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	05/01/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to document resident assessments for 1 of 3 residents (R1) reviewed for change in condition in the sample of 3.The findings include:R1s face sheet documents she was admitted to the facility on [DATE] with multiple diagnoses including but not limited to dementia, transient cerebral ischemic attack, atrial fibrillation, presence of cardiac pacemaker, and hypertension.R1s nursing progress notes for [DATE] document at 9:23 AM, resident observed during medication administration to have difficulty swallowing a pill and began exhibiting signs of choking. The Heimlich maneuver was performed, abdominal thrust, CPR (cardiopulmonary resuscitation) was initiated, and she was sent to the emergency room. The record did not indicate R1s return, her assessment upon return including vital signs or any new orders from the emergency department.On [DATE] at 12:47 PM, V3 Licensed Practical Nurse LPN said I want to say I was still her nurse when she came back and definitely should have documented when she came back. A note of the time of arrival, any new physician orders, do an assessment, vitals, listen to her heart and lungs, bowels, if she had any bandages, and do a skin check. That should all be in the progress notes.R1s nursing progress note for [DATE] at 10:14 AM, documents resident complains of chest pain 10/10. Sent to ED (emergency department). No assessment, vital signs or related information was noted in the record. No transfer, change of condition report.On [DATE] at 11:10am V6 LPN said on [DATE] R1 was sitting in her recliner stating she had non-radiating chest pain. She (R1) had increased respirations; they were at 26 or 28. Her blood pressure was 140 something or 80 something, it was not too bad. V6 said she did check her pulse oxygenation level, and it was 91%, she thinks. She did not apply any oxygen at the time of the event. V6 said her color was fine and she was not diaphoretic (sweaty). V6 said after the choking incident (on [DATE]), as soon as (R1) said she had chest pain, she sent her out immediately. V6 said she did not write or document any information in the record.On [DATE] at 12:30 PM, V2 Director of Nursing said when a resident returns from the emergency room or hospital stay, there should be an assessment and documentation of their orientation status, a summary of what happened, vital signs, pain level, a skin check and a review of the orders. She said when a resident is sent out to the ER with chest pain there should be a description of the pain, what was done for that resident, vital signs, if oxygen was placed, and the reason for sending the resident out. After reviewing R1s note for [DATE] she stated the note is missing all the needed information, and any other symptoms R1 was having, and if she was diaphoretic, her orientation- was she confused, was her skin cool, clammy, or hot. V2 stated all that information should have been put in the note.The facility's undated policy for documentation in the medical record shows the policy as: each resident's medical record shall contain an accurate representation of the actual experiences of the resident and includes enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Policy explanation and compliance guidelines: 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 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