documents R4 returned from hospital visit with a terminal prognosis and diagnosis of acute renal failure, hyperkalemia, urosepsis, and protein calorie malnutrition and on hospice services with a stage 3 coccyx pressure ulcer. R4 is at risk for falls related to deconditioning, gait/balance problems, and psychoactive drug use with history of falls at home and prior nursing facility. R4 had falls on 3/10/24, 3/11/24, and 3/25/24. R4 is receiving hospice services, requires total assist of two staff for turning and repositioning at least every two hours in bed and for toileting. R4's Care Plan was revised with fall intervention added on 3/11/24 to include, Notify hospice to bring in air mattress with built in bolsters and on 3/25/24 Notify hospice (company) to exchange (R4's) bed for a large bed with air mattress with bolsters. The #499 Un-witnessed fall investigation for R4, dated 3/10/24 at 9:40 pm, documents R4 noted to be laying on floor next to her bed. Nurse assessed. R4 noted to have abrasion to head and discoloration to arm with complaints of head pain. R4 has impaired balance coordination and weakness with poor safety awareness. Resident has a terminal condition and on hospice services. Nurse initiated neuros (neurological checks) and R4 was assisted back to bed per mechanical lift. (R4's) Care plan was reviewed and revised to add: Bed to be in lowest locked position with fall mats next to bed. Nurse documented, (R4) has poor upper body control, tends to lean towards right side while in bed. Requires constant repositioning. The #501 Un-witnessed fall investigation for R4, dated 3/11/24 at 3:00 pm, documents, Prior fall note exact same incident on 3/10/24. R4 was observed on left side of bed on the floor, lying on her right side, with pillow under face with no injuries. The root cause was documented as poor balance, coordination, weakness, restlessness, and terminal condition. Hospice notified for an air mattress with bolsters. The #505 Witnessed fall investigation for R4, dated 3/25/24 at 10:15 pm, documents V9 LPN (Licensed Practical Nurse) and V10 CNA (Certified Nursing Assistant) repositioned R4 from the far right of the bed to the center of the bed, turned R4 to left side, facing V10 CNA and while (V10) CNA had (R4) turned towards him (V10 CNA) and (V10) was wiping (R4's) buttocks, (R4's) upper body slid off of air mattress. R4 complained of face and nose pain and rated pain a 5 out of 10 on pain scale. V9 LPN assessed R4 noting 6. 0 cm (centimeter) x 5.0 cm hematoma (abnormal collection of blood outside of blood vessel) to middle of forehead and the tip of R4's nose was potentially crooked. The local hospice to order a bariatric air mattress and V2 DON (Director of Nursing) requesting air mattress with bolsters. Care Plan reviewed and revised to add: Notify hospice (company) to provide a larger bed, air mattress with bolsters. The Post Fall Evaluation for R4, dated 3/26/24 at 2:54 am, documents reason for R4's fall as slipped out of air mattress, needs a bigger bed and injury as hematoma to forehead. Contributing Factors Noted: slippery bed/air mattress. R4 verbalized pain of 4 out of 10 on pain scale with grimacing, withdrawing and shows non-verbal signs of pain. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/5/24 at 3:24 pm, V18 LPN/Licensed Practical Nurse stated she was called down to R4's room on 3/10/24 because R4 was on the floor. R4 was found on the floor next to her bed, face down with an abrasion to her forehead. R4 was not able to move her legs but could move her upper body some, could move her arms, had poor control and would lean to the right. R4 had an air mattress, that seemed a bit unleveled, floor mats on the floor, and the bed was kept as low as it would go but was not a low to the floor bed. V18 LPN stated R4 was not morbidly obese but was wide and round and needed a bigger bed and was requested from the hospice company. R4's bed and nightstand were also moved because it looked like (R4) may have hit her head on the nightstand. V18 LPN stated she called and requested the hospice company to come to the facility to see R4 and after coming they just said to monitor R4 and never brought a bigger mattress. On 4/3/24 at 2:45 pm, V5 LPN stated R4 returned from a hospital visit on hospice services due to kidney and cardiac issues and was actively dying prior to her last fall. V5 LPN stated on the morning of 3/26/24, during shift report, V9 LPN reported R4 had fallen out of bed during the night, while cares were being provided, and V5 LPN only recalls seeing bruising to R4's forehead but nothing abnormal to R4's face. V5 LPN stated R4 was restless at times but mostly at nighttime. V5 LPN stated the air mattresses are slick and R4 wore silky nightgowns which probably didn't help. V5 LPN stated R4 had previous falls on 3/10/24 and 3/11/24 and on 3/11/24 V5 LPN requested the hospice