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 09/13/2025

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 Facility Reported Incident of 9/4/25/2609104.	S0000		09/23/2025
S9999	Final Observations Statement Of Licensure Findings: 300.610a) 300.1210a) 3001210b) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's	S9999		09/23/2025

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

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S9999	Continued from page 1 guardian or representative, as applicable 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 evidenced by: Based on observation, interview, and record review the facility failed to provide immediate and adequate supervision after a resident's family member notified facility staff of a resident voicing R1 was going to escape out of his window and implement 15-minute visual checks as directed by the plan of care, for a cognitively impaired resident at risk for elopement for one (R1) of three residents reviewed for elopement in a sample of three. These failures resulted in (R1) a cognitively impaired resident with a previous elopement attempt from the facility, exiting the facility through his room window without staff knowledge or supervision on 9/3/25. (R1) was found across the road from the facility, a block away and close to active railroad tracks. Findings include: The facility's Elopements and Wandering Residents Policy, dated 2025, documents "Policy: The facility ensure that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, 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-directed (example: the person appears to be searching for something such as an exit) or not-goal directed or aimless. Elopement: Occurs when a resident leaves the premises or a safe area without authorization (an order for discharge or leave of absence) and/or any necessary supervision to do so. Policy Explanation and Compliance Guidelines: 3. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. 4. Monitoring and	S9999		

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S9999	Continued from page 2 Managing Residents at Risk for Elopement or Unsafe Wandering: A. Resident will be assessed for risk of elopement and unsafe wandering upon admission throughout their stay by the interdisciplinary care plan team. B. The interdisciplinary Team will evaluation the unique factors contributing to risk in order to develop a person-centered care plan. C. Interventions to increase staff awareness of the resident's risk, modify the residents' behaviors, or to minimize risk associated with hazards will be added to the resident's care plan and communicated to appropriate staff. D. Adequate supervision will be provided to help prevent accidents or elopements. E. Charge Nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly." R1's current Face Sheet documents R1 is a 69-year-old male admitted to the facility on 6/27/25 with the following, but not limited to, diagnoses: Alzheimer's Disease, Restlessness and Agitation, Essential Hypertension, Congestive Heart Failure, Peripheral Vascular Diseases, Acute Respiratory Failure with Hypoxia, Muscle Wasting/Atrophy, and Other Abnormalities of Gait and Mobility. R1's MDS (Minimum Data Set), dated 6/30/25, documents R1 is severely cognitively impaired. R1's Care Plan, dated 6/27/25 documents, "Cognition/Disorientation: (R1) experiences disorientation to place, time. My memory is similarly impaired. I have problems with decision making, insight, logic, reasoning, social skills, judgment. This problem is related to my cognitive deficits." R1's Progress Notes, dated 8/22/25 and signed by V7/RN (Registered Nurse) documents, "(V7) called (V11/R1's Physician Assistant) and reported that (R1) is not being cooperative to reenter the facility." R1's BIMS (Brief Interview of Mental Status) Assessments dated 8/22/25 and 9/4/25 documents R1 is cognitively impaired. R1's Elopement Evaluation, dated 8/22/25, documents R1 is at risk of Elopement. This same evaluation documents "Focus: Risk for Wandering/Elopement Identified. Goal: (R1) will not leave facility unattended. Goal: (R1's) safety will be maintained." R1's Community Survival Skills, dated 8/22/25, documents, "The resident sufficiently alert, oriented, and knowledgeable allowing him/her to be considered for	S9999		

