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 05/14/2025

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 4/13/25/IL191173	S0000		
S9999	Final Observations Statement Of Licensure Findings: 300.610a) 300.1210a) 200.1210b) 300.1210d)6) 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	S9999		

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

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S9999	Continued from page 1 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 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 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These regulations were not met as evidenced by: Based on observation, interview, and record review the facility failed to prevent resident physical abuse after (R1) displayed increased agitation and aggression and no interventions were implemented to prevent potential resident abuse for one (R3) of 23 residents reviewed for abuse in the sample of 26. These failures resulted in R1 physically shoving a trash can in R3's face and R3 sustaining a bleeding laceration to upper and lower lips. These failures have the potential to affect all 19 residents (R2, R3, R9 through R25) residing in the facility's Dementia unit. Findings include:	S9999		

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S9999	Continued from page 2 The Facility Abuse, Neglect and Exploitation Policy, reviewed/revised 2/1/25, 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. "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. The facility will develop and implement written policies and procedures that: prohibit ad prevent abuse, neglect, bribery, and exploitation of residents and misappropriation of resident property; Establish policies and procedures to investigate any such allegation; include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriate of resident property, reporting procedures, and dementia management and resident abuse prevention; and establish coordination with the QAPI (Quality Assurance and Performance Improvement) program. The facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state agency and other officials in accordance with state law. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written. The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, bribery, misappropriation of resident property, and exploitation that achieves: The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which lead to conflict or neglect. The facility will make an effort to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator; and revision of resident's care plan if	S9999		

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S9999	Continued from page 3 the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse." The Facility Behavioral Health Services Policy, not dated, documents, "It is the policy of this facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning and well-being. The facility will ensure that a resident who, upon admission was not assessed or diagnosed with a mental or psychosocial adjustment difficulty or a documented history of trauma and/or PTSD (Post Traumatic Stress Disorder) does not develop patterns of decreased social interaction and/or increased withdraw, angry, or depressive behaviors while residing in the facility. The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. The assessment and care plan will include goals that are person-centered and individualized to reflect and maximize the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. Staff will: obtain history from medical records, the resident, and as appropriate the resident's family and friends, regarding mental, psychosocial, and emotional health; monitor closely for expressions or indications of distress; evaluate whether the resident's distress was attributable to their clinical condition and demonstrate that the change in behavior was unavoidable; utilize MDS (Minimum Data Set) and care area assessments; assess and develop a person-centered care plan for concerns identified in the resident's assessment; share concerns with the interdisciplinary team (IDT) to determine underlying causes of mood and behavior changes, including differential diagnosis; accurately document the changes, including the frequency of occurrences and potential triggers in the resident's record; ensure appropriate follow-up assessment, if needed; discuss potential modifications to the care plan; evaluate resident and care plan routinely to ensure the approaches are meeting the needs of the resident. The resident, and as appropriate the resident's family, are included in comprehensive assessment process along with the interdisciplinary team and outside sources, as indicated. The care plan shall: have interventions that person-centered, evidenced-based, culturally competent, trauma-informed, and in accordance with professional standards of practice; provide for meaningful activities which promote engagement and positive, meaningful relationships; be reviewed and revised as needed, such	S9999		

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S9999	Continued from page 4 as when interventions are not effective or when the resident experiences a change in condition. Facility staff will implement person-centered care approaches designed to meet the individual goals and needs of each resident, which includes non-pharmacological interventions." R1's Admission record documents R1's date of admission to the facility was 2/22/25 and his diagnoses included: Cerebral Infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, Unspecified Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety, Depression, unspecified and Gastro-Esophageal Reflux Disease without Esophagitis. R1's Minimum Data Set (MDS) assessment, dated 2/28/25, documents R1 has a Brief Interview for Mental Status (BIMS) score of 5/15, indicating severe cognitive impairment and documents R1's transfers/ambulation as supervision or touching assistance. R1's progress notes dated 3/30/25, 3/31/25, 4/1/25, 4/2/25, 4/7/25, 4/12/25, 4/13/25 and 4/15/25 document behaviors of increased wandering, suspicion, agitation, and combativeness. R1's abuse investigation, Final Five-Day Report, dated 4/13/25, documents that R1 became agitated when staff attempted to redirect R1 from another resident room. V22 (Certified Nursing Assistant/CNA) was walking R1 to his room when R1 grabbed a handheld radio from nurse's station desk. V22 (CNA) asked R1 to give her the radio and R1 refused continuing to walk down the hall. V22 (CNA) noted R2 sitting in the hallway and moved her out of R1's way for safety. V22 (CNA) continued to redirect R1 at which time he threw the handheld radio in the hallway striking R2 in the back of the head. R2 assessed for injury with none sustained. Report also stated that R1 was sent to emergency room for a psychiatric evaluation. R1 returned to the facility later that evening with no new orders and facility initiated frequent checks with increase in agitation. No documentation of frequent checks noted in R1's medical record. On 5/7/25, V9 (LPN), V11 (LPN), and V8, V23, and V25 all Certified Nursing Assistants (CNA) stated that they were not educated on increasing supervision on R1 after	S9999		

