Illinois State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **0056697** | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED **09/11/2025** |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **ALLURE OF GALESBURG** | **1145 FRANK 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 |
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| S0000 | Initial Comments<br><br>FRI of 8/15/2025/2596094 | S0000 | | 09/12/2025 |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>300.610a)<br><br>300.1210b)<br><br>300.1210d)1<br><br>300.1210d)2<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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.<br><br>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: | S9999 | | 09/12/2025 |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| S9999 | Continued from page 1<br>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.<br><br>2) All treatments and procedures shall be administered as ordered by the physician.<br><br>These Requirements were NOT MET as evidenced by:<br><br>Based on record review and interview the facility failed to properly prepare and administer medications to prevent a significant medication error for one resident (R4) of three residents (R3, R4, and R5), reviewed for medication administration errors in a total sample of 21. These failures resulted in R4 receiving the wrong medication and being hospitalized for lethargy, heart rate in 40s, difficult to arouse, and subsequently being intubated.FINDINGS INCLUDE:<br><br>The Facility's "Medication Administration" Policy, not dated, documents: 10. Ensure that the six rights of medication administration are followed: a. Right resident b. Right drug; c. Right dosage; d. Right route; e. Right time; f. Right documentation; 11. Review MAR to identify medication to be administered; 12. Compare medication source (bubble pack, vial, etc.) with MAR [Medication Administration Record] to verify resident name, medication name, form, dose, route, and time; 14. Remove medication from source, taking care not to touch medication with bare hand; 17. Administer medication as ordered in accordance with manufacturer specifications; and 23. Correct any discrepancies and report to nurse manager."<br><br>The Facility's "Medication Error" policy, not dated, documents: "3. Medication errors, once identified, will be evaluated to determine if considered significant or not by utilizing the following three general guidelines: a. The nurse assesses and examines the resident's condition and notifies the physician or care practitioner as soon as possible; b. Monitor and document the resident's condition, including response to medical treatment 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 completes the incident or occurrence report."<br><br>The facility's "Medication Error Report Form", dated 8/15/25, document: "Resident Name [R4]; Date/Time Error Occurred: 8/15/25 at 4:24 a.m.; Date/Time Error Discovered: 8/15/25 at 7:15 a.m.; Discovered by [V4/Licensed Practical Nurse-LPN]; Medication(s) involved: Vit[amin] C 500 mg, ASA [aspirin] 81 mg, | S9999 | | |

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| S9999 | Continued from page 2<br>Claritin 10 mg, clonazepam 1 mg, Plavix 75 mg, fluoxetine 60 mg, Ibuprofen 600 mg, Lyrica 300 mg, MVI [multivitamin], Methocarbamol 750 mg, Seroquel 100 mg, and vitamin D3 5000 IU; Description of Error: Nurse gave another residents medications to wrong resident; and What symptoms, if any did the resident experience: lethargy, decreased BP [Blood Pressure]".<br><br>R4's Electronic Medical Record/EMR document R4's diagnosis to include Hemiplegia, Poisoning by Unspecified Drugs Accidental, Bradycardia, Parkinson's Disease, Muscle Wasting, Acute Pain due to Trauma, Major Depressive Disorder, Crohn's Disease, and Acute Hepatitis C.