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	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allure of Galesburg	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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to assess two residents (R12 and R87) for available walking pass privileges of 24 residents reviewed for choices in a total sample of 42. Findings include: The facility's undated Walking Pass Program documents that the program is designed to help you function in healthy ways both inside the facility and out in the community. Your involvement in the Walking Pass Program is a privilege that requires you to meet all referral criteria before you first utilize your walking pass. Your participation in the program will help you develop necessary skills for activities of daily living and successful community life while increasing your independence. The walking pass program requires you to meet. criteria of each level before advancing to the next level. 1. R12's Medical Record documents he was admitted on [DATE] with diagnoses to include but not limited to depression, schizoaffective disorder, narcissist, and antisocial personality. On 6/29/25 at 8:00 AM, R12 stated I want a walking pass; I have asked multiple times. I really just want to be able to go for short walks or maybe walk up to dollar general. On 6/30/25 at 10:30 AM (V5 (Social Service Director) confirmed R12 has asked for a walking pass. I think it was April when he asked me about it. V5 confirmed she has not started any walking pass assessment for R12 I haven't gotten to it; I have been swamped. 2. R87's medical records indicate that R87 was admitted [DATE] with diagnoses to include, but not limited to: Schizoaffective Disorder, Depression, Bipolar Disorder, and Suicidal Ideations. R87's medical record documents Walking Pass Program Contract signed by R87 on 6/18/25. On 6/30/25 at 9:30 AM, R87 stated he felt his walking pass took a long time to get. I know (V5/ Social Service Director) has been by herself and now she has some help so it's better for her. On 7/1/25 at 12:30 PM, V1 (Administrator) stated that a Walking Pass Assessment should be completed no longer than thirty days from time of resident's request. V1 confirmed three months after a resident request is too long to wait. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/29/25 at 10:41 AM, V5 (Social Service Director) stated that after the first walking program violation that a resident would lose walking pass privileges for twenty-four hours, after the 2nd violation a resident would lose privileges for two weeks, and after the third violation a resident would lose privileges for one month. On 6/30/25 at 10:30 am V5 (Social Service Director) stated that all residents are informed of the availability of the walking pass program upon admission, but it is up to each resident to request a walking pass program assessment. On 7/1/25 at 12:35 PM, V5 (Social Service Director) confirmed that R87 had requested a walking pass assessment upon admission [DATE]) and was approved 3/12/25. R87's walking pass was rescinded on 3/13/25 due to possession of contraband. V5 confirmed that R87 did not have walking pass privileges from 3/13/25 until 6/18/25 and R87's walking pass was reinstated on 6/18/25.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review the facility failed to ensure one resident (R26) was free from verbal abuse of two residents reviewed for abuse in a total sample of 42. Findings Include: The Abuse, Neglect, and Exploitation policy dated 2/3/25 documents 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 and prevent abuse, neglect, exploitation and misappropriation of resident property. 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. The Facility's Long-Term Care Facility & IID (Individuals with Intellectual Disabilities) Serious Injury Incident Communicable Disease Report dated 5/2/25 documents that V11 (Registered Nurse) and V12 (Certified Nurse Aide) both reported that they overheard V10 (Certified Nurse Aide) tell R26 to Shut the f*ck up. The final investigation documents that R26 stated that he did not like the way that (V10/Certified Nurse Aide) had spoken to him and didn't think it was professional. She shouldn't be allowed to talk to me like that. The Facility's Long-Term Care Facility & IID (Individuals with Intellectual Disabilities) Serious Injury Incident Communicable Disease Report dated 5/2/25 documents that V10 Certified Nurse Aide was terminated from employment at the facility. On 7/1/25 at 8:20 AM R26 stated that V10 (Certified Nurse Aide) yelled and cursed at him couple of months ago. R26 stated She shouldn't be able to talk to us (residents) like that.