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 04/15/2026
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)
F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 interview, and record review, the facility failed to prevent physical abuse from happening for four (R1, R2, R4, and R5) of four residents reviewed for abuse in a sample of seven. The abuse altercation on 3/1/26 between R1 and R2 resulted in R1 going to the hospital to be evaluated for injuries. The abuse altercation between R1 and R5 resulted in R5 going to the hospital to be evaluated due to neck pain after being hit in the back of his head.Findings include:Facility Resident Rights Policy, copyright 2026, documents The resident has the right to a dignified existence inside and outside the facility.Facility Abuse, Neglect, and Exploitation, copyright 2024, documents It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Abuse means the willful infliction of injury resulting in physical harm, pain, or mental anguish which can include resident to resident altercations. The facility will develop and implement written policies and procedures that prohibit and prevent abuse. The facility will implement policies and procedures to prevent and prohibit all types of abuse. Possible indicators of abuse include physical abuse of a resident observed.On 4/14/26 at 10:00AM, V1 Administrator provided facility reported abuse allegations to the state dated 3/1/26, 3/22/26, and 3/27/26. At that time V1 verified R1, R2, R4, and R5 were involved in resident-to-resident physical alterations; and were reported to the state.1.R1 and R2's incident reported to the state by V1 Administrator, dated 3/1/26 at 1:40PM, documents R1 and R2 are alert, oriented, and able to make informed decisions. (R1 and R2) were involved in a verbal altercation that turned physical. (R1) stated (R2) took a cane that he had and poked him with it. (R1) stated his side hurt as a result. (R2) stated there was a verbal altercation that was taking place, but the reason he poked (R1) with the cane was due to (R1) having struck him on his side. (R2) stated he did not poke (R1) hard, I just wanted him to get away from me after he hit me. Police department was notified and officer responded to the call. (R1) was sent to local hospital for evaluation and treatment per resident request. (R1) returned to the facility with no injuries and no new orders. (R1) decided to press charges and both residents have a notice to appear in court.R1's nurses note, dated 3/1/2026 at 8:58am by V5 RN/Registered Nurse, documents Resident had an argument with his roommate (R2) which led to him reporting that his roommate hit him across his chest with a cane. Res is now headed to Emergency Department to be evaluated.On 3/14/26 at 3:00PM, R2 was alert and oriented walking around independently and stated on 3/1/26 he was roommates with R1. On that date, R1 said R2 hit him with a cane but R2 denies hitting R1 with a cane. R2 stated the cops were called, had to go to court, and both were to pay a $100 fine. R2's MDS/Minimum Data Set, dated [DATE], documents R2 is cognitively intact.On 3/14/26 at 1:35PM, R1 Resident was in a manual wheelchair, alert and oriented, and stated on3/1/26 he was asleep in his room and his roommate at that time (R2) hit him with a cane across his chest. R1 stated it woke him up and he screamed and yelled for help. I went to the ER/emergency room later that night to be evaluated. R1 stated the cops were called, they had to go to court and were ordered to pay $100 fine.2. R1 and R5's incident reported to the state by V1 Administrator, dated 3/22/26, documents R1 (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

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 04/15/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	and R5 are alert, oriented, and able to make informed decisions. (R1 and R5) were involved in an alleged resident to resident altercation. (R1 and R5) were engaged in an altercation in the dining room during meal time. (R1 and R5) were in an argument over snack food that (R1) alleged (R5) took. (R1) continued to get more upset at (R5's) dismissal of him, causing (R1) to throw a cup of liquid at (R5).R1's nurses note, dated 3/22/2026 at 1:29PM by V7 RN, documents Resident eating lunch at table, got up and started moving chairs then poured cup of coffee on another residents (R5) back for 'stealing'. Incident appeared to be unprovoked.On 3/14/26 at 1:35PM, R1 Resident was in a manual wheelchair, alert and oriented, and stated on 3/22/26 he was in the dining room with his cookies and R5 wanted his cookies. R1 and R5 made an agreement to trade cookies for a Mountain Dew. R1 gave R5 the cookies, R5 started stuffing the cookies in his mouth and then told R1 he did not have any Mountain Dew or the $1.75 for the vending machine. R1 stated he asked R5 for a Mountain Dew or money multiple times and then told R5 that he was a liar and stealer. R5 laughed at R1 and R1 stated I snapped. When someone steals from you, you punch them in the head. I punched (R5) in the head with a coffee cup.On 3/14/26 at 1:15PM, R5 was alert and oriented, ambulatory, and stated on 3/22/26 he was hit in the back of his head with a tray by R1 over cookies and a Mountain Dew when they were in the lunchroom. I went to the ER after that because I had my neck fused four years ago from a fall and I wanted to make sure the fusion was not messed up. It did hurt at the time.3. R2 and R4's incident