

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/09/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ALLURE OF PINECREST	STREET ADDRESS, CITY, STATE, ZIP CODE 414 SOUTH WESLEY AVENUE MOUNT MORRIS, IL 61054
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 2319300/IL166438	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/09/2023
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ALLURE OF PINECREST	STREET ADDRESS, CITY, STATE, ZIP CODE 414 SOUTH WESLEY AVENUE MOUNT MORRIS, IL 61054
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 1 of notification.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>These Regulations are not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident's safety while using a mechanical stand lift machine for 1 of 3 residents (R1) reviewed for safety in the sample of 6. This failure resulted in R1 having a decline in the ability to raise her left arm, and R1's Physician diagnosing R1 with a complete rotator cuff tear.</p> <p>The findings include:</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/09/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALLURE OF PINECREST	STREET ADDRESS, CITY, STATE, ZIP CODE 414 SOUTH WESLEY AVENUE MOUNT MORRIS, IL 61054
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 2</p> <p>R1's Admission Record, printed by the facility on 11/8/23, showed she had diagnoses including enterocolitis due to clostridium difficile (C-diff), generalized osteoarthritis, hypertension, a history of falling, iron deficiency anemia, atrial fibrillation, chronic kidney disease, seizures, unsteadiness on feet, lack of coordination, and weakness.</p> <p>R1's care plan, with a revision date of 11/8/23, showed R1 "requires sit to stand by staff to transfer." R1's alteration in skin integrity care plan, with a revision on 11/1/23, showed R1 received a skin tear measuring 0.5 cm (centimeters) x 0.3 cm. Skin is very fragile. Cleansed and dry dressing applied. Stand lift checked and no safety concerns noted.</p> <p>R1's Order Summary Report, printed by the facility on 11/8/23, showed the following order dated 10/31/23 Cleanse skin tear to LFA (left forearm) using normal saline. Pat dry. Apply dry dressing daily and as needed. The Order Summary Report also showed an order for Vancomycin HCL (hydrochloride) 125 mg by mouth two times a day for suspected C-diff for 14 days. R1's facility assessment dated 8/29/23, showed she was cognitively intact and required extensive assist of staff for toileting.</p> <p>On 11/7/23 at 5:21 PM, V8 (R1's daughter/POA-power of attorney) said a family member (V13) was in the facility on 11/1/23 and noticed that R1 was not moving her left arm. V8 said V13 asked R1 what happened. R1 told her that a CNA (Certified Nursing Assistant) was using the sit-to-stand lift, and she (R1) told the CNA that her arm was hurting, R1 told V13 that the Aide kept going and did not adjust the straps or anything. V8 said R1 told V13 that when the aide lowered R1 down, her whole left arm was</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/09/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ALLURE OF PINECREST	STREET ADDRESS, CITY, STATE, ZIP CODE 414 SOUTH WESLEY AVENUE MOUNT MORRIS, IL 61054
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 3</p> <p>hurting. V8 said the incident happened sometime during the night on 10/31/23 and 11/1/23 in the morning. V8 said other than some of the CNAs coming up and saying how sorry they are that it happened, and the Social Worker coming in asking what happened; No one else in management had talked to them about the incident. V8 said R1 also had a skin tear on her left arm. V8 said R1's Doctor came in to see R1 the next day or two and diagnosed R1 with a complete torn rotator cuff. V8 said R1 is not having any pain and was told by V7 (R1's Doctor) that R1 would not feel pain with a complete torn rotator cuff. V8 said an X-ray was done and the results showed no fracture or dislocation. V8 said R1 cannot move her left arm and is not able to feed herself like she used to. V8 said R1 will be 95 years old on Sunday and is not a candidate for surgery. V8 said she requested an MRI be completed. V8 said the MRI is scheduled to be done on 11/16/23. V8 said her sister (V9) goes to the facility almost every day to see R1. V8 said R1 had been weak due to her age, having C-diff (Clostridium difficile) infection, and the sit to stand lift is fairly new to R1. V8 said R1 is cognitively intact and able to give details about what happened.</p> <p>On 11/8/23 at 9:18 AM, R1 was in her room, sitting in her chair. V9 (R1's daughter) was in the room with R1. R1 was making potholders for her family, with the assistance of V9. R1 mostly used her right hand to make the potholders. V9 showed this surveyor a picture she had on her phone of R1 from 6/12/23. R1 was holding her left arm straight up in the air. V9 said R1 had been excited because she found her missing cell phone and she (V9) took a picture of her. V9 asked R1 if she could raise her arm up like she did in the picture. R1 tried to lift her arm but was</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/09/2023