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, the facility failed to notify the state mental health authority to reevaluate residents when the Preadmission Screening and Resident Review (PASRR) approval had ended for six of 26 residents (R26, R41, R79, R81, R87, R498) reviewed for PASRR compliance in a sample of 42 residents. Findings include: The Resident Assessment-Coordination with PASARR Program policy, not dated, documents all applicants to this facility will be screened for serious mental disorders (MD) or intellectual disabilities (ID) and related conditions in accordance with the State's Medicaid rules for screening. A PASRR Level II is a comprehensive evaluation by the appropriate state-designated authority that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual and recommends any specialized services and/or rehabilitative services the individual needs. The PASRR Outcome Explanation Notice of Short-Term Nursing Facility Approval documents short term nursing facility services are approved for the length of time listed on the Notice of PASRR Level II Outcome that came with this letter. The Effective date on the Notice of PASRR Level II Outcome is the first approved day for you to enter a nursing facility. 1. R26's Notice of PASRR Level II Outcome dated 5/8/24 documents the short-term approval ended on 8/4/24. R26's medical record did not include documentation a referral to the state mental health authority was made or a reevaluation was conducted by the state mental health authority when the PASRR short-term approval had ended. 2. R41's Notice of PASRR Level II Outcome dated 2/20/25 documents the short-term approval ended on 5/21/25. R41's medical record did not include documentation a referral to the state mental health authority was made or a reevaluation was conducted by the state mental health authority when the PASRR short-term approval had ended. 3. R79's Notice of PASRR Level II Outcome dated 10/4/24 documents the short-term approval ended on 1/2/25. R79's medical record did not include documentation a referral to the state mental health authority was made or a reevaluation was conducted by the state mental health authority when the PASRR short-term approval had ended. 4. R81's Notice of PASRR Level II Outcome dated 11/21/24 documents the short-term approval ended on 1/20/25. R81's medical record did not include documentation a referral to the state mental health authority was made or a reevaluation was conducted by the state mental health authority when the PASRR short-term approval had ended. 5. R87's Notice of PASRR Level II Outcome dated 1/21/25 documents the short-term approval ended on 5/21/25. R87's medical record did not include documentation a referral to the state mental health authority was made or a reevaluation was conducted by the state mental health authority when the PASRR short-term approval had ended. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. R498's Notice of PASRR Level II Outcome dated 4/20/24 documents the short-term approval ended on 10/17/24. R498's medical record did not include documentation a referral to the state mental health authority was made or a reevaluation was conducted by the state mental health authority when the PASRR short-term approval had ended. On 6/30/25 at 10:54 AM, V5 (Social Services Director) stated R26, R41, R79, R81, R87 and R498 were not reevaluated by the state mental health and should have been revaluated when the short-term approval had ended.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** B. Findings include: Facility Fall Prevention Program, dated 2024, documents: each Resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls; the nurse will indicate on the Resident's fall risk and initiate interventions on the Resident's base line care plan, accordance with the Resident's level of risk; each Resident's risk factors and environmental hazards will be evaluated when developing the Resident's comprehensive plan of care; and interventions will be monitored for effectiveness and the plan of care revised as needed. 1. R24's Fall Report (#410), dated 12/22/24, document a fall in R24's bathroom hitting head on tub. The Report or R24's Care Plan does not document fall interventions. R24's Fall Report (#411), dated 12/26/24, documents a fall in R24's bathroom (communal bathroom). R24 was ambulating without assistance and got up from the toilet, went to sit in wheelchair, feet slipped on wet floor and sat himself down. The intervention was to place non-skid strips in front of toilets in communal bathroom. R24's Fall Report (#412), dated 12/30/24, documents R24 slipped out of bed, mattress to bed noted to be displaced, bed in lowest position. The Report documents an intervention of non-adhesive pad to the bed frame. R24's Fall Report (#493), dated 6/13/25, documents R24 attempted to transfer self to bed and slipped out of the chair. The Report documents that non-skid strips to left side of the bed/opposite side of bed from the bathroom. 