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	06/26/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to supervise a resident at high risk for falls for one of six residents (R1) reviewed for safety/supervision in the sample of six. This failure resulted in R1 experiencing a fall and rib fracture that resulted in R1 transferring to the local hospital. The findings include: R1's Discharge paperwork from the local hospital shows R1 was admitted to the local hospital from [DATE]-June 13, 2025, with diagnoses of wet gangrene, osteomyelitis, and dementia. R1's admission Record dated June 25, 2025, shows he was admitted to the facility on [DATE] with diagnosis of vascular dementia. R1's Fall Risk assessment dated [DATE], shows R1 was a high risk for falling with a score of 16. On June 25, 2025, at 12:44 PM, V9 Registered Nurse (RN) stated R1 arrived in the facility prior to her getting to the facility for her shift that started at 3:00 PM. V9 stated when she arrived for her shift, R1 had not been admitted by a nurse yet. V9 stated she did rounds on R1 first since he was not officially admitted by a nurse yet. V9 stated during report she (V9) was told R1 was a high fall risk. V9 stated she gave R1 a urinal, oriented R1 to his room and asked R1 to use the urinal and his call light. V9 stated she was at the nurse's station when the Certified Nursing Assistant (CNA) came and got her because R1 had fallen. V9 stated R1 reported head and back pain. V9 stated R1 was sent to the hospital since the fall was unwitnessed and R1 reported that he hit his head. (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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On June 25, 2025, at 1:31 PM, V10 CNA stated she got to work at 2:00 PM and got report from the other CNA. V10 stated she got report that there was a new admission, but he had not been checked in by the nurse or CNA. V10 stated she asked the day nurse who was going to do R1's admission, and the day nurse said the 2nd shift nurse was going to do R1's admission. V10 stated that R1 was at the facility before her shift started at 2:00 PM. V10 stated the nurses get to the facility at 3:00 PM. V10 stated that at the time of R1's fall on June 13, 2025, she was performing incontinence care to R1's roommate. V10 stated she could hear R1 trying to get up from his bed because she could hear the mattress creaking. V10 stated she looked around the privacy curtain and asked R1 if he needed something. V10 said that R1 was sitting on the edge of the bed. V10 said that R1 told her that he needed to use the bathroom. V10 said she told R1 to use his urinal. V10 said she did not know if R1 could walk or not because he had not been evaluated by the nurse yet. V10 said there was a walker by R1's closet but she was not sure if it was R1's or not. V10 said she asked R1 if he wanted to use the walker and unfolded it. V10 said that R1 was still trying to get up without the walker when V10 left the room to throw away the trash from R1's roommate. V10 said, Obviously he did not wait for me. I heard a loud noise and the resident across from the hall from R1's room said R1 fell. V10 said R1 was on the floor in the fetal position. V10 said she thought R1 hit his head. V10 said that R1 was sent to the local emergency room. On June 24, 2025, at 4:32 PM, V11 (R1's daughter) said R1 was admitted to the facility June 13, 2025. V11 said R1 fell the day he got to the facility. V11 stated on June 13, 2025, she was waiting for a phone call from the facility telling her that R1 arrived at the facility because she knew that R1 would be disoriented and needed V11 to be at the facility. V11 said, Next thing I know, about 5:00 PM, the facility called me and stated my father had fallen and the ambulance was on its way. V11 stated the facility said that R1 hit his head so it was protocol to send him to the local hospital. V11 stated the hospital just did a cat scan on R1's head that came back negative and R1 was sent back to the facility. V11 stated her father has advanced dementia. V11 said she saw her father about mid night at the facility when he came back from the hospital on June 14, 2025. V11 said she saw her father in the evening on Saturday June 14, 2025, and her father was grabbing his side. V11 stated she demanded X rays from the facility because when she saw her father on June 15, 2025, R1 was still in pain and holding onto his right side. V11 stated her father was in pain each time he took a deep breath. V11 stated she never saw her father like this. V11 stated the facility got X rays done and the facility called her and said R1 had a broken rib. The facility told V11 that they were sending R1 back to the local hospital. On June 25, 2025, at 2:00 PM, V3 Assistant Director of Nursing stated R1 had a fall shortly after he arrived at the facility. V3 stated the facility called R1's daughter (V11) and told her about the fall. V3 stated that V11 told her that R1 should have been 1:1. V3 stated the facility was not aware of that and the hospital that R1 came from did not report that to the facility staff. R1's Medication Administration Record shows he received tylenol 650 mg (milligram) for pain rated at a 5/10 on June 14, 2025. R1's Progress Notes dated June 15, 2025, by V8 RN shows, At approximately 11:30 AM, the resident's daughter arrived at the facility and informed the nurse on duty that the resident was experiencing pain on the right side near the rib area, as well as in both hips. Nurse Practitioner ordered a stat bilateral rib x ray and bilateral hip x ray. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's Radiology Results Report dated June 15, 2025, shows, Minimally displaced fracture of the right eighth rib laterally. The facility's Accidents and Supervision policy dated 2024 shows, The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents. Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer medications as ordered by the physician for one of six residents (R1) reviewed for medications in the sample of six. The findings include: R1's Discharge Instructions from the local hospital dated June 13, 2025, shows R1 was admitted to the local hospital on June 4, 2025, with diagnoses including wet gangrene, osteomyelitis, and dementia. Amoxicillin-clavulanate (Augmentin 500 mg(milligram)-125 mg oral tablet/antibiotic) one tablet every eight hours with next dose due on June 13, 2025, at 5:00 PM was ordered by the discharging physician. R1's Physician Orders shows an order was entered for Augmentin one tablet three times per day for toe amputation with a start date of June 13, 2025. R1's Physician Orders show that R1 was admitted to the facility on [DATE]. R1's Medication Administration Record shows Augmentin was not administered until June 15, 2025, at 9:00 AM. On June 26, 2025, at 11:26 AM, via telephone interview with V2 Director of Nursing (DON), V2 stated R1's Augmentin was not delivered yet when the day nurse came on June 14, 2025. V2 stated the day nurse went to the facility's convenience box to look for Augmentin, but did not know the facility's convenience box had Augmentin in the box. V2 said R1's Augmentin was not delivered until the evening of June 14, 2025. V2 stated the facility's convenience box does contain Augmentin. At 11:47 AM, V3 Assistant Director of Nursing (ADON) stated V8 RN updated R1's Augmentin order on June 14, 2025, because the pharmacy said the medication was not available. R1's Administration Notes dated June 14, 2025, at 8:59 AM and 11:18 AM shows the Augmentin was not available. The facility's Medication Administration Policy dated 2025 shows, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.