

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  12/18/2025
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)		
F 0744  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.  (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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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to monitor dementia residents with wandering behaviors. The facility failed to immediately intervene and redirect dementia residents exhibiting wandering and dementia related behaviors. These failures apply to 2 of 3 residents (R1, R2) reviewed for dementia care in the sample of 4. The findings include: A facility report dated 12/8/25 showed V13 Certified Nursing Assistant (CNA) observed R1 lying next to R2 in R2's bed. R1 and R2 were fully dressed. The report showed video surveillance of the incident, reviewed by V1 Administrator, showed R1 entered R2's room at 5:31 AM on 12/8/25. R1 was not removed from R2's room by facility staff until 6:03 AM. R2 exited her room at 5:52 AM, on her own will. The report showed R1 and R2 both had a diagnosis of dementia. R2's admission record showed R2 was admitted to the facility on [DATE] and discharged home with family on 12/17/25. R2's care plan dated 11/24/25 showed R2 was cognitively impaired related to her diagnosis of dementia. R2's progress notes dated 11/22/25, 11/24/25, and 11/30/25 showed R2 would attempt to get up on her own and could propel herself in her wheelchair throughout the facility. R2's 11/30/25 note showed R2 was confused, keeps on going to other resident room, calling other male resident her husband. R1's care plan dated 10/16/25 showed R1 was severely cognitively impaired related to his diagnosis of dementia. The plan showed R1 wanders aimlessly throughout the building. The plan showed facility staff were to distract R1 from wandering, offering him pleasant diversions, and intervene as appropriate. Progress notes dated November 7, 16, and 29, 2025 showed R1 was found wandering at night throughout the facility. On 12/18/25 at 9:08 AM, this surveyor attempted to interview R1 about the incident on 12/8/25 however R1 could not be interviewed due to his impaired cognition. R1 was confused to person, place and time. R1 stated he didn't know R2. R1 denied any recollection of the incident on 12/8/25, stating, I don't remember anything. On 12/18/25 at 9:35 AM, V8 CNA stated on 12/8/25 she found R1 lying in R2's bed, fully dressed. V8 stated R2 was dressed, seated in her wheelchair, next to R1 as he laid in her bed. V8 stated she tried to get R1 out of R2's bed but R2 got verbally aggressive with V8. V8 stated she left R2's room and reported her findings to V9 Registered Nurse (RN) but (V9) was busy passing meds so I waited for the day shift to come in so they could help me get (R1) out of the bed. V8 stated she had no idea how long R1 had been in R2's room. On 12/18/25 at 9:49 AM, V9 RN stated on 12/8/25 he observed R1 lying in R2's bed. R2 was seated in a wheelchair in the room. V9 stated he did not immediately attempt to intervene or remove R1 from R2's bed because while V9 was aware R1 and R2 were severely cognitively impaired related to their dementia diagnoses, V9 stated, I didn't know if they were in some type of relationship. V9 stated he had no idea how long R1 had been in R2's room. V9 stated he knew both R1 and R2 had a history of wandering behaviors. On 12/18/25 at 12:28 PM, an attempt to contact V13 CNA via phone for an interview was unsuccessful. On 12/18/25 at 12:05 PM, V1 Administrator stated the facility no longer had video of the incident on 12/8/25 involving R1 and R2 for this surveyor to review. V1 stated he watched facility video recorded on 12/8/25. V1 stated the video showed R1 wandering all over the place for about an hour in the facility. V1 stated no staff were present during that time. V1 stated the video then showed R2 coming out of her room into the hallway to speak to R1. V1 stated, You see them talking in the hall. Then you see (R1) go into (R2's) room with her. Both residents are fully clothed. They are in (R2's) room for about 10-15 minutes. Our cameras only record what is in the hallway, not in resident rooms. Then you see (R2) propelling herself out of the room in her wheelchair. On 12/18/25 at 10:53 AM, V11 Family of R2 stated, (R2) is very confused. Her dementia is getting worse. She thinks every man is her husband. She could get around in her wheelchair. I asked her what happened (on 12/8/25). She told me (R1) laid with her on the bed. Both were fully clothed. The facility knew (R2) had these behaviors and were supposed to watch her, but I guess they weren't watching her that morning. On 12/18/25 at 11:40 AM, V3 Assistant Director of Nursing (ADON) stated if staff see a dementia resident wandering, they are to intervene and redirect the resident immediately. V3 stated facility staff were aware of R1 and R2's wandering behaviors prior to the incident on 12/8/25. The facility's Elopements and Wandering Residents policy (undated) showed, This facility ensures that residents that exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factor contributing to wandering or elopement risk. The facility's Dementia Care policy (undated) showed, it is the policy of this facility to provide the appropriate treatment and services to every resident who displays signs of, or is diagnosed with dementia, to meet his or</p>		