STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145220	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Crest Health Care	3300 West 175th Street Hazel Crest, IL 60429

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to revise a comprehensive care plan, failed to develop care plan with measurable goals, objectives and individualized interventions to meet the need for increased supervision in preventive interventions for one resident (R1) reviewed for elopement in the sample.Findings include:R1 medical report admission Record showed that R1 was admitted to the facility on [DATE] with diagnosis that includes but not limited to Schizophrenia, hyperlipidemia, cerebral infarction and bilateral primary osteoarthritis of knee.R1 eloped from the facility on 07/17/2025 without authorization and without facility staff being aware that R1 was missing until the V22 (family) called the facility staff on 07/18/2025 at approximately 12:30am to inform them of R1 whereabout.R1's V22 (family) with the local police department advice sent R1 to the hospital for evaluation.R1's hospital emergency room record diagnosis includes but not limited to Dementia, PTSD (Post Traumatic Stress Disorder) schizophrenia and aggressive behavior.R1's medical record MDS (Minimum Data Set, dated [DATE] showed R1's BIMS (Brief Interview for Mental Status) score of 11 indicating that cognitively R1 is moderately impaired.R1's previous (MDS) section C dated 12/04/2024 and 2/26/2025 scored R1 BIMS as 15 and 14 indicating that cognitively intact. Showing that R1 has decline cognitively. R1's medical record Elopement Risk Review dated 03/19/24 timed 18:48 (6:48pm) documented under comments that resident (referring to R1) is confused, voicing that he is trying to go home. Resident does actively engage in themed behavior and is a new admit. Resident will be placed on elopement protocol and will be monitored.R1's medical record recent Elopement Risk Review dated 07/21/25 four days after the incident of 07/17/25 documented that R1 is presently at risk for elopement and should be placed on elopement risk protocol. Comments documentation read R1 left from the building on 07/17/25 without authorization to go home. R1 can make his own decisions. Resident stated he knew what to do and where to go. Resident has history of hallucinatory behaviors but does not display those behaviors currently (currently). Resident is not able to live at home due to him showing aggression towards family. On 07/21/25 at 2:10pm, V12 SSD stated in part that she has been on vacation but worked about three hours on Friday (07/18/25). V12 said did talk to V1 (Administrator), he mentioned that R1 left the facility, but did not give me any details of how it happened. This morning around 9am (7/21/25). V1 said the care plan should be updated. During the same interview with V12, V12 stated in part that R1 has been on elopement risk since admission because he did not want to be in the facility and R1 was voicing it.R1 plan of care for elopement with initiated date of 3/19/2024 with revision date of 07/21/25 documentation that showed that this care plan was not revised until 07/21/25 five days after the incident on 07/17/25 and four days after R1 had returned to the facility with no new intervention put in place until 07/28/25.The facility Elopement Risk Assessment policy presented dated 5/14 documents that the policy purpose is to identify residents who may be potentially at risk for elopement and at risk for harm. To use as a baseline to maintain a secure resident environment. Listed under Responsibility is the Social Services Department. Equipment to be used listed as the facility approved form. Procedure listed includes but not limited to a Social Service department will conduct the elopement assessment during the admission process, when there is a significant change in mood or behavior(s), and quarterly. Risk factors that will be assessed includes but not limited to verbalization of wanting to leave the facility and/or go home, inability or refusal to follow instructions diagnosis that includes but not limited to dementia and schizophrenia. In event the assessment was initiated because of an elopement (where the resident's whereabout were unknown), the elopement will be reported in accordance with the facility's Accident/Incident Unusual Occurrence Policy.

