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 04/13/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review the facility failed to ensure a resident was free from verbal abuse for 1 of 4 residents (R1) reviewed for abuse in the sample of 4.Findings Include:On 4/9/26 at 12:14 PM, V3 (Certified Nursing Assistant/CNA) said R1 is alert to self only and is dependent on staff for all care. V3 said R1 is nonverbal and cries out often. V3 said R1 is incontinent of bowel and bladder. On 4/9/26 at 12:22 PM, R1 was sitting in a wheelchair in the nurses' station. R1 was alert and looking around the room but did not respond when spoken to.On 4/9/26 at 2:16 PM, V6 (CNA) said she asked V7 (Licensed Practical Nurse/LPN) to help her change R1 who had been incontinent of stool. V6 said they both entered the room together and V7 was not aware that V13 (R1's son) was sitting in the corner of the room. V6 said V7 spoke out loud, this sh*t is getting old, here we go again, you are acting like a child. I should leave you here naked. V6 said later in the shift, V7 told her she did not know V13 was in the room. V6 said told V7 that is why you watch what you say. V6 said V7 was inappropriate and said things that she wouldn't say to her own child. V6 said she talked to someone about it that day but was not sure who. V6 said it is not appropriate to talk to residents that way. On 4/9/26 at 3:05 PM, V8 (Social Service Director) said V6 came to her and told her that V7 had come into help change R1 and said something about leaving R1 naked, here we go again with this sh*t. V8 said she felt very uncomfortable and reported it to V1 (Administrator). V8 said it is not appropriate to talk to residents that way, and so she reported it to V1 the abuse person.On 4/9/26 at 2:52 PM, V1 said V8 reported to her that V7 was inappropriate and used curse words when providing care for R1. V1 said she went and talked to V13, who told her V7 was inappropriate and asked her to educate the nurses. V1 said since V13 didn't seem that concerned about the situation, she completed a grievance form and did not do an abuse investigation. V1 said V13 wanted V7 moved from R1's unit and so she had V7 re-assigned to another unit.On 4/9/26 at 3:02 PM, V7 (LPN) said she did use curse words when providing care to R1 with V6. V7 said she remembered saying what the h*ll did you do now because R1 had torn up her incontinence brief and it was all over the room. V7 could not recall if she said sh*t or not. V7 said what she said was not right to say in front of the resident.The facility's Abuse, Neglect, and Exploitation Policy dated 2025 shows it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Verbal abuse means the use of oral, written or gestured communication of sound that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.

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

Printed: 06/25/2026
Form Approved OMB
No. 0938-0391

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 04/13/2026

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review the facility failed to report an allegation of abuse to the state agency for 1 of 4 residents (R1) reviewed for abuse in the sample of 4.Findings Include:On 4/9/26 at 2:16 PM, V6 (Certified Nursing Assistant/CNA) said she asked V7 (Licensed Practical Nurse/LPN) to help her change R1 who had been incontinent of stool. V6 said they both entered the room together and V7 was not aware that V13 (R1's son) was sitting in the corner of the room. V6 said V7 spoke out loud, this sh*t is getting old, here we go again, you are acting like a child. I should leave you here naked. V6 said V7 was inappropriate and said things that she wouldn't say to her own child. V6 said she talked to someone about it that day but was not sure who. V6 said it is not appropriate to talk to residents that way. On 4/9/26 at 2:52 PM, V1 (Administrator) said V8 reported to her that V7 was inappropriate and used curse words when providing care for R1. V1 said she went and talked to V13, who told her V7 was inappropriate and asked her to educate the nurses. V1 said since V13 didn't seem that concerned about the situation, she completed a grievance form and did not report the incident to the state agency.The facility's Abuse, Neglect, and Exploitation Policy dated 2025 shows it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. The facility will have written procedures that include: Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specific timeframes:a. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury orb. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review the facility failed to ensure an allegation of verbal abuse was investigated for 1 of 4 residents (R1) reviewed for abuse in the sample of 4.Findings Include: On 4/9/26 at 2:16 PM, V6 (Certified Nursing Assistant/CNA) said she asked V7 (Licensed Practical Nurse/LPN) to help her change R1 who had been incontinent of stool. V6 said they both entered the room together and V7 was not aware that V13 (R1's son) was sitting in the corner of the room. V6 said V7 spoke out loud, this sh*t is getting old, here we go again, you are acting like a child. I should leave you here naked. V6 said V7 was inappropriate and said things that she wouldn't say to her own child. V6 said she talked to someone about it that day but could not recall whom. V6 said it is not appropriate to talk to residents that way. On 4/9/26 at 2:52 PM, V1 (Administrator) said V8 reported to her that V7 was inappropriate and used curse words when providing care for R1. V1 said she went and talked to V13, who told her V7 was inappropriate and asked her to educate the nurses. V1 said since V13 didn't seem that concerned about the situation, she completed a grievance form and did not do an abuse investigation.The facility's Grievance form dated 3/30/26 for R1 shows the person making complaint was V8 (Social Service Director) and person completing the form as V1. The form shows detail of compliant/grievance: I went to talk to family in room (V13) about comment made to R1 oh you wet yourself again. He seemed like it was just an inappropriate comment. (V13) did not seem bothered by anything that was being said. I told him I would educate the nurse and he thanked me.The facility's Abuse, Neglect, and Exploitation Policy dated 2025 shows it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Verbal abuse means the use of oral, written or gestured communication of sound that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. An Immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect or exploitation occur. Identifying and interviewing all involved person, including the alleged victim, alleged perpetrator witnessed, and others whom might have knowledge of the allegations.

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F 0659 Level of Harm - Actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to provide documentation showing staff was qualified to replace a gastrostomy tube (g-tube) per standards of practice for 1 of 4 residents (R1) reviewed for staff qualifications in the sample of 4. This failure resulted in R1's g-tube migrating into the small intestines leading to complications requiring hospitalization.Findings Include: On 4/13/26 at 12:10 PM, V1 (Administrator) said she did not know if V2 had any certification or training on changing a urinary catheter g-tube and to ask V2 directly. On 4/13/26 at 12:16 PM, V2 (Director of Nursing/DON) said she was not sure what prompted R1's urinary catheter g-tube to be changed, the nurse approached her and said the family wanted her to change it. V2 said it was a routine procedure, a standing order, and she didn't speak with V10 (R1's Physician). V2 said she replaced R1's 16 French with a 20 French urinary catheter because R1's stoma had stretched and the 20 French and the feeding would go in easier. V2 said she didn't speak with V10 regarding the use of the 20 French versus the 16 French either. V2 said the procedure was not something that was normally done at this facility. V2 said she had experience from a previous facility. V2 said she had no certification, just hands on training from her previous employer. V2 said there was not a policy or procedure at this facility for changing the g-tube. On 4/13/26 at 12:57 PM, V2 said she spoke with her previous employer, and they were not able to provide any certifications or competencies regarding urinary catheter g-tube replacements for her.R1's Hospital Discharge summary dated [DATE] shows (R1) with a history of major Cerebral Vascular Attack resulting in right sided hemiparesis and aphasia was admitted from long term skilled nursing facility for a leaking g-tube, fever, and an episode of vomiting. Son who is Power of Attorney is at bedside and states that the facility changed out (R1's) g-tube and the placed a 20 French urinary catheter. The son states it had been leaking since that time. On evaluation (R1's) g-tube was found to be displaced into the proximal jejunum. Labs were significant for an elevated lipase, consistent with pancreatitis. A cat scan (computed axial tomography) of the abdomen confirmed the placement of the g-tube position. Gastroenterology was consulted and successfully replaced the g-tube. The patient was treated with intravenous fluids and medications for pancreatitis. Procedure Note: Standard g-tube, 20 French with outside stopper- The balloon of the old g-tube was deflated (it was a urinary catheter placed through the gastrostomy stoma). It was noticed that urinary catheter use as the g-tube had migrated into the jejunum. Only the tip of the urinary catheter was showing at the skin site. Last it was causing partial bowel obstruction and substantial leakage from the stoma site.The facility's Care and Treatment of Feeding Tubes dated 12/1/25 shows Only tubes designed or intended for enteral feeding will be utilized, except under extenuating circumstances and for the shortest time possible. Directions for staff regarding the conditions and circumstances under which a tube is to be changed will be provided:When to replace and/or change a feeding tube (generally as ordered/scheduled by the physician, when a long-term feeding tube comes out unexpectedly, or when the tube is worn or clogged). The importance of, and frequency of, inspecting the feeding tube and infusion plug to identify splits or crack that could produce leakage.Instance when a tube can be replaced within the facility and by whom.Instances when a tube must be replaced in another setting (e.g. hospital).

