Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057588	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2025

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

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S0000	Initial Comments Complaint Investigation: 2515578/IL195012	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 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. 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	S9999		

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

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S9999	Continued from page 1 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 are not met as evidenced by: Based on interview and record review, the facility failed to supervise a resident at high risk for falls for one of six residents (R1) reviewed for safety/supervision in the sample of six. This failure resulted in R1 experiencing a fall and rib fracture that resulted in R1 transferring to the local hospital. The findings include: R1's Discharge paperwork from the local hospital shows R1 was admitted to the local hospital from June 4, 2025-June 13, 2025, with diagnoses of wet gangrene, osteomyelitis, and dementia. R1's Admission Record dated June 25, 2025, shows he was admitted to the facility on June 13, 2025 with diagnosis of vascular dementia. R1's Fall Risk Assessment dated June 13, 2025, shows R1 was a high risk for falling with a score of 16. On June 25, 2025, at 12:44 PM, V9 Registered Nurse (RN) stated R1 arrived in the facility prior to her getting to the facility for her shift that started at 3:00 PM. V9 stated when she arrived for her shift, R1 had not been admitted by a nurse yet. V9 stated she did rounds on R1 first since he was not officially admitted by a nurse yet. V9 stated during report she (V9) was told R1	S9999		

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S9999	Continued from page 2 was a high fall risk. V9 stated she gave R1 a urinal, oriented R1 to his room and asked R1 to use the urinal and his call light. V9 stated she was at the nurse's station when the Certified Nursing Assistant (CNA) came and got her because R1 had fallen. V9 stated R1 reported head and back pain. V9 stated R1 was sent to the hospital since the fall was unwitnessed and R1 reported that he hit his head. On June 25, 2025, at 1:31 PM, V10 CNA stated she got to work at 2:00 PM and got report from the other CNA. V10 stated she got report that there was a new admission, but he had not been checked in by the nurse or CNA. V10 stated she asked the day nurse who was going to do R1's admission, and the day nurse said the 2nd shift nurse was going to do R1's admission. V10 stated that R1 was at the facility before her shift started at 2:00 PM. V10 stated the nurses get to the facility at 3:00 PM. V10 stated that at the time of R1's fall on June 13, 2025, she was performing incontinence care to R1's roommate. V10 stated she could hear R1 trying to get up from his bed because she could "hear the mattress creaking." V10 stated she looked around the privacy curtain and asked R1 if he needed something. V10 said that R1 was sitting on the edge of the bed. V10 said that R1 told her that he needed to use the bathroom. V10 said she told R1 to use his urinal. V10 said she did not know if R1 could walk or not because he had not been evaluated by the nurse yet. V10 said there was a walker by R1's closet but she was not sure if it was R1's or not. V10 said she asked R1 if he wanted to use the walker and unfolded it. V10 said that R1 was still trying to get up without the walker when V10 left the room to throw away the trash from R1's roommate. V10 said, "Obviously he did not wait for me. I heard a loud noise and the resident across from the hall from R1's room said R1 fell." V10 said R1 was on the floor in the fetal position. V10 said she thought R1 hit his head. V10 said that R1 was sent to the local emergency room. On June 24, 2025, at 4:32 PM, V11 (R1's daughter) said R1 was admitted to the facility June 13, 2025. V11 said R1 fell the day he got to the facility. V11 stated on June 13, 2025, she was waiting for a phone call from the facility telling her that R1 arrived at the facility because she knew that R1 would be disoriented and needed V11 to be at the facility. V11 said, "Next thing I know, about 5:00 PM, the facility called me and stated my father had fallen and the ambulance was on its way." V11 stated the facility said that R1 hit his head so it was protocol to send him to the local hospital. V11 stated the hospital just did a cat scan	S9999		

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S9999	Continued from page 3 on R1's head that came back negative and R1 was sent back to the facility. V11 stated her father has advanced dementia. V11 said she saw her father about mid night at the facility when he came back from the hospital on June 14, 2025. V11 said she saw her father in the evening on Saturday June 14, 2025, and her father was grabbing his side. V11 stated she demanded X rays from the facility because when she saw her father on June 15, 2025, R1 was still in pain and holding onto his right side. V11 stated her father was in pain each time he took a deep breath. V11 stated she never saw her father like this. V11 stated the facility got X rays done and the facility called her and said R1 had a broken rib. The facility told V11 that they were sending R1 back to the local hospital. On June 25, 2025, at 2:00 PM, V3 Assistant Director of Nursing stated R1 had a fall shortly after he arrived at the facility. V3 stated the facility called R1's daughter (V11) and told her about the fall. V3 stated that V11 told her that R1 should have been 1:1. V3 stated the facility was not aware of that and the hospital that R1 came from did not report that to the facility staff. R1's Medication Administration Record shows he received tylenol 650 mg (milligram) for pain rated at a 5/10 on June 14, 2025. R1's Progress Notes dated June 15, 2025, by V8 RN shows, "At approximately 11:30 AM, the resident's daughter arrived at the facility and informed the nurse on duty that the resident was experiencing pain on the right side near the rib area, as well as in both hips. Nurse Practitioner ordered a stat bilateral rib x ray and bilateral hip x ray." R1's Radiology Results Report dated June 15, 2025, shows, "Minimally displaced fracture of the right eighth rib laterally." The facility's Accidents and Supervision policy dated 2024 shows, "The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents. Supervision is an intervention and a means	S9999		

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S9999	Continued from page 4 of mitigating accident risk. The facility will provide adequate supervision to prevent accidents." (B)	S9999		