Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002646	A. BUILDING: ______ B. WING ______	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLURE OF MOLINE	430 SOUTH 30TH AVENUE EAST MOLINE, IL 61244

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 2320686/IL155721	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

These requirements were Not Met as evidenced by:

Based on interview and record review, the facility failed to provide timely radiology services for one resident (R1) of three residents reviewed for falls. This failure resulted in R1 not receiving an X-ray after a noted deformity to the left leg and being diagnosed with a left femur fracture that was not immobilized for over 24 hours with increased pain and decreased range of motion of the left leg.

Findings include:

Physician's Order Summary Report indicates R1 was re-admitted to the facility 1/3/23 with diagnoses that include Left Femur Fracture, Disc Degeneration.

Hospice Certification and Plan of Care dated 1/18/23 indicates R1 also has the following diagnoses:

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S9999	Continued From page 2 Malignant Neoplasm of Lung/Bronchus Malignant Neoplasm of Bone Malignant Neoplasm of Liver and Intrahepatic Bile Duct Dementia (unspecified) Chronic Pain Syndrome Comprehensive Assessment dated 1/8/23 indicates R1 had moderate cognitive impairments. Progress Note dated 12/30/22 at 2:30pm indicates staff reported that R1 was experiencing increased pain when attempting to remove the lift sling. Upon assessment R1 was noted to be lying in the bed with the lift sling under her and R1 did not want staff to remove the sling from under her because it "hurt too bad." When asked, R1 stated her "whole left leg hurt." Note indicates R1's left leg was assessed with no bruising, warmth or redness noted, however R1's left knee was slightly "bowed in." Note indicates that R1 was able to straighten her leg "with staff assistance." Note indicates R1 stated that she has an old injury and her "left lower extremity often bows inward and outward." Note indicates V2 (Director of Nursing/DON) was notified, and portable X-rays were ordered. Note indicates a narcotic pain medication was given for pain and discomfort. Physician's Orders indicate left hip/unilateral pelvis/left knee X-rays were ordered on 12/30/23 at 2:57pm. Progress Note dated 12/31/22 at 5:38pm indicates mobile X-ray company was called at 1pm (on 12/31/23) to check on the status of R1's X-ray. Note indicates mobile X-ray company confirmed they had an order for R1's X-ray	S9999		

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however they did not have a time frame for when the X-ray would be done.

Progress Note dated 12/31/22 at 10:20pm indicates staff notified the nurse that R1 was in excruciating pain, R1's leg was assessed by the nurse and found R1's left leg to be rotated inward. Note indicates "(R1) was screaming out in pain without any movement or touching." Note indicates new orders were received to transfer R1 to the hospital.

Hospital Radiology Report, dated 1/1/23 at 12:26am, indicates left femur fracture - no dislocation.

Progress Note dated 1/1/23 at 4:20am indicates R1 was admitted to the hospital with diagnosis of left femur fracture.

On 1/31/23 at 2:45pm, V5 stated (on 12/30/23) "R1 was fussing more than usual, complaining of pain all over - wasn't just her leg. V5 stated that she told V7 (Licensed Practical Nurse/LPN) that R1 was having pain. R1 prefers to have the sling left under her - doesn't want to be moved around. Always like that. R1 was screaming bloody murder. I know they didn't come to do the Xray when they should have."

On 2/1/23 at 10:20am, V7 (LPN) stated that R1 was getting pain medications around the clock to manage her pain. V7 stated when R1 was left alone, she was fine but had a lot more pain than usual when she was touched or moved. V7 stated that R1's left leg was turned inward. V7 stated when she came on shift (12/31/22), she noticed that R1's X-ray had still not been done, and that's when she called the X-ray company to find out when they were coming. V7 stated that she was

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confused when the X-ray company told her they didn't know when they could get to the facility. V7 stated "I really wasn't sure what to do. I thought we had to get the X-ray results before we could send a resident to the hospital - and the X-ray still hadn't even been done." V7 stated that she texted V3 (Assistant Director of Nursing/ADON) but wasn't told to send R1 to the hospital. V7 stated they have had ongoing problems with the mobile X-ray company not showing up and not notifying when they couldn't show up. V7 stated in the past, she's waited 2 or 3 days for them to finally show up to do an X-ray.

On 2/1/23 at 1:15pm, V2 (Director of Nursing/DON) stated that she was aware of the problems the nurses have had with the mobile X-ray company and a new company was to start (on 2/1/23). V2 acknowledged that if a resident's leg is turned inward and they are in a lot of pain - whether they fell or not - they should be sent to the hospital rather than waiting on X-rays as they are going to need surgery if there is a fracture. The standard is X-rays should be done within 4 hours if STAT and within 12 hours if routine.

On 2/1/23 at 2:30pm, V4 (Certified Nurse Assistant/CNA) stated, "I was still on the floor- around 2-2:30 pm (on 12/30/23) waiting for my replacement and heard R1 yelling in pain. R1 told me she was in pain and rubbing her leg. I pulled back the blanket and saw her leg/knee was turned inward and her foot was still straight. I knew not to touch her any further and notified the nurse."

MAR (Medication Administration Record) dated 12/2022 indicates R1 received Norco (narcotic) 5-325mg (milligrams) 10 times from 12/26 to 12/31 as needed for pain and only 6 times from

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S9999	Continued From page 5 12/1 to 12/25, 2022. X-rays that were ordered on 12/30/22 were not obtained with R1 being transferred to the hospital greater than 24 hours later to obtain X-rays to rule out fracture. (A)	S9999		