reported to the state by V1 Administrator, dated 3/27/26 at 9:55PM, documents R2 and R4 are alert, oriented, and able to make informed decisions. (R2 and R4) alleged resident-to-resident altercation occurred. Police department was notified and officer responded. Neither resident wanted to press charges.R2's nurses note, dated 3/27/2026 at 11:08PM by V6 RN, documents: Resident stated that other resident (R4) hit him and wanted to press charges on him. Police called and upon speaking to both the residents they agreed not to press charges.On 3/14/26 at 3:00PM, R2 was alert and oriented, walking around independently, and stated on3/27/26 R4 started the argument and hit him, the cops were called, and charges were not pressed.On 3/14/26 at 2:13PM, R4 was alert and oriented, walking independently and stated the incident on 3/27/26 R2 started an argument and hit him. We were roommates, I was sleeping, and he hit me in the legs to wake me up so I hit him in the stomach. The cops were called but no charges were pressed.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide significant medications for High Blood Pressure, Depression, Anxiety, High Cholesterol, and Bipolar Schizoaffective Disorder for one (R3) of three residents reviewed for medications in a sample of seven. These failures resulted in R3 having an increase in blood pressure of 198/101 where he was dizzy and had headaches, and an increase in his anxiety which resulted in R3 getting an increase in his dosage of Hydroxyzine from twice a day to three times a day for his anxiety.Findings include:Facility Therapeutic Leave policy, copyright 2025, documents The facility will coordinate with the resident and/or representative the length of time the resident will be gone to ensure the adequate amounts and appropriate medications is ready for administration while on the leave.R3's electronic health record documents the following medical diagnoses: Schizoaffective disorder Bipolar type; suicidal ideations; major Depressive disorder, recurrent; essential (Primary) Hypertension (high blood pressure); mixed Hyperlipidemia (elevated cholesterol); restlessness and agitation; and anxiety disorder.R3's medical record documents R3's current medication orders for April 2026 documents R3 takes the following: Amlodipine 5mg/Benazepril 10mg given once a day at 7am related to Essential (Primary) Hypertension (high blood pressure) hold for b/p less than 100, with an order date of 1/10/26 and to give at 7AM; Cariprazine HCl Oral Capsule 3 MG Give 1 capsule by mouth one time a day related to Schizoaffective Disorder, Bipolar with an order date of 1/22/26 and to give at 7am; Fenofibrate Oral Tablet 160 MG give 1 tablet by mouth one time a day related to mixed Hyperlipidemia (high cholesterol) with an order date of 1/12/2026 and to give at 7am ; Wellbutrin XL Oral Tablet Extended Release 24 Hour 150 MG give 1 tablet by mouth one time a day related to major depressive disorder, recurrent with an order date of 2/13/2026 and to give at 7am; Hydroxyzine HCl Oral Tablet 50 MG give 1 tablet by mouth two times a day related to anxiety disorder with an order date of 3/30/26 and to give at 7AM which was discontinued on 4/7/26; and was increased to Hydroxyzine HCl Oral Tablet 50 MG give 1 tablet by mouth three times a day related to anxiety disorder with an order date of 4/7/26 and to give at 7am, 12pm, and 5pm.R3's electronic and paper medical record has no documentation R3 was sent with all his medications for his therapeutic leave.R3's electronic medical record documents on 4/7/26 documents R2 asked his nurse to have his Hydroxyzine (anxiety medication) 50mg/milligrams increased from BID/twice a day to TID/three times a day. This record documents R3 got the extra dose on 4/7/26 at 12pm for anxiety.R3's medical record documents R3's blood pressure/b/p on the day he left (4/3/26) at 8:36AM his b/p was 126/84. Upon R3's return to the nursing home on 4/6/26, his b/p on 4/6/26 at 8:33 AM was 198/101.R3's medical record census sheet documents R3 was on therapeutic leave from 4/3/26 (Friday) until 4/6/26 (Monday) when his census was marked active (meaning back in the building from leave).R3's Medical Record nurses note, dated 4/4/26 at 5:30am by V8 LPN documents Resident. called and stated he did not get his morning meds this am and they were not packed for the home visit for the rest of the week. Nurse told him he could come back and I could check them for him and that I was sorry that happened. Resident stated he will try to stay the home visit but if he has problems he will go to the ER. Nurse stated ok and notified the Administrator of this.R3's Medication Regimen Review Nursing Staff Recommendation, dated 4/14/26, documents the following: Residents medications were reviewed per regional nurse request after resident missed morning medications on [NAME] visit. It appears resident left on 4/3 and returned on 4/6/26. Of note, B/P (blood pressure) was elevated on return from home visit. Resident also voiced increased depression and anxiety upon return from visit. Amlodipine 5mg/Benazepril 10mg given once a day at 7am related to Essential (Primary) Hypertension (high blood pressure) hold for b/p less than 100. Residents b/p was elevated upon return from home visit which could have been secondary to missing this medication. The antihypertensive effect of Amlodipine is at least 24 hours. The half life of Benazapril is lower at 10 to 11 hours and therefore could lead to an increase in b/p