

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145443	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2024
NAME OF PROVIDER OR SUPPLIER Allure of Zion		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.</p> <p>34490</p> <p>Based on interview and record review the facility failed to ensure a resident was notified in writing of a facility-initiated room change and failed to ensure the resident was shown the new room and introduced to her new roommate before the room change for 1 of 3 residents (R1) reviewed for room changes in the sample of 9.</p> <p>The findings include:</p> <p>R1's Census Report shows that she was transferred to another room on 11/25/24.</p> <p>On 12/4/24 at 9:30 AM, R1 stated that a male resident came into her room and kissed her on the cheek and after the facility heard about the incident, they made her change rooms so R2 could not find her. R1 stated that she was upset because she didn't understand why she had to change rooms when she did not do anything wrong. R1 stated that she really liked her previous room because she had a nice view out the window. R1 stated that after her room transfer, she did not get along with the other resident in the room due to her keeping her TV very loud. R1 stated that she could not hear her visitors nor her own TV. R1 stated, I feel like I am getting punished for what happened. R1 stated that she did not get to see her new room or get introduced to her new roommate before she was transferred. R1 stated that she never received anything in writing about the room change.</p> <p>On 12/4/24 at 1:19 PM, V4 (Social Service Director) stated that the team had met and decided to move R1's room after the incident between R1 and R2. V4 stated, We always move the complainer. V4 stated that the admissions director fills out a form, but she is not sure if the resident gets a copy of the form or not. At 1:35 PM, V4 stated that she verified with admissions, and they do not give the resident anything in writing about the room change. V4 stated that the form is only filled out and filed for their records.</p> <p>R1's Room Change Notification Form shows that R1's room was changed on 11/25/24 and the reason for the change was due to bed management.</p> <p>There was no documentation in R1's electronic medical record regarding the room change on 11/25/24.</p> <p>(continued on next page)</p>

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
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<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's undated Change of Room or Roommate Policy shows, The notice of change in room or roommate will be provided in writing, in a language and manner the resident and representative understands and will include the reason(s) why the move or change is required. Social Service staff will assist the resident to adjust to the new room or roommate by:. Involving the resident in the decision and selection of a room or roommate when possible Showing the resident where the room is located .Introducing the resident to his/her new roommate and sharing information about the new roommate .</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>34490</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident with wandering and aggressive behaviors was supervised and not allowed to enter other resident rooms for 1 of 1 resident (R2) reviewed for safety and supervision in the sample of 9.</p> <p>The findings include:</p> <p>On 12/4/24 at 9:45 AM, R2 was lying in bed. R2 was awake and speaking in Russian.</p> <p>On 12/4/24 at 1:13 PM, video footage from 11/24/24 was viewed. At 9:55 AM, R2 exited his room that is at the beginning of the hallway. R2 was walking independently. R2 walked about halfway down the hallway and entered a resident room at 9:57 AM. V8, Certified Nursing Assistant (CNA) went to the doorway of the room and R2 exited the room. R2 then proceeded down to the end of the hallway and V8 went in the opposite direction of R2. R2 then entered R1's room at 9:58 AM. At 9:59 AM, V6 (CNA) went into R1's room and came out of the room with R2. R2 then proceeded to walk the hallway.</p> <p>On 12/4/24 at 9:30 AM, R1 stated that a couple weeks ago (11/24/24) a man came into her room and placed his hands on her shoulders and kissed her cheek. R1 stated that once she noticed it was not her grandson, she started yelling for him to get out of her room. R1 stated that a nurse then came and took him out of her room.</p> <p>On 12/4/24 at 9:45 AM, V5 (CNA) stated that R2 frequently wanders and goes into other resident rooms. V5 stated that R2 attached her and grabbed her arm in the past.</p> <p>On 12/4/24 at 11:32 AM, V7 (CNA Supervisor) stated that R2 is very confused, cannot see very well, wanders and gets agitated very easily. V7 stated that R2 needs someone watching him at all times when he is wandering to make sure that he does not go in other resident rooms for his safety and the safety of other residents. V7 stated that R2 should not be going into other resident room because he is confused and we do not know what he will do in there. V7 stated that he needs to be watched a lot more than other residents. V7 stated that if R2 is getting close to an area where he should not go, staff should distract him with another activity.</p> <p>R2's Psychiatric Initial Evaluation dated 11/13/24 shows, The patient is a Russian-speaking gentleman with a history of traumatic brain injury (TBI) and dementia. He progressively exhibited aggressive behavior, both physically and verbally, towards his family .</p> <p>R2's Health Status Note dated 11/16/24 shows, .He grabbed [V5] right wrist and pulled it. [V5] c/o (complained of) pain in right wrist/shoulder. He held his slipper and tried to throw to [CNA]. Resident continued with aggressive behavior .</p> <p>R2's Psychiatric Evaluation dated 11/20/24 shows, The patient displayed aggressive outbursts and physically confronted the staff. The staff was unable to de-escalate the situation, and Haldol 2.5 mg (milligrams) was ordered to protect the patient from harming himself and others.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R2's Behavior Note dated 11/21/24 shows, At 8:00 AM, resident noted walking in hallway, [CNA] was following him with his wheelchair, he was very agitated, aggressive/combatative, not cooperative, once this writer and other CNA tried to approach to him he became more agitated, waving his hand to them, refusing to sit on wheel chair, wanted to enter other resident's room. He punched 2 CNA. He was extremely difficult to handle</p> <p>R2's Care Plan printed on 12/4/24 show, The resident is an elopement risk/wanderer r/t (related to) disoriented to place, history of attempts to leave facility unattended, impaired safety awareness. This was initiated on 12/4/24 with interventions to include: Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers: [blank] . Identify pattern of wandering .Intervene as appropriate .</p>		