STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145987	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allure of Galesburg	1145 Frank Street Galesburg, IL 61401

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to protect a resident from staff-to-resident sexual abuse, failed to assess a resident's ability to consent to sexual activity, and failed to protect residents from staff-to-resident verbal abuse for three of seven residents (R2, R3, and R6) reviewed for abuse in the sample of seven. These failures resulted in V7 (Prior Dietary Aide) engaging in behavior indicating an attempt to initiate a personal or romantic relationship with R3 in June 2025, V7 continuing to have sexually inappropriate conversations and video nudity by electronic communication with R3, and V7 sexually assaulting R3 on at least three occasions while R3 was attending church services. These failures also resulted in V7 verbally abusing R6 on multiple occasions once R6 witnessed R3 and V7 engaging in inappropriate conversations and video nudity by electronic communications.These failures resulted in an Immediate Jeopardy:While the immediacy was removed on 1/31/26, the facility remains out of compliance at a severity Level II as additional time is needed to evaluate the implementation and effectiveness of their removal plan and Quality Assurance monitoring.Findings include:The facility's Abuse, Neglect, and Exploitation dated 2/3/25 documents, Policy: 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 abuse, neglect, exploitation, and misappropriation of property. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Sexual Abuse included but is not limited to, sexual harassment, sexual coercion, or sexual assault. Verbal abuse means the use of oral, written, or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend or disability. Allegations of staff to resident sexual abuse-Nursing home staff are entrusted with the responsibility to protect and are for the residents of that facility. Nursing home staff are expected to recognize that engaging in a sexual relationship with a resident, even an apparently willingly engaged and consensual relationship, is not consistent with the staff members role as a caregiver and will be considered an abuse of power. Also, for some health care professionals to have a relationship with a resident. Any sexual relationship between a staff member and a resident with or without diminished capacity may constitute sexual abuse in the absence of a sexual relationship that existed prior to the resident admitted to the facility, such as a spouse or partner, and must be (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	thoroughly investigated to prevent abuse and implement policies and procedures to prevent and prohibit all types of abuse, neglect, bribery, misappropriation of resident property, and exploitation that achieves: A. Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. This may include identifying when, how and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship. B. Identifying, correcting, and intervening in situations in which abuse, neglect, exploitation, bribery, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms. The facility's current Agreement with the Employees International Union Healthcare Illinois/Indiana documents, These work and safety rules and regulation shall be applicable to each facility and its employees in the bargaining unit. It is essential to the successful operation of the facility's business and the welfare of its patients and employees that fairly established standards of discipline, health, safety, attendance, workmanship, and honesty be maintained. Employees shall have an opportunity to sign formal warning, acknowledging that such warning has been given and to comment on such warning. Maintaining or attempting to maintain a relationship (whether or not consensual) with a resident that is sexual or romantic in nature unless the resident is the employee's spouse. First offense-Discharge. The Illinois Guardianship and Advocacy Commission Guardianship Fact Sheet (undated) documents, Guardianship Facts: Guardianship is needed when a person is unable to make and communicate responsible decisions regarding his personal care or finances due to a mental, physical, or developmental disability. The extent to which a guardian is allowed to make decisions for a ward is determined by the court based on a thorough clinical evaluation and report. Two basic types of guardianship are person guardianship and estate guardianship. A guardian of the person is appointed by the court when a disabled individual cannot make or communicate responsible decisions regarding his personal care. This guardian will make decisions about medical treatment, residential placement, social services, and other needs. The court appoints a guardian of the estate when a disabled person is unable to make or communicate responsible decisions regarding the management of his estate or finances. The guardian will, subject to court supervision, make decisions about the ward's funds and the safeguarding of the ward's income or other assets. The Illinois Probate Act gives the court the flexibility to tailor guardianship to meet the needs and capabilities of disabled persons. Depending on the decision-making capacity of the disabled person, the court can appoint a limited guardian who is granted the power to make only those decisions about personal care and/or personal finances that the court specifies. The court can also appoint a plenary guardian who generally has the power to make all decisions about personal care and/or finances for the disabled person. R3's Legal Guardianship dated 2/27/15 and signed by V12 (Judge) documents, Because of (R3's) physical and mental conditions, (R3) is not able to manage her person or property and is therefore a disabled person. Because of (R3's) disability (R3) lacks sufficient capacity to make and communicate responsible decisions concerning the care of her person and because of (R3's) disability, (R3) lacks capacity to manage her estate; and for these reasons it is necessary to appoint a guardian of the person and estate of (R3). A limited guardianship will not provide sufficient protection for (R3). (V3/R3's Plenary Guardian) is qualified to act as a guardian. In order to protect the best interests of (R3), a guardian of (R3's) person and (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	estate should be appointed. (V3) is capable of making residential decisions for (R3). Now, therefore, it is hereby ordered and adjudged: A. That (R3) is a disabled person in need of the appointment of a plenary guardian of her person and or estate. R3's Face Sheet Form documents R3 is a [AGE] year-old that was admitted to the facility on [DATE] with the diagnoses of Borderline Personality Disorder, Attention-Deficit Hyperactivity Disorder, Major Depressive Disorder, Anxiety Disorder, Suicidal Ideations, and Major Depressive Disorder with Severe Psychotic Symptoms. This same Form documents V3 is R3's Legal Guardian. R3's Emergency Department Provider Notes dated 7/8/25 document R3 was sent to the emergency room for suicidal ideations and had been feeling suicidal for the past couple days and having thoughts of cutting her wrist in order to attempt suicide. This report documents R3 reports that she was living (at the facility) and was physically assaulted by two other resident yesterday and has not been able to sleep since then. This same report documents R3 was transferred to an inpatient psychiatric treatment for the treatment of suicidal ideations. R3's Sign In/Sign Out Report Sheets dated 11/1/25 through 12/31/25 document R3 attended outside church services or the library on 11/9/25, 11/14/25, 11/16/25, and 11/23/25. These sheets do not include the staff/family/friend that R3 attended the library with on 11/14/25 or the church on 11/23/25. R3's Progress Notes dated 11/10/25 at 6:27 PM document, Staff talked to (R3) about roommate (R6) complaint of getting completely naked in the room with door and curtain open talking or videoing on social media. Staff reminded (R3) to close curtains and doors and be respectful of roommate's concerns. R3's Behavior Note dated 11/20/25 at 8:30 AM and signed by V6 (Psychosocial Rehabilitation Coordinator) documents, Another resident (R6) approached (V6) to report that (R3) was engaging in sexual conversation. When (R6) asked (V3 and R7) to refrain from doing this while (R6) was in the room, the male (V7) on the call began cursing at (R6) and calling (R6) names. (R6) stated that incidents like this occur often, and it is making (R6) feel uncomfortable. R3's IDT (Interdisciplinary Team) Note dated 11/21/25 documents, IDT reviewed (R3's) behavior involving smart phones, social media contact, and video calling and potential risk to (R3) and peers. (R3) continues to require assistance to think through logically regarding safety and well-being and refrain from impulsive decisions/actions per behavior documentation. (R3) did not successfully follow (R3's) suggested social media guidelines during walking pass trial. In order to help (R3) better manage impulsivity and better gauge whether (R3's) putting herself at risk of exploitation or abuse or how her choices impact peer residents' safety and well-being, IDT recommended a behavior management program where all phone use occurs with supervision/in supervises area upon request and when not in use as outlines, smartphones are secured at the nurses' station. These safety interventions are not included in R3's current care plan. R3's Progress Note dated 11/25/25 at 5:53 PM and signed by V5 (SSD/Social Service Director) documents V3 (R3's Plenary Guardian) gave authorization for R3 to receive phone calls, receive visits at the facility, or leave for therapeutic outings or scheduled community activities with only V3 (R3's Plenary Guardian, V21-V24 (R3's Family Members) or facility staff. These safety interventions were not included in R3's current care plan. R3's Final Abuse Investigation dated 12/3/25 and signed by V1 (Administrator) documents on 11/23/25 R3 had multiple instances of non-consensual sexual contact with a male (V7/Prior Dietary Manager) in the parking lot of a church on Sundays during church services. This same report documents, (R3) stated that (R3) had at least three encounters with (V7) and that none were consensual. (R3) states that the first time it