STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0051318	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE CREST HEALTH CARE	3300 WEST 175TH STREET , HAZEL CREST, Illinois, 60429

(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) COMPLETION DATE
S0000	Complaint Survey 2596576 / 2566261	S9999		08/26/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300. 1210a) 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 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. 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: 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. These regulations were not met as evidence by: 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.	S9999		

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S9999	Continued from page 2 Findings include: R1 medical report admission Record showed that R1 was admitted to the facility on 03/19/24 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 5/28/2025 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.	S9999		

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S9999	Continued from page 3 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 that the facility exits (in the facility) have alarms	S9999		

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S9999	Continued from page 4 especially the front door, so if staff or resident goes through without proper code the alarm goes off to alert every-one in the building. The alarm is loud enough that everyone can hear it. When a resident is missing or eloped, the facility policies should be followed. The surveyor then asked whether it is normal occurrence for the facility residence to walk out of the facility without staff's knowledge. V2 said "It is not normal for any of our resident to walk out of the building without anyone knowing about it. R1 is here (facility) to be cared for and monitored. On 07/23/25 at 3:23pm, V22 (Family) stated that I am the son, (R1) left the nursing home (facility) during the night of 07/17/25. (R1) walked back to his home which is about 4hours walk because they said he left around 9:00pm. V22 said "I call the facility to ask about him, they (facility staff) did not know he was gone". V22 stated that he called the facility at 12:30am on 07/18/25 when R1 showed up at their house at 12:20am, so he called the police, they arrive with an ambulance and was advice to send R1 to the hospital. V22 stated that R1 did not recognize him was calling V22 by his brother's name, he was confused. Using the address V22 gave the surveyor R1 had walked approximately eight miles from the facility unsupervised and unauthorized to V22 home. On 07/23/25 at 3:51pm, V15 CNA (certified Nurse's Aide) stated that she was the 2nd shift CNA for R1 on 7/17/25. V15 stated that during her shift R1 was observed in the dining room socializing with peers. She made her last round at about 9:00pm 10:00pm and R1 was in the building then between 13:30am and 1:00am on 07/18/25 the facility staff called asking about R1's whereabout because he was missing. V15 stated that R1 is not capable of going out in the community without supervision, so R1 should not be out there without supervision of staff or family. He knows what time to come for medicine and dinner time, independent at times but still need staff to re-direct him. On 07/23/25 at 4:07pm, during interview with V23 RN (Registered Nurse) assigned to R1 on 11:pm to 7am shift 07/17/25, V23 stated that when I clocked in at the facility (timecard preview showed V23 clocked in at 11:09pm). V23 stated in part that V17 LPN (Licensed Practical Nurse) was at the nurse's station with V27 (RN), I got the shift change report from V17 that nothing was going on. The surveyor asked what V23 meant by nothing going and she said, "to mean everything was normal with the residents assigned to her (V23)". V23 stated that V17 (LPN) that worked 3pm to 11pm did not report that R1 eloped or has gone out unauthorized. V23	S9999		

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S9999	Continued from page 5 stated that it was after V22 (family) called the facility around 12:30am that the staff started looking for him. V1 (Administrator) was notified, and he came into the facility asked for the police be called. When the police called, he (V22) told them that he had his father, and he is on the way to the local hospital to get evaluated. V23 could not explain or give account of how R1 eloped with the door alarm on because the front door alarm goes off when coming in or out then you will have to put the code in to stop it. V23 stated in part that every staff knows the code to get in or out and the alarm did not sound on my shift. On 07/24/25 at 3:33pm, V25 (Maintenance Director) stated that all the exit doors in the facility are in working condition, the front exit door is always working. The alarm goes off when staff or resident goes through the door without the code. After 8:00pm the receptionist set the code so no one can go in or out without the alarm not going off, the staff knows the code to reset the alarm not the residents. On 07/24/25 at 4:37pm, V18 NP (Nurse Practitioner) stated that she is not the direct NP for R1 but in cases where a resident has dementia and MI (Mental illness) diagnosis these types of residents need constant supervision and are not capable of going out without someone supervision, family or staff. They should be monitored closely. If the resident has a MI (Mental Illness) diagnosis schizophrenia, takes his/her medicine and in a stable mind may be go into the community. The surveyor then asked V18 that in your professional opinion what are the risk this type of resident might face? V18 stated that they can be in a danger to self or orders, and they should be monitored /supervised. On 07/28/25 at approximately 10:23am, V27 RN (Registered Nurse) confirmed that R1 was not in the facility at the start of her shift and none of the staff was aware of R1 missing until V22 (family) called at 12:45am 07/18/25 and the staff started looking for him. When asked whether it is safe for R1 to be out there in the community at that time of the night, V27 stated that it is not safe for R1 to be out in the community at that time of the night stating No, it is not safe because we don't know where he could be, and anything could have happened to him. On 07/28/25 at 3:35pm, V36 (Physician) for R1 stated that she is familiar with R1, was made aware of R1 leaving the facility unsupervised. V1 (Administrator) called me right away after the event cannot recall what time. V36 said she talk to V1 immediately believed R1	S9999		

