

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001515	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ALLURE OF MT CARROLL	STREET ADDRESS, CITY, STATE, ZIP CODE 1006 NORTH LOWDEN ROAD MOUNT CARROLL, IL 61053
---	--

(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 Annual Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and	S9999		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
06/07/24

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001515	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ALLURE OF MT CARROLL	STREET ADDRESS, CITY, STATE, ZIP CODE 1006 NORTH LOWDEN ROAD MOUNT CARROLL, IL 61053
---	--

(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
S9999	<p>Continued From page 1</p> <p>provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)</p> <p>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 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.</p> <p>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:</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review the facility failed to implement weight loss prevention interventions prior to a resident (R32) experiencing a significant weight loss. This failure resulted in R32 experiencing a significant weight loss of 9.6% in three months. This failure applies to 1 of 5 residents (R32) reviewed for</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001515	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ALLURE OF MT CARROLL	STREET ADDRESS, CITY, STATE, ZIP CODE 1006 NORTH LOWDEN ROAD MOUNT CARROLL, IL 61053
---	--

(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
S9999	<p>Continued From page 2</p> <p>weight loss in the sample of 14.</p> <p>The findings include:</p> <p>R32's admission care plan dated 12/29/23 showed R32 was at risk for malnutrition and weight loss related to her diagnoses of dementia, dysphagia (trouble swallowing), depression, and a history of pneumonia.</p> <p>R32's Weights and Vitals Summary showed R32's weights as 156 pounds (lbs.) on 2/6/24, 151 lbs. on 3/4/24, 147 lbs. on 4/17/24, and 141 lbs. on 5/3/24. The record showed R32 experienced a significant weight loss of 9.6% in three months, from 2/6/24 - 5/3/24.</p> <p>R32's Mini Nutritional Assessment dated 4/22/24 showed R32 was deemed at risk for malnutrition and weight loss by V3 (Registered Dietician/RD). The assessment showed V3 RD documented R32's weight as 147 lbs., which showed R32 had experienced a nine-pound weight loss since 2/6/24, but no weight loss preventions, such as supplements and/or supervised dining, were initiated at that time.</p> <p>R32's dietary note dated 5/8/24 showed R32 had sustained a significant weight loss in three months (2/2024-5/2024). The note showed R32 "would benefit from ONS/tray additions (supplements added to food tray) to aid in weight management/caloric intakes." The note showed supervised dining, nutritional juice, nutritional shakes, and house supplements were to be initiated at that time.</p> <p>R32's May 2024 physician orders showed a house supplement, nutritional juice, and nutritional shakes were started on 5/9/24.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001515	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ALLURE OF MT CARROLL	STREET ADDRESS, CITY, STATE, ZIP CODE 1006 NORTH LOWDEN ROAD MOUNT CARROLL, IL 61053
---	--

(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
S9999	<p>Continued From page 3</p> <p>R32's current care plan showed supervised dining for R32 was started on 5/21/24.</p> <p>On 5/21/24 at 11:05 AM, V3 (Registered Dietician) stated prior to 5/21/24, she had last assessed R32, in-person, in January 2024. V3 stated the Mini Nutritional Assessment she completed on R32 in April 2024, was completed remotely. V3 stated, "I completed her assessment by reviewing (R32's) information via the computer. I didn't see her in-person." V3 stated the facility monitors residents weight loss, weekly, to intervene before any weight loss becomes significant. V3 stated, "I did document she was at risk for weight loss in April (2024). She had also been recently hospitalized which could potentially put her more at risk." When V3 was asked why R32 was not started on weight loss supplements and supervised dining until after R32 had sustained significant weight loss, V3 stated, "I don't have a wonderful answer for you. I should have started her on supplements sooner ..."</p> <p>The facility's Nutrition at Risk policy dated 9/16/23 showed, "Weight loss, poor nutritional status, or dehydration should be considered avoidable unless the facility can prove it has assessed/reassessed the resident's needs, consistently implemented related care planned interventions, monitored for effectiveness, and ensured coordination of care among the disciplinary team. Early identification of risk factors, regardless of the presence of any associated weight changes, can help the facility choose appropriate interventions to minimize any subsequent complications ..."</p> <p>The facility's Weight Monitoring policy dated 2/22/23 showed, "A significant change in weight is</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001515	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ALLURE OF MT CARROLL	STREET ADDRESS, CITY, STATE, ZIP CODE 1006 NORTH LOWDEN ROAD MOUNT CARROLL, IL 61053
---	--

(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
S9999	Continued From page 4 defined as: 5% change in weight in 1 month, 7.5% change in weight in 3 months, 10% change in weight in 6 months." "B"	S9999		