

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 12/05/2025
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide incontinence care to a resident (R1) that is dependent on staff for incontinence care. This applies to 1 of 3 residents reviewed for ADL's (Activities of Daily Living) in the sample of 3. The findings include: R1's electronic face sheet printed on 12/4/25 showed R1 has diagnoses including but not limited to Parkinson's Disease, congestive heart failure, major depressive disorder, hallucinations, and anxiety disorder. R1's facility assessment dated [DATE] showed R1 has severe cognitive impairment, is incontinent of bladder, and requires staff assistance for personal hygiene. R1's care plan dated 7/22/24 showed, I have bladder incontinence .clean perineal area with each incontinence episode. On 12/4/25 at 10:10AM, R1 was sitting up in her (reclining wheelchair). The front of R1's pants were wet with an unknown substance and R1 had a strong urine odor. On 12/4/25 at 10:37AM, V4 (R1's daughter) stated, I have concerns with my Mom not being changed every 2 hours. She uses a (full body mechanical lift), and when they lift her up her pants are usually wet and the brief, she is wearing is brown and soaking wet. On 12/4/25 at 11:41AM, R1 was sitting up in her (reclining wheelchair) in the same position. The front of R1's pants were still wet. Surveyor notified (V5-Certified Nursing Assistant-CNA) that R1's pants were soiled. On 12/4/25 at 11:54AM, V5 came into R1's room and began wheeling her down the hallway. V5 stated R1 was not assigned to her; however, she believes R1 may have been changed around 8AM today. Surveyor questioned V5 as to if R1 gets changed in her room or the community bathroom and V5 stated, I will change her I guess but we usually change after lunch. V5 then brought R1 back to her room with V6 (CNA) and performed incontinence care. R1 was lifted up out of her chair and a strong urine odor was present. The front, back, and sides of R1's pants were wet. V5 and V6 removed R1's pants, revealing R1 was wearing 2 disposable incontinence briefs. V5 stated this is normal for R1 and that staff always put 2 briefs on her. When V5 removed R1's incontinence brief is was heavily soiled with urine and had a strong urine odor. At 12:23PM, V7 (CNA) stated she is assigned to care for R1 today and she has not provided incontinence care to R1 since her shift started at 8:00AM. V7 stated R1 is a night shift get up and is up before day shift arrives at 6:00AM every day. On 12/4/25 at 2:00PM, V2 (Interim Director of Nursing) stated, (R1) should not wear 2 incontinence briefs because that is just a way for staff to not have to change her as often. Her family never requested that. In my opinion, 6 hours is too long for a resident to go without being changed and even repositioned. This could contribute to urinary tract infections and skin breakdown. The facility's policy titled, Incontinence dated 2025 showed, Based on the resident's comprehensive assessment, all residents that are incontinent will receive the appropriate treatment and services. 4. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible.</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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure fall prevention measures were in place, failed to ensure skin tear prevention measures were in place. These failures apply to 1 of 3 residents (R1) reviewed for safety/supervision in the sample of 3. The findings include: R1's electronic face sheet printed on 12/4/25 showed R1 has diagnoses including but not limited to Parkinson's Disease, congestive heart failure, major depressive disorder, hallucinations, and anxiety disorder. R1's facility assessment dated [DATE] showed R1 has severe cognitive impairment, has skin tears, utilizes a chair alarm, and has experienced falls since admission to the facility. R1's care plan revised 10/10/25 showed, The resident is at risk for falls related to deconditioning/gait/balance problems .R1's care plan revised 10/27/25 showed, I have the potential impairment to skin integrity related to fragile skin .skin tears 8/1/25, 8/22/25, 9/3/25, 9/29/25, 10/10/25, 10/27/25 . (protective sleeves) in place to right and left arm .R1's physician's orders dated 1/6/25 showed, Clip alarm at all times. R1's physician's orders dated 10/9/25 showed, Apply (protective sleeves) to bilateral upper extremities for protection. R1's fall risk evaluation dated 9/1/25 showed R1 is at risk for falls. On 12/4/25 at 10:10AM, R1 was sitting up in her reclining wheelchair. One alarm was located on the back of each side of her chair, with the clips hanging down on either side, not clipped to her. R1 had a protective sleeve to her left arm but not her right arm. There was a protective sleeve in the chair next to her. On 12/4/25 at 11:41AM, R1 continued to have a protective sleeve on her left arm but not her right arm. R1's skin appears thin and dry with multiple areas of healed scabs and small, healing bruises. On 12/4/25 at 11:54PM, V5 (Certified Nursing Assistant-CNA) stated R1 is supposed to have 1 alarm clipped to her but she does not know why there are 2 alarms on her chair. V5 stated the alarms help to ensure staff are alerted when R1 leans too far forward or tries to get up so they can respond quickly and prevent her from falling. V5 stated R1 is supposed to have protective sleeves on her arms because she has fragile skin and has recently had multiple skin tears. On 12/4/25 at 2:00PM, V2 (Director of Nursing) stated, (R1) requires the use of an alarm at all times because she has a history of falls. I'm not sure why she would have had 2 alarms on her chair, but she does need 1 of them hooked to her at all times. She definitely needs the protective sleeves on because she has had several skin tears over the last few months due to her extremely fragile skin. The facility's policy titled, Accidents and Supervision dated 2025 showed, 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 .1. Implementation of Interventions- using specific interventions to try to reduce a resident's risks from hazards in the environment. The process includes .e. Ensuring that the interventions are put into action .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure glove changes were performed during incontinence care for a resident with a history of ESBL (Extended-spectrum beta-lactamase) in the urine. This applies to 1 of 3 residents (R1) reviewed for incontinence care in the sample of 3. The findings include: R1's electronic face sheet printed on 12/4/25 showed R1 has diagnoses including but not limited to Parkinson's Disease, congestive heart failure, major depressive disorder, hallucinations, and anxiety disorder. R1's facility assessment dated [DATE] showed R1 has severe cognitive impairment, is incontinent of bladder, and requires staff assistance for personal hygiene. R1's physician's orders dated 1/8/25 showed, Enhanced Barrier Precautions due to history of ESBL in urine. R1's care plan dated 7/31/25 showed, The resident requires Enhanced Barrier Precautions related to history of ESBL (Extended-Spectrum Beta-Lactamases) in the urine. wear personal protective equipment properly. On 12/4/25 at 11:54AM, V5 and V6 (Certified Nursing Assistants) provided incontinence care for R1. V5 removed R1's incontinence brief soiled with urine, cleansed R1's perineal area, applied a clean incontinence brief, assisted R1 with clean clothing, grabbed the mechanical lift remote, and combed through R1's hair without changing her gloves. V5 stated she was just nervous being observed and should have changed her gloves more often. V5 stated she can't remember why R1 is on precautions. On 12/4/25 at 2:00PM, V2 (Director of Nursing) stated, The aides should be changing their gloves when going from a dirty to clean task. She has a history of ESBL in her urine and we don't want to spread that around. They definitely shouldn't be touching surfaces of shared items with the same gloves either, that is an infection control concern.</p>		