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S9999	Continued from page 6 was taken to the hospital to get him fully evaluated and to have drug test done because he was out of the facility. The surveyor asked whether V36 have seen R1 since he returned to the facility, V36 said “No, I am out of the country now but when I returned, I will see him”. The surveyor asked is it appropriate for R1 to go out without authorization / supervision? V36 said “It shouldn’t be safe for anyone in the nursing home even if they are alert and oriented because he was able to make his own decision to get to his son. The surveyor then clarifies from V36 “Are you saying it is okay”. V36 said “I am saying is not okay, I would not want any of the resident at that time (of the day) to go out in the dark. The surveyor also asked V36 about what are the risk for R1 going out at that time without supervision and authorization, V36 said “The risk can be fall like any one being at risk, there is traffic, loose your way”. V36 added that R1 is alert times three knows what he was doing with BIMS of 15 at the time (tie of incident). The surveyor informed V36 that at the time of the incident R1’s BIMS score was 11 and not 15. V36 stated that I don’t know how they get 15 that is what I was told, R1 needs assistance and supervision to be out (out of the facility). On 07/21/25 at 1:32pm, V11 PRSC (Psychiatrist Rehabilitation Service Coordinator) assigned to R1 stated that R1 is alert oriented times three, R1 has some delusion and hallucinations, hard to redirect because he wants to do want to do against the facility policy. V11 stated she is aware about R1 going out of the facility without any supervision, I was informed on Friday (7/18/25) that (R1) left the building at 9:00pm on 7/17/25. He walked home rang the doorbell and his son answered the doorbell and then took him to the hospital for evaluation. The hospital released R1 back to us (Facility) on Friday and at that time my shift was over. V11 stated that R1 left the building because is fully aware of what he was doing, cognition is intact he wanted to go home, and he executed his plan. The receptionist leaves at 8pm, He (R1) waited till the front door was closed and left out of the building. When asked how she knows all these, V11 said V1 told her. The surveyor asked about how the residents are monitored /supervised to make sure the residents did not just go out without a pass/supervision. V22 said “When the receptionist leaves there should be nurses and CNAs to redirect the residents”. When asked about her professional opinion if R1 is able cognitively to go out of the facility without supervision/monitoring. V11 stated “I want to say yes and no. Cognitively he was intact depending on his mental status at the time. When he is medication compliant, he is on right mind but when he refuses his medication that’s when he	S9999		

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S9999	Continued from page 7 delusional and hear voices. V11 stated I did not see him until today because he came back after the end of my shift. On 07/21/25 at 2:10pm, V12 SSD (Social Services Director) stated that she is familiar with R1, he is one of our veterans, alert but can be delusional, not easy to re-direct. I did talk to V1 (Administrator), he mentioned that R1 left the facility, but he 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. I asked V11 to do a wellness visit on (R1) and document on him. V11 stated that R1 has been on elopement risk since admission because he did not want to be here at the facility and was voicing it. R1 is at risk for elopement and need staff supervision. He hears voices, talk to himself. When asked about pass privilege, V12 stated that R1 is not on independent pass because he must be supervised either by family or staff. Family must sign him, before going into the community unless he is going with staff on appointment. The front door has an alarm, and I have his picture on the list of our residents on elopement risk at front desk (receptionist desk). On 07/23/25 at 1:58pm, V4 ADON (Assistant Director of Nurses) stated in part that the facility policy is that the CNAs are supposed to make rounds every two hours and as needed. The facility visitation is over at 8:00pm unless the administrator makes exceptions, the only time the resident can go out is if they have independent pass. R1 is ambulatory and sits in the dining room most of the time at night. When asked whether she is aware that R1 went out of the facility without supervision of staff and the reason for him been moved to another floor. V4 said “I don’t have the details about it the (V1) Administrator did not discuss the detail with me, so I don’t know any detail about that. I just know he was coming from the hospital and need to be moved; I will have to discuss with V1 to know why he was moved. The surveyor V4 as the ADON and in her professional opinion is R1 cognitively capable of going about in the community without supervision? V4 said “Hun-hum, prior to that day (7/21/25), I will have to get back to you on that one, I was told he called for a ride to come and get him. On 07/21/25 at 4:14pm, V17 LPN (Licensed Practical Nurse) stated that the last time she saw R1 was around 8pm. When asked how the staff know when the resident tries to leave the facility without supervision/ unauthorized and whether she would let any of the resident go into the community without supervision, unauthorized and unaccompanied during the night. V17	S9999		

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S9999	Continued from page 8 stated that “No” she will not allow any resident to go out; that the receptionist leaves at 8pm, the alarm on the door exit will sound if any of the resident tries to leave. V17 stated that R1 cannot function without staff supervision or family supervision in the community. Families normally will have come and sign out the residents with social services or V1 authorization. V17 stated that rounds are made every two hours the CNAs at even hours and nurses at odd hours. Facility Pass Privilege policy presented dated