STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145443	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allure of Zion	3615 16th Street Zion, IL 60099

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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33760 Based on interview and record review, the facility failed to complete skin assessments for 4 weeks prior to identifying a resident's pressure injury that was unstageable when identified. This failure applied to 1 of 3 residents (R1) reviewed for pressure injuries in the sample of 4. The facility's failure to assess the resident's skin led to staff not identifying the resident's pressure injury until it was unstageable and then progressed to a Stage 4, which required wound debridement. The findings include: R1's face sheet shows R1 is [AGE] year-old with diagnoses that include diabetes mellitus, liver cirrhosis and stroke. R1's facility assessment dated [DATE] show R1 has moderate cognitive impairment. R1's Braden scale (predicting pressure score risk), dated 11/3/23, shows R1 is at risk for developing pressure ulcers/injuries. R1's Skin Evaluation dated 11/3/23 shows a skin issue-pressure ulcer/injury, location-coccyx, unstageable measuring 2.0 centimeters (cm) x 1.0 cm, wound bed with slough (yellow white material in the wound bed). A Wound Physician note dated 11/8/23 shows R1's pressure injury was now at a stage 3 measuring 1.8 cm x 0.6 cm x 0.3 cm. to sacral area (coccyx). A Wound Physician note dated 12/13/23 shows R1's sacral wound had deteriorated to stage 4 measuring 2. 0 cm x 0.3 cm x 0.3 cm and a surgical excisional wound debridement done due to necrotic tissues in the wound. On 4/1/24 at 11 AM, V5 (R1's granddaughter-POA-power of attorney) stated R1 was now in the hospital due to R1's large wound in her back. The wound in R1's back had developed at the nursing home. R1 was now at a local hospital on hospice as R1's family decided for R1 to be made comfortable. V5 stated during her visits, R1 would be laying on her back for long periods of time. V5 stated she was aware of R1's wound but was not aware how large the wound was, the bone was exposed. V5 stated the hospital told her that it was possible the wound was infected. (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
	145443	A. Building B. Wing	04/03/2024

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Allure of Zion	3615 16th Street Zion, IL 60099

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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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R1's care plan with date initiated 11/6/23 shows: Stage 4 sacrum with goal: wound will show sign of improvement and remain free from deterioration or infection, intervention to include: educate the resident/family caregivers as to the causes of skin breakdown including transfer/ positioning requirements, good nutrition, and frequent repositioning. On 4/1/24 at 1PM, V4 (Facility Wound Physician) stated she had seen R1's facility-acquired sacral wound weekly at the facility until the week prior to R1 being sent to the hospital. R1's wound had gotten worse as the depth was greater. V4 stated she had debrided R1's wound more than once and adjusted R1's wound treatments. V4 stated she cannot say if R1's wound was avoidable or unavoidable. V4 stated residents with pressure injuries should be turned and repositioned every 2 hours- offloading is important for wound healing. On 4/3/24 at 12PM V2 (Director of Nursing-DON) confirmed with this surveyor that R1 had no skin assessments performed and signed off by nurses for approximately 4 weeks prior to the discovery of R1's sacral wound as unstageable to stage 3 and eventually declined to stage 4. (R1's last skin assessment was done on 10/3/23 then not again until 11/3/23 when R1's sacral wound was discovered.) V2 DON stated she will again implement skin assessments weekly and as needed. The Facility Policy Entitled Pressure Injury Prevention and Management (undated) show, The facility is committed to the prevention of avoidable pressure injuries unless clinically unavoidable and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcer/injuries.