2. R25's Fall Report (#427), dated 3/2/25, documents R25 was found sitting on the floor in front of recliner and the intervention was for non-skid strips in front of recliner. 3. R72's Fall Report (#428), dated 2/14/25, documents R72 had fallen out of bed and needed assistance and the intervention was a perimeter/scooped edge mattress. On 7/1/25 at 11:45 am, V2 (Director of Nursing/DON) did a tour of R24's R25's and R72's rooms and communal bathroom, and verified that no fall interventions were in place. R24's non-skid strips in bathroom, non-skid strips by bed and non-adhesive to R24's bed frame were not in place. R25's non-skid strips in front of the recliner were not in place. R72's perimeter/scooped edge mattress were not in place. V2 stated, I just came here not long ago to work and I do not know why none of these interventions are in place. I have not had a chance to review all of the falls here yet, that is on my list of things to do so these things do not happen. Facility failures resulted in two deficinct practices. A. Based on interview and record review the facility failed to accurately assess one resident (R87) for smoking safety and the facility failed to follow facility smoking policy for one resident (R87) of two residents reviewed for smoking in a total sample of 42. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Based on observation, record review and interview the Facility failed to implement documented fall interventions for three of four Residents (R24, R25 and R72) reviewed for Falls in a sample of 99. A. Findings include: R87's Resident Smoking Contract/Agreement dated 1/22/25 documents: You must first be evaluated for smoking safety skills before you obtain your smoking privileges. Marijuana/cannabis/gummies/THC/edibles are not allowed in (the facility) building. There is absolutely no use of vapes or any kind of tobacco product inside (the facility) or in any (facility) vehicle. All smoking materials must remain locked in a secure designated location when not in use. R87's medical record documents R87 was admitted [DATE] with diagnosis to include, but not limited to: Schizoaffective Disorder, Bipolar Disorder, Depression, and Suicidal Ideations. R87's progress notes dated 02/14/2025 at 9:37 PM documents: This nurse was doing med pass and smelled marijuana in the hall, checked rooms, the smell was the strongest in this resident's room. The resident admitted that he had a marijuana vape and turned (it) over to the nurse and was very sorry for what he did. R87's progress notes dated 02/15/2025 at 2:52 am documents: Checking on resident, had another vape in his hand while sleeping, this nurse woke resident up with aide in room and asked for the vape that was in his hand, handed it over to the nurse and went back to sleep. R87's progress notes dated 02/27/2025 at 1:50 PM documents: Resident was informed it is against facility policy for him to have a lighter in his room. He explained he wanted to hold on to it due to sentimental value. He was informed his lighter would be labeled with his name and put in the social services file cabinet. R87's progress notes dated 03/12/2025 at 11:17 PM documents that Nicotine vape juice, a lighter, (and) (marijuana) edibles found in resident's room (and) placed in (medication) room. Administrator notified. R87's progress notes dated 03/28/2025 at 2:54 am documents: CNA (Certified Nurse's Aide) was doing 15 (minute) checks, and resident had obtained a vape, which was in his bed. CNA came and got the nurse; Nurse woke resident up and requested that he hand it to her. Resident handed this nurse the vape with no altercation. Resident then went back to sleep. R87's Smoking and Safety assessment dated [DATE] documents: follows facility's policy on smoking times and location. On 7/1/25 at 12:30 PM V14 (Chief Nursing Officer) stated that Smoking and Safety Assessments should be done on admission and quarterly. V14 confirmed that R87's Smoking and Safety assessment dated [DATE] was not marked correctly because R87 had multiple documented incidents of noncompliance with smoking policy. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/1/25 at 12:35pm V5 (Social Service Director) confirmed R87's noncompliance with the facility's Smoking Policy. V5 confirmed there was not any documentation to confirm that facility followed Resident Smoking Policy to ensure R87's safety.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review the facility failed to ensure safe handling of oxygen humidification vessels and change oxygen supplies (oxygen tubing and humidification bottles) for four of four residents (R15, R23, R24 and R37) reviewed for oxygen therapy in a sample of 42. Findings include: The facility's undated Oxygen Administration policy documents the following: Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. Change humidifier bottle when empty, every 72 hours or per facility policy. 