STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145151	A. Building B. Wing	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allure of Mendota	1201 First Avenue Mendota, IL 61342

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31285 Based on record review and interview, the facility failed to verify a resident's code status prior to starting CPR/Cardio-Pulmonary Resuscitation for one of three residents (R1) reviewed code status in the sample of three. Findings include: The facility's undated Residents' Rights Regarding Treatment and Advance Directives policy documents, Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to staff. The facility's undated Communication of Code Status policy states: It is the facility's policy to adhere to residents' rights to formulate advance directives. In accordance with these rights, the facility will implement procedures to communicate a resident's code status to those individuals who need to know. Designated sections of the medical record are: miscellaneous tab under Advanced Directives. Additional means of communication of code status include: PCC/Point Click Care (the facility's electronic medical record data system) under resident's name is code status. R1's medical record documents R1 was admitted to the facility from the hospital on [DATE] with the following diagnoses: Acute Respiratory Failure with Hypoxia; Chronic Obstructive Pulmonary Disease; Chronic Kidney Disease; Congestive Heart Disease; Hypertension and Diabetes Mellitus Type 2. R1's medical record included a POLST/Physicians Order for Life Sustaining Treatment Form, signed and dated [DATE] by R1 and V16 (R1's Physician). This POLST documented R1's code status was, Do Not Attempt Resuscitation/DNR. R1's Health Status Note by V4 RN/Registered Nurse, dated [DATE] at 3:25pm, documented R1 was admitted by V4 on [DATE] at 3:25pm. V4 documented R1 was alert and oriented, able to answer all questions appropriately. V4 documented R1's code status as Full Code. R1's Health Status Note by V5 LPN/Licensed Practical Nurse, dated [DATE] at 2:25am, documents V5 found R1 unresponsive, pulseless, without respirations, and unable to auscultate an apical pulse. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1:41pm, V5 LPN stated, during shift change on [DATE], V14/LPN reported that R1's code status was DNR/Do Not Resuscitate. V5 stated he did not check R1's electronic medical record for verification of R1's code status or POLST form at that time. V5 stated when they found R1 unresponsive, pulseless and without respirations, V5 did not start Cardio-Pulmonary Resuscitation/CPR, based on the verbal report V5 received when coming on duty. V5 stated he called V6 RN/Registered Nurse on a separate hall, to verify R1's death and attempted to notify R1's POA/Power of Attorney and family members of her passing. V5 stated he then called the on-call Nurse (V4 RN) to report (R1's) death. V3 ADON/Assisted Director of Nursing then called the facility and told V5 R1's code status was Full Code. At that time, V5 stated he called [DATE] (emergency services) and directed V6 RN, V7 and V8 CNAs to start CPR. V5 stated V2 DON/Director of Nursing called the facility shortly after CPR was started and informed V5 that R1's code status is DNR. V5 stated he then located R1's POLST/Physicians Order for Life-Sustaining Treatment Form in R1's electronic medical record documenting R1's DNR code status and informed staff to stop CPR. On [DATE] at 10:45am, V4 stated she was the admitting nurse for R1 on [DATE]. V4 stated she called the admitting hospital for report from R1's nurse, who stated R1's code status was a Full Code. V4 stated R1 did not voice her code status to V4 during the admission process. V4 stated on [DATE], she passed on during report to V15/LPN/Licensed Practical Nurse, the oncoming night shift nurse, that R1's code status was a Full Code. V4 confirmed R1's code status was a DNR, and she had passed on incorrect information after admitting R1. V4 stated CPR was started when R1's code status was DNR per R1's POLST form. V4 stated she did not verify R1's code status by checking R1's POLST form sent with R1 on admission. On [DATE] at 11:05am, V12 MDS/Minimum Data Set Coordinator stated R1's POLST form that R1 admitted with on [DATE] documented R1 as a DNR. On [DATE] at 11:12am V13 Social Services Director stated R1 was admitted to the facility from the hospital on [DATE] with transfer orders and a signed POLST Form documenting R1's code status as (Do Not Resuscitate) DNR. V13 stated R1 was alert and oriented when she met with R1 upon admission to the facility and confirmed R1's DNR code status with R1, personally. V13 stated R1 confirmed her code status as DNR.