

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/21/2026
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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to provide adequate supervision and reassess elopement risk status to prevent a resident with known cognitive impairment, and with a known attempt of exiting the building unauthorized, from eloping from the facility for one of three residents (R1) reviewed for elopement in the sample of three. Specifically, the facility failed to adequately supervise (R1) with a known diagnoses of Bipolar and with cognitive impairment, who was documented at risk for elopement and a history of unauthorized exit attempts. The facility also failed to respond to and investigate sounding door alarms at secured facility exits and conduct a missing resident sweep/headcount when exit alarms were triggered. These systemic failures resulted in (R1) eloping from the facility undetected through an alarmed exit door, (R1) then crossed a busy roadway after exiting the building unauthorized and remained unsupervised during a weather-related heat advisory (ambient outdoor temperature of 86-degrees F (Fahrenheit) with a 95-degree F heat index). (R1) remained unsupervised in these extreme weather conditions for approximately 21 minutes, traveling approximately 0.6 miles to a previous residence (group home). The facility failed to identify the elopement, remaining completely unaware of (R1's) absence until notified by staff at (R1's) former residence. Serious adverse outcomes likely to occur include the risk to (R1's) health and safety, medical complications, or being struck by a motor vehicle. The Immediate Jeopardy began on 7/1/26, with R1 eloping from the facility. V1/Administrator, V16/Regional Nurse Consultant, and V17/Vice President of Operations were notified of the Immediate Jeopardy on 7/20/26 at 11:03 AM. The surveyor confirmed by interview and record review that the Immediate Jeopardy was removed, and the deficient practice corrected, as of 7/5/26, prior to the start of the survey on 7/17/26, and was therefore Past Noncompliance. This past non-compliance occurred from 7/1/26 - 7/5/26. Findings include: The Facility's Elopements and Wandering Residents Policy, dated 7/1/26, documents Policy: This ensures that the residents who exhibit wandering behavior and/or are at risk for elopement received adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Definitions: Wandering is random or repetitive locomotion that may be goal direct. (Example: the person appears to be searching for something such as an exit) or non-goal directed or aimless. Elopement occurs when a resident leaves the premises or a safe area without authorization (example: order for discharge or leave of absence) and/or any necessary supervision to do so. Policy Explanation and Compliance Guidelines: 1. The facility is equipped with doors locks/alarms to help avoid elopements. 2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. 3. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 145987	Facility ID: 145987
		If continuation sheet Page 1 of 6

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	at their facility, which was the first we knew (R1) was out of the building. I reviewed the video surveillance, and it showed that at 11:29 AM, (R1) came up B hallway, went through the activity area, and waited around for staff to go down different hallways while (V5/CNA) was standing at the nurses' station with her hands on her hips and (V4/CNA) was by the indoor smoking area. From the video footage you could see (R1) wait for staff to not pay attention, lay a piece of paper on the table, then ran out the door, and bolted, which caused the front door alarm to sound. You could see (R1) did not have his wander guard on at that time. (V5) stood by the nurses' station with her hands on her hips for around a good minute, and as others headed toward the dining room, (V4) literally peeked through the glass on the main door, entered the code to turn off the alarm, and walked away. You could see by the video surveillance that all (V4) did was quickly glance out the door window for a brief second and then reset the alarm. Although (V4) claimed she looked out and saw a resident she thought was going home leave in a car, the video surveillance showed no cars or families in view, and that specific resident she thought she saw was seated at a table in the dining room. (V4) never even opened the door to check outside. When (R1) arrived back to the facility, (R1) told us that he took off his wander guard and placed it under his pillow that morning. I am not sure how (R1) got his wander guard off, because the band was not cut or ripped or anything. (R1) was wearing blue jeans, a t-shirt, shoes, and a hat when he left the building. V1 verified that there is no documentation indicating when R1 was last seen wearing his wander guard. Additionally, V1 was unaware of the last time anyone observed R1 with the device in place. V1 acknowledged that all staff members must respond to a door alarm, following the facility's protocol prior to silencing it. V1 acknowledged R1's initial elopement attempt occurred after he was caught smoking in his room and his smoking privileges were taken away for a day and because R1 was caught smoking in his room a second time, resulting in the revocation of his smoking privileges. Staff should have implemented specific interventions to help him cope with this restriction and prevent further elopement attempts. Prior to 7/17/26, survey, the facility took the following actions to correct the deficient practice: Per skin assessment, progress notes, and interviews R1 returned to the facility on 7/1/26 and assessed for injuries, with no injuries identified. Per Care Plan and Physician Orders, R1's wander guard was changed from R1's wrist to R1's left ankle on 7/1/26. All residents who identified at risk for elopement were reviewed by V2/Director of Nursing and V3/Assistant Director of Nursing and completed 7/2/26. Facility Wide elopement assessments were completed by staff with a completion date of 7/2/26. Care Plans for residents at risk for elopement were reviewed and updated as needed by V18/MDS Coordinator and completed 7/2/26. Facility elopement book updated on 7/1/26 by V2/Director of Nursing. V1/Administrator and V3/Assistant Director of Nursing In-serviced all staff regarding door alarms response times and expectations, elopement and wandering policy, wander guard policy, accidents and supervision policy, wander guard book (location and how to use), behavioral interventions and redirection, and wander guard placement and functionality checks as ordered starting on 7/1/26 and ending on 7/5/26. Quality Assurance Study, Quality Assurance Performance Improvement, and Root Cause Analysis completed on 7/1/26. An audit tool to review compliance was developed to ensure elopement book is up to date, elopement risk assessments and care plans are up to date, wander guard is functioning as it should and documented, and wander guard in place and documented. An audit tool to review compliance was also developed to monitor if any resident attempted to elope and if staff were able to redirect resident, if an alarm alerted staff and if staff responded appropriately. The audits will be done weekly for six weeks then monthly for three months. Elopement drills have been completed on 7/1/26 and then weekly and will continue for six weeks then monthly for three months by V1/Administrator.		