1. R23's correct physicians Order sheet documents Oxygen at 2L (liters) per minute per nasal cannula via O2 (Oxygen) concentrator and/or tank PRN (as needed) to maintain pulse ox (oximetry above 90%. On 6/29/25 at 9:12am R23 was seated in her room with humidified oxygen in place via nasal cannula at 2 liters per minute connected to the oxygen concentrator at her bedside. R23's oxygen humidification bottle was dated 6/9/25 and the oxygen tubing was not dated. 2. R15's medical record documents R15 has a diagnosis of COPD/Chronic Obstructive Pulmonary Disease. R15's Physicians Order Sheet includes the following order: Oxygen at 2 liters per nasal cannula at HS (bedtime) for shortness of breath related to Chronic Obstructive Pulmonary Disease. On 6/29/25 at 9:15am R15 was sitting in her room with humidified oxygen in place via nasal cannula at 2 liters per minute connected to an oxygen concentrator at her bedside. R15's oxygen humidification bottle was dated 6/9/25 and the oxygen tubing was not dated. On 7/2/25 at 3:10pm V15 Regional Nurse Consultant stated the facility's policy is to change oxygen humidification bottles and oxygen tubing weekly, every Sunday by the night shift. 3. R24's Phsysician Order Sheet, dated 6/30/25, does not document an order for oxygen or tubing/humidifcation bottle changes. R24's Progress Note, dated 6/23/25 at 12:57 am, documents oxygen via nasal cannula. On 6/29/25 at 9:48 am (laying in bed) and 6/20/25 at 10:00 am (sitting in wheelchair), R24 was wearing oxygen tubing and oxygen was running at two liters per nasal cannula (2LNC) and R24's oxygen tubing and humidifcation bottle was not dated. 4. R37's Physician Order Sheet, dated 6/30/25, documents an order to change oxygen tubing/cannula/mask/water bottle every week on Sunday. On 6/29/25 at 9:45 am and 6/30/25 at 9:48 am, R27 was laying in bed with oxygen at two liters per nasal cannula (2LNC) running and R37's oxygen tubing was not dated and R37's humidification bottle was dated 6/22/25.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview and record review, the facility failed to ensure their nurse staffing information was posted and accessible to residents and visitors. This has the potential to affect all 91 residents in the facility. Findings include: The facility's Long-Term Care Facility Application for Medicare and Medicaid dated 6/29/25, documents 91 residents currently reside in the facility. On 6/30/25 at 10:00 AM, the facility's nurse staffing sheet dated 6/9/25, 21 days prior, was posted on a board in the dining area behind a document titled Summary for Filing Year 2022 Injury Tracking Application and was not viewable. On 6/30/25, at 10:00 AM, V1 (Administrator) confirmed the nurse staffing sheet was not posted daily at the beginning of each shift nor was the posting visible.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to store food in accordance with professional standards for food service safety. This failure has the potential to affect all 91 residents in the facility. Findings include: The facility's Food Safety Requirements policy dated 2025 documents the following: Practices to maintain safe refrigerated food storage include: iv. Labeling, dating and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable) discarded; d and v. Keeping foods covered or in tight containers. On 6/29/25 at 7:35am 11 individual servings of mixed fruit and two individual cups of applesauce were uncovered and undated on a shelf in one of the refrigeration units at the front of the kitchen. In the back refrigerated unit six cooked chicken breast servings were undated and wrapped in foil with open areas exposing the chicken breasts. On 6/29/25 at 8:10am V16 Dietary Manager verified refrigerated foods should not be stored undated or uncovered. On 6/29/25 the facility's Matrix documents 91 residents are currently residing in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. R13's Physicians Orders include the following orders: Cleanse wound to sacrum with normal saline, pat dry and apply hydrocolloid (TTHSA) every day shift, every Tuesday, Thursday and Saturday for pressure wound. R13's physicians Orders also the following wound care: Cleanse open area to right hip with normal saline, pat dry and apply a border form (bordered dressing) until healed one time a day for opening to old incision. R13's current TAR/Treatment Administration Record includes the task to implement EBP/Enhanced Barrier Precautions every shift. On 7/1/25 at 11:00am there were no gowns in or outside of R13's room for facility staff to utilize and no signage indicating Enhanced Barrier Precautions were in place. On 7/1/25 at 11:30am V13 LPN/Licensed