happened, (R3) was in (V7's) vehicle in the church parking lot, and (V7) forced himself on (R3). The second time that it occurred, (V7) told (R3) to get in (V7's) vehicle because (V7) had food for (R3). (R3) stated she ate the food and then started to feel woozy and then blacked out. (R3) states she awoke by herself in the vehicle and proceeded to go to church services. The (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	third time that it happened (V7) lured (R3) into (V7's) vehicle because (R3) offered her snacks and once again, (R3) became woozy and blacked out and woke up alone and went to services after.Undated text message screenshots stored on R3's personal cellular phone and provided to this surveyor by V3 (R3's Plenary Guardian) on 1/31/26 documents ongoing personal, romantic, and sexually explicit communication between R3 and V7 (former Dietary Aide). The messages documented expressions of emotional attachment, intimate relationship discussions, and sexual content between V7 and R3. Text messages sent from V7 to R3 included statements such as, I miss you so much already, with R3 responding, I miss you more. Additional messages reflected plans to meet in the community, including R3 stating, Just come inside [NAME], I don't want to go back outside, it's cold and I'm starting to get a cough, and V7 responding, The car is warm (though), it's up to you. Further review of the text messages revealed discussions of a committed romantic relationship and future plans together. V7 texted R3, I really wanted to start a family with you and have a real life together.more than anything, and later stated, I do love you and miss you.you're my life, but I want more. Additional messages between R3 and V7 contained sexually explicit content. V7 texted R3, Making love to you means the world to me and I love you, and I want a real relationship with you. R3 sent a message to V7 stating, I love you more than I have ever loved anyone, and R3 stated she wanted V7 to c*m inside her and not pull out.R3's Individual Psychotherapy Follow-Up Evaluation Note dated 12/19/25 and signed by V8 (Clinical Therapist) documents R3 reported continued contact from R3's ex-partner (V7) and V7 gave R3 a note asking R3 to contact V7 however R3 stated she is setting boundaries and telling V7 to leave R3 alone. R3's Individual Psychotherapy Notes dated 1/9/26 and signed by V8 (Clinical Therapist) document, (R3) reported ongoing stress related to (R3's) ex-partner who continues attempting to contact (R3) directly and through others. (R3) expressed being done with the situation and wanting to leave town to feel safer. (R3) noted an increase in night tremors and shares significant fear that (V7) may approach (R3) when (R3) is not with staff or family, stating (R3) worries that something bad will happen. (R3) described how this fear has begun to affect her faith, though she continues coping by reading her Bible and listening to sermons. V7's Employee File documents V7 was hired at the facility on 9/26/23. V7's Employee File indicates V7 received Abuse Prevention training on 3/2/25. The Facility's In-Service Training Logs document V7 received training on 2/1/25 on what constitutes abuse, sexual abuse, sexual contact, sexual images, and staff requesting images from the residents, personal boundaries with the residents, and what constitutes all forms of abuse and bribery. The Facility's In-Service Training Logs document V7 received training regarding the facility's Abuse policy on 4/15/25 and 5/20/25. V7's Employee Termination Form dated 6/27/25 and signed by V1 (Administrator), V10 (Prior Dietary Manager), and V11 (Human Resource Manager) documents, (V7's) last day worked 6/27/25. Type of termination: Resignation. Reason for termination: Due to (V7's) growing feelings for a resident (R3). (V7) resigned effectively immediately. Eligible for rehire: No. R3's Police Report #25-049356 dated 11/26/25 at 1:17 PM and signed by V27 (Local Police Officer) documents, On 11/26/25 I (V27) was dispatched to (the facility) in regard to a sexual assault report. Upon arrival I met with (R3) and (V1/Administrator) who had reported the incident. (V1) advised that on 11/23/25, (R3) and (V3/R3's Guardian) had an argument regarding (R3) meeting former facility employee (V7) at (local church) on Sundays and having sex in (V7's) car in the parking lot during Sunday school before church. It should be noted that (V7) chose to resign from (the facility) due to a romantic interest in (R3), in which (V7) was told (V7) could not work at (the facility) due to a romantic interest in a resident (R3). (V3) also took (R3's) electronic devices after the argument and discovered inappropriate messages between (R3) and (V7). Today, (V1) advised that (R3) told one of her caregivers that (V7) forced (R3) to have (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	sex without (R3's) consent, therefore (V7) was alerted and contacted the police. (R3) stated that she does love (V7) but was not ready to have sex with (V7). (R3) advised there has been three occasions where (V7) lured (R3) to (V7's) vehicle in the parking lot of the church and forced (R3) to have sex with (V7) which has occurred each Sunday, since the first week of November. I asked (R3) to walk me through each occurrence, beginning with the first time it happened. First Occurrence: (R3) stated that the first time this occurred, (R3) went to church on the shuttle that transports (facility) residents to church. Shortly after (R3) arrived at church (R3) received a message from (V7) to come outside to talk. (R3) believed (V7) just wanted to talk and then (V7) asked (R3) to get into his vehicle, which (R3) described as a black SUV (Sport Utility Vehicle). (R3) stated she was hesitant to get in the vehicle, but (V7) kept persisting and it was cold outside, so (R3) got inside the vehicle in the front passenger seat. After (R3) sat down, (R3) stated that (V7) said he wanted to show her how a real man makes loves to somebody, and locked the doors, opened his driver door, and walked around to the back of the car where he opened the trunk. (R3) stated (V7) climbed into the back seat from the trunk. (R3) did not know why he did it this way. (R3) then stated that (V7) pulled her into the back seat and (R3) told (V7) to leave her alone. (R3) advised that (V7) said, It'll be fun and proceeded to remove (R3's) pants and underwear and began to have sex with (R3) without a condom or any protection. After (V7) had sex with (R3), (R3) stated she kicked (V7) to get (V7) off, and to get out of the vehicle, and then ran into the church. At this time, (R3) was advised church was ending, and (R3) departed on a shuttle back to (the facility). Second Occurrence: The second time this occurred, (R3) advised she arrived at church and (V7) told her he had breakfast and coffee in the car. (R3) came out and sat in the car when (V7) told her because (R3) was scared. This time (R3) sat in the back seat because (R3) did not want to sit right next to him. (R3) said (V7) did have breakfast and (R3) began to eat, and (V7) left for five to ten minutes. When (V7) came back (R3) was feeling very tired and disorientated and (R3) said You're ready. (R3) advised she kept telling (V7) no but does not remember what happened after that. (R3) advised that when (R3) started becoming aware again, (R3's) pants and underwear were off and (V7) was not there. (R3) stated she remembered feeling pain in (R3's) groin area after this occurred but did not seek help. Third Occurrence: On the third occurrence, (R3) advised (V7) told (R3) he had snacks in the car. When (R3) came outside with (R3), (R3) stated that (V7) was sitting in the backset and told (R3) he wanted to apologize, and he asked (R3) to get in the car so he could apologize. (R3) stated that she refused, and then (V7) grabbed her waist and said, You're mine and pulled (R3) into the car. (R3) told (V7) she had a headache and said (V7) offered a square shaped red pill that (R3) said was ibuprofen and forced it down (R3's) throat. After that, (R3) said (V7) told her if she ever tells anyone (V7) will stop at nothing to finish her off, and if (R3) screams (V7) would knock her ass out and do (R3) right there. (R3) stated she felt like she blacked (out) shortly after and believed it was from the pill (V7) gave her. (R3) stated that this time, she woke up, she was completely naked and believed (R3) felt semen inside of her, and once again, (V7) was no longer there. (R3) stated that again, (R3) went back inside the building and came back to (the facility) on the shuttle. Follow-up with (V1/Administrator): Following my interview with (R3), (R3) returned to her room. I met with (V1), who advised that (R3) has diagnoses Borderline Personality Disorder, Anxiety Disorder, and Impaired Social Interaction. (V1) advised that there were notes in her file stating that (R3) has a history of lying to and manipulating staff, especially when attempting to leave the building, and using (R3's) phone to manipulate men online and engage in inappropriate communication. (V3/R3's Plenary Guardian) found out (R3) was meeting (V7) at church this past Sunday, which led to an argument with (R3) in which officers had to response. (V3) had (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Criminal Sexual Assault.R3's current Plan of Care as of 1/30/26 documents, Focus date initiated 3/6/25: Impaired Social Interaction-(R3) is frequently speaking with, texting, or calling objects of opposite sex. (R3) is easily emotionally involved and makes poor decisions related to opposite sex related to diagnoses of Borderline Personality Disorder, Anxiety, MDD (Major Depressive Disorder), and ADHD (Attention-Deficit Hyperactivity Disorder). Goal: (R3) will embrace positive thinking statement and will participate in social situations. Focus date initiated 7/8/25: (R3) has a behavior problem related to Borderline Personality Disorder, ADHD, MDD, Anxiety Disorder, and history of SI (Suicidal Ideation). (R3) will manipulate situations/peers/staff to be able to leave the building and go where (R3) is potentially not safe and lie about where (R3) is going against guardian's wishes and also use manipulation to be sent to the hospital at will. (R3) takes other belongings thinking that it is comical, uses cell phone to attempt to manipulate men online to come pick her up from facility (unsafe decision making) as (R3) does not know these men. (R3) makes false