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S9999	Continued from page 3 independent outside pass privileges? No." This same form documents R1 requires supervision to be out in the community. R1's Care Plan, dated 9/3/25, documents "Focus: Risk for Wandering/Elopement Identified (Date initiated 8/22/25). Interventions: 8/22/25 Wander guard to right ankle. 8/22/25 15-minute checks initiated, 9/3/24 (R1) was moved to memory care unit, 9/3/25 Engage (R1) in purposeful activity, 9/3/25 Provide clear, simple instructions, Provide reorientation to surroundings, environment." R1's 15-Minute Checks, dated 8/22/25 through 9/4/25, does not document any safety concerns under "safety concerns" located on the top right corner of the 15-minute checks. R1's Illinois Department of Public health First and Final Report, dated 9/4/25, documents on 9/3/25 R1 left the building through his room window. A phone call was made to the facility at 7:34 PM by Local Police Department. Staff located R1 at 7:41 PM. R1's Police Report, dated 9/3/25, documents at 7:28 PM V4/R1's Family Member notified the police department advising that R1 had taken off from the local nursing facility. At 7:34 PM the police department attempted to call the facility with no answer. At 7:38 PM the police department spoke with V7/RN. V7 advised they would look for R1. In the background while V7 had set the phone down the police officer could hear employees stating they could not locate R1. On 9/3/25 at 7:55 PM the police department called the facility and spoke with V7. V7 advised the police department they (facility staff) had located R1 a block away from the facility. R1's Progress Note, dated 9/3/25 and signed by V7/RN, documents, "(V7) received a call from (Local Police Department) at 7:33 PM to report that (R1) may have left facility through (R1's) window. Per Local Police Officer, (R1) is on the phone with (V4/R1's Family Member). (V7) and another CNA (Certified Nursing Assistant) identified as (V5), went to (R1's) room and observed that (R1) was not in the room or personal bathroom. (V7) did observed window opened about 14 inches and screen was missing. (V5) went through window to search for (R1) and this nurse informed the other staff on the floor to begin a search in the building. This nurse called (V12/Sister Facility Administrator) at 7:38 PM to report that (R1) had possibly left from facility exiting through windows. (V7) went out the back door and searched in the parking lot. (V7) met up with (V5) and got into (V7's) car and began to search	S9999		

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S9999	Continued from page 4 for (R1). (V7) went around the corner and one-half block from facility and observed (R1) walking with a steady gait carrying a plastic bag with a small number of belongings at 7:41 PM. (V7) parked vehicle and approached (R1). (R1) was observed by (V7) that (R1) was on the phone with (V4) when (V7) approached (R1). (R1) agreed to get into vehicle and (R1) was returned to the facility." On 9/8/25 at 10:32 AM R1 was on the memory care unit lying in his bed. R1 was unable to answer questions appropriately but did state he was able to continually work on sliding his window over little by little and hit the window stopper until it would move. R1 stated he would do it a little every day until he knew it was wide enough to get through. R1 denies knowing where he went when he got out the window, speaking to V4/R1's Family Member, or how he got back to the facility on 9/3/25. On 9/8/25 at 3:05 PM this surveyor and V1/Administrator watched the video surveillance on the hallway R1 resided the night R1 left the facility unattended through his window on 9/3/25. At 7:04 PM a male with a meal tray cart (identified as V10/Cook) was observed slightly opening R1's room and grabbing R1's meal tray. At 7:36 PM two females (identified as V5/CNA and V6/CNA) were observed running down the hallway towards R1's room. Once they arrived to R1's room, they both look into (R1's) room and immediately started running back up the hallway. At 7:46 PM two females (identified as V5 and V7) were observed walking (R1) back into the facility's back door. (R1) was observed to have pants, shoes, and a t-shirt on. V1/Administrator confirmed at this time that R1 was on 15-minute checks and that no staff was observed on the camera going in R1's room and checking on R1 every 15 minutes. V1 stated staff should have been implementing R1's 15-minute checks and staff should have physically gone into R1's room and checked on R1 when performing the 15-minute checks. On 9/9/25 at 1:50 PM this surveyor, V1/Administrator, V2/Interim Director of Nursing, and V20/Regional Director of operations watched the video surveillance on the hallway R1 resided the night R1 left the facility unattended on 9/3/25 between 6:00 PM and 7:00 PM. From 6:00 PM to 6:28 PM R1's door is slightly cracked open. At 6:29 PM R1 is observed opening his door and standing slightly in the doorway. At that time V6/CNA is observed walking down the hallway and goes into a different resident's room, next to R1's room. At 6:31 PM V5/CNA is observed going into R1's room to deliver R1's meal tray and then immediately leaves R1's room. From 6:32 PM to 7:00 PM no other staff is	S9999		

