STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057794	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLURE OF KNOX COUNTY	280 EAST LOSEY STREET , GALESBURG, Illinois, 61401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Complaint Investigation: 2528227/2602679	S0000		09/18/2025
S9999	Final Observations Statement Of Licensure Violations: 300.610a) 300.1210b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident These regulations were not met as evident by: Based on observation, interview and record review the facility failed to ensure one resident (R4) was free of significant medication error of three residents reviewed for medications. This failure caused R4 to be visibly uncomfortable and anxious.	S9999		09/18/2025

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

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S9999	Continued from page 1 The Facility's undated "Medication Errors" policy documents "Medications errors, once identified will be evaluated to determine if considered significant or not by utilizing the following three general guidelines: a. Resident's condition: if the resident's condition requires rigid control, such as strict intake and output measurement, daily weights, or monitoring of lab values. b. Drug category: if the medication is from a category that usually requires the resident to be titrated to a specific blood level such as a medication with a narrow therapeutic index. c. Frequency of Error: if an error is occurring repeatedly such as an omission of a resident's medication several times. " The Facility's undated "Medication Errors" policy documents "the facility will consider factors indicating errors in medication administration, including, but not limited to, the following: a. medication administered not in accordance with the prescriber's order. Examples include but not limited to: 1. Incorrect dose, route of administration, dosage form, time of administration." "If a medication error occurs, the following procedure will be initiated: a. The nurse assesses and examines the resident's condition and notifies the physician or health care practitioner as soon as possible. b. Monitor and document the resident's condition, including response to medical treatment or nursing interventions. c. Document actions taken in the medical record. d. Once the resident is stable, the nurse reports the incident to the appropriate supervisor and completes the incident or occurrence report. R4's Medical Record documents that she was admitted to the facility on 2/15/22 with diagnosis to include but not limited to left below the knee amputation, spinal stenosis, anxiety and depression. On 8/27/25 at 10:50 AM R4 was alert and answered questions appropriately. R4 was lying bed, appeared pale, her hairline was damp and she seemed to be breathing rapidly. R4 stated she was in pain, stated "The nurse knows, she hasn't brought my morning medicine yet. Sometimes it takes these agency nurses longer." On 8/27/25 at 10:55 AM V13 (Registered Nurse) confirmed that R4 had not gotten her scheduled 8:00 AM morning medications. V13 stated "I'm agency" when asked if there was a reasoning or incident causing R4's medications to be late. R4's Medication Administration Record dated August 2025 documents that on 8/27/25, R4's scheduled 8:00 AM	S9999		

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S9999	Continued from page 2 medications were administered at 11:22 AM by V13 (Registered Nurse). R4's Medication Administration Record dated August 2025 documents R4's scheduled 8:00 AM medications were: Cranberry (vitamin) 450 mg (milligrams), Duloxetine 30 mg for depression, Lasix (diuretic) 40 mg, Hydrocodone (narcotic) 5-325 mg, Losartan Potassium (anti-hypertensive) 100 mg, Miralax ((laxative)17 Grams, multivitamin 1 tablet, oxybutynin (anticholinergic) 10 mg, Pregabalin (for pain) 75 mg, Spironolactone (diuretic) 25 mg, Tizanidine (muscle relaxer) 2 mg. R4's Medication Administration Record dated August 2025 documents that R4 has a scheduled 12:00 PM dose of Pregabalin (for pain) 75 mg also. R4's noon dose of Pregabalin was not signed out at all. R4's Medication Administration Record dated August 2025 documents that on 8/19/25 R4's scheduled 5:00 PM medications were given at 9:20 PM by V15 (Licensed Practical Nurse). R4's Medication Administration Record dated August 2025 documents R4's scheduled 5:00 PM medications were: Pregabalin (for pain) 75 mg and Tizanidine (muscle relaxer) 2 mg. R4's Medical Record did not contain any documentation regarding why R4's medications were not given at the scheduled time or what R4's condition was on 8/19/25. V15 (Licensed Practical Nurse) was not reachable during the survey to answer questions. R4's Medication Administration Record dated August 2025 documents that on 8/11/25 R4's scheduled 8:00 AM medications were given by V5 (Registered Nurse) at 10:34 AM. R4's Medication Administration Record documents that on 8/18/25 R4's scheduled 8:00 AM medications were given by V5 (RN) at 10:44 AM. Neither date (8/11/25 or 8/18/25) document R4's scheduled 12:00 PM dose of Pregabalin as given. R4's Medical Record did not contain any documentation regarding why R4's medications were not given at the scheduled time or what R4's conditions was on 8/11/25 or 8/18/25. On 8/29/25 at 9:40 AM V5 (RN) stated "One of two things happened, either (R4) slept in and I gave the medications late, or I gave (R4)'s medications on time but just did not sign them out until later." V5 stated she did not remember "specifically." V5 confirmed that	S9999		

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S9999	Continued from page 3 there was no documentation as to which possible reason was what occurred on either date. V5 stated that she did not notify the doctor or any other staff member of what occurred. "I might have passed it on verbally to the next shift, I'm not sure." V5 (RN) stated that "if" she gave R4's Pregabalin late for the 8:00 AM dose she "would have waited" on giving the scheduled 12:00 PM dose until 1:30 PM or 2:00 PM she "wasn't sure." V5 confirmed "there is no way of telling" based on the documentation in R4's medical record what happened on either day. On 8/29/25 at 10:15 AM Dr. Ahearn did acknowledge that she had chronic pain and that it was “usually” controlled with her scheduled medications as far as he knew. (B)	S9999		