accusations against staff and peers. (R3) Makes false allegation against other residents stating they have come into her room and hit her, and investigations show untruth. This same care plan does not include any updated interventions since the last update on 6/27/25 to address and protect R3 from sexually inappropriate conversations and video nudity by electronic communication with V7 or any other male and does not address or protect R3 from being sexually assaulted by V7 or any other male. This care plan also does not include R3's cognitive ability to consent to sexual activity. R3's Electronic Health Record dated 2/25/25 (admission) through 1/29/26 does not include an evaluation to determine R3's ability to consent to sexual activity. The facility's Root Cause Analysis Worksheet (undated) documents, (R3) was engaged in a relationship with (V7) in the community. (R3) would attend church services with groups from the facility on Sundays, with no staff supervision. (R3 and V7) would meet at a church and attend services together. (R3) was noted to leave church services and go to the parking lot with (V7). It was reported (R3 and V7) were having sexual relations in the parking lot of the church. (V3/R3's Plenary Guardian) was made aware of the sexual relationship between (R3 and V7) and (V3) stopped (R3) from attending church services. (R3) then alleged that the sexual relationship was non-consensual. The facility's QAPI (Quality Assurance and Performance Improvement)/QAA (Quality Assurance Assessment) Meeting Agenda dated 11/26/25 documents the facility immediately implemented protection measures and increased supervision of R3. R3's current Care Plan does not include these increased supervision and protection measures as documents in the QAPI agenda.On 1/28/26 at 10:30 AM V3 (R3's Plenary Guardian) stated, I am (R3's) legal guardian. At seven years old I adopted (R3). About the age of three to four years old (R3) wasn't reaching goal marks. (R3's) doctor told me I need to file for guardianship to keep (R3) safe from others, so I did. On 6/26/25, (V1/Administrator) called me and told me that (R3's) roommate (R6) had reported to (V1) that (R3) was in a relationship with (V7/Dietary Aide). (V1) told me they (the facility) were going to do an investigation, and I gave permission to look through (R3's) electronics. (V1) reported to me that (R3 and V7) were not having a sexual relationship but (V7) was sending (R3) messages saying, I love you. I am going to get you out of this place. You are the best thing that has happened to me. (V1) also said (R3 and V7) were video chatting at night. I had a CNA (Certified Nursing Assistant) tell me that she had gone into check on (R3) and saw (R3) was on a video call with (V7). I cannot remember that CNAs name. I was very upset over this whole thing of an employee trying to have a sexual relationship with (R3). I asked (V1) for (V7's) discharge records and I was told (V7) left on his own, so the facility did not have to do the paperwork or report this to IDPH (Illinois Department of Public Health). I told them IDPH needs to know that one of their employees (V7) is trying to have a sexual relationship and boyfriend-girlfriend (continued on next page)

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	145987	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allure of Galesburg	1145 Frank Street Galesburg, IL 61401

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	relationship with my daughter (R3) and this is exploitation of my daughter. I am a nurse and know a staff member should never try to have a relationship with a resident. I told the facility to take (R3's) electronics and that (R3) was not to have any further contact with (V7). After that (R3) was calling me and screaming at me that I am the worst mom ever. (R3) wanted to have a relationship with (V7) and started threatening suicide and was sent to a psychiatric unit for treatment. When (R3) returned to the facility, (R3) was put on lockdown and was not to leave the facility without supervision. I allowed (R3) to go to church back in November 2025. (R3) was able to leave to go to church with the facility dropping (R3) off and the church would bring (R3) back to the facility, and I told the facility to ensure (R3) was supervised at church. (R3) has a history of lying and being manipulative and a nurse (unknown name) told me that she thought (R3) was meeting up with (V7) while at church. I decided to drive three hours down and went to that church and sat in the back row. (R3) was not at church when I was there, even though I was told by the facility (R3) was going to church. About an hour into church, (R3) came into church from a side door. After church was over, I waited for (R3) to notice me. I walked up behind (R3) and tapped (R3) on the shoulder. I took (R3) back to the facility myself. I went outside and was looking for her and one of the residents in the facility van said to me, Just so you know (R3) has not been going to Sunday school for weeks. (R3) was angry at me for questioning her. The van driver (V13) told me he knew for weeks that (R3) had been sneaking around with (V7) at church. (R3) admitted to me that (R3) and (V7) were having intercourse while (V7) was working at the facility and (R3) had even met (V7's) daughter. The facility did not keep (R3) safe, and the facility said they would keep (R3) safe. (R3) is not allowed to leave now. (R3) cannot consent to sex. I told the police officer (V27) that (R3) cannot consent, and I am her legal guardian and did not consent to (R3) having a relationship with (V7). After (R3 and V7) were caught together at church, (V27) and (V1) were made fully aware that (V7) was the male meeting up with my daughter at church. I am legal guardian, and the police and facility should have done a rape kit on Sunday (11/23/25). There was also no STD (Sexually Transmitted Disease) testing done. I have since read all the text messaging done between (R3 and V7) and I turned all those text messages over to (V27). (V7) knows (R3) is disabled and takes advantage of (R3). (V7) needs to leave my daughter alone! The messages between (R3 and V7) started before June 2025. (V7) would send messages to (R3) saying, I[TRUNCATED]

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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** Based on record review and interview the facility failed to prevent misappropriation of a resident's controlled-substance medication for one of three residents (R8) reviewed for misappropriation of medications in the sample of seven. Findings include:The facility's Abuse, Neglect, and Exploitation Policy dated 2/3/25 documents, Policy: 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 abuse, neglect, exploitation, and misappropriation of property. Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent us of a resident's belongings or money without the resident's consent. R8's Face Sheet documents R8 is a [AGE] year-old admitted to the facility on [DATE] with the diagnoses of Major Depressive Disorder, Suicidal Ideations, Anxiety Disorder, Alcohol Abuse with Intoxication, Insomnia, and Muscle Spasms of the Back. R8's MDS (Minimum Data Set) assessment dated [DATE] documents R8 is cognitively intact. R8's Order Summary Report printed on 1/28/26 documents, Order Date 3/13/25: Norco (Hydrocodone-Acetaminophen) 10/325 mg (milligrams) one tablet by mouth every eight hours as needed for pain. The Pharmacy's Proof of Delivery and Packing Slip dated 12/6/25 documents 30 tablets of (R8's) Hydrocodone-APAP 10/325 mg were delivered to the facility on [DATE]. R8's Final Report dated 12/17/25 and signed by V1 (Administrator) documents, Incident Date: 12/9/25, (V2/Director of Nursing) noted (R8's) medication card missing. Pharmacy records show that the medication was sent on 12/6/25. The nurse (V28/Agency RN/Registered Nurse) receiving the medication states that she signed the medication in and appropriately stored the medication. This is backed by video evidence. Medication was reordered on 12/9/25 at 12:00 PM (and) was denied due to just being filled. Investigation initiated to verify delivery from pharmacy. Investigation includes video footage, interviews, and medication records. The investigation has narrowed down to an agency nurse (V19/Agency RN). This nurse (V19) has been DNR (Do No Return) from the facility as a precaution. (Local) police department has been given all requested information. V28's (Agency RN) statement dated 12/9/25 and signed by V33 (ADON/Assistant Director of Nursing) documents V28 received a delivery from pharmacy on 12/6/25 at 4:00 AM which include 30 tablets of R8's Norco (10/325 mg). This same statement documents V28 placed the 30 tablets of R8's Norco 10/325 mg in the medication cart. On 1/28/26 at 10:00 AM V2 (Director of Nursing) stated, On 12/8/25 when I came into work (V34/LPN/Licensed Practical Nurse) told me she tried to re-order (R8's) Norco from pharmacy and the pharmacy told (V34) the Norco could not be refilled because the Norco had been refilled and sent to the facility on [DATE]. I watched video footage and saw that (V28/Agency RN) received (R8's) Norco 30 tablets from pharmacy on 12/6/25 and put (R8's) Norco in the medication cart. By the time I found out (R8's) Norco was missing, two days had passed by. I did an audit of the controlled substance inventory sheets and noticed numerous nurses were not counting the controlled substances and cards at the beginning and end of their shifts like they were supposed to. I watched video surveillance and could not see if a nurse had stolen (R8's) Norco. In the video surveillance there are times the medication cart cannot be visualized. After I did an investigation, I determined that the only nurse that could have taken (R8's) Norco was (V19/Agency Nurse) because all the other nurses have worked here and we have never had missing narcotics. (V19) was the only new nurse that had worked. On 2/2/26 at 11:34 AM V28 stated, On a Friday (12/6/25) I received (R8's) Norco 10/325 mg 30 tablets from pharmacy. I put (R8's) Norco in the medication cart. I signed the pharmacy delivery sheets to confirm I received (R8's) Norco 30 tablets and when I left the facility in the morning around 6:00 AM (12/6/25) I counted all the controlled medications cards and pills and there were no discrepancies. That is the (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	last time I worked.