if missed for two (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	days. Cariprazine HCl Oral Capsule 3 MG Give 1 capsule by mouth one time a day related to Schizoaffective Disorder, Bipolar half life is two to four days.Fenofibrate Oral Tablet 160 MG give 1 tablet by mouth one time a day related to mixed Hyperlipidemia (high cholesterol) half life is 20 hours. Wellbutrin XL Oral Tablet Extended Release 24 Hour 150 MG give 1 tablet by mouth one time a day related to major depressive disorder it is not recommended to abruptly discontinue Buproprion/Wellbutrin therapy, and the half life is also approximately 21 hours after chronic dosing. Hydroxyzine HCl Oral Tablet 50 MG give 1 tablet by mouth three times a day related to anxiety disorder. Increased on 4/7/26; residents orders was for 50mg twice daily when gone for home visit. Hydroxyzine has a half life of approximately 20 hours in adults. It is possible to experience rebound anxiety if abruptly stopping. R3's current care plan has no documentation that R3 has a history of false allegations or not being truthful.R3's MDS/Minimum Data Set, dated [DATE], documents R3 is cognitively intact.On 4/13/2026 at 11:42 AM, R3 was in his room, dressed, shoes on, and sitting on the edge of his bed. R3 stated on the morning of 4/4/26 he called the facility to let them know he did not receive any morning medications for the weekend. At that time, R3 provided white envelop medication packets dated 4/3/26, 4/5/26, and 4/6/26 which indicated his name and to Take at 5pm signed byV10 LPN.On 4/15/26 at 2:25PM, R3 was dressed, alert and oriented in his room, and stated he left on 4/3/26 about 5pm and was given his medications for 4/3/26 nighttime in a white medication packet envelop to take home. He stated his medications were already packed for the day before his brother came to get him because he told the nurse early he was leaving so the medications would be ready to be given to him when he left. R3 stated he was given his medication packets right before he left (4/3/26) and R3 stated he never paid attention to what the medication packets were the nurse gave him (he just put them in his pocket after he saw the one marked 4/3/26 at 5pm, and multiple other medication packets) because he has never had a problem before with not getting all his medications. R3 stated he got his night medication for 4/3, 4/4, and 4/5/26. R3 stated his b/p was The highest it had ever been after the weekend because I did not get my b/p medications for three days. R3 stated he came back on 4/6/26 about 8am and the nurse checked his b/p and it was high. R3 also stated he was more anxious, dizzy, and had headaches after the weekend from not getting his medications for the morning for three days on Sat, Sun, and Mon. After the nurse noticed my b/p was high I got medications for 4/6/26 in the morning.On 4/15/26 at 11:15AM, V8 Licensed Practical Nurse/LPN stated (R3) called me when he was out on leave, he stated he did not get his morning medications for while he was on leave, I told him he could come back in and we could see what medications he was missing, he stated he did not have a ride back to the nursing home because he was (out of town 45 minutes away), he told me he would go to the ER/emergency room if he had any problems, and I notified (V1 Administrator). We usually chart in the medical record when they go out on home visits and if medications were sent, we use a lot of agency nurses here, and when (R3) came back he said he was anxious so I got an order to increase his Hydroxyzine 50mg from twice a day to three times a day. (R3) has been getting the Hydroxyzine three times a day since the home visit. (R3) has never called or stated before he has not gotten his medications when on a home visit except for this time, he is alert and oriented and able to speak for himself. I do not know who packed his medications or sent them with him, but we pack them for each day for morning, noon, evening or night and indicate that with their name and the dates on the packets. He goes home frequently on home pass and has never complained of not getting his medications before. Sometimes residents refuse medications, and each nurse distributes the medications their own way (when asked if the medication cards indicate whether the medications were punched out on the day they were to be given).On 4/15/26 at 1:01PM, V9 RN/Registered Nurse Nurse Consultant stated nursing home staff said (R3) has never complained of not getting his medications on home pass before; and R3's blood pressure was elevated when he came back and they rechecked it and it went down after medication. I know he missed his B/P medications; his chart does not have a note in the record that he was sent with his medications and there usually is; his brother brought him home that weekend; his MAR/Medication (continued on next page)

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Allure of Galesburg	1145 Frank Street Galesburg, IL 61401