NAME OF PROVIDER OR SUPPLIER ALLURE OF PINECREST		STREET ADDRESS, CITY, STATE, ZIP CODE 414 SOUTH WESLEY AVENUE MOUNT MORRIS, IL 61054		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4 only able to lift it a few inches off her lap. R1 leaned her upper body to the right side to try to get the arm up higher, with no success. R1 was also not able to move her left arm outwards, away from her body when prompted to do so by V9. R1 was alert and oriented. When asked how she got the skin tear on her left arm and why she is not able to move her arm like she was in the picture, R1 said she would say the girl did not know how to use the stand lift machine. R1 said it hurt when the CNA started lifting her up with the machine, adding "I felt like I was being hung." R1 said she yelled at the girl, but she did not stop when she screamed that it hurt. On 11/8/23 at 10:49 AM, V2 and V3 (CNAs) transferred R1 from her recliner chair to the toilet using the sit-to-stand lift. R1 was not able to lift her left arm high enough to grab the handles, so V2 grabbed R1's left hand and placed it on the handle for her. R1 was then able to grip the handle. R1 stood up with the lift and followed V2's cues to stand up straight and tall during the transfer. At 11:16 AM, V2 said R1 had a change in her range of motion. V2 said R1 was able to move her arms above her head, put on her bra and shirt and feed herself. V2 said now staff have to help her get dressed on the left side and put her hand on the stand lift for transfers, because R1 cannot lift it. V2 said she worked a double shift from 10:00 PM on 10/29/23-2:00 PM on 10/30/23 and R1 was fine. V2 said the next time she worked was on 11/1/23 on the day shift. V2 said the third shift CNA reported that R1 complained about pain that night in her shoulder and that her arm and shoulder were sore. V2 said R1 told her that when the Aide was lifting her up, she was raising the stand-lift all the way up. V2 said R1 told her that she screamed that it hurt, and the aide kept lifting it up. V2 said she told the	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/09/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALLURE OF PINECREST	STREET ADDRESS, CITY, STATE, ZIP CODE 414 SOUTH WESLEY AVENUE MOUNT MORRIS, IL 61054
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 5</p> <p>nurse; the Social Services person and she thinks the Director of Nursing. V3 CNA) was present during this surveyor's conversation with V2 and said she was the CNA for R1 on 10/31/23 during the day shift (6:00 AM-2:15 PM). V3 said R1 was fine on her shift, V3 said R1 was able to lift her arms, get dressed and had no complaints of pain during her shift.</p> <p>On 11/8/23 at 1:30 PM, V6 (Licensed Practical Nurse-LPN) said she was the nurse for R1 on 10/31/23 on second shift (2:00 PM-10:00 PM). V6 said no staff reported any concerns regarding a resident's report of pain during a stand-lift transfer. V6 said no CNA reported any concerns to her regarding R1 not being able to move her arm per her baseline. V6 said she is an agency nurse and is not familiar with the residents, however she does not recall anything being out of the normal that night.</p> <p>On 11/8/23 at 1:41 PM, V4 (CNA) said she worked on 10/31/23 from 2:00 PM-10:00 PM. V4 said she is new to the facility. V4 said she transferred R1 a couple of times that shift; The first time was without the stand lift machine. V4 said she did a stand pivot transfer and R1 kept trying to sit down. V4 said she was informed by another CNA that they use a stand-lift machine for R1. V4 said later she transferred R1 using the sit-to-stand lift machine. V4 said every time she would try to wipe R1, she (R1) would try to sit down. V4 said she (V4) would then lower the stand-lift. V4 said she got on the walkie-talkie and told V5 (CNA) that she needed help because she was having trouble with R1; adding, it was up and down, up, and down. V4 denied R1 complaining of any pain while she was in with her. V4 said V5 said they could just switch residents.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/09/2023