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to report allegations of staff-to-resident sexual abuse and exploitation, allegations of resident-to-resident physical abuse, and allegations of staff-to-resident verbal abuse immediately to the State Agency, Local Police, and Administrator once the facility was made aware for two of seven residents (R3 and R6) reviewed for abuse in the sample of seven. These failures resulted in V7 (Prior Dietary Aide) continuing to have non-consensual sex with R3, V7 continuing to sexually exploit R3 by electronic communications, and V7 verbally abusing R6 on multiple occasions once R6 witnessed R3 and V7 engaging in inappropriate conversations and video nudity by electronic communications.These failures resulted in an Immediate Jeopardy:While the immediacy was removed on 1/31/26, the facility remains out of compliance at a severity Level II as additional time is needed to evaluate the implementation and effectiveness of their removal plan and Quality Assurance monitoring.Findings include:The facility's Abuse, Neglect, and Exploitation dated 2/3/25 documents, Policy: 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 abuse, neglect, exploitation, and misappropriation of property. Investigation of Alleged Abuse, Neglect and Exploitation. Reporting/Response. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (law enforcement when applicable) within specified timeframes: a. immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Any sexual relationship between a staff member and a resident with or without diminished capacity may constitute sexual abuse in the absence of a sexual relationship that existed prior to the resident admitted to the facility, such as a spouse or partner, and must be thoroughly investigated to prevent abuse and implement policies and procedures to prevent and prohibit all types of abuse, neglect, bribery, misappropriation of resident property, and exploitation that achieves: A. Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. This may include identifying when, how and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship. B. Identifying, correcting, and intervening in situations residents and, neglect, exploitation, bribery, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms.1.R3's Legal Guardianship dated 2/27/15 and signed by V12 (Judge) documents, Because of (R3's) physical and mental conditions, (R3) is not able to manage her person or property and is therefore a disabled person. Because of (R3's) disability (R3) lacks sufficient capacity to make and communicate responsible decisions concerning the care of her person and because of (R3's) disability, (R3) lacks capacity to manage her estate; and for these reasons it is necessary to appoint a guardian of the person and estate of (R3). A limited guardianship will not provide sufficient protection for (R3). (V3/R3's Plenary Guardian) is qualified to act as a guardian. In order to protect the best interests of (R3), a guardian of (R3's) (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	person and estate should be appointed. (V3) is capable of making residential decisions for (R3). Now, therefore, it is hereby ordered and adjudged: A. That (R3) is a disabled person in need of the appointment of a plenary guardian of her person and or estate. V7's Employee Termination Form dated 6/27/25 and signed by V1 (Administrator), V10 (Prior Dietary Manager), and V11 (Human Resource Manager) documents, (V7's) last day worked 6/27/25. Type of termination: Resignation. Reason for termination: Due to (V7's) growing feelings for a resident (R3). (V7) resigned effectively immediately. Eligible for rehire: No. R3's Electronic Health Record dated 2/25/25 (admission) through 1/29/26 does not include an evaluation to determine R3's ability to consent to sexual activity. R3's Progress Notes dated 11/10/25 at 6:27 PM document, Staff talked to (R3) about roommate (R6) complaint of (R3) getting completely naked in the room with door and curtain open talking or videoing on social media (with another male). Staff reminded (R3) to close curtains and doors and be respectful of roommate's concerns. R3's Behavior Note dated 11/20/25 at 8:30 AM and signed by V6 (Psychosocial Rehabilitation Coordinator) documents, Another resident (R6) approached (V6) to report that (R3) was engaging in sexual conversation. When (R6) asked (R3 and R7) to refrain from doing this while (R6) was in the room, the male (V7) on the call began cursing at (R6) and calling (R6) names. (R6) stated that incidents like this occur often, and it is making (R6) feel uncomfortable. R3 and R6's Medical Records and the facility's Abuse Investigations do not include evidence of R3 and R6's allegations of R3 being sexually exploited by video on social media or R6 witnessing this sexual exploitation on 11/10/25 or 11/20/25 being reported to the State Agency or Local Police.R3's Police Report #25-049356 dated 11/26/25 at 1:17 PM and signed by V27 (Local Police Officer) documents R3 was sexually assaulted by V7 (Prior Dietary Aide) on three separate occasions while R3 was attending church services. This same Police Report documents V27 requested this Police Report be sent to the State's Attorney's Office for a probable cause review for (V7) to be charged with Criminal Sexual Assault.R3's Final Abuse Investigation dated 12/3/25 and signed by V1 (Administrator) documents, On 11/23/25 R3 had multiple instances of non-consensual sexual contact with a male (V7/Prior Dietary Manager) in the parking lot of a church on Sundays during church services. This same report documents, (R3) stated that (R3) had at least three encounters with (V7) and that none were consensual. (R3) states that the first time it happened, (R3) was in (V7's) vehicle in the church parking lot, and (V7) forced himself on (R3). The second time that it occurred, (V7) told (R3) to get in (V7's) vehicle because (V7) had food for (R3). (R3) stated she ate the food and then started to feel woozy and then blacked out. (R3) states she awoke by herself in the vehicle and proceeded to go to church services. The third time that it happened (V7) lured (R3) into (V7's) vehicle because (R3) offered her snacks and once again, (R3) became woozy and blacked out and woke up alone and went to services after. R3's Sign In/Sign Out Report Sheets dated 11/1/25 through 12/31/25 document R3 attended outside church services or the library on 11/9/25, 11/14/25, 11/16/25, and 11/23/25. These sheets do not include the staff/family/friend that R3 attended the library with on 11/14/25 or the church on 11/23/25. R3's Individual Psychotherapy Notes dated 1/9/26 and signed by V8 (Clinical Therapist) document, (R3) reported ongoing stress related to (V7) who continues attempting to contact (R3) directly and through others. (R3) expressed being done with the situation and wanting to leave town to feel safer. (R3) noted an increase in night tremors and shares significant fear that (V7) may approach (R3) when (R3) is not with staff or family, stating (R3) worries that something bad will happen. (R3) described how this fear has begun to affect her faith, though she continues coping by reading her Bible and listening to sermons.On 1/28/26 at 10:30 AM V3 (R3's Plenary Guardian) stated, I am (R3's) legal guardian. At seven years old I adopted (R3). About the age of three to four years old (R3) wasn't reaching goal marks. (R3's) doctor told me I (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	need to file for guardianship to keep (R3) safe from others, so I did. On 6/26/25, (V1/Administrator) called me and told me that (R3's) roommate (R6) had reported to (V1) that (R3) was in a relationship with (V7/Dietary Aide). (V1) told me they (the facility) were going to do an investigation, and I gave permission to look through (R3's) electronics. (V1) reported to me that (R3 and V7) were not having a sexual relationship but (V7) was sending (R3) messages saying, I love you. I am going to get you out of this place. You are the best thing that has happened to me. (V1) also said (R3 and V7) were video chatting at night. I had a CNA (Certified Nursing Assistant) tell me that she had gone into check on (R3) and saw (R3) was on a video call with (V7). I cannot remember that CNAs name. I was very upset over this whole thing of an employee trying to have a sexual relationship with (R3). I asked (V1) for (V7's) discharge records and I was told (V7) left on his own, so the facility did not have to do the paperwork or report this to IDPH (Illinois Department of Public Health). I told (V1) IDPH (Illinois Department of Public Health) needs to know that one of the employees at the facility, (V7), is trying to have a sexual relationship and boyfriend-girlfriend relationship with my daughter (R3) and this is exploitation of my daughter. I am a nurse and know a staff member should never try to have a relationship with a resident. When (R3) returned to the facility, (R3) was put on lockdown and was not to leave the facility without supervision. I allowed (R3) to go to church back in November 2025. (R3) was able to leave to go to church with the facility dropping (R3) off and the church would bring (R3) back to the facility, and I told the facility to ensure (R3) was supervised at church. (R3) has a history of lying and being manipulative and a nurse (unknown name) told me that she thought (R3) was meeting up with (V7) while at church. I decided to drive three hours down and went to that church and sat in the back row. (R3) was not at church when I was there, even though I was told by the facility (R3) was going to church. About an hour into church, (R3) came into church from a side door. After church was over, I waited for (R3) to notice me. I walked up behind (R3) and tapped (R3) on the shoulder. I took (R3) back to the facility