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	04/30/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 22499 Based on interview and record review the facility failed to ensure a residents-controlled medication was misappropriated. This applies to 1 of 10 residents (R1) reviewed for controlled medications in the sample of 10. The findings include: The Facility Reported Incident dated 4/28/25 states, Nurse (V4- Licensed Practical Nurse- LPN) wrote a statement stating she believed she threw the meds in the garbage. Writer looked through several garbage bags and was unable to locate the missing medication. Writer noted per narcotic sign out sheet that med was last administered 4/25/25 at 9:00 AM. Writer asked nurse if med was administered throughout her shift, and she stated yes. Writer asked why med was not signed out on MAR (Medication Administration Record) or paper record. Nurse stated she forgot and at this time she recorded administration. Nurse left the building at this time. This same document states, Cameras reviewed showing nurse in 200 preparing medications. Per video footage, nurse appears to empty bottle of tablets and toss the bottle in the garbage. On 4/30/25 at 10:00 AM V3 (Assistant Director of Nursing) stated, The resident's Ativan (Lorazepam) tablets are in a bottle- that is how hospice sends them to us. The resident is not able to say if she got an Ativan or not. (V4) was working a double shift and she said she gave the Ativan at 6:35 PM. We watched the cameras and saw her preparing the medication but never saw her administer the medication. They were doing the narcotic count from nights to days and (V5- LPN) noticed that the count was off and (V4) called me. There were 11 tabs in the bottle. I told (V4) to wait for me I would be there in 15 minutes but when I got here, she was gone. I called her and she returned in about 20 minutes. (V6- LPN) had gotten report from (V4) and said she had some paranoid behaviors. (V4) had access to the 200 and the 400 cart. At this point she is suspended and when the investigation is complete, she will probably be terminated. We are just trying to go through all the steps of the investigation. On 4/30/25 at 10:30 AM V6 (Wound Care- LPN) stated, I don't usually work the floor- I am the wound nurse. But that day they needed a nurse on the floor, and I came in early to help out until they could find someone. I got report from (V4) for the 400 hall. I asked her a question and she jumped back and said something like she didn't want anyone around her. She was acting very paranoid. I have not really worked with her, but the other nurses say that she raises her voice to them a lot and she is loud. (continued on next page)

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/25 at 11:00 AM V5 stated, We were doing the count and there was no bottle for the one paper. The resident (R1) had 2 bottles, and the one said 29 and it was correct. The other one said 11 and there was no bottle. The other nurse started looking for it and said she might have thrown it away. She said she gave 2 tabs, I think. One from the one bottle and one from the other bottle and then threw the bottle away. I told her to call the DON/Director of Nursing or the ADON and she did. She was acting normal. Resident was acting normal throughout the day; I didn't see anything different with her. On 4/30/25 at 12:05PM V4 stated, I was giving (R1) a dose in the evening around 6:30 and I must have thrown the whole bottle with the other 10 pills into the garbage. I put the med into the cup then I just tossed the others in the garbage. In the morning when we were counting, she noticed the bottle was missing and I thought, shoot I must have thrown it in the garbage. I might have given her another dose in the morning. When we counted in the morning there were 30 in the bottle. I offered to go through the garbage and look for it, but I know the maintenance had already taken the garbage out the night before. I used to work for waste management, I had no problem going through the garbage. I had already left with (V3) pulled in the parking lot. She called me and asked me to come back, and I said no problem and turned around to come back. (V3) talked to me and I wrote a statement and then I left. HR/Human Resources called me yesterday and told me I was suspended pending the investigation. V4's written statement dated 4/28/25 states, To whom it may concern, on 4/27/25 I accidentally threw away a bottle of Lorazepam 0.5 mg 10 tablets after giving medication. I did (didn't) realize until counting, that the bottle was no longer there. I looked through the morning garbage, it wasn't there. The evening garbage was removed by 9:00PM. I do remember that I threw bottle in the garbage without realizing there were still 10 pills in the bottle until count this morning at 7:00 AM. R1's April MAR shows she has an order for Lorazepam 0.5 mg every 4 hours as needed for increased Anxiety. This document shows that V4 signed out 1 tablet at 6:35 PM on 4/27/25. R1's Controlled Substances Proof of Use form for bottle #1 shows that V4 signed out 1 tablet of Lorazepam 0.5 mg (Antianxiety) at 6:35 PM on 4/27/25. This left 10 tablets left in the (missing) bottle. The facility policy entitled Controlled Substance Administration and Accountability, Reviewed /revised on 4/29/25 states, It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure. This same policy states, Staff may not leave the area until discrepancies are resolved or reported as unresolved discrepancies.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 22499 Based on interview and record review the facility failed to ensure the accurate reconciliation of a controlled substance. This applies to 1 of 10 residents (R1) reviewed for controlled substances in the sample of 10. The findings include: The Controlled Substance Proof of Use form for Bottle #2 shows 1 tablet removed from the bottle of 30 on 4/28/25, leaving 29 tablets. There is no time as to when this medication was administered and no signature from the person that administered it. The next entry is 4/28/25 at 9:30 PM given by V7 (Licensed Practical Nurse- LPN), leaving 28 tablets. R1's April MAR (Medication Administration Record) shows she has an order for Lorazepam 0.5 mg every 4 hours as needed for increased Anxiety. This document shows that V4 (LPN) signed out 1 tablet at 6:35 PM on 4/27/25 and V7 (LPN) signed out 1 tab at 9:30 PM on 4/28/25. There is no Lorazepam signed out on 4/28/25 prior to the 9:30 PM dose. On 4/30/25 at 12:05PM V4 stated, I might have given her another dose in the morning. When we counted in the morning there were 30 in the bottle. On 4/30/25 at 12:15 PM V3 stated, (R1) doesn't take it that often so it would have been strange for her to take 2 so close together. I didn't know about this missing dose until (V7) brought it to my attention. It either had to be given by V5 (LPN) or V4. V4 signed out the one tab after we discovered the missing bottle, I don't know why she wouldn't have signed out the other one at the same time. On 4/30/25 at 12:20 PM V5(LPN) stated, I didn't give (R1) anything (Lorazepam) on day shift. When we were counting (V4) wrote it in on the sheet. There was 29 in the bottle and she filled out the sheet and said she gave one from one bottle and one from the other bottle. They can see, they have cameras and they can see that she signed it then. One bottle was missing and the other one had 29. The facility policy entitled Controlled Substance Administration and Accountability last reviewed/revised on 4/29/25 states, All controlled substances obtained from a non-automated medication cart or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided .