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 04/07/2026
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure assessed elopement interventions were in place for 3 of 3 sampled residents (R1, R2, R3) at risk for elopement and failed to ensure the elopement alert system was implemented at exit doors in resident areas. These failures resulted in R1 exiting through a resident wing door on 3/26/26 at 5:35 AM and found by staff at 5:38 AM walking outside in the dark approximately 50 feet down the facility's sidewalk with a slope to the right side, without a walker, and without wearing her elopement alert bracelet or temperature appropriate clothing.Findings include:1. On 4/1/26 at 9:00 AM, the facility's wing 3 had an exit door at the end of the hall. This exit door had a banner with a stop sign across the door, attached to each side of the door frame. This surveyor opened the door, and an alarm was heard overhead wing 3 door open. There was a sidewalk beyond the door that went straight out approximately 20 feet and then turned sharply left continuing until turning sharply left again to go into the door to resident wing 1. Beyond the sidewalk was grass covered hill ending into a parking lot. On 4/1/26 at 10:19 AM, V5 (Certified Nursing Assistant/CNA) said she was working the morning R1 got outside on 3/26/26. V5 said she last saw R1 in bed sleeping around 5:30 AM. V5 said she went to answer a call light in another resident's room and when she was finished and coming out of that room heard the alarm go off for wing 3. V5 said she heard the alarm go off twice and then ran down the hall of wing 3. V5 said she looked out the door to the right and to the left and didn't see her until she went out further and looked all the way to the left. V5 said R1 was on the sidewalk without her walker, halfway between wing 3 and wing 1. V5 said she went to R1 who seemed confused, and walked R1 to the wing 1 door. V5 said R1 was wearing a striped long sleeve t-shirt, pants, and had socks on. V5 said R1's socks were not the grippy kind. V5 said R1's slippers were on her walker in her room. V5 said R1 asked her where her room was and said it was dark out there. On 4/1/26 at 10:56 AM, V7 (Licensed Practical Nurse/LPN) said she was the nurse on duty on 3/26/26 when R1 got out. V7 said R1 is alert and sometimes confused in general, but on that day was particularly confused due to a urinary tract infection. V7 said she last saw R1 in her bed sleeping around 4:30 AM when she was passing morning medications. V7 said she heard the alarm sounding when she was in a room with another resident. V7 said she went down the hall and looked out the door but didn't see anything from just looking straight out the door. V7 said V5 went outside and found R1 on the sidewalk. V7 said V5 escorted R1 into the building to her room to get her walker. V7 said R1's elopement alert bracelet was on her walker, which was in R1's room. V7 said the elopement alert bracelets are supposed to be placed on resident ankles, but when she tried to place it on R1's ankle the band was too tight, so she placed it on R1's wrist. V7 said R1 was brought to the nurses' station so staff could keep an eye on her and R1 became somewhat agitated. V7 said R1 told her she didn't know what she was doing outside. V7 said R1 was on the secured dementia unit, but R1's family didn't feel that R1 needed to be down there so R1 was moved upstairs to the non-locked unit. V7 said R1 was put on 15-minute checks and later that day was moved back to the secured dementia unit. V7 said she would see R1 walk up to the desk from her room on occasion prior to this incident.On 4/1/26 at 12:17 PM, V1 (Administrator) said the elopement (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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