Practical Nurse, V21 and V22 CNAs/Certified Nurse's Assistant entered R13's room to perform R13's wound cares. V13 performed wound cares for R13's stage 3 sacral pressure ulcer and right ischial (hip) opened incisional wound area. V21 and V22 CNAs assisted in turning and positioning R13 throughout the wound cares. V21 and V22 turned R13 onto his left side to expose the dressings covering R13's sacrum and R13's surgical incision wound dressings. V13 removed the dressing from R13's sacrum, exposing a quarter-size open pressure ulcer with cream-colored wound base. V13 sprayed wound cleansing solution onto the open pressure ulcer and wiped the pressure ulcer with gauze V13 replaced a new hydrocolloid dressing over the pressure ulcer. V13 then removed the bordered dressing from an approximately 3 centimeter long by 1-centimeter-wide open area at the distal end R13's right hip surgical incision. A moderate amount of creamy and light brown drainage was noted on the dressing after it was removed. V13 sprayed wound cleansing solution into the wound, cleaned the wound with a gauze pad and replaced a new bordered dressing over the wound. V21 and V22 CNAs/Certified Nursing Assistants entered R13's room and did not don protective gowns prior to assisting V13 by turning, positioning, exposing the wound sites and supporting R13 throughout the wound cares. V13 LPN did not don a protective gown prior to performing the wound cares for R13. On 7/2/25 at approximately 12:45pm V15, the facility's Regional Nurse Consultant verified EBP should have been in place due to R13's pressure ulcer and open wound. Based on interview and record review the facility failed to implement an antibiotic stewardship program that included assessment and monitoring of residents for signs and symptoms of infections and failed to ensure that the antibiotic usage was appropriate which has the potential to affect all 91 residents that reside in the facility; failed to ensure Enhanced Barrier Precautions (EBP) were utilized per policy for one of two residents (R13) observed on EBP; and failed to follow manufacturer's guidelines for disinfecting blood glucose monitor which has the potential to effect nine residents (R15, R19, R23, R30, R37, R41, R43, R52, R62) that require blood glucose monitoring from that medication cart in a sample of 42. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings include: The Facility Resident Census Roster and Facility Matrix/802, dated 6/29/25, were reviewed. The Census Roster documented 91 Residents resided in the Facility. The Infection Surveillance policy, not dated, documents McGeer criteria or other nationally recognized surveillance criteria will be used to define infections. Surveillance activities will be monitored facility-wide and may be broke down by department or unit, depending on the measure being observed. The facility will collect data to properly identify possible communicable diseases or infections among residents and staff before they spread by identifying a. Data to be collected including how often and the type of data to be documented including: i. The infection site, pathogen, signs and symptoms, and resident location, including summary and analysis of the number of residents (and staff, if applicable) who developed infections: ii. Observations of staff including the identification of ineffective practices, if any; and iii. The identification of unusual or unexpected outcomes, infection trends and patterns. 8. Monthly time periods will be used for capturing and reporting data. Line charts will be used to show data comparison over time and will be monitored for trends. 9. All resident and infections will be tracked. Separate, site-specific measures may be tracked as prioritized from the infection control risk assessment. The Facility assessment dated [DATE] documents surveillance of infections is on-going among residents and personnel with documentation to support the evidence. The facility has established an Infection Prevention Committee that meets weekly to discuss trends and patterns. The Quality Assurance Performance Improvement (QAPI) committee meets quarterly and as needed to review and make adjustments to the facility infection prevention plan. The blood glucose monitor system owner's manual documents to Disinfect the meter between each patient to prevent infection. Disinfecting Procedures: put on non-sterile gloves; take out one disinfecting wipe from the package and squeeze out any excess liquid in order to prevent damage to the meter; wipe all meter's exterior surface display and buttons; hold the meter with the test strip slot pointing down and wipe the area; keep meter wet with disinfection solution contained in wipe for a minimum of 2 minutes for (disinfecting wipe). The facility's Enhanced Barrier Precautions policy documents the following: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multi-drug-resistant organisms. Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multi-drug-resistant organisms that employs targeted gowns and gloves use during high contact resident care activities. An order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds (e.g., chronic wounds such as pressure ulcers .unhealed surgical wounds . Make gowns and gloves available immediately near or outside of the resident's room. 1. The Monthly Infection Log had not been completed for February, March, April, May, and June 2025. (continued on next page)