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to have a system in place to prevent unauthorized and unsupervised leave from the facility. This failure resulted in one resident's (R1) elopement from the facility without staff knowledge who has documented assessments related to elopement/wandering behaviors.This was identified as an immediate jeopardy which begin on 07/17/25 at 8:55pm when R1 eloped from the facility without supervision and authorization.V1 (Administrator) was informed of the immediate jeopardy and a template was presented on 07/28/25.On 08/04/25 acceptable removal plan was received after revision of the original plan submitted on 7/28/25.The Immediate Jeopardy was removed on 08/04/25, however, the non-compliance remains at the level two because additional time is needed to evaluate the implementation and effectiveness of in-service training.On 08/06/25 the surveyor confirmed by observation, interview, and record review that the removal plan was initiated, and Immediate Jeopardy was removed on 08/04/25. However, the non-compliance remains at the level two because additional time is needed to evaluate the implementation and effectiveness of in-service training. FINDINGS INCLUDE:R1 medical report admission Record showed that R1 was admitted to the facility on [DATE] with diagnosis that includes but not limited to Schizophrenia, hyperlipidemia, cerebral infarction and bilateral primary osteoarthritis of knee.V1 (Administrator said R1 placed in the facility due to being aggressive towards family.On 07/17/25 at approximately 8:55pm/9:00pm, R1 eloped from the facility unauthorized and without staff supervision. R1's police report dated 07/18/25 documents when reported by the facility as 01:23:27 07/18/25, time of occurrence 21:00:00 07/17/25 and 01:23;53 07/18/25. Offense codes listed as A433 missing Adult.R1's hospital emergency room record dated 07/18/25 showed that diagnosis includes but not limited to Dementia, PTSD (Post Traumatic Stress Disorder) schizophrenia and aggressive behavior. R1's medical record electronic physician order did not have a physician order documentation allowing him to go out independently without any supervision.R1's medical record MDS (Minimum Data Set, dated [DATE] showed R1's BIMS (Brief Interview for Mental Status) score of 11 indicating that cognitively R1 is moderately impaired.R1's previous (MDS) section C dated 12/04/2024 and 2/26/2025 scored R1 BIMS as 15 and 14 indicating that cognitively intact. Showing that R1 has decline cognitively. R1's medical record Elopement Risk Review dated 03/19/24 timed 18:48 (6:48pm) documented under comments that resident (referring to R1) is confused, voicing that he is trying to go home. Resident does actively engage in themed behavior and is a new admit. Resident will be placed on elopement protocol and will be monitored.R1's medical record recent Elopement Risk Review dated 07/21/25 four days after the incident of 07/17/25 documented that R1 is presently at risk for elopement and should be placed on elopement risk protocol. Comments documentation read R1 left from the building on 07/17/25 without authorization to go home. R1 can make his own decisions. Resident stated he knew what to do and where to go. Resident has history of hallucinatory behaviors but does not display those behaviors currently (currently). Resident is not able to live at home due to him showing aggression towards family. V13 (Receptionist) presented facility visitor registration log dated 7/17/25 that showed no documentation that R1 signed self out to the community or that the family member visit or sign out R1 to the community.V2 and V4 ADON (Assistant Director of Nurses) stated that any unusual occurrence should be documented The facility video monitor showed R1 walking around the nurse's station on the 1st floor at 8:55pm but did not show the front exit door. V1 stated that the video did not show the rest of the night footage because it has been discarded. R1's hospital visit record showed documentation that R1diagnosis includes but not limited to Dementia, PTSD (Post traumatic stress disorder, schizophrenia and aggressive behavior. R1 was treated on 07/18/25 with medications that includes Haloperidol lactate (Antipsychotic) at 3:26am and Midazolam (Versed) at 3:27am. On 07/23/25 at 2:00pm, interview conducted with V2 DON (Director of Nurse's) regarding the event of 07/17/25 with R1. V2 stated that R1 is one of our vets (veterans). Alert and oriented times 3, delusional, able to verbalize needs, needs re-direction constantly, has good days and bad days, needs supervision and cues from the staff. On the day R1 went out (referring to 07/17/25), I was on vacation I hardly took time off, but I was off. I did not do any investigation, V1 (Administrator) did the investigation so I could not tell you what happened. When asked about potential risk that could have happened to R1, V2 said Any-thing could have happened to (R1). Safety issues, accident can happen. R1 wants the son to get out of his home and that is part of why he (R1) is in the facility I think they V1 said they are in court, but he (V1) does not have the paperwork (court document) yet. V2 explained