

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  01/08/2025
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>40085</p> <p>Based on interview and record review the facility failed to carry out a physician order for an Infectious Disease consultation for 1 of 3 residents (R2) reviewed for Quality of Care in the sample of 9.</p> <p>The findings include:</p> <p>On 1/8/25 at 10:45 AM, R2 was in bed and appeared drowsy and unable to stay awake during a conversation with this surveyor. Outside of R2's doorway was a sign indicating she (R2) is on contact isolation.</p> <p>R2's urinalysis report dated 12/19/24 shows her urine tested positive for ESBL (extended-spectrum beta-lactamases) via a urine culture that was completed on 12/22/24.</p> <p>A facility provided timeline for R2 shows R2 had a Urinary Tract Infection (UTI's) on 9/11/24 which did not require treatment. One 10/25/24 which required antibiotic usage and another on 12/19/24 which also required antibiotic treatment, with Ertapenm sodium solution for 7 days.</p> <p>On 1/8/25 at 11:44 AM, V4 (Nurse Practitioner) stated she had been monitoring R2's increase in UTI's and her recent diagnosis of ESBL in her urine and decided she should refer her to an Infectious Disease doctor for further consultation as R2 has been overall declining. V4 stated a couple weeks ago she gave an order to V5 (Registered Nurse/RN) to start the referral process because it can take a while to get in to see the physician sometimes. V4 stated she was looking at R2's Physicians orders today and did not see that the order was ever entered by V5, so she entered it herself. V4 stated she expected when she gave the order to V5 she would enter it the same day and start the process and call for the appointment. V4 was able to indicate it was 12/26/24 when she gave V5 this order because of the charting in R2's medical record completed by V5.</p> <p>R2's nursing progress notes completed by V5 on 12/26/24 do not show any order or documentation about R2 being referred to an Infectious Disease doctor by V4.</p> <p>On 1/8/25 at 12:26 PM, V5 (RN) stated now that she thinks about it, she does remember V4 giving her an order for two residents to see the Infectious Disease doctor and that she (V5) did not enter the order for R2 and did not call for an appointment.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/8/25 at 2:31 PM, V2 (Director of Nursing) stated she was not aware before today of V5 not carrying out the order for R2 to see the Infectious Disease doctor. V2 stated she would expect nurses to carry out any physician order immediately and to start the referral process.</p> <p>On 1/8/25 at 2:32 PM, V3 (Assistant Director of Nursing) stated the Infectious Disease doctors will sometimes do a tele health appointment which can be done usually pretty quick, and the facility also has transportation to get residents to appointments so if V5 had started the process R2 could have possibly been seen quick.</p> <p>The facility provided undated Consulting Physician/ Practitioner Orders policy that shows the nurse should note and carry out a physicians order.</p>		