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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 0693 Level of Harm - Actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to monitor a urinary catheter gastrostomy tube (g-tube) placement, failed to have policies in place for the care of a urinary catheter g-tube, and failed to have polices in place for replacing a urinary catheter g-tube for 1 of 2 residents (R1) reviewed for gastrostomy tubes in the sample of 4. This failure resulted in R1's being hospitalized due to her gastrostomy tube advancing into her small intestine causing a partial small bowel obstruction and pancreatitis.Findings Include: On 4/9/26 at 10:09 AM, V13 (R1's son) said after R1's g-tube was replaced, the tube was leaking. The only part of the tube sticking out of R1 was the nipple on the end. V9 and V2 were at the bedside looking at R1's g-tube. V2 asked him if he did this, which he told her no. Shortly after R1 was sent to the emergency room. V13 said R1 was exhibiting pain and the tube feeding was leaking all over. On 4/9/26 at 12:22 PM, R1 was sitting in a wheelchair at the nurses' station with her gastrostomy tube connected to a feeding pump running at 65 cc/hr. V4 (Licensed Practical Nurse/LPN) showed this surveyor R1's gastrostomy (g-tube) site. V4 said R1's g-tube was put in at R1's last hospital stay. R1's g-tube extended out from R1's abdomen with a small circular disc around the entrance site and was connected to tubing leading to the feeding pump. R1's abdominal area around the g-tube site had a small amount of dried tube feeding.On 4/9/26 at 2:08 PM, V2 (Director of Nursing/DON) said R1 admitted to the facility with a surgically placed g-tube. V2 said R1 pulled her g-tube out and was sent to the local emergency room. V2 said there was no surgical team available to put a new g-tube in at the time, so the emergency room inserted a urinary catheter tubing to be used as a gastrostomy tube and sent R1 back to the facility. V2 said R1's discharge orders showed to schedule surgical g-tube placement with the gastrointestinal surgeon within 1-2 weeks. V2 said the family requested to wait for a video swallow test to be done before having the surgical g-tube placed in hopes that R1 would not need a g-tube. V2 said R1's husband requested that R1's temporary urinary catheter g-tube be changed and because she had experience, she changed the catheter. V2 said when she changed the catheter tubing, she did not mark or measure the tubing where it entered R1's abdomen, but she recalled approximately 12 inches or so of tubing extending out of R1's abdomen. V2 said to check that the tube is in the correct place in the stomach, gastric content is aspirated. V2 said staff monitor placement by checking gastric content before administering medication, water flushes, or feeding. V2 said staff does not monitor tube placement by checking for the markings on the tubing or measuring the tubing. V2 said the day after she replaced R1's g-tube, staff reported that the tube was leaking, and she assessed R1's g-tube. V2 said R1's g-tube seemed ok to her. V2 said the next day (2 days after replacement) V9 (LPN) called her and said R1's tube was leaking to the point of soaking the bed. V2 said she told V9 to send R1 to the emergency room, that much leaking was not right. V2 said she did not assess R1's g-tube at that time, she didn't want to mess with it anymore. V2 said she read on R1's hospital paperwork that the g-tube had migrated to R1's jejunum (middle section of the small intestine). V2 said after R1 had been admitted to the hospital, V9 reported to her that R1's g-tube had been pushed all the way in, there was no visible tubing on the outside, except the end. R1's Hospital Discharge Instruction dated 2/1/26 shows Patient's percutaneous endoscopic gastrostomy tube was replaced with a 16 French coude foley catheter. This can be used for tube feeds and medications. Please be gentle when administering medications. Patient will need to follow up with general surgery in the next 1-2 weeks for replacement of the feeding tube with a longer-term g-tube endoscopically. How to care for the tube site: Check the number on the tube (guide mark) where it meets the skin. It should not change. If it does the feeding tube might be coming out. Use tape or an anchoring device to hold the loose end of the tube against the skin. This helps keep the tube from getting pulled on.R1's Physician Orders shows check tube placement before initiation of formula, medication administration, and flushing tube. (continued on next page)