<br><br>R4's August 2025 Medication Administration Record/MAR document, on the 15th, V3/Licensed Practical Nurse-LPN, [after administering R5's medication to R4], administered R4's Carbidopa/Levodopa 25/100 two tablets, and Diazepam 5 mg. The MAR also document V4 gave R4 his 7:00 a.m. medications-Lexapro 10 mg, Celebrex 200 mg, Protonix 40 mg, Keppra 1500 mg, Metoprolol 50 mg, Morphine Sulfate Extended Release 15 mg, Carbidopa/Levodopa 25/100 2 tabs, Entacapone 200 mg, and Lacosamide 100 mg.<br><br>R4's EMR progress notes document: 8/15/25, at 7:15 AM, this nurse [V4] was notified by resident [R5] that he saw the third shift B/E Hall nurse [V3] give his 5 AM medications to this resident. Resident stated he felt unwell this a.m. Resident laying bed and vitals checked, and resident noted to be hard to arouse and lethargic. [V8/medical doctor], 911, Local hospital], and brother notified.<br><br>On 9/9/25, at 1:25 p.m., V2/Director of Nursing confirmed: On 8/15/25, V3 (3rd Shift Nurse) pre-popped [pre-prepared] and stacked residents' medications. R4 was subsequently administered R5's medications-Ascorbic Acid 500 milligram/mg, Aspirin 81 mg, Claritin 10 mg, Clopidogrel 75 mg, Fluoxetine 60 mg, Multivitamin, Seroquel 100 mg, Vitamin D3 125 µg (micrograms), Lyrica 300 mg, Klonopin 1 mg, ibuprofen 600 mg, Robaxin 750 mg; After realizing the error, V3 then administered R4's correct medication which included-diazepam 5 mg, carbidopa/levodopa 25/100 2 tabs; V3 did not report the error; V4/Licensed Practical Nurse/LPN 1st shift nurse administered R4's 7:00 a.m. medications-Lexapro 10 mg Celebrex 200 mg Protonix 40 mg, Keppra 1500 mg, Metoprolol 50 mg, Morphine Sulfate Extended Release 15 mg, Carbidopa/Levodopa 25/100 2 tabs, Entacapone 200 mg, and Lacosamide 100 mg; R5 then told V4 that V3 had given his medications to R4; and R4 was sent to the emergency room where R4 was admitted. | S9999 | | |

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| S9999 | Continued from page 3<br><br>R4's hospital documentation: 8/15/25 Emergency Room-Critical care was necessary to treat or prevent imminent or life-threatening deterioration of the following conditions: CNS [Central Nervous System] failure or compromise, metabolic crisis and respiratory failure; Hospital Admission History & Physical-Admitting diagnosis: Medication overdose; and "Discharge Summary", dated 8/18/25, document: [R4] was admitted after unintentional medication overdose given at facility. Patient noted to be lethargic, upon arrival is also bradycardic into 40s. Patient given Narcan x3 in ED and was protecting his airway and brought to ICU [Intensive Care Unit]. ICU attending when rounding on the patient noted that he had gone apneic and was difficult to arouse and patient was then intubated. He was extubated the following day and did well. He was started on a diet and his home medications and was at his baseline mental status.<br><br>On 9/10/25, at 4:00 a.m., the State Agency entered the facility and found V5/Registered Nurse and V6/LPN had pre-prepared and stacked medicine cups on and in their medicine carts. Among the medicines, pre-popped, five resident med cups contained controlled medicines which were signed out on the narcotic log. V5 and V6 confirmed they should not have pre-prepared/stacked medicine cups.<br><br>On 9/10/25, at 4:15 a.m., R4 stated, "The facility tries to make me feel better by telling me that the nurse is no longer working, but it doesn't make me feel better. If [R5] didn't tell them [facility staff] I got the wrong medicine, I would be dead."<br><br>On 9/10/25, at 1:55 p.m., V8/Regional Nurse confirmed the medication error should have been immediately reported and all medications held pending the medical doctor's approval.<br><br>On 9/10/25, at 3:25 p.m., R5 confirmed he saw the nurse give his medicine, with pudding, to R4. He did not know that those were R5's meds at the time. Then the nurse, realizing her mistake, took the empty med cup which had R5's name written on it and said to R5, "I suppose this is you?" When R5 said, yes, she popped his meds out again and gave them to him. R5 went to the dayshift nurse [V4] and asked her if his meds were double punched, and when she said, yes, he told V4 that his meds had been given to R4.<br><br>(A) | S9999 | | |