NAME OF PROVIDER OR SUPPLIER ALLURE OF PINECREST		STREET ADDRESS, CITY, STATE, ZIP CODE 414 SOUTH WESLEY AVENUE MOUNT MORRIS, IL 61054		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 6</p> <p>On 11/8/23 at 2:22 PM, V5 (CNA) said she worked on 10/31/23 from 2:00 PM-10:00 PM. V5 said she transferred R1 from the chair to the toilet. V5 said R1 did not complain of pain when she transferred her to the toilet. V5 said she got R1 on the toilet and then V4 came in the room. V5 said "Good you're here, can you take over?" and V5 said V4 told her "Sure." V5 said she had a resident that she was toileting at the same time across the hall. V5 said she went over to assist the resident across the hall, and she got a call on the walkie talkie from V4 to please come back. V5 said she went back and V4 complained that R1 kept lowering herself down. V5 said V4 told her that she (V4) said she would raise the stand-lift higher, and R1 would lower herself down again. V5 said when she went back into R1's bathroom, R1 said "Thank God you're here, she was making my shoulders hurt." V5 said she told V4 that she would finish with R1 if V4 went over to take care of the other resident across the hall. V5 said she finished cleaning R1 up and transferred R1 from the toilet to her bed. V5 said that is when she noticed the skin tear on R1's left arm. V5 said R1 did not complain of pain while she was transferring her from the wheelchair to the toilet and from the toilet to the bed after toileting.</p> <p>On 11/9/23 at 6:10 AM, V11 (CNA) said she worked the overnight shift on 10/31/23 (10:00 PM-6:15 AM). V11 said during her shift R1 told her that the girl must not have known what she was doing on the previous shift, because "She almost hung me." V11 said R1 had to use her right hand to raise her left arm, or she (V11) would help her lift it up to hold onto the stand-lift handles. V11 said the CNA that gave her report at the beginning of her shift informed her that she had to go in and help with R1, because V4 had</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/09/2023
--	--	--	---

NAME OF PROVIDER OR SUPPLIER ALLURE OF PINECREST	STREET ADDRESS, CITY, STATE, ZIP CODE 414 SOUTH WESLEY AVENUE MOUNT MORRIS, IL 61054
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 7</p> <p>the stand lift raised too high when toileting R1. V11 said she believes it may have been V5 that told her that during the shift report. V11 said it was not V4 that told her that.</p> <p>On 11/9/23 at 8:03 AM, V12 (Licensed Practical Nurse-LPN) said she worked the overnight shift on 10/31/23. V12 said no CNA reported any concerns regarding R1 having a decline to her range of motion of her left arm, or saying the previous shift CNA almost hung her. V12 said if they had, she would have called R1's doctor (V7). V12 said the second shift nurse reported R1's skin tear to her and asked her how to document it, so she instructed the nurse on how to do that. V12 said the nurse from the previous shift did not report R1 complaining of her shoulder hurting or a decline/change in R1's range of motion. V12 said when she went in during her shift to check on R1, she was asleep, so she did not voice any complaints of pain.</p> <p>On 11/9/23 at 9:04 AM, V10 (Registered Nurse-RN) said she was R1's nurse on 10/31/23 from 6:00 AM-10:00 AM. (The shift before R1 complaining that a CNA was hurting her shoulder when using a stand-lift). V10 said R1 had no difficulty with her left arm on her shift, and no complaints of pain to her left shoulder or arm on 10/31/23 when she was working. V10 said she was also the nurse for R1 on 11/1/23 from 6:00 AM-10:00 AM. V10 said one of the CNAs informed her that R1's family wanted to talk to her. V10 said R1's family was concerned that she was not able to move her arm. V10 said she assessed R1, and she was not able to move her left arm more than a short way away from her lap. V10 said she put it on the Doctor's Board because she was told the Nurse Practitioner was going to be in the facility that day.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/09/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALLURE OF PINECREST	STREET ADDRESS, CITY, STATE, ZIP CODE 414 SOUTH WESLEY AVENUE MOUNT MORRIS, IL 61054