myself. I went outside and was looking for her and one of the residents in the facility van said to me, Just so you know (R3) has not been going to Sunday school for weeks. (R3) was angry at me for questioning her. The van driver (V13) told me he knew for weeks that (R3) had been sneaking around with (V7) at church. (R3) admitted to me that (R3) and (V7) were having intercourse while (V7) was working at the facility and (R3) had even met (V7's) daughter. The facility did not keep (R3) safe, and the facility said they would keep (R3) safe. (R3) is not allowed to leave now. (R3) cannot consent to sex. I told the police officer (V27) that (R3) cannot consent, and I am her legal guardian and did not consent to (R3) having a relationship with (V7). (V7) knows (R3) is disabled and takes advantage of (R3). (V7) continued to text me and say he cares about (R3), and they love each other. I do not want (V7) to have any further contact with (R3).On 1/28/26 at 12:51 PM V6 (Psychosocial Rehabilitation Coordinator) stated, (R3) came into my office and said she was upset because they (R3 and V7) were in love and were texting back and forth and video chatting while (V7) worked here. (R3) let me read text messages and (V7) texting (R3) saying he missed and loved (R3) and knows (R3) is with other people and how (R3) could do that too (V7). I reported this to (V1) immediately and (V7) was given the option to resign or be terminated. On 11/20/25 (R6) reported to me that she saw (V7), who (R6) described as the little guy that used to work here, on a phone video with (R3) and (R3 and V7) were being provocative, having sexually inappropriate conversations, and having sexual acts. (R6) said she told (R3 and V7) to Knock that off. (R6) said (V7) began cursing at (R6) and told (R6) to Shut the f**k up and (R3) continued to yell at (R6). (R6) was frustrated. I reported (R6's) report to (V1) and we discussed it in an IDT (Inter-Disciplinary) meeting and then (R3) was supposed to stop using electronics.On 1/28/26 at 1:15 PM R3 (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	stated, I want to leave and get closer to my family. I got involved with a staff member, (V7), while he worked here. I started to play songs that I had written and (V7) would come out and say he was into music. Around March of last year (V7) sent me a message request on Facebook and I said back to (V7), How did you find me? (V7) said we (R3 and V7) share mutual friends on Facebook. After that we started text messaging back and forth while (V7) was at work. Eventually (V7) started asking me for phone sex and naked pictures and I was not okay with that. (V7) was living with the mother of his child during this time. (V7) told me that (V1/Administrator) gave (V7) the option to leave and not have legal repercussions or (V7) could stay employed and get both of us in trouble. (V7) started to say I was f**cked up in the head and (V7) did not want me. Our relationship grew and when I started to go to church, (V7) would meet up with me at church. (V7) lured me into his car by saying he wanted to talk to me privately. That should have been my first red flag. I went to (V7's) car and (V7) raped me and it was not consensual. (V7) raped me on three different Sundays. I asked (V7) to stop. (V7) wanted me to tell everyone it was consensual. (V7) told me he wanted our conversations to make it sound consensual. I talked to (V7) once since church by phone here at the facility and told (V7) to leave me the h**l alone. (V7) said he was not going to leave me alone and that he loved me. I told (V7) I am leaving this town because of (V7). (V3) is my guardian, and I am not sure if (V3) decides if I can have sex or not. I told the police and (V1) that (V7) raped me. The police said they were investigating. I am okay with the police seeing my phone messages and I am okay with you (this surveyor) seeing those messages. I feel like I could scream and do not feel comfortable here and I am having night terrors about what happened to me from (V7). I just want to leave this town. (V7) is not allowed on the property, and I am not allowed to leave because I do not want to put myself in an unsafe spot and see (V7). I told (V1) that (V7) raped me, and it was (V7).On 1/29/26 at 10:30 AM V11 (Human Resources Director) stated, On 6/27/25 me and (V1) met with (V7) after (V1) read text messages between (R3 and V7). (V7) was inappropriately texting (R3's) cellphone as in boyfriend/girlfriend type texting and telling (R3) he wanted to have a relationship with (R3).On 1/30/26 at 1:00 PM (V29/LPN/Licensed Practical Nurse) stated, (V3)(R3's Plenary Guardian) came to the facility on [DATE] and was livid after (V3) caught (R3 and V7) having sex in the parking lot of the facility. I reported this to (V1) on 11/23/25.On 1/29/26 at 12:40 PM V1 (Administrator) stated, (V10/Prior Dietary Manager) came to me around 6/26/25 and said he was told a dietary staff member (V7) was texting with (R3). (V7) told (V10) he was not texting with anyone. (R3) gave me her phone. I found out (V7) was texting (R3) and trying to have a relationship with (R3). It did not look like anything sexually inappropriate at that time. I said to (V7), I thought you weren't texting (R3). I told (V7) he could not be an employee and have a relationship with (R3). (V7) decided to resign because he wanted to have a relationship with (R3) and was having feelings for (R3). I called (V3) and told (V3) that (V7) decided to resign. Later, I was told by (V3) that (V7 and R3) were having sex in the parking lot. At this time V1 verified he did not notify the State Agency or the local police when V1 became aware that V7 was trying to initiate a personal relationship with a resident (R3). The police and state agency were not notified about (R3) and (V7) having sexual relations while at church until 11/26/25 (three days after (V3) reported this to (V29/LPN).On 1/29/26 at 1:05 PM V17 (CNA) stated, There were several evenings that (V7) and (R3) were videochatting sexually back and forth in November. I would report this to the nurses anytime I witness them. I do not recall the nurses I was reporting this to as a lot of them were agency nurses and I do not know their names. I know it was inappropriate and should not have been happening. We (facility) staff were never told whether or not (R3) could consent to sexual relationships. Still today I am not sure if (R3) can consent to sexual relationships or not and have (continued on next page)

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	145987	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allure of Galesburg	1145 Frank Street Galesburg, IL 61401

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	not been told that we need to supervise (R3).On 1/29/26 at 1:30 PM V10 (Prior Dietary Manager) stated, While I was the dietary manager at the facility I started noticing (V7) was not doing his job and spending a lot of time around (R3) in the day room and out on the patio. I asked (V7) about it and told (V7) it is not appropriate to have a relationship with a resident. Later, sometime in June (2025), (V7) came to me and said he was starting to have feelings for (R3). I immediately reported this to (V1). (V1) then asked (R3) if he could see her cellphone messages between (R3 and V7) and found out (R3) had more than one cellphone (V1) read the messages that were being sent back between (R3 and V7) while (V7) was an employee and (V7's) messages to (R3) were that (R3) was the love of his (V7's) life and (V7) wanted to get (R3) pregnant. (V7) was trying to have an intimate relationship with (R3). The next day after (V1) read the inappropriate text messages between (R3 and V7), (V7) was asked to resign.On 2/1/26 at 9:15 AM V1 (Administrator) stated no one had reported R6's report of R3 being naked and videochatting with a male on 11/10/25, therefore V1 has not reported this to the State Agency or the Local Police.2.R3's Emergency Department Notes dated 7/8/25 document, (R3) reports that she has been feeling suicidal for the past couple days. (R3) reports having thoughts of cutting her wrists in order to attempt suicide. (R3) reports that she was physically assaulted by two other (unknown) residents yesterday and has not been able to sleep since then. (R3) denies any injuries or complaints from that assault.R3's Medical Record and the facility's Abuse Investigations do not include evidence of R3's allegation on 7/8/25 being reported to the State Agency or Local Police.On 2/1/26 at 9:15 AM V1 (Administrator) verified he found out about R3's allegation regarding being physically assaulted by roommates, after receiving R3's hospital records on 1/30/26. V1 stated he has yet to notify the local police or State Agency regarding R3's allegation.3. R6's Face Sheet documents R6 is a [AGE] year-old that was admitted to the facility on [DATE]. R6's MDS (Minimum Data Set) assessment dated [DATE] documents R6 is cognitively intact and has no behaviors. R3's Behavior Note dated 11/20/25 at 8:30 AM and signed by V6 (Psychosocial Rehabilitation Coordinator) documents, Another resident (R6) approached (V6) to report that (R3) was engaging in sexual conversation. When (R6) asked them to refrain from doing this while (R6) was in the room, the male (V7) on the call began cursing at (R6) and calling (R6) names. (R6) stated that incidents like this occur often, and it is making (R6) feel uncomfortable. R6's Progress Notes do not include any documentation regarding R6's alleged altercation with V7 on 11/20/25. On 1/28/26 at 12:05 PM R6 stated, I watched (R3) and (V7) having sex on her phone several times (unknown dates) and whenever I would try to make (R3 and R7) stop (V7) would yell at me and tell me to mind my own business and call me a b***h. I asked (R3 and V7) to stop. I didn't want to see or hear that. The