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	02/10/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident's medical record contained documentation of a change of condition for 1 of 3 residents reviewed for medical record accuracy in the sample of 4.The Findings include:R3's face sheet documents she was admitted to the facility on [DATE] with multiple diagnoses including gastrostomy status, and cognitive communication deficit. R3's 1/9/26 care plan documents she requires a tube feeding related to dysphagia (difficulty swallowing).The 2/1/26 emergency department documents R3 arrived at 5:36 AM with a chief complaint of a pulled out feeding tube. The notes show a temporary tube was placed with an outpatient procedure to be scheduled to replace the percutaneous endoscopic gastrostomy (PEG).R3s facility record was reviewed and had no details relating to an incident of R3s PEG tube being dislodged or coming out. The notes do not show she left the facility. On 2/10/26 at 12:06 PM, V5 certified nursing assistant said during her rounds last week, she found R1 in bed, and her feeding tube was on the floor with the bulb intact. R3 had very minimal blood present at the site. She reported the incident to V4 Registered Nurse (RN) and completed vital signs and prepared R3 for transport to the emergency room. She said R3s vital signs were normal, nothing stands out to her. R3 was in no apparent distress or pain.On 2/10/26 at 11:52 AM, V4 said she was on another wing in the facility when V5 reported R3s PEG tube had been removed. V4 had V5 get vital signs, and she (V4) notified the on-call manager and the physician prior to sending R3 out to the emergency room. V4 said she had multiple emergencies at the same time, and it would not surprise her if nothing was documented. V4 said she would have charted the details as they occurred.On 2/10/26 at 10:43 AM, V6 Licensed Practical Nurse (LPN) said there should have been an order for the transfer to the hospital, progress notes with details of what happened, and notifications to the family and physician.On 2/10/26 at 1:46 PM, V2 Director of Nursing said the nurses should be putting in a progress note why a resident is leaving the facility and when they leave, including who they left with and their condition. It is important to have the documentation, so staff know why they were sent and where they were sent.The facility's 12/2025 policy for documentation in medical record states each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Policy explanation and compliance guidelines: 2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred.

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