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S9999	Continued from page 5 observed checking on R1. During this time V1/Administrator and V2/Interim Director of Nursing both verify that R1 was not physically being checked on every 15-minutes as implemented and should have been. On 9/9/25 at 6:38 PM V17/Prior Administrator-in-Training stated she was the administrator in the building when R1 attempted to elope from the facility on 8/22/25. V17 stated, “After (R1) attempted to elope, (R1) was determined to be a risk for elopement, so I placed a wander guard on (R1) and implemented 15-minute checks. (R1) was ambulatory and when he attempted to elope on 8/22/25, staff could not get him to come back into the facility. (R1) walked at least five blocks across main roads and railroad tracks (with staff present) and then finally agreed to get back into the facility van and come back to the facility with us. (R1) is not safe to be out in the community by himself.” On 9/8/25 at 11:59 AM V7/RN (Registered Nurse) stated, “The past two weeks prior to (R1) getting out of the facility on 9/3/25, he was verbalizing that he wanted to go home, or he wanted to get out. (R1) never stated how he was going to get out and rarely ever left his room. I didn’t start work on the night of 9/3/25 until around 6:00 PM. While I was getting report between 6:00 PM and 6:15 PM, (V4/R1’s Family Member) had called the facility and told me (R1) was wanting to leave and said he was going to get out through his window. I then told (V5/CNA and V6/CNA) to keep an eye on him and check on him periodically through the night. I didn’t go down and look at the window myself to see if he could get out at that point. The windows never open very far so I didn’t figure there was any way he could get out through his window. Around 7:30 PM the police department called the facility. I was doing my medication pass and had gone to answer the phone. The police department told me that (V4) had called them and stated (R1) had left the building. I then yelled to (V5) and (V6) to go check on him. (V5) ran down to (R1’s) room and noticed (R1) was not in the room. (V5) jumped out the window to go look for (R1) and I told staff to start looking for (R1), and then I went outside to look for (R1). I was in the back parking lot looking for (R1) when I saw (V5). We both jumped in my car to go look for (R1). There are railroad tracks, and he was half a block from the tracks when we found (R1). We found (R1) approximately a block away from the facility. (R1) agreed to get in the car and allowed me to drive him back to the facility. We arrived back to the facility around 7:45 PM.” On 9/10/25 at 12:25 PM V22/LPN (Licensed Practical	S9999		

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S9999	Continued from page 6 Nurse) stated, "(V4/R1's Family Member) called on 9/3/25 while I was giving report to (V7/RN). It would have been approximately between 6:00 PM and 6:15 PM. (V4/R1's Family Member) told me (R1) and (V4) had been arguing and that (R1) had told (V4) he was going to escape out of his window tonight. I assured (V4) that we would keep an eye on (R1), I then reported what (V4) had stated to (V7). I did not go down to (R1's) room and assess (R1) or his window. I would have never thought (R1) would have been able to get through his window. The windows usually only open four inches." On 9/8/25 at 1:33 PM V4/R1's Family Member stated, "(R1) had called me between 5:00 PM and 6:00 PM the night of 9/3/25 and told me he wanted to leave the facility and that he was almost able to get through his window. I got off the phone and called the facility and spoke to some nurse and told them what (R1) had stated. They told me they would check on (R1). Later, that night around 7:30 PM (R1) had called me and stated he had got out his window and was walking down the street. We then got disconnected so I attempted to call the facility and could not get anyone to answer so I called the local police department and let them know. I was told by the facility (R1) was found around a block away." On 9/8/25 at 11:01 AM V5/CNA stated she was working on the unit where R1 resided when R1 got out of the building on 9/3/25. V5 stated, "I do remember (V7/RN) stating (V4/R1's Family Member) had called and told (V7) (R1) was saying he was going to escape out his window and to check on (R1) periodically. It was around 6:15 PM. I did not go down there immediately to check on (R1) but do know I had checked on (R1) at some time, I just don't remember the time. I did not frequently check on (R1) because his room is at the end of the hallway, and I didn't figure there was any way for (R1) to escape since (R1) would have to walk past the nurse's station or try to go through an exit (which he had a wander guard on). I did not look at (R1's) window though to see if he could get through it and should have. I worked with (V6/CNA) that night on that hallway. I was the one in charge of the 15-minute checks. I was not sure why (R1) was on the 15-minute checks. It does not say anywhere. If I had known, I would have kept a better eye on him. I do physically go down and check on (R1) when I am completing the 15-minute checks, but I may not get down there every 15 minutes. I did not know (R1) had attempted to get out of the facility prior to 9/3/25 or that he was a high-risk wanderer. I have never been trained on how to access a resident's care plan or if I even have access." V5 stated the night R1 got out his window on	S9999		