last time I asked (R3) and (V7) to stop having phone sex, (V7) yelled at me, You b***h! You are going to get you're a** kicked. I told (V5/SSD/Social Service Director) that (V7) threatened me and has threatened me several times. I definitely felt abused and worried that (V7) would do something to me.On 1/28/26 at 12:51 PM V6 (Psychosocial Rehabilitation Coordinator) stated, On 11/20/25 (R6) reported to me that she saw (V7), who (R6) described as the little guy that used to work here, on a phone video with (R3) and (R3 and V7) were being provocative, having sexual inappropriate conversations, and having sexual acts. (R6) said she told (R3 and V7) to Knock that off. (R6) said (V7) began cursing at (R6) and told (R6) to Shut the f**k up and (R3) continued to yell at (R6). (R6) was frustrated. I reported this immediately to V1.On 1/29/26 at 12:40 PM V1 verified he has not notified the local police or the State Agency regarding R6's allegations made on 11/20/25 regarding V7.The Immediate Jeopardy started June 26 2025 when V1 became aware that (V7/Prior Dietary Aide) started engaging in behavior indicating an attempt to initiate a personal or romantic relationship with R3, while V7 was employed at the facility, and did not report this to (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	the police or state agency, which resulted in V7 continuing to have sexually inappropriate conversations and video nudity by electronic communication with R3 that was not reported to the police or state agency, and V7 sexually assaulting R3 on at least three occasions while R3 was attending church services.On 1/30/26 at 11:25 AM V1 (Administrator), V25 (Corporate Nurse Consultant), and V26 (Regional Nurse Consultant) were notified of the Immediate Jeopardy.On 2/3/26 this surveyor confirmed through observation, interview, and record review that the facility took the following actions to remove the Immediate Jeopardy:1.V7 resigned from the facility on 6/27/25. 2. V1 initiated an abuse investigation into R3's abuse allegation dated 7/8/25 to IDPH on 1/31/26 and a final report will follow. 3.V1 initiated an abuse investigation into R3's abuse allegation dated 11/10/25 to IDPH on 1/31/26 and a final report will follow. 4. V1 initiated an abuse investigation into R3 and R6's abuse allegations dated 11/20/25 to IDPH on 1/30/25 and a final report to follow. 5. On 11/26/25, V1 initiated an abuse investigation, notified IDPH, and notified the local police regarding R3's abuse allegation that occurred on 11/23/25. 6. On 1/29/26 and 1/31/26 V5 (Social Service Director) completed assessments on R3's capacity to consent to sexual relations with the involvement of V3 (R3's Plenary Guardian), V35 (R3's Physician), and V36 (R3's Psychiatrist). The facility is still evaluating R3's capacity to consent to sexual relations and have implemented precautions to keep R3 safe. The facility also developed a plan to ensure R3 has staff supervision while using the facility phones to ensure safe communication with others. On 11/26/25 V3 (R3's Plenary Guardian) removed R3's phone from R3 and V3 restricted R3's church visits. R3's Care Plan was updated with interventions to increase R3's safety on 1/31/26. 7. On 1/30/26 V26 (Regional Nurse Consultant) reviewed all residents to ensure no residents suffered from past abuse. 8. On 1/30/26, the Quality Assessment and Assurance Committee met for an emergency QAPI (Quality Assurance and Performance Improvement) meeting and developed and implemented plans to ensure no further abuse occurred within the facility and all policies and procedures were followed correctly. 9. On 1/30/26 the facility's abuse policies were reviewed by the QA (Quality Assurance) committee prior to educating staff. 10. On 1/30/26 the facility's staff intimate relationships policy was reviewed by the QA committee. 11. On 11/19/25, 11/26/25, 1/13/26, and again on 1/30/26 V1, V2 (Director of Nursing/DON), and V38 (MDS Coordinator) educated all staff on abuse prevention and abuse reporting and all abuse related policies and procedures. 12. On 1/31/26 V25 (Regional Director of Operations) educated V1 on the facility's Abuse, Neglect and Exploitation Policy and compliance with reporting allegations of Abuse/Neglect/Exploitation Policy to IDPH. 13. On 1/30/26 V1, V2, and V38 educated all staff on maintaining professional boundaries with residents and staff are not to have any inappropriate relationship with residents. 14. On 1/28/26 through 1/31/26 R3 and R6's care plans have been updated with safety interventions to protect them from abuse. Completion Date: 1/31/26.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to protect residents from staff-to-resident sexual abuse and verbal abuse, failed to develop and implement interventions to increase safety and adequately supervise the residents, failed to immediately initiate and investigation of allegations of staff to resident sexual and verbal abuse, and failed to submit a final investigation report of allegations of staff-to-resident sexual and verbal abuse to the State Agency within five working days for two of seven residents (R3 and R6) reviewed for abuse in the sample of seven. These failures resulted in V7 (Prior Dietary Aide) having continual access to R3 after V7 was engaging in behavior indicating an attempt to initiate a personal or romantic relationship with R3 in June 2025 and V7 continuing to sexually exploit R3 and have non-consensual sexual relations with R3. These failures also resulted in V7 verbally abusing R6 on multiple occasions once R6 witnessed R3 and V7 engaging in inappropriate conversations and video nudity by electronic communications.These failures resulted in an Immediate Jeopardy:While the immediacy was removed on 1/31/26, the facility remains out of compliance at a severity Level II as additional time is needed to evaluate the implementation and effectiveness of their removal plan and Quality Assurance monitoring.Findings include:The facility's Abuse, Neglect, and Exploitation dated 2/3/25 documents, Policy: 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 abuse, neglect, exploitation, and misappropriation of property. Prevention of Abuse, neglect, bribery, and Exploitation: The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, bribery, misappropriation of resident property, and exploitation that achieves: A. Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. This may include identifying when, how, and by whom determinations of capacity to consent to sexual contact will be made and where this documentation will be recorded; and the residents' right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship. B. Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, bribery, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents care needs and behavioral symptoms; D. the identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect; E. Ensuring the health and safety of each resident with regard to visitors such as family members or resident representatives, friends, or other individuals subject to the residents right to deny or withdraw consent at any time and to reasonable clinical and safety restrictions. V. Investigation of Alleged Abuse, Neglect and Exploitation. A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect, bribery, or exploitation occur. Written policies for investigations include: 1. Identifying staff responsible for the investigation;2. Exercising caution in handling evidence that could be used in a criminal investigation;3. Investigating different types of alleged violations;4. Identifying and interviewing all involved persons, including the alleged victim, alleged preparator, witnesses, and others who might have knowledge of the allegations;5. Focusing the investigation on determining if abuse, neglect, exploitation, bribery, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation. Protection of Resident: (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: Responding immediately to protect the alleged victim and integrity of the investigation; increased supervision of the alleged victim and residents; room or staffing changes, if necessary, to protect the residents from the alleged perpetrator. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of incident or abuse. Reporting/Response: The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within five working days of the incident, as required by state agencies.1.R3's Legal Guardianship dated 2/27/15 and signed by V12 (Judge) documents, Because of (R3's) physical and mental conditions, (R3) is not able to manage her person or property and is therefore a disabled person. Because of (R3's) disability (R3) lacks sufficient capacity to make and communicate responsible decisions concerning the care of her person and because of (R3's) disability, (R3) lacks capacity to manage her estate; and for these reasons it is necessary to appoint a guardian of the person and estate of (R3). A limited guardianship will not provide sufficient protection for (R3). (V3/R3's Plenary Guardian) is qualified to act as a guardian. In order to protect the best interests of (R3), a guardian of (R3's) person and estate should be appointed. (V3) is capable of making residential decisions for (R3). Now, therefore, it is hereby ordered and adjudged: A. That (R3) is a disabled person in need of the appointment of a plenary guardian of her person and or estate. V7's Employee Termination Form dated 6/27/25 and signed by V1 (Administrator), V10 (Prior Dietary Manager), and V11 (Human Resource Manager) documents, (V7's) last day worked 6/27/25. Type of termination: Resignation. Reason for termination: Due to (V7's) growing feelings for a resident (R3). (V7) resigned effectively immediately. Eligible for rehire: No. R3's Electronic Health Record dated 2/25/25 (admission) through 1/29/26 does not