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F 0693 Level of Harm - Actual harm Residents Affected - Few	These same orders do not contain orders to check external tube measurements of R1's g-tube. On 4/13/26 at 9:35 AM, V9 (LPN) said she took care of R1 the day R1 was sent out to the hospital for her leaking g-tube. V9 said that day was the first time she had ever seen a urinary catheter used as a g-tube before. V9 said she was not given any education or training regarding the use of this type of g-tube. V9 said the night nurse just told her it was a 16 French urinary catheter with a 10 milliliter balloon. V9 said when she assessed R1 at the beginning of her shift (6:00 AM) she noted the catheter was flush against R1's stomach and there was feeding all over R1's stomach and bed. V9 said she called V2 who came and looked at the tube and said it was not supposed to look like that. V9 said she called to send R1 out to the hospital. V9 said there was no tape or anchoring device that she recalled. V9 said she checks g-tube placement by aspirating stomach contents. On 4/13/26 at 10:10 AM, V10 (R1's Physician) said nurses should be monitoring the external placement of g-tubes as part of determining that the g-tube is the correct position. There should be a protocol for the nurses to follow. The g-tube should be in the stomach not the jejunum (middle section of the small intestine). R1's g-tube advancing into the jejunum could cause a blockage of the bile duct which in turn could lead to pancreatitis. V10 said he did not recall speaking to staff about changing out R1's urinary catheter g-tube. V10 said that is something that is typically done in the emergency room by a doctor. V10 said he would have had the patient sent out to have the procedure done. V10 said on an emergent basis (the tube came out) a nurse might place the g-tube back but then the patient would still be sent out to the emergency room to make sure the tube was correctly placed. V10 said there would be complications if the g-tube is not in the correct place. On 4/13/26 at 11:30 AM, V11 (LPN) said she doesn't have experience with urinary catheter tubes being used as g-tubes and would check placement by aspirating gastric content. V11 said she was not sure how to tell if the tube had moved in or out of the body. V11 said she had not been educated on that type of g-tube.On 4/13/26 at 11:42 AM, V7 (LPN) said she had not had any education on R1's g-tube and checked placement by listening to the stomach. V7 said R1's was the first type of that g-tube she had encountered. V7 said there were no markings on R1's g-tube external tubing that she could recall.R1's Progress Notes dated 3/6/26 at 12:00 PM shows Resident g-tube continuously leaking, with the majority of tube feeding coming out around stoma. This nurse attempted to reinflate the balloon with 5 ml (milliliters) more of normal saline however the stoma continues to leak an excessive amount of fluids. Received order to send to emergency room. R1's Progress Notes dated 3/6/26 at 6:04 PM shows Resident admitted to local hospital with diagnosis of pancreatitis.R1's Hospital Discharge summary dated [DATE] shows (R1) with a history of major Cerebral Vascular Attack resulting in right sided hemiparesis and aphasia was admitted from long term skilled nursing facility for a leaking g-tube, fever, and an episode of vomiting. Son who is Power of Attorney is at bedside and states that the facility changed out (R1's) g-tube and the placed a 20 French urinary catheter. The son states it had been leaking since that time. On evaluation (R1's) g-tube was found to be displaced into the proximal jejunum. Labs were significant for an elevated lipase, consistent with pancreatitis. A cat scan of the abdomen confirmed the placement of the g-tube position. Gastroenterology was consulted