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S9999	Continued from page 5 altercation with R2. On 5/7/25 at 2:12pm, V8 (Certified Nursing Assistant/CNA) stated, "I saw that R1 was agitated and (R1) grabbed a walkie talkie (handheld radio) off the nurse's station desk. We (V8, V9, V22) tried to get it from R1, but he got more agitated and kept walking down the hall, so we let him be. Next thing I (V8) know I heard "Ow" and saw the walkie talkie (handheld radio) hit R2 in the back of the head. R2 was sitting in her wheelchair by room 104 with her back to R1 who had just gotten by room 105. I (V8) went and got the nurse (V9/Licensed Practical Nurse) and V9 took over after I told her what I saw. I (V8) had separated R1 from R2 by taking R1 to his room and then I left because my shift was over." On 5/7/25 at 2:15pm, V9 (Licensed Practical Nurse/LPN) stated, "I was working when R1 grabbed the walkie (handheld radio) off my cart by the nurse's station. R1 was agitated that day. I (V9) did not know what had happened until V8 (CNA) told me R1 had threw the walkie (handheld radio) and it hit R2. I went and assessed R2 and R2 had no visible injuries. R1 was redirected away from R2. I don't think R1 threw the walkie (handheld radio) at R2 on purpose, I think R1 threw the walkie (handheld radio) to just get rid of it." On 5/8/25 at 3:30pm, V22 (Certified Nursing Assistant/CNA) stated, "R1 was agitated prior to the incident with R2. R1 grabbed a walkie talkie (handheld radio) off the nurse's station, and I (V22) tried to get it from him, but he just got more agitated, so the nurse (V9/Licensed Practical Nurse) told me to leave R1 alone. I (V22) followed R1 down the hallway to redirect him and noted R2 was sitting in her wheelchair in the way, I moved R2 so R1 could get past to go to his (R1) room. As R1 went around the corner R1 tossed the walkie talkie (handheld radio) and it hit R2 in the back of the head. I don't think he (R1) was aiming at R2; I think R1 threw the walkie (handheld radio) to get rid of it." R1's Health Status note dated 4/17/25, documents, "R1 very agitated before supper. R1 was walking down the hall when this nurse (V9/Licensed Practical Nurse) heard what sounded like trash can being thrown down the hallway. This nurse went to investigate where noise came from and R1 was standing in hallway and trash can was sitting on the floor in front of R1. Another	S9999		

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S9999	Continued from page 6 resident (R3) was sitting in his doorway. R1 then came running at this nurse (V9) trying to hit nurse. R1 then turned around and tried to run after resident (R3) sitting in his doorway. The nurse (V9) then looked at the other resident (R3) and he (R3) had a bloody lip. The other resident (R3) states that resident (R1) hit him. Resident (R1) was trying to speak with nurse (V9), but his words were making no sense. This nurse (V9) tried to get resident (R1) to go into his room to try and calm him (R1) down but very resistive and combative. Not able to redirect. MD (doctor) notified. Nurse Manager notified and administrator notified. Resident (R1) then sent to (local hospital emergency department) to eval and treat." R1's abuse investigation, Final Five-Day Report, dated 4/17/25, documents that R1 and R3 were involved in a physical altercation in the hallway. V9 (Licensed Practical Nurse/LPN) heard a waste basket tumble across the floor. V9 (LPN) noted R3 sitting in the doorway to his room and R1 standing a few feet away. R3 had a laceration to his lip and stated R1 hit him. R1 and R3 were separated. R3 was given first aid and R1 was sent to emergency department for further evaluation. Report also documents R3 was identified by a witness (V17/R26's spouse) as the initiator. V17's witness statement documents that R3 yelled at R1 and threw the trash can at R1 when he was walking toward R3. R1 threw trash can back at R3 and R3 threw it back at R1 again. R1 then picked up trash can and pushed it into R3's face, open side up, causing injury. Report also documents facility took the following action: Power of Attorney and Physician notified, R1 sent to emergency department for evaluation and then transferred to psychiatric hospital for further evaluation and treatment. R1's care plan will be updated per physician recommendations. R3's care plan updated, and staff educated on communication needs, redirection strategies and monitoring for signs of agitation. On 5/7/25 V9 (LPN), V11 (LPN), and V8, V23, and V25 all Certified Nursing Assistants (CNA) stated that they were not educated on communication, redirection strategies or monitoring for signs of agitation after altercation with R3. On 5/7/25 at 3:00pm, V9 (Licensed Practical Nurse/LPN) stated R1 became increasingly agitated during a conversation with V9. In R1's agitated state and without staff member supervision, R1 walked down the hallway out of V9's or any other staff members' view.	S9999		

