

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145024	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/07/2025
NAME OF PROVIDER OR SUPPLIER  Allure of Pinecrest		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0689  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (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 0689</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 ensure the safety and supervision was maintained for 2 of 3 residents (R1, R2) reviewed for elopement in the sample of 3. The findings include: On 8/6/2025 R1 was observed in the activity room, sitting in a recliner. R1 looked at surveyor and smiled when surveyor waved at him. R1 was observed at 3:46 PM in the dining room in another activity. R1 was sitting at a table with other residents and their family. R1 was smiling while sitting at the table. R2 was observed on 8/6/2025 sleeping while sitting up, on a couch on the 300 wing. R2 was observed on 8/7/2025 during the lunch meal eating. V2 (unit coordinator/social services) was sitting next to R2 encouraging intakes. R2 was observed being assisted with walking to his room and being provided personal cares. R2 was resistive to care at first, but staff were able to convince R2 to allow them to assist him. On 8/6/2025 at 3:07 PM, V3 (Licensed Practical Nurse-LPN) said she was not working when the incidents occurred. V3 said she was told R1 and R2 both got off the memory care unit. V3 said R1 and R2 both have a wander guard in place. The wander guards work for the main entrance to the memory care unit. They do not work for the exit doors. V3 said at the beginning of her shifts, she checks to make sure all the exit doors are secure and do not open when she pushes on them. V3 said she makes sure the light is blinking; that means the door is secure and locked. V3 said she makes sure the alarm sounds when the handle is pushed in. V3 said R2 is new to the facility and staff. He has been at the facility for less than a week and staff are all getting to know him. He walks a lot. Today he has been pushing the door. It will make the initial sound, and he would walk away from it. He has done it at least once, maybe a couple times. V3 said it was on second shift that R2 got out. She is not sure what shift R1 got out. V3 stated, I am a floor nurse. my job is to keep the residents on the unit as safe as possible. On 8/6/2025 at 3:30 PM, V2 (Memory Care Coordinator/Social Services) said she was not at the facility for either incident. V2 said both incidents happened on second shift. V2 said she wasn't aware of what all happened, or how they both got out. V2 said the exit doors on the memory care unit have a dual alarm and the bar alarm. The dual alarm is on the door and goes off when the door is opened. The bar alarm goes off when the bar is pushed on the door handle. V2 said she does not know what happened to allow both R1 and R2 to get out without the doors alarming. V2 said she knows R2 had triggered the alarm earlier, but she does not know how much later it was before he got out of the building. V2 said she does not know if the door was alarmed or not. V2 said she asked the nurse about R2's incident. V2 said she asked if the door alarm was set. V2 said the nurse said it was flashing and when the handle was pushed in, it alarmed. V2 said she was not sure about the details of when R1 got out of the building. V2 identified V11 (LPN) as the nurse on duty when R2 got out of the building. V2 said V11 is new to the facility. V2 identified V5 (LPN) as the nurse on duty when R1 got out of the building. On 8/6/2025 at 3:50 PM, V5 (LPN) said R1 got out of the building on 7/3/2025, after dinner, between like 6:00 -7:00 PM. V5 said there were certain times where R1 would start having episodes of confusion. R1 would get agitated easily. R1 thought he was supposed to be going home to his wife. V5 said that day we had to redirect him more frequently. R1 went to the end of hall 1, took his walker, banged it up against the door and set the alarm off. V5 said he (V5) was passing medications on hall 300. I heard the Activity Aide say the alarm was off and someone is trying to get outside. V5 said he and V12 (CNA) ran to the door. It was open. V5 said R1 was about 10-15 feet from the door. on the sidewalk. (V12) and I ran out to R1. V5 said they were able to easily redirect R1 back into the building and gave him his after-dinner snack. V5 said he has been told during reports that R1 has tried to get out before by banging his walker against the door and set the alarm off. V5 said the nurse must manually reset the door alarm, after the door is opened and it alarms. V5 demonstrated how the door alarm is reset. V5 said the light could be red but not blinking if the latch is not all the way shut. To reset the alarm, you put the key in, turn it, then you make sure the latch is on the inside of the door, and push on the door to make sure it does not come open. You remove the key. the light will be red at first, then if set right, it will start blinking. V5 said you push the handle in, and the door will beep. At 4:20 PM, V5 came up to this surveyor and said the Aide yelled alarm going off, not alarm is off. On 8/7/2025 at 8:39 AM, V8 (Activity Aide) said she has been an activity aide on the Terrace unit since Mid-May. V8 said she was working on 7/3/2025 when R1 got out of the building. V8 said it was between 7:00-8:00 pm. V8 said after dinner we went to the TV room. At first, (R1) was fine, but he gets overstimulated. V8 said R1 gets mad and wants to leave. V8 said she let V5 (LPN) know that R1 wanted to leave the TV room and V5 told her to let him go down the hall and we will watch him</p>		