STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145789	A. Building B. Wing	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allure of Geneseo	704 South Illinois Street Geneseo, IL 61254

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure safety of a resident by ensuring the shower room door was closed for 1 of 3 residents (R1) reviewed for safety and supervision. This failure resulted in R1 wandering into the shower room and experiencing a slip and fall to the floor and sustaining a laceration to her head and a right femoral fracture. The findings include:R1's face sheet showed she was admitted to the facility 11/13/25 with diagnoses to include ataxia, cognitive communication deficit, macular degeneration, depression, chronic kidney disease, and protein calorie malnutrition. R1's facility assessment dated showed she has moderate cognitive impairment, required partial to moderate assistance for transfers, and uses a manual wheelchair for mobility. The facility's report to the state agency dated 3/29/26 showed, . Resident had a fall on 3/28/26, in the shower room. The CNA (Certified Nursing Assistant) was heating up the water for a resident and left the door open. [R1] entered the shower room, but due to cognitive impairment was not able to explain what she was trying to do in the room. Nurse assessed resident, vital signs stable, had a small laceration to the right temple. On 3/29/26 resident complained of pain in the right leg. Nurse notified doctor, new order received to send to the ER (emergency room) for evaluation and treatment. Resident was found to have right femoral fracture. Resident is scheduled to have surgery and will return to the facility. Resident should be in highly visible area. Intervention: All staff educated on the importance of keeping shower doors closed. Signs posted on the shower room doors to remind staff to keep closed.A copy of the sign posted on the shower room door was provided and showed, Shower room doors must stay closed for resident safety. When warming up the water, the shower room door should be closed. Please keep this door shut!!!R1's 3/28/26 Health Status Note entered at 10:54 PM showed, 8:10 PM, resident was found laying on the shower/bathroom area floor, positioned between the toilet and wheelchair. Resident was found on her right side and exhibited a laceration on the right temple area, measuring approximately 2cm x 3 cm. The bathroom/shower water was running. Clean the wound and applied sterile strips. Assess level of consciousness alert and oriented x 1. Family notified. DON (Director of Nursing) notified, and fax communication to [physician] for information. R1's 3/28/26 eMAR (electronic Medication Administration Record) Note entered at 9:54 PM showed acetaminophen given for pain. R1's 3/29/26 Health Status Note entered at 7:07 AM showed, Resident complaining of right sided leg pain post fall from last night. This nurse attempted to perform passive ROM (range of motion) and resident did not tolerate well. ST (Skin Tear) on right forehead steri strips still intact. Resident states my head is fine, it's my leg I'm worried about. Another nurse making appropriate phone calls related to concern.R1's 3/29/26 Health Status Note entered at 10:28 AM showed, Spoke to [Acute Care Nurse] at [Acute Care Hospital]. [R1] fractured her femoral neck and will be admitted . will do surgery later this week.R1's 4/3/26 Admission/readmission Note entered at 1:33 PM showed, Resident arrived at 1:21 PM via ambulance from [acute care hospital] . Alert and oriented to person per baseline. Fatigued. Right surgical hip dressing intact.R1's Care Plan showed, The resident is at risk for falls related to history of falls, osteoporosis, difficulty in walking, muscle wasting and atrophy, muscle weakness, unsteadiness on feet, other symptoms and signs involving (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 0689 Level of Harm - Actual harm Residents Affected - Few	musculoskeletal system.R1's care plan initiated 11/22/25 with a new intervention added 3/28/26 showed, The resident has had an actual fall. Intervention: . 3/28/26. Resident found lying on the floor in the shower room. Assessed by nurse, laceration noted to right temple. Resident assisted to wheelchair by staff and treatment given to head wound. 