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 8</p> <p>On 11/8/23 at 3:33 PM, V7 (R1's Physician) said from what he gathered, they were using a stand-lift and it was a new CNA trying to transfer R1 to the bathroom. V7 said It sounds like R1 kind of slipped down in the sling during the transfer and then got a skin tear on her left forearm and her left shoulder was affected. V7 said he thinks due to R1's loss of muscle control, and it is happening so quick, that before the sling was tight enough and in place, it allowed her to go down. V7 was informed about this surveyor's interviews with R1, V4 and V5. V7 said he guesses if the resident is trying to sit down and the lift is raised, that it could have caused the injury. V7 said with 85-95-year-olds, there can be injuries with the slightest twist or movements due to their fragile tissues. V7 said R1 had a current C-diff (Clostridium difficile) infection and weakness, which makes falls more likely. V7 said he is not sure what the facility's policy says about 1 or 2 staff being needed for a stand-lift transfer. V7 said for a resident with a C-diff infection and weakness, it would be a good idea to have more than one staff present during transfers and toileting with a stand lift. V7 said something happened during the stand-lift transfer and toileting. V7 said he did not think an MRI was needed for the diagnoses of a complete tear in R1's rotator cuff, because R1 has the textbook signs of a complete rotator cuff tear. V7 said he went to the facility and assessed R1. V7 said he would bet a hundred dollars that it is a complete tear in her rotator cuff. V7 said there are very few things that would cause no pain and the resident not being able to move her arm.</p> <p>On 11/9/23 at 10:52 AM, R4 (resident that resides across the hall from R1) said she vaguely remembers having a resident yell out on</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/09/2023
--	--	--	---

NAME OF PROVIDER OR SUPPLIER ALLURE OF PINECREST	STREET ADDRESS, CITY, STATE, ZIP CODE 414 SOUTH WESLEY AVENUE MOUNT MORRIS, IL 61054
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 9</p> <p>Halloween night while she was in the bathroom using the toilet. R4 said she could not make out what they said, it was just a quick yell and that was it. R4 said the aide that was helping her (R4) had to go over and help the other girl after that.</p> <p>R1's incident report, dated 10/31/23, showed she obtained a 0.5 cm x 0.3 cm skin tear while transferring using the sit-to-stand. The report showed no complaints of pain or discomfort to the area. The report showed on 11/1/23 additional information was added in the notes section of the report showing 11/1/23 Resident complained of shoulder discomfort and not being able to complete full ROM (range of motion). The note showed V7 (R1's physician) was notified and came in and completed an in-person exam with the patient and then talked with R1's family. On 11/3/23 the notes showed R1's family requested an X-ray be completed. The X-ray was completed on 11/4/23 and the results showed mild degenerative joint disease with no fracture or dislocation noted. Suggested to consult with family about completing an MRI. MRI scheduled for 11/16/23.</p> <p>A hand-written note provided by V1 on 11/8/23, showed R1 asked to see staff on 11/1/23. Went and talked to (R1). She said the CNA was assisting her to use the restroom and (R1) told her that she was hurting her arm. Aide got her to the toilet and then another aide (V5) took over.</p> <p>V7's (R1's Physician) Progress Note date 11/2/23 showed "Assessment/Plan ...3. Left total rotator cuff tear-We are going to get an X-ray of this area just to make sure that there are no bony lytic lesions, or fractures, or dislocations; although all of that seems very unlikely given the physical exam findings." The progress note showed "It</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007447	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/09/2023
NAME OF PROVIDER OR SUPPLIER ALLURE OF PINECREST			STREET ADDRESS, CITY, STATE, ZIP CODE 414 SOUTH WESLEY AVENUE MOUNT MORRIS, IL 61054		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S9999	<p>Continued From page 10</p> <p>does seem like there was a traction type injury in the (mechanical lift) that led to a complete tear."</p> <p>The facility's policy and procedure titled Safe Resident Handling/Transfer, dated 12/1/23, showed "It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines." The policy showed "4. Mechanical lifts may include equipment such as full body lifts, sit to stand lifts, or ceiling track mounted lifts ...10. Two staff members must be utilized when transferring residents with a mechanical lift."</p> <p>On 11/14/23 at 9:45 AM, V1 (Administrator) said the policy and procedure titled Safe Resident Handling/Transfer, dated 12/1/23 was 12/1/22, when the new company took over.</p> <p>(B)</p>	S9999			