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S9999	Continued from page 7 V9 then reported hearing what sounded like a trash can hitting the floor and went to investigate. V9 reports seeing R1 standing in the hallway directly facing R3, who was in the doorway of his (R3) room. A trash can was noted on the hallway floor. V9 noted bleeding to R3's mouth. R3 reported to V9 that R1 had hit him with the trash can. V9 stated she felt the altercation was intentional because "R1 and R3 do not seem to like each other, they make rude comments to each other all the time." On 5/8/25 at 3:20pm, V11 (Licensed Practical Nurse/LPN) stated, "R1 and R3 do not like each other, they make rude comments to each other and I'm surprised that their (R1, R3) rooms are still next to each other after their altercation." On 5/6/25, 5/7/25, and 5/8/25 tour of the facility conducted. R1 and R3's rooms observed to be next to each other, R1 in room 110 and R3 in room 112. On 5/7/25 at 1:30pm, V11 stated that there are no specific individualized interventions to use for any of the residents on the dementia unit, "we try what we can and utilize our dementia training but that's about it." R1's current care plan documents a behavior care plan for aggression initiated on 4/29/25, no previous behavior care plan for aggression in medical record. R3's current plan of care documents, "Behaviors: I (R3) demonstrate verbally abusive behavior when agitated such as use of profanity/demeaning statements; racial, ethnic, religious, gender slurs; physically abusive behavior when agitated; attempting to push, shove, scratch, hit, slap, kick, grab, or otherwise harm another person related to ineffective coping skills, poor verbal skills and inability to express self, and dementia. Interventions include Ask (R3) to calmly explain what is causing this upsetting behavior; If talking to (R3) is not successful in stopping the behavior, try to take (R3) to a quiet area, away from other individuals, and intervene by speaking calmly and professionally in a soft tone of voice. Staff should avoid raising own voice, since this tends to make a resident more upset and may cause the situation to escalate." R3's current care plan also includes: "Behaviors: I (R3) display behavioral symptoms such as verbal and physical aggression due to dementia diagnosis. 4/17/25: (R3) became physically aggressive with another resident throwing a trash can at him.	S9999		

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S9999	Continued from page 8 Interventions include: 4/17/25: Staff education provided to monitor for signs of agitation and re-direct away from others if agitation is noted; conduct an evaluation of the behavioral symptoms to determine what strengths or abilities and needs are communicated via behavior; use interventions that address the abilities and needs reflected in the specific symptom: (i.e. rummaging may be an indicator that s/he needs to be busy and work with their hands)." On 5/7/25 at 1:41pm, V19 stated she is responsible for aggression assessments when residents are admitted to facility and then initiates the care plans from that assessment. V19 verified that R1's behavior care plan was not initiated until 4/29/25 when he returned from inpatient psychiatric stay. On 5/8/25 at 8:30am, V1 (Administrator in Training/AIT) stated that the facilities dementia unit just opened mid-April and verified that there are system failures regarding care plans, documentation, and communication on interventions with the floor staff. On 5/8/25 at 11:00am, V21 (Chief Nursing Officer/CNO) stated that V16 (Registered Nurse/RN/Former Director of Nursing) was told to educate the floor staff and initiate increased supervision of R1 with documentation of the supervision after R1's incident involving R2 but verified it was not done. R2's Admission Record documents R2's date of admission to the facility was 4/2/25 and her diagnoses included: Unspecified Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, Anemia, Diabetes, Depression, Anxiety Disorder, Hypertension, and Insomnia. R2's Minimum Data Set (MDS) assessment, dated 4/8/25, documents R2 has a Brief Interview for Mental Status (BIMS) score of 8/15, indicating severe cognitive impairment. On 5/8/25 at 11:00am, R2 stated she does not remember being hit and feels safe. R2 also stated, "If anyone was mean to me, I'd, (R2 shook her fist) then laughed." R3's Admission Record documents R3's date of admission	S9999		

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S9999	Continued from page 9 to the facility was 3/3/25 and his diagnoses included: Unspecified Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, Unspecified Dementia, unspecified severity, with agitation, Iron deficiency and Hypertension. R3's Minimum Data Set (MDS) assessment, dated 3/10/25, documents R3 has a Brief Interview for Mental Status (BIMS) score of 7/15, indicating severe cognitive impairment. R3's progress notes dated 4/13/25, 4/17/25, 4/23/25, 4/30/25, and 5/3/25 document behaviors of yelling, cussing, hitting, kicking, and biting during cares by staff. On 5/9/25 at 10:00am, R3 stated he does not remember the altercation with R1. R3 shook his head no and propelled wheelchair away from surveyor and down the hall. (B)	S9999		