3/29/26: Resident has complaints of right-side leg pain, sent to ER (emergency room) and admitted with right femoral neck fracture. Resident will have surgery this week. Signs posted and staff educated on having shower doors closed at all times when not in use.R1's Acute Care Hospital After Visit Summary documents dated 4/3/26 showed, Closed displaced fracture of right femoral neck. admitted [DATE] through 4/3/26.On 4/19/26 at 2:03 PM, V4 CNA (Certified Nursing Assistant) said, I was just showering a different resident. I was coming out of the shower room with that resident, and I went around the corner. One of my coworkers said they had just taken [R1]to the bathroom and they put her by the nurse's cart which was near the shower room. She was in her wheelchair. I was going to put the other resident in the recliner nearby the nurse's station. [R1] went from right where she was by the nurse's cart, into the shower room, and fell. We have to keep a close eye on her because she likes to be up and down all the time. She was in the middle of the shower room when we found her on the floor. I don't know what she would have been doing. She is just very fast. I felt terrible, but I was in the middle of showering the resident I was with and taking her out. The shower door is typically closed. We even have a sign on the door that says the door has to remain shut. I left the door open because I was going to go back and clean up the towels and everything. [R1] is someone that we just really have to keep a close eye on, and everyone was so busy at the time. As soon as I finished helping the other resident into the recliner, I got the nurse right away. The nurse and another CNA went in there. The nurse looked her over, looked at her eyes was asking her questions. We hoisted her up off the floor, one on each side and put her back in her wheelchair. I remember at the time the nurse had us put her at the nurse's station and she got her vitals. I think the nurse was more worried about the bump on her head. She was bleeding from that area. She was not complaining of any pain at the time. The nurse was asking her if she was hurting anywhere. The nurse was concerned about the head wound. She said no honey I'm fine. She didn't appear to be in pain. We kept her at the nurse's station. She was across from the nurse's station in the recliner that is where she stayed overnight. She had no complaints of pain overnight. It seemed like more toward the end of the shift, around 4 AM, she was saying ?my leg hurts honey'. I told the nurse [R1] was now complaining of her leg hurting. The nurse rechecked her vitals and gave her something for pain. My shift ended at 6 AM and I think she got sent out shortly after I left. On 4/20/26 at 9:11 AM, V5 CNA said, I was working with V4, and I remember [R1] had fell in the shower room, she hit her head and was bleeding everywhere. We had to do vitals on her every 15 minutes until I left at 10. I know she gets up without permission. She just gets up. [V4] found her because she was assigned to her. What happened was [V4] walked out to get a towel or something and that is when [R1] fell. She was on the floor by the toilet when I went in there. We had to put stuff on her head to stop the bleeding. They didn't send her out to the hospital because the nurse said they didn't need to send her, but I know they were talking about it. She had a big ole bruise on the side of her head. I didn't hear her complaining of pain, she was acting like it was normal and we were all freaked out. I go there a lot in the last couple of months. I know she likes to get up throughout the night and we have to have her sit out with us. The shower room door is usually closed and has a lock on it. I think [V4] was getting the shower ready, so I think she had it propped open.On 4/20/26 at 9:48 AM, V6 LPN (Licensed Practical Nurse) said, At night [R1] has the dementia that makes her wander a lot. I think the CNA at the time took her to the bathroom and we keep her in the front near the nurse's station where the common area is. I asked ?where is [R1]' and that is how the CNA found out that she had went into the shower room and she was laying on the floor. The shower was running. The CNA was doing a shower with another lady, so she had the water running to get warm. I don't know exactly how she got in there. The door requires a code. The resident wouldn't be able to get in the shower room if the door was shut.On 4/20/26 at 10:12 AM, V2 DON (Director of Nursing) said, It was (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	reported to me that [R1] had fallen in the shower room unattended because the door was left open. The shower room doors are usually shut. It is typically shut unless someone is in there. It should not be left open all the time. We educated the staff on ensuring the shower room doors remain closed and we placed signs on each shower room door reminding them the doors are to be shut.The facility's undated policy and procedure showed, Fall Prevention Program. Policy: 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. Implement universal environmental interventions that decrease the risk of resident falling. Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive plan of care.