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	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allure of Galesburg	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Infection Control Binder included Antimicrobial Days of Therapy Reports dated 2/1/25 through 2/28/25; 3/1/25 through 3/31/25; 4/1/25 through 4/30/25; and 5/1/25 through 5/31/25. The Reports did not include the infection site, pathogen, signs and symptoms, resident location, x-ray/culture report, McGeer criteria or an analysis. The Reports did not include a diagnosis/indication for antibiotic use for the following residents: R29 (2/15/25-2/25/25); R73 (1/28/25-2/11/25); R33 (2/18/25-2/28/25); R7 (1/16/25-3/13/25); R63 (1/30/25-no end date); R47 (2/28/25-3/7/25); R46 (3/24/25-4/3/25); R34 (3/15/25-3/20/25); R20 (3/21/25- 4/4/25); R7 (2/9/25-3/13/25); R47 (2/28/25-3/7/25); R52 (5/15/25-5/25/25); R49 (5/8/25-5/18/25); R24 (5/9/25-5/16/25); R65 (5/10/25-5/14/25); R41 (5/21/25-5/26/25); R22 (5/10/25-5/20/25); R3 (4/16/25-4/26/25); R46 (3/24/25-4/3/25); and R20 (4/2/25-4/4/25). The Antimicrobial Days of therapy Report documented R72 (2/19/25 -2/26/25); R25 (3/3/25-3/10/25); R92 (5/8/25-5/18/25) were treated with an antibiotic for Urinary Tract Infections. The UTI (Urinary Tract Infection) Log dated 1/1/25 through 6/29/25 did not include R72, R25 or R92's Urinary Tract Infections. On 7/1/25 at 12:30 PM, R14 (Chief Nursing Officer) agreed the Monthly Infection Logs had not been completed for February, March, April, May, and June 2025. The Antimicrobial Days of Therapy Reports did not include the infection site, pathogen, signs and symptoms, resident location, x-ray/culture report, McGeer criteria or an analysis. The UTI (Urinary [NAME] Infection) Log dated 1/1/25 through 6/29/25 did not include R72, R25 or R92's Urinary Tract Infections. On 5/9/25 at 11:30 AM, V2 (Director of Nursing/Infection Preventionist) stated she does review McGeer criteria for infections but does not document the review. 3. On 06/29/25 at 11:45 AM After V13 (Licensed Practical Nurse) performed blood glucose monitoring on R43, V13 wiped blood glucose meter with alcohol wipe and returned meter to the medication cart. On 07/01/25 at 09:10 AM V2 (Director of Nursing) confirmed that blood glucose meter should not have been cleaned with an alcohol wipe. V2 stated that V13 should have used the disinfectant wipes provided. On 7/1/25 at 2:30 PM V2 (Director of Nursing) provided a list of residents that require blood glucose monitoring on the B/C medication cart. The list included: R15, R19, R23, R30, R37, R41, R43, R52, R62.

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	07/02/2025

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Influenza and Pneumococcal immunizations were offered to four of five residents (R26, R87, R81, R498) reviewed for immunization compliance in a sample of 42. Findings include: The Influenza Vaccination, no date, documents the influenza vaccination will be routinely offered annually from October 1st through March 31st. The Pneumococcal Vaccine (Series), no date, documents each resident will be assessed for pneumococcal immunization upon admission. Self-report of immunization shall be accepted. R26 was admitted on [DATE]. The Immunization Audit Report sheet did not include a pneumococcal immunization history or evidence the vaccine was offered, declined, or administered. R81 was admitted on [DATE]. The Immunization Audit Report sheet did not include a pneumococcal immunization history or evidence the vaccine was offered, declined, or administered. R87 was admitted on [DATE]. The Immunization Audit Report sheet did not include an influenza or a pneumococcal immunization history or evidence the vaccines was offered, declined, or administered. R498 was admitted on [DATE]. The Immunization Audit Report sheet did not include a Pneumococcal immunization history or evidence the vaccine was offered, declined, or administered. On 7/1/25 at 12:30 PM, V15 (Regional Nurse Consultant) agreed R26, R81, R87 and R498's Immunization Audit Report sheets did not include an influenza and/or a pneumococcal immunization history or evidence the vaccine was offered, declined, or administered.