

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145987	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2025
NAME OF PROVIDER OR SUPPLIER  Allure of Galesburg		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 Frank Street Galesburg, IL 61401	

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 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>(continued on next page)</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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145987	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2025
NAME OF PROVIDER OR SUPPLIER  Allure of Galesburg		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 Frank Street Galesburg, IL 61401	
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 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview the facility failed to properly prepare and administer medications to prevent a significant medication error for one resident (R4) of three residents (R3, R4, and R5), reviewed for medication administration errors in a total sample of 21. These failures resulted in R4 receiving the wrong medication and being hospitalized for lethargy, heart rate in 40s, difficult to arouse, and subsequently being intubated. These failures resulted in an Immediate Jeopardy. While the immediacy was removed on 9/10/25, the facility remains out of compliance at severity level 2 while the facility continues to educate the nursing staff on proper medication preparation and administration and conduct audits to ensure continued compliance. FINDINGS INCLUDE: The Facility's Medication Administration Policy, not dated, documents: 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; 11. Review MAR to identify medication to be administered; 12. Compare medication source (bubble pack, vial, etc.) with MAR [Medication Administration Record] to verify resident name, medication name, form, dose, route, and time; 14. Remove medication from source, taking care not to touch medication with bare hand; 17. Administer medication as ordered in accordance with manufacturer specifications; and 23. Correct any discrepancies and report to nurse manager. The Facility's Medication Error policy, not dated, documents: 3. Medication errors, once identified, will be evaluated to determine if considered significant or not by utilizing the following three general guidelines: a. The nurse assesses and examines the resident's condition and notifies the physician or care practitioner as soon as possible; b. Monitor and document the resident's condition, including response to medical treatment nursing interventions; c. Document actions taken in the medical record; d. Once the resident is stable, the nurse reports the incident to the appropriate supervisor completes the incident or occurrence report. The facility's Medication Error Report Form, dated 8/15/25, document: Resident Name [R4]; Date/Time Error Occurred: 8/15/25 at 4:24 a.m.; Date/Time Error Discovered: 8/15/25 at 7:15 a.m.; Discovered by [V4/Licensed Practical Nurse-LPN]; Medication(s) involved: Vit[[NAME]] C 500 mg, ASA [aspirin] 81 mg, Claritin 10 mg, clonazepam 1 mg, Plavix 75 mg, fluoxetine 60 mg, Ibuprofen 600 mg, Lyrica 300 mg, MVI [multivitamin], Methocarbamol 750 mg, Seroquel 100 mg, and vitamin D3 5000 IU; Description of Error: Nurse gave another residents medications to wrong resident; and What symptoms, if any did the resident experience: lethargy, decreased BP [Blood Pressure]. R4's Electronic Medical Record/EMR document R4's diagnosis to include: Hemiplegia, Poisoning by Unspecified Drugs Accidental, Bradycardia, Parkinson's Disease, Muscle Wasting, Acute Pain due to Trauma, Major Depressive Disorder, Crohn's Disease, and Acute Hepatitis C. R4's August 2025 Medication Administration Record/MAR document, on the 15th, V3/Licensed Practical Nurse-LPN, [after administering R5's medication to R4], administered R4's Carbidopa/Levodopa 25/100 two tablets, and Diazepam 5 mg. The MAR also document V4 gave R4 his 7:00 a.m. medications-Lexapro 10 mg, Celebrex 200 mg, Protonix 40 mg, Keppra 1500 mg, Metoprolol 50 mg, Morphine Sulfate Extended Release 15 mg, Carbidopa/Levodopa 25/100 2 tabs, Entacapone 200 mg, and Lacosamide 100 mg. R4's EMR progress notes document: 8/15/25, at 7:15 AM, this nurse [V4] was notified by resident [R5] that he saw the third shift B/E Hall nurse [V3] give his 5 AM medications to this resident. Resident stated he felt unwell this a.m. Resident laying bed and vitals checked, and resident noted to be hard to arouse and lethargic. [V8/medical doctor], 911, Local hospital], and brother notified. On 9/9/25, at 1:25 p.m., V2/Director of Nursing confirmed: On 8/15/25, V3 (3rd Shift Nurse) pre-popped [pre-prepared] and stacked residents' medications. R4 was subsequently administered R5's medications-Ascorbic Acid 500 milligram/mg, Aspirin 81 mg, Claritin 10 mg, Clopidogrel 75 mg, Fluoxetine 60 mg, Multivitamin, Seroquel 100 mg, Vitamin D3 125 ug (micrograms), Lyrica 300 mg, Klonopin 1 mg, ibuprofen 600 mg, Robaxin 750 mg; After realizing the error, V3 then administered R4's correct medication which included-diazepam 5 mg, carbidopa/levodopa 25/100 2 tabs; V3 did not report the error; V4/Licensed Practical Nurse/LPN 1st shift nurse administered R4's 7:00 a.m. medications-Lexapro 10 mg Celebrex 200 mg Protonix 40 mg, Keppra 1500 mg, Metoprolol 50 mg, Morphine Sulfate Extended Release 15 mg, Carbidopa/Levodopa 25/100 2 tabs, Entacapone 200 mg, and Lacosamide 100 mg; R5 then told V4 that V3 had given his medications to R4; and R4 was sent to the emergency room where R4 was admitted. R4's hospital documentation: 8/15/25 Emergency Room-Critical care was necessary to treat or prevent imminent or life-threatening deterioration of the following conditions: CNS [Central Nervous System] failure or compromise, metabolic crisis and</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145987	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2025
NAME OF PROVIDER OR SUPPLIER  Allure of Galesburg		STREET ADDRESS, CITY, STATE, ZIP CODE  1145 Frank Street Galesburg, IL 61401	
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>Based on observation, interview, and record review, the facility failed to ensure nurses do not pre-prepare and stack clear medication cups (with meds) in/on medicine carts for 16 residents (R5-R21) of 16 residents reviewed for medications not being pre-prepared, in a total sample of 21. FINDINGS INCLUDE: Facility Policy, entitled Medication Storage, copyright 2025, document: 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; b. Only authorized personnel will have access to the keys to locked compartments; and 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. On 9/10/25, at 4:00 a.m., the State Agency entered the facility and observed V5/Registered Nurse and V6/LPN had pre-prepared and stacked medicine cups, with resident medication, on and in their medicine carts. Among the medicines, pre-prepared, five resident med cups (R8, R12, R13, R14, R15), along with non-controlled medication, contained controlled medicines which were signed out on the Controlled Drug Received/Record/Disposition Form. On 9/10/25, at 4:00 a.m., V5/Registered Nurse confirmed V5 should not have pre-prepared and stacked the clear med cups, containing residents' morning medication, on top of the medicine cart for R6, R7, and R8-R14. Additionally, V5 stated, I am forced to do that here because the type of residents who get mad when they are not ready and it takes time to pop them out one at a time. On 9/10/25, at 4:05 a.m., V6 confirmed V6 should not have pre-prepared and stacked the clear med cups, containing residents' morning medication for R15-R21, in the top drawer of the medicine cart. The individual medicine carts, Controlled Drug Received/Record/Disposition Form document the following controlled medicine was signed out, as morning medication, by V5 and V6: R8-Clonazepam 0.5 mg, R12-Ativan 0.5 mg, R13 Tylenol with Codeine 300/30 mg, R14-Ativan 1 mg, and R15-Ativan 1 mg. On 9/10/25, V1/Administrator confirmed V5 and V6 should not have pre-prepared resident medication, and they won't be back.</p>		