Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008163	A. BUILDING: ________ B. WING ________	06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLURE OF ZION	3615 16TH STREET ZION, IL 60099

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 1/2 300.615e) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e.) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act). This requirement was not met as evidenced by: Based on interview and record review the facility failed to ensure resident's background checks were done within 24 hours of admission. This applies to 3 of 10 residents (R2, R54 and R71) reviewed for background checks in the sample of 18. The findings include: 1. R2's face sheet shows her admission date to	S9999	Attachment A Statement of Licensure Violations	

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

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S9999	Continued From page 1	S9999		

the facility was 3/16/23. Facility provided background check documents show R2's background check was not done until 3/22/23.

2. R54's face sheet shows his admission date to the facility was 5/24/23. Facility provided background check documents show R54's background check was not done until 5/26/23.

3. R71's face sheet shows her admission date to the facility was 5/24/23. Facility provided background check documents show R71's background check was not done until 5/26/23.

On 6/13/23 at 1:08 PM, V3 (Director of Admissions) said resident background checks should be completed within 24 hours of a residents admission to the facility, and she is the person responsible for completing them. V3 said she was out sick in March of 2023 and no one was backing her up so R2's background check was done late. V3 said if residents are admitted on Saturday there are times the background checks may not be done until Monday.

The facility provided Identified Offender Facility Policy and Procedure document dated 2011 states, "It is the policy of this facility to establish a resident sensitive and resident secure environment. In according with the provisions of the Nursing Home Care Act, this facility shall check the criminal history background check on any resident seeking admission to this facility. 3.) Conduct a criminal history background check: within 24 hours of admission."

(AW)

2/2
300.610a)

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S9999	Continued From page 2	S9999		

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.

Section 300.1210 General Requirements for Nursing and Personal Care
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:
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for

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S9999	Continued From page 3	S9999		

further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

These requirements were not met as evidenced by:

Based on interview and record review the facility failed to ensure pain medication was administered to a resident experiencing pain after a fall. This failure resulted in (R45) experiencing uncontrolled pain for 4 hours. This applies to 1 of 18 residents (R45) reviewed for pain in the sample of 18.

The findings include:

R45's face sheet shows she is a 72 year old female admitted to the facility on 3/22/23 with diagnoses including: Parkinson's disease, lack of coordination, and hypertension.
R45's 3/28/23 facility assessment shows her cognition is mildly impaired.

A post fall evaluation documented by V16 (Licensed Practical Nurse/LPN) on 6/10/23 at 1:57 PM, shows R45 had a fall in her room earlier that day at 7:30 AM. After the fall R45's left hip pain was documented to be a 8/10 on a 1/10 pain scale. The note states R45's "pain is constant."

R45's nursing progress note completed on 6/10/23 at 2:42 PM, by V16 states, "till 12 noon X-ray has not arrived and resident still c/o pain to left hip. NP (Nurse Practitioner- V10) notified with orders to send to the ER. resident left facility with ambulance at 12:30 PM."

R45's nursing progress notes show a Health

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S9999	Continued From page 4	S9999		

Status Note documented on 6/10/23 at 3:55 PM, that states "resident {R45} has a comminuted angulated mildly displaced intratrochanteric fracture of the left hip. Resident will be admitted to {local hospital} for further evaluation and treatment."

R45's 6/10/23 and 6/11/23 hospital records show that an X-ray was completed for R45 on 6/10/23 and R45 was found to have a comminuted mildly displaced intratrochanteric fracture of the left hip. The same hospital records show R45 underwent surgical intervention for her hip fracture on 6/11/23.

On 6/14/23 at 10:21 AM, V14 (Certified Nursing Assistant/CNA) said she was the CNA assigned to R45 on 6/10/23 the day she fell. V14 said after R45 had fallen (approx. 7:30 AM) she continued to complain of pain to her left hip and V14 told the nurse on duty.

On 6/14/23 at 10:43 AM, V15 (CNA) said she was helping care for R45 on 6/10/23 the day she had the fall. V15 said R45 kept asking for pain medication because she was in a lot of pain after the fall that morning. V15 said pain medication was not administered right away and she knows this because R45 kept asking for pain medication after the fall.

On 6/14/23 at 11:05 AM, V12 (Registered Nurse/RN) said she was going off duty on 6/10/23 when R45 had her fall. V12 said after R45's fall she was complaining of pain to her left hip. V12 said she did not personally administer pain medication to R45 and cannot speak for when R45 received pain medication.

On 6/14/23 at 11:50 AM, V2 (Director of

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S9999	Continued From page 5	S9999		

Nursing/DON) said she is still investigating R45's fall from 6/10/23. V2 said she had spoken with V16 (LPN) because there was no documentation that R45 had received any pain medication and V16 informed her that she did give R45 pain medication (Tylenol) at 11:30 AM. V2 was asked if R45 should have received the pain medication sooner after her fall and V2 responded "it would have been appropriate to do that."

On 6/14/23 at 11:13 AM, V10 (Nurse Practitioner/NP) said that R45 had an order for Tylenol 650 milligrams (mg.) for pain and she should have been given that. V10 said when she was called the second time (later that morning before noon) about R45's X-ray not being able to be done at the facility timely and that R45 was experiencing increased pain to her left hip, she decided to send her to the emergency room. At 12:15 PM, V10 said she was not aware that R45 was not given pain medication (Tylenol) until 11:30 AM and she could have gotten it sooner.

On 6/14/23 at 12:02 PM, V11 (R45's daughter) said she was contacted by her mom (R45) at about 7:45 AM on 6/10/23 about having a fall. V11 said R45 was complaining about having hip pain at that time.

On 6/14/23 at 1:00 PM, V16 (LPN) said she was the nurse assigned to R45 on 6/10/23 the day she had fallen. V16 said she recalls R45's fall to be around 7:15 AM. V16 said R45 was complaining of hip pain being an 8/10 after the fall and the CNA's also were reporting to her that R45 was continuing to have pain so she gave her Tylenol 650 mg. for the pain at 11:30 AM. (4 hours after R45's fall). V16 was asked by the surveyor if she called a physician for any additional pain medication orders and she said she did not. V16

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S9999	Continued From page 6	S9999		

was asked if there was any reason that R45 was not given the Tylenol for her pain sooner to which V16 replied, "Uh No."

A Medication Administration note completed by V16 on 6/12/23 at 3:34 PM, was documented as a late entry for 6/10/23 at 11:30 AM. That note shows R45 was given Tylenol 650 milligrams at 11:30 AM. R45's Medication Administration summary does not show any pain medication was given to R45 after her fall on 6/10/23.

The facility provided Pain Management policy dated 2022 states, " The facility will utilize a systemic approach for recognition, assessment, treatment and monitoring of pain. 1. In order to help a resident attain or maintain his/her highest practicable level of physical, mental and psychosocial well-being and to prevent or manage pain, the facility will: a. Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated. b. Evaluate the resident for pain and causes upon admission, during ongoing scheduled assessments, and when a significant change in condition or status occurs (e.g. after a fall.)

(B)