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S9999	Continued from page 7 9/3/25 V5 was sitting at the nurse's station charting. V7 had told V5 she received a phone call that R1 had escaped from the building. V5 reported she immediately ran down to R1's room, noticed R1's window was wide open and R1 was not in his room. V5 stated she immediately told V7 and V5 jumped through the window in an attempt to locate R1. V5 reported she did not notice anything broken on the window. V5 noticed V7 out in the parking lot and got in the car with V7 to go locate R1. V5 stated, "I got in (V7's) car in the back parking lot. We took a right out of the parking lot. Then at the stop sign we took another right, then a left at the following stop sign. (R1) was observed to be right at the corner of that block by the stop sign about a half block from the railroad tracks. (R1) was cooperative and did get back in the car with us." On 9/8/25 12:30 PM V6/CNA stated she had no means to check on R1 that night and that she did not know anything about him. V6 denies V7/RN telling her to keep an eye on R1 or that R1 was wanting to escape on 9/3/25. V6 stated, "I don't remember the last time I saw (R1) that night. I honestly didn't even know who (R1) was." On 9/8/25 at 2:05 PM V10/Cook stated, "I didn't witness anything on 9/3/25 regarding (R1). They just said he was out of the building, and they were looking for him. I don't recall how (R1) got out his window. I would have picked up (R1's) room tray after 7:00 PM, but I don't even know if (R1) was in there. (R1) leaves his door cracked open and I just grabbed (R1's) tray. I didn't put my eyes on (R1)." V10 stated no one interviewed him the night of 9/3/25 to ask if he had observed R1 that night or not. On 9/8/25 at 11:26 AM V3/Maintenance Director reports when he came into work on 9/4/25, V3 was told about R1 escaping out his window without staff knowledge. V3 stated, "I went down to (R1's) room to observe his window. There are locks located on the bottom of the window seals, they only allow the windows to be open four inches. When I got down to his room, a visible scratch was observed along the bottom of the window seal, and the lock was observed to be next to the other four-inch lock. It looked like (R1) had been working on moving the bottom lock over for a while. I had to physically loosen the set screws and slide it back down to the original position and then set the screws again. I did put a new lock on it with the pointed screws." V3 stated it would have taken R1 a while to get the bottom lock to slide over, R1 would have had to use excessive force, and it was not something that could have happened quickly. V3 reported the only other way to get	S9999		

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S9999	Continued from page 8 the bottom window locks to move is by utilizing a special tool to undo the locks. On 9/8/25 at 2:54 PM V1/Administrator stated she would have expected someone (a staff member) to immediately go down and assess R1's window at that time and then move R1 closer to the nurse's station to be monitored closely, after receiving a phone call that R1 was wanting to leave the facility and escape through his window. V1 stated, "(R1) most definitely should have been checked on more than 15 minutes at that time if staff were aware he was voicing he was going to get out the window." "B"	S9999		