and successfully replaced the g-tube. The patient was treated with intravenous fluids and medications for pancreatitis. Procedure Note: Standard g-tube, 20 French with outside stopper- The balloon of the old g-tube was deflated (it was a urinary catheter placed through the gastrostomy stoma). It was noticed that urinary catheter use as the g-tube had migrated into the jejunum. Only the tip of the urinary catheter was showing at the skin site. Last it was causing partial bowel obstruction and substantial leakage from the stoma site.R1's Care Plan dated 1/9/26 shows the resident requires tube feeding related to dysphagia. This same Care Plan shows on 2/6/26 sent to emergency room for g-tube malfunction, but no interventions for care were updated reflecting the urinary catheter used as a g-tube.The facility's Appropriate use of Feeding Tubes Policy dated 12/1/25 shows Feeding tubes (naso-gastric, gastrostomy, jejunostomy, coude urinary catheter) will be utilized in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible.The facility's (continued on next page)

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F 0693 Level of Harm - Actual harm Residents Affected - Few	Care and Treatment of Feeding Tubes dated 12/1/25 shows Only tubes designed or intended for enteral feeding will be utilized, except under extenuating circumstances and for the shortest time possible. The residents' plan of care will address the use of feeding tube, including strategies to prevent complications. In accordance with facility protocol, licensed nurses will monitor and check that the feeding tube is in the right location (e.g. stomach or small intestine depending on the tube): The enteral retention device will be checked daily to assure it is properly approximated to the abdominal wall and that the surrounding skin is intact. Direction for staff will be given on how to provide the following care will be provided: How to secure a feeding tube externally. The policy did not define how licensed staff check the feeding tube is in the right location. This same policy shows Directions for staff regarding the conditions and circumstances under which a tube is to be changed will be provided:When to replace and/or change a feeding tube (generally as ordered/scheduled by the physician, when a long-term feeding tube comes out unexpectedly, or when the tube is worn or clogged). The importance of, and frequency of, inspecting the feeding tube and infusion plug to identify splits or crack that could produce leakage.Instance when a tube can be replaced within the facility and by whom.Instances when a tube must be replaced in another setting (e.g. hospital).On 4/13/26 at 12:10 PM, V1 (Administrator) said she did not believe an in-service was done for nurses on a urinary catheter g-tube. V1 said she did not know if V2 had any certification or training on changing a urinary catheter g-tube and to ask V2 directly. On 4/13/26 at 12:16 PM, V2 said she was not sure what prompted R1's urinary catheter g-tube to be changed, the nurse approached her and said the family wanted her to change it. V2 said it was a routine procedure, a standing order, and she didn't speak with V10. V2 said she replaced R1's 16 French with a 20 French urinary catheter because R1's stoma had stretched and the 20 French and the feeding would go in easier. V2 said she didn't speak with V10 regarding the use of the 20 French versus the 16 French either. V2 said the procedure was not something that was normally done at this facility. V2 said she had experience from a previous facility. V2 said she had no certification, just hands on training from her previous employer. V2 said there was not a policy or procedure at this facility for changing the g-tube. V2 said she did not educate staff on urinary catheter g-tubes but two staff had watched her replace the g-tube. On 4/13/26 at 12:57 PM, V2 said she spoke with her previous employer and they were not able to provide any certifications or competencies regarding urinary catheter g-tube replacements for her.On 4/13/26 at 1:07 PM, V1 said the facility did not have any other policies specific to urinary catheter g-tubes or policies regarding urinary catheter g-tube replacement.