company bring a bariatric air mattress and bolsters for R4's bed so there was more room for R4, but they never brought anything. On 4/5/24 at 12:53 pm, V10 CNA/Certified Nursing Assistant stated on 3/25/24 he and V9 LPN went in to clean up R4 and care for R4's coccyx wound treatment. V10 CNA stated R4 had to be moved to the middle of the bed before starting due to R4 leaning to the right side. V10 CNA stated, We rolled R4 towards me, and V9 LPN started cleaning R4 up because R4 had a bowel movement. V10 CNA stated both he and V9 LPN were holding onto R4 and both trying to clean R4 up and R4 just slid off the bed. V10 CNA stated (R4) had an air mattress and had already fallen numerous times before. In my opinion air mattresses are not safe for all residents. V10 CNA stated there were no bolsters on R4's air mattress and (R4) should have had a bigger bed to start with. R4 was actively dying prior to the fall and wasn't able to help, she just rolled right out. V10 CNA stated, I told them on my witness statement that I told V9 LPN that (R4) needed a bigger bed and that I didn't think the air mattress was safe because (R4) had prior falls. V10 CNA stated, The only thing I can think of is that we could have gotten another person to help but we only had to have two before. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/5/24 at 4:20 pm, V9 LPN stated she and V10 CNA went in to do (R4's) coccyx wound treatment on 3/25/24 but R4 had a bowel movement and needed cleaned up first. V9 LPN stated R4 had to be moved to the middle of the bed because R4 tended to lean to her right. V9 LPN stated R4 was rolled onto her left side facing V10 CNA. V10 CNA was standing at about R4's pelvis area holding R4 at the hip area with one hand and was wiping R4's buttock with his other hand. V9 LPN stated she was on the back side of R4 and had hand on R4's shoulder or hip area and at times she and V10 CNA were both wiping stool from R4's buttocks at the same time. V9 LPN stated R4's bed was in the up position while they were giving care and R4's head and top half of body just slid right off the bed. V9 LPN stated they tried to stop R4 from falling but couldn't, it happened so fast. V9 LPN stated R4's body fell on to the fall mat but R4's head hit the floor, causing a goose egg on her forehead and her nose did look a little crooked at the tip but I honestly didn't know if it was already like that or not. V9 LPN stated, (R4) has fallen other times because of the air mattress and R4 needed a bigger bed because (R4) was very round and filled the mattress she had. V9 LPN stated the hospice company was asked to bring a bigger mattress and bolsters for R4 but never brought them. V9 LPN stated she did notify the hospice company who told her to just put ice wherever R4 was hurting. V9 LPN stated, A bigger bed or bolsters probably would have helped prevent (R4) from falling. V9 LPN also confirmed that if V10 CNA had just been holding her and not wiping (R4), might have had better control of R4 and prevented R4's fall. On 4/5/24 at 2:23 pm, V2 DON/Director of Nursing stated generally during incontinence care of residents requiring two assist; the staff member the resident is facing holds and secures the residents position while the staff member facing the residents back side does the incontinence care. V2 DON stated it was reported that V9 LPN and V10 CNA were in the room providing cares for R4 and R4 fell out of the bed. V9 LPN and V10 CNA were cleaning R4 up and preparing R4 for the wound treatment. V10 CNA tried to stop R4 but R4 was top heavy and fell to the floor. V2 DON stated the facility had been trying to get a larger air mattress or bolsters from the hospice company for some time. V2 DON stated a bariatric air mattress and bolsters were requested from the hospice company multiple times. V2 DON stated, We went back and forth with (hospice company) and evidently they have requirements based on the resident's condition in order to provide one. V2 DON confirmed not having a larger air mattress or bolsters may have potentially contributed to R4's fall and that V10 CNA should have had both hands on R4 securing R4's position on the bed. On 4/5/24 at 4:27 pm, V1 Administrator stated the facility was having trouble getting a bigger air mattress and bolsters from the hospice company, who said they weren't allowed to deliver one due to their rules and the cuts that were made. V1 Administrator stated she called the facility's corporate office who called the hospice company's corporate office and they finally agreed they would deliver one but would be a week or so. V1 Administrator stated R4 ended up passing before the hospice company delivered anything to the facility. V1 Administrator confirmed that V10 CNA should have had both hands holding onto R4 while V9 LPN performed the incontinence care, and she would make sure the nursing staff was educated.