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	12/13/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility failed to notify the wound care provider of a resident's critical lab value prior to wound care. This applies to 1 of 3 residents (R1) reviewed for notification in the sample of 5. The findings include:R1's admission Record (Face Sheet) showed an admission date of 8/12/25 with diagnoses to include but not limited to stage four pressure ulcer to the left heel, atrial fibrillation (rapid/irregular heartbeat), and left hip fracture. R1's Face Sheet showed she was discharged from the facility on 11/6/25. R1's October 2025 electronic medication administration record (eMAR) showed an order for 3 milligrams of Warfarin (anticoagulant) to be given at bedtime. The eMAR showed the order was started on 9/23/25; it was not given on 10/8/25 then the order was discontinued on 10/9/25. R1's Lab Result Report from 10/8/25 collected at 6:32 AM and reported at 5:26 PM showed her International Normalized Ratio (INR, a lab result used to measure a person's ability to clot and is used to determine therapeutic dosages of anticoagulants like Warfarin. Higher INR values indicate less clotting ability. Typical therapeutic INR range for atrial fibrillation patients is 2.0 to 3.0.) was 7.8. This INR value was highlighted in red, and it was flagged. R1's Progress Notes from 10/8/25 showed no provider or family notification regarding R1's INR results. R1's 10/9/25 Skin/Wound Note from 3:36 PM showed V10 Wound Care Physician assessed and treated R1's left heel pressure wound. The note showed, After debridement, (procedure of removing infected, dead, or damaged tissue) wound was bleeding heavily and provider cauterized it. Pressure bandage applied. Nurse notified to monitor this area. R1's 10/9/25 Health Status Note from 5:23 PM, showed R1's Power of Attorney wanted to speak with V11 regarding R1's wound care performed that day. On 12/13/25 at 1:35 PM, V3 Corporate Regional Nurse stated warfarin is an anticoagulant and INR lab draws are used to measure and determine therapeutic dosages for warfarin. V3 stated warfarin thins the blood and makes it more likely for a person to bleed. V3 stated it is the nurse's responsibility to notify the provider of all INR results. On 12/13/25 at 1:35 PM, V11 Wound Care Nurse (interviewed in tandem with V3) stated she was rounding with V10 on 10/9/25. V11 stated at the time of R1's wound care on 10/9/25, she was not aware of R1's high INR. V11 stated it is the floor nurse's responsibility to notify her of abnormal lab results so she can notify V10. V11 said, R1's wound was debrided and dressed then the CNA notified her the wound had bled through R1'd dressing. V11 said, R1's dressing was removed and V10 cauterized (burned) the bleeding. On 12/13/25 at 11:32 AM, V10 Wound Care Physician stated he was not aware of R1's INR lab value on 10/9/25 prior to debriding her wound. V10 stated he assesses residents when he first takes on their care then after that point the facility needs to notify him of resident changes. V10 said the nurse or the provider who ordered the INR should have notified him of the high value. V10 stated, had he been notified of R1's INR, he would not have debrided her wound due to the risk of bleeding. V10 stated R1 did bleed; however, it was not clinically significant and he was able to stop the bleeding. The facility's Notification of Changes policy (undated) showed The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. The policy stated Circumstances requiring notification include. Circumstances that require a need to alter treatment.