include an evaluation to determine R3's ability to consent to sexual activity. R3's Progress Notes dated 11/10/25 at 6:27 PM document, Staff talked to (R3) about roommate (R6) complaint of (R3) getting completely naked in the room with door and curtain open talking or videoing on social media (with another male). Staff reminded (R3) to close curtains and doors and be respectful of roommate's concerns. R3's Behavior Note dated 11/20/25 at 8:30 AM and signed by V6 (Psychosocial Rehabilitation Coordinator) documents, Another resident (R6) approached (V6) to report that (R3) was engaging in sexual conversation. When (R6) asked (R3 and R7) to refrain from doing this while (R6) was in the room, the male (V7) on the call began cursing at (R6) and calling (R6) names. (R6) stated that incidents like this occur often, and it is making (R6) feel uncomfortable. R3 and R6's Medical Records and the facility's Abuse Investigations do not include evidence of a final abuse report being submitted to the state agency regarding R3 and R6's allegations of R3 being sexually exploited by video on social media or R6 witnessing this sexual exploitation on 11/10/25 or 11/20/25 being investigated, a final abuse report being submitted to the state agency, or any safety interventions being developed or implemented to protect R3 and R6 from further sexual exploitation by video.R3's Police Report #25-049356 dated 11/26/25 at 1:17 PM and signed by V27 (Local Police Officer) documents R3 was sexually assaulted by V7 (Prior Dietary Aide) on three separate occasions while R3 was attending church services. This same Police Report documents V27 requested this Police Report be sent to the State's Attorney's Office for a probable cause review for (V7) to be charged with Criminal Sexual Assault.R3's Final Abuse Investigation dated 12/3/25 and signed by V1 (Administrator) documents, On 11/23/25 R3 had multiple instances of non-consensual sexual contact with a male (V7/Prior Dietary Manager) in the parking lot of a church on Sundays during church services. This same report (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	(V13) told me he knew for weeks that (R3) had been sneaking around with (V7) at church. (R3) admitted to me that (R3) and (V7) were having intercourse while (V7) was working at the facility and (R3) had even met (V7's) daughter. The facility did not keep (R3) safe, and the facility said they would keep (R3) safe. (R3) is not allowed to leave now. (R3) cannot consent to sex. I told the police officer (V27) that (R3) cannot consent, and I am her legal guardian and did not consent to (R3) having a relationship with (V7). (V7) knows (R3) is disabled and takes advantage of (R3). (V7) continued to text me and say he cares about (R3), and they love each other. I do not want (V7) to have any further contact with (R3).On 1/28/26 at 12:51 PM V6 (Psychosocial Rehabilitation Coordinator) stated, (R3) came into my office and said she was upset because they (R3 and V7) were in love and were texting back and forth and video chatting while (V7) worked here. (R3) let me read text messages and (V7) texting (R3) saying he missed and loved (R3) and knows (R3) is with other people and how (R3) could do that too (V7). I reported this to (V1) immediately and (V7) was given the option to resign or be terminated. On 11/20/25 (R6) reported to me that she saw (V7), who (R6) described as the little guy that used to work here, on a phone video with (R3) and (R3 and V7) were being provocative, having sexually inappropriate conversations, and having sexual acts. (R6) said she told (R3 and V7) to Knock that off. (R6) said (V7) began cursing at (R6) and told (R6) to Shut the f**k up and (R3) continued to yell at (R6). (R6) was frustrated. I reported (R6's) report to (V1) and we discussed it in an IDT (Inter-Disciplinary) meeting and then (R3) was supposed to stop using electronics. I do not see that any interventions have been added to (R3) or (R6's) care plans to protect them from further sexual exploitation or verbal abuse.On 1/28/26 at 1:15 PM R3 stated, I want to leave and get closer to my family. I got involved with a staff member, (V7), while he worked here. I started to play songs that I had written and (V7) would come out and say he was into music. Around March of last year (V7) sent me a message request on Facebook and I said back to (V7), How did you find me? (V7) said we (R3 and V7) share mutual friends on Facebook. After that we started text messaging back and forth while (V7) was at work. Eventually (V7) started asking me for phone sex and naked pictures and I was not okay with that. (V7) was living with the mother of his child during this time. (V7) told me that (V1/Administrator) gave (V7) the option to leave and not have legal repercussions or (V7) could stay employed and get both of us in trouble. (V7) started to say I was f**cked up in the head and (V7) did not want me. Our relationship grew and when I started to go to church, (V7) would meet up with me at church. (V7) lured me into his car by saying he wanted to talk to me privately. That should have been my first red flag. I went to (V7's) car and (V7) raped me and it was not consensual. (V7) raped me on three different Sundays. I asked (V7) to stop. (V7) wanted me to tell everyone it was consensual. (V7) told me he wanted our conversations to make it sound consensual. I talked to (V7) once since church by phone here at the facility and told (V7) to leave me the h**l alone. (V7) said he was not going to leave me alone and that he loved me. I told (V7) I am leaving this town because of (V7). (V3) is my guardian, and I am not sure if (V3) decides if I can have sex or not. I told the police and (V1) that (V7) raped me. The police said they were investigating. I am okay with the police seeing my phone messages and I am okay with you (this surveyor) seeing those messages. I feel like I could scream and do not feel comfortable here and I am having night terrors about what happened to me from (V7). I just want to leave this town. (V7) is not allowed on the property, and I am not allowed to leave because I do not want to put myself in an unsafe spot and see (V7). I told (V1) that (V7) raped me, and it was (V7).On 1/29/26 at 10:30 AM V11 (Human Resources Director) stated, On 6/27/25 me and (V1) met with (V7) after (V1) read text messages between (R3 and V7). (V7) was inappropriately texting (R3's) cellphone as in boyfriend/girlfriend type texting and telling (R3) he wanted to have a (continued on next page)

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	145987	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allure of Galesburg	1145 Frank Street Galesburg, IL 61401

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	relationship with (R3).On 1/30/26 at 1:00 PM (V29/LPN/Licensed Practical Nurse) stated, (V3) came to the facility on [DATE] and was livid after (V3) caught (R3 and V7) having sex in the parking lot of the facility. I reported this to (V1) on 11/23/25. I am not aware of any interventions to increase supervision or safety of (R3) to keep (R3) free from further sexual abuse. I am not even sure if (R3) can consent to sex.On 1/29/26 at 12:40 PM V1 (Administrator) stated, (V10/Prior Dietary Manager) came to me around 6/26/25 and said he was told a dietary staff member (V7) was texting with (R3). (V7) told (V10) he was not texting with anyone. (R3) gave me her phone. I found out (V7) was texting (R3) and trying to have a relationship with (R3). It did not look like anything sexually inappropriate at that time. I said to (V7), I thought you weren't texting (R3). I told (V7) he could not be an employee and have a relationship with (R3). (V7) decided to resign because he wanted to have a relationship with (R3) and was having feelings for (R3). I called (V3) and told (V3) that (V7) decided to resign. Later, I was told by (V3) that (V7 and R3) were having sex in the parking lot. V1 verified R3 and R6's care plans have not been updated with interventions to keep R3 and R6 safe from V7 and R3's medical record does not include an evaluation to determine if R3 has the ability to consent to sex.On 1/29/26 at 1:05 PM V17 (CNA/Certified Nursing Assistant) stated, There were several evenings that (V7) and (R3) were videochatting sexually back and forth in November. I would report this to the nurses anytime I witness them. I do not recall the nurses I was reporting this to as a lot of them were agency nurses and I do not know their names. I know it was inappropriate and should not have been happening. We (facility) staff were never told whether or not (R3) could consent to sexual relationships. Still today I am not sure if (R3) can consent to sexual relationships or not and have not been told that we need to supervise (R3).On 1/29/26 at 1:30 PM V10 (Prior Dietary Manager) stated, While I was the dietary manager at the facility I started noticing (V7) was not doing his job and spending a lot of time around (R3) in the day room and out on the patio. I asked (V7) about it and told (V7) it is not appropriate to have a relationship with a resident. Later, sometime in June (2025), (V7) came to me and said he was starting to have feelings for (R3). I immediately reported this to (V1). (V1) then asked (R3) if he could see her cellphone messages between (R3 and V7) and found out (R3) had more than one cellphone (V1) read the messages that were being sent back between (R3 and V7) while (V7) was an employee and (V7's) messages to (R3) were that (R3) was the love of his (V7's) life and (V7) wanted to get (R3) pregnant. (V7) was trying to have an intimate relationship with (R3). The next day after (V1) read the inappropriate text messages between (R3 and V7), (V7) was asked to resign.On 1/31/26 at 9:00 AM V29 (LPN/Licensed Practical Nurse) stated, I have been told (R3 and V7) were caught