STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145024	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allure of Pinecrest	414 South Wesley Avenue Mount Morris, IL 61054

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38488 Based on interview and record review the facility failed to ensure a resident was treated in a dignified manner for 1 of 3 residents (R1) reviewed for dignity in the sample of 6. The findings include: R1's face sheet showed she was admitted to the facility on [DATE] with diagnoses to include restless legs syndrome, Alzheimer's Disease, idiopathic neuropathy, diastolic congestive heart failure, chronic kidney disease, peripheral vascular disease, primary osteoarthritis, lymphocytic colitis, anxiety disorder, spinal stenosis, major depressive disorder, and bilateral sensorineural hearing loss. R1's facility assessment dated [DATE] showed R1 has moderate cognitive impairment and requires partial to moderate assistance with dressing and personal hygiene and supervision or touching assistance with transfers. R1's Social Services note dated 5/1/24 showed, Writer met with resident to inquire of any interaction that occurred previous day between resident and staff. Resident was quick to recall and to share with writer details of interaction between her and 2nd shift CNA (Certified Nursing Assistant) without hesitation. Resident was appreciative of follow up. The facility's investigation showed an incident occurred on 4/30/24 involving R1 and V6 CNA (Certified Nursing Assistant). (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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NAME OF PROVIDER OR SUPPLIER Allure of Pinecrest		STREET ADDRESS, CITY, STATE, ZIP CODE 414 South Wesley Avenue Mount Morris, IL 61054	

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/24 at 1:11 PM, R1 stated earlier in the day (4/30/24) after lunch she was not feeling well. R1 stated a CNA came to her room and took her vitals and told her the nurse would be coming down to see her. R1 state a nurse checked her out between lunch and dinner and told her she would not be going to the dining room, so she went ahead and put on her pajamas. R1 state a little bit later, V6 opened the door and said, come on, we are going to dinner. R1 stated she couldn't remember everything that V6 said to her but that she was trying to take her blanket off her lap the whole time she was in the room. V6 stated she held onto the blanket but V6 was stronger than her, so she did take the blanket away. R1 stated she told V6 she was not going down to the dining room and that V6 kept saying yes you are. R1 stated then another woman came into her room (V5) and saw she was wearing her nightgown. R1 stated the lady who had been yelling (V6) whispered something to V5 who just came into the room. R1 stated she heard V6 say 'why didn't they tell me that?'. R1 stated she asked [V6] if she would mind putting her wheelchair back where she got it from and also told [V6] she should apologize for the way she spoke to her. R1 stated V6 had been yelling and being loud. R1 stated V6 told her you think this is loud, you haven't seen anything yet. R1 stated it made her feel scared when V6 made that statement. R1 stated the first time she said anything about it was to V4 RN (Registered Nurse) after dinner. On 5/15/24 at 2:01 PM, V6 CNA stated, I worked there up until a couple of weeks ago . [R1] was very nasty toward me because I wasn't her primary CNA . She is nasty to all new faces . I went back in at about 4:15 PM to get her up for dinner. She was being nasty to the other CNA too. I took her blanket off her lap, and she wouldn't let me have it. Then [V5] took her blanket off of her and that's when I saw she had her pajamas on so I knew she couldn't go down to the dining room like that . [R1's] tone of words were sharp, short, and not friendly at all. She is also confused and should be on the Alzheimer's unit in my opinion. On 5/15/24 at 2:15 PM, V5 CNA stated, I was outside the room and V6 CNA heard me in the hall. She asked me to come in and help her. [R1] had a blanket on and I took her blanket off her lap and saw she was in her nightgown. At that time, I just said, 'Looks like we get her a tray' . I never heard her say anything bad to anyone. I did hear that there were other residents on another wing that were complaining about [V6]. [V6] could not have been in [R1's] room very long before I got in there . When we got into the hallway [V6] made a 'not too smart' comment. It sounded like [R1] must have said something to [V6] before I went into the room about [V6] being 'nasty to her'. Then in the hall [V6] said to me 'hasn't seen nasty yet'. I was thinking why would you say something like that out loud in the hall. I told her she should not have said that. We were 100% without doubt in the hallway when she said it but [R1] could have heard it. Other people could have heard it too. [R1's] room is at the beginning of the hall so there could have even been people around the corner hear her. On 5/15/24 at 11:33 AM, V4 RN (Registered Nurse) stated when she came onto her shift on 4/30/24 she received in report that R1 was already in her pajamas and was going to stay in her room for dinner. V4 stated she did hear someone say something about nasty or you haven't heard or seen nasty yet but when she looked down the hall, she didn't see anyone. V4 stated when she took R1's medications into her room after dinner R1 told her about the incident with V6. V4 stated R1 told her V6 ripped her blanket off her lap, told her she was going down for dinner, and was yelling at her. V4 stated she called V1 (Administrator) right away and V1 spoke with R1 on the phone to find out what happened. V4 stated V1 told her V6 would be dismissed from her shift while an investigation was conducted. V4 stated she had heard complaints from residents before regarding V6's abrasive tone. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/24 at 2:53 PM, V9 CNA stated she was not present when the incident occurred but that she was assigned to R1's hall after V6 was sent home. V9 stated R1 did not say anything to her at all that night about V6. V9 stated her experience with V6 is that she is very rude to both staff and residents at times and quite a few residents have complained about her tone. V9 stated V6 would use swear words toward staff within ear shot of residents as well. On 5/15/24 at 2:40 PM, V1 Administrator stated, . I interviewed [R1] on the phone when I was told about the incident. [V4 RN] said [R1] didn't want to go to dinner because she had diarrhea and that [V6] was rude to her. When I spoke with [R1] she told me about the [V6] grabbing her blanket off of her and that's when she told me about the comment . [V6] was suspended immediately pending investigation . [V6] had certain halls she liked to work and if she wasn't on those halls, she would complain . We talked about her tone a lot. [V6] called and terminated her own employment during the investigation . V1 stated V6 would have been terminated by the facility had she not self-terminated her employment. The facility's policy and procedure with review date of 12/1/23 showed, Promoting/Maintaining Resident Dignity . Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Compliance Guidelines: 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. 2. During interactions with residents, staff must report, document and act upon information regarding resident preferences . 5. When interacting with a resident, pay attention to the resident as an individual . 10. Speak respectfully to residents; avoid discussions about residents that may be overheard .