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Administration Record does not have where he was sent home with his medications; I am not sure why the medications missing were only for day shift (acknowledged it was a PM shift agency nurse that packed the medications); and stated she verified with R3 that he had all his PM shift medications and he left on the PM shift of 4/3/26. None of the medications missing were narcotics, they were for his B/P, cholesterol, and mental health. He does have a history of depression and anxiety and gets frequent medication changes either to increase or decrease. The medications are delivered in cards for the month, and some places push them out of the card on the numbered day of the month they are to be given but that was not done here because we have agency and they just dispense the medication from any day on the card.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store medications in their original packaging and failed to destroy medications according to their policy for one (R1) of three residents reviewed for medications in a sample of seven.Findings include:Facility Medication Storage Policy, copyright 2026, documents It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medications rooms to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Unused medications: The consultant pharmacist routinely inspects for medications with worn, illegible, or missing labels. These medications are destroyed in accordance with our policy.R3's current care plan has no documentation that R3 has a history of false allegations or not being truthful.R3's MDS/Minimum Data Set, dated [DATE], documents R3 is cognitively intact.R3's electronic health record documents the following medical diagnoses: Schizoaffective disorder Bipolar type; suicidal ideations; major Depressive disorder, recurrent; essential (Primary) Hypertension (high blood pressure); mixed Hyperlipidemia (elevated cholesterol); restlessness and agitation; and anxiety disorder. This record also has multiple prescription medications ordered for each diagnosis.On 4/15/26 at 2:25PM, R3 was dressed, alert and oriented in his room, and stated I have brought back medications before when I forgot to take them when out on leave.On 4/15/26 at 11:15AM, V8 Licensed Practical Nurse/LPN stated) (R1) has brought back medication to the nursing home he has not taken when out on leave before.On 4/15/26 at 1:01PM, V9 RN/Registered Nurse Consultant stated Nursing home staff said (R3) has brought back medications from home pass before, still had the returned medications in the cart in envelopes, and the facility had not destroyed them (the medications observed were in white paper medication envelopes with R3's name on them, were not dated or signed by the nurse, but indicated the times they were to be taken.) At that same time, V9 verified the medications in the white paper envelopes were in the nurse's medication cart and she was unsure what pills were in the envelopes. V9 stated she was not sure what day these were from, what medications they were, and why they were still in the medication cart from when R3 brought them back from a previous home visit/therapeutic pass. V9 was not sure why the medications were not destroyed because they should have been.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to have accurate medical records regarding a therapeutic leave, medications, and a physical altercation for two (R1 and R2) of seven residents reviewed for accurate medical records in a sample of seven.Findings include:Facility Maintenance of Electronic Clinical Records Policy, copyright 2025, documents A complete and accurate electronic clinical record will be maintained on each resident and kept accessible and systematically organized for appropriate personnel to deliver the appropriate level of care for each resident.1.R3's current care plan has no documentation that R3 has a history of false allegations or not being truthful.R3's MDS/Minimum Data Set, dated [DATE], documents R3 is cognitively intact.R3's electronic medical record notes have no documentation when R3 left or returned from therapeutic leave. A resident sign in/out sheet for the facility documents R3 left the faciity on 4/3/26 at 5:00PM with his brother but has no sign in date or time.R3's Medication Administration Record/MAR for April 6, 2026, documents for the 7am medication pass R3 was out on therapeutic leave, and did not get his medications that morning.On 4/15/26 at 2:25PM, R3 was dressed, alert and oriented in his room, and stated he left on 4/3/26 about 5pm, and returned on 4/6/26 about 8am. At that same time, R3 stated he got his morning medications on 4/6/26 because After the nurse noticed my b/p (blood pressure) was high I got medications for 4/6/26 in the morning.On 4/15/26 at 11:15AM, V8 Licensed Practical Nurse/LPN verified a resident's electronic medical record should document when the resident leaves, returns, who they left with, and whether the resident was sent with their medications for the durations of their days on leave.On 4/15/26 at 1:01PM, V9 RN/Registered Nurse/Nurse Consultant verified R3's medical record was not accurate/complete for when R3 left and returned to the facility, and the MAR was also not accurate for medications given.2. R2's electronic medical record has no documentation of his 3/1/26 physical altercation with R1.R1 and R2's incident reported to the state by V1 Administrator, dated 3/1/26 at 1:40PM, documents R1 and R2 are alert, oriented, and able to make informed decisions. (R1 and R2) were involved in a verbal altercation that turned physical.On 3/14/26 at 3:00PM, R2 was alert and oriented walking around independently and stated on 3/1/26 he was roommates with R1. On that date, R1 said R2 hit him with a cane but R2 denies hitting R1 with a cane. R2 stated the cops were called, had to go to court, and both were to pay a $100 fine. R2's MDS/Minimum Data Set, dated [DATE], documents R2 is cognitively intact.