having a sexual relationship together which is a big no. A staff member should never have relationships with a resident. I have never been told that (R3) needs supervised with her electronics or using the phone. I also have not been told whether (R3) can consent or have sexual relations with other residents or not.2.R3's Emergency Department Notes dated 7/8/25 document, (R3) reports that she has been feeling suicidal for the past couple days. (R3) reports having thoughts of cutting her wrists in order to attempt suicide. (R3) reports that she was physically assaulted by two other (unknown) residents yesterday and has not been able to sleep since then. (R3) denies any injuries or complaints from that assault.R3's Medical Record and the facility's Abuse Investigations do not include evidence of R3's allegation on 7/8/25 being investigated or a final report being sent to the State Agency.On 2/1/26 at 9:15 AM V1 (Administrator) verified he found out about R3's allegation regarding being physically assaulted by roommates, after receiving R3's hospital records on 1/30/26. V1 stated he has not started an investigation into this allegation at this time.3. R6's Face Sheet documents R6 is a [AGE] year-old that was admitted to the facility on [DATE]. R6's MDS (Minimum Data (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Set) assessment dated [DATE] documents R6 is cognitively intact and has no behaviors. R3's Behavior Note dated 11/20/25 at 8:30 AM and signed by V6 (Psychosocial Rehabilitation Coordinator) documents, Another resident (R6) approached (V6) to report that (R3) was engaging in sexual conversation. When (R6) asked them to refrain from doing this while (R6) was in the room, the male (V7) on the call began cursing at (R6) and calling (R6) names. (R6) stated that incidents like this occur often, and it is making (R6) feel uncomfortable. R6's Progress Notes do not include any documentation regarding R6's alleged altercation with V7 on 11/20/25. On 1/28/26 at 12:05 PM R6 stated, I watched (R3) and (V7) having sex on her phone several times (unknown dates) and whenever I would try to make (R3 and R7) stop (V7) would yell at me and tell me to mind my own business and call me a b***h. I asked (R3 and V7) to stop. I didn't want to see or hear that. The last time I asked (R3) and (V7) to stop having phone sex, (V7) yelled at me, You b***h! You are going to get you're a** kicked. I told (V5/SSD/Social Service Director) that (V7) threatened me and has threatened me several times. I definitely felt abused and worried that (V7) would do something to me.On 1/28/26 at 12:51 PM V6 (Psychosocial Rehabilitation Coordinator) stated, On 11/20/25 (R6) reported to me that she saw (V7), who (R6) described as the little guy that used to work here, on a phone video with (R3) and (R3 and V7) were being provocative, having sexual inappropriate conversations, and having sexual acts. (R6) said she told (R3 and V7) to Knock that off. (R6) said (V7) began cursing at (R6) and told (R6) to Shut the f**k up and (R3) continued to yell at (R6). (R6) was frustrated. I reported this immediately to V1. I do not think (R6's) care plan has been updated to keep (R6) safe from (V7's) threats.On 1/29/26 at 12:40 PM V1 verified he has not investigated or submitted a final report to the State Agency regarding R6's allegations made on 11/20/25 regarding V7 and is not aware of R6's care plan being updated with interventions to keep R6 safe from V7.The Immediate Jeopardy started June 26 2025 when V1 became aware that (V7/Prior Dietary Aide) started engaging in behavior indicating an attempt to initiate a personal or romantic relationship with R3, while V7 was employed at the facility, and did not submit a final report to the state agency regarding V7's attempt to initiate a personal relationship with R3 or develop and implement interventions to keep R3 safe from V7 which resulted in V7 continuing to have sexually inappropriate conversations and video nudity by electronic communication with R3, and V7 sexually assaulting R3 on at least three occasions while R3 was attending church services. On 1/30/26 at 11:25 AM V1 (Administrator), V25 (Corporate Nurse Consultant), and V26 (Regional Nurse Consultant) were notified of the Immediate Jeopardy.On 2/3/26 this surveyor confirmed through observation, interview, and record review that the facility took the following actions to remove the Immediate Jeopardy:1.V7 resigned from the facility on 6/27/25. 2. V1 initiated an abuse investigation into R3's abuse allegation dated 7/8/25 to IDPH on 1/31/26 and a final report will follow. 3.V1 initiated an abuse investigation into R3's abuse allegation dated 11/10/25 to IDPH on 1/31/26 and a final report will follow. 4. V1 initiated an abuse investigation into R3 and R6's abuse allegations dated 11/20/25 to IDPH on 1/30/25 and a final report to follow. 5. On 1/29/26 and 1/31/26 V5 (Social Service Director) completed assessments on R3's capacity to consent to sexual relations with the involvement of V3 (R3's Plenary Guardian), V35 (R3's Physician), and V36 (R3's Psychiatrist). The facility is still evaluating R3's capacity to consent to sexual relations and have implemented precautions to keep R3 safe. The facility also developed a plan to ensure R3 has staff supervision while using the facility phones to ensure safe communication with others. On 11/26/25 V3 (R3's Plenary Guardian) removed R3's phone from R3 and V3 restricted R3's church visits. R3's Care Plan was updated with interventions to increase R3's safety on 1/31/26. 7. On 1/30/26, the Quality Assessment and Assurance Committee met for an emergency QAPI (Quality Assurance and Performance Improvement) meeting and developed and (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	implemented plans to ensure no further abuse occurred within the facility and all policies and procedures were followed correctly. 8. On 1/30/26 the facility's abuse policies were reviewed by the QA (Quality Assurance) committee prior to educating staff. 9. On 1/30/26 the facility's staff intimate relationships policy was reviewed by the QA committee. 10. On 11/19/25, 11/26/25, 1/13/26, and again on 1/30/26 V1, V2 (Director of Nursing/DON), and V38 (MDS Coordinator) educated all staff on abuse prevention and abuse reporting and all abuse related policies and procedures. 11. On 1/31/26 V25 (Regional Director of Operations) educated V1 on the facility's Abuse, Neglect and Exploitation Policy and compliance with reporting allegations of Abuse/Neglect/Exploitation Policy to IDPH. 12. On 1/30/26 V1, V2, and V38 educated all staff on maintaining professional boundaries with residents and staff are not to have any inappropriate relationship with residents. 13. On 1/28/26 through 1/31/26 R3 and R6's care plans have been updated with safety interventions to protect them from abuse. Completion Date: 1/31/26.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to properly store and account for a resident's controlled-substance medication for one of three residents (R8) reviewed for medication storage in the sample of seven.Findings include:The facility's Controlled Substance Administration and Accountability Policy dated 2025 documents, It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substance. The facility will have safeguards in place in order to prevent loss, diversion, or accidental exposure. Controlled substances are stored in a separate compartment of an automated dispensing system or other locked storage unit with access limited to approved personnel. Areas without automated dispensing systems utilize a substantially constructed storage unit with two locks and a paper system for 24-hour recording of controlled substance use. Controlled substances are delivered to and signed for by a licensed nurse. For areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift. The facility's Controlled Substance Inventory Count Sheets dated 12/6/25 through 12/9/25 document, Nurse coming on to shift must verify all controlled substance with nurse coming off shift or anytime the medication cart keys are exchanged. Nurse must count total number of cards/containers and total number of count sheet, both for individual residents and applicable contingency supplies with controlled drugs. Nurse must verify actual drug counts against each individual resident count sheet. Any discrepancies must be reported immediately to (V2/Director of Nursing/DON) or nursing supervisor. These same Inventory Count Sheets document two nurses did not count or verify the number of controlled substances/controlled substance cards within the medication cart for six oncoming/offboarding shifts between 12/6/25 and 12/9/25. The Pharmacy's Proof of Delivery and Packing Slip dated 12/6/25 documents 30 tablets of (R8's) Hydrocodone-APAP 10/325 mg were delivered to the facility on [DATE]. R8's Final Report dated 1217/25 and signed by V1 (Administrator) documents, Incident Date: 12/9/25. (V2/Director of Nursing) noted (R8's) medication card missing. Pharmacy records show that the medication was sent on 12/6/25.On 1/28/26 at 10:00 AM V2 (Director of Nursing) stated, On 12/8/25 when I came into work (V34/LPN/Licensed Practical Nurse) told me she tried to re-order (R8's) Norco from pharmacy and the pharmacy told (V34) the Norco could not be refilled because the Norco had been refilled and sent to the facility on [DATE]. I watched video footage and saw that (V28/Agency RN/Registered Nurse) received (R8's) Norco 30 tablets from pharmacy on 12/6/25 and put (R8's) Norco in the medication cart. By the time I found out (R8's) Norco was missing, two days had passed by. I did an audit of the controlled substance inventory sheets and noticed numerous nurses were not counting the controlled substances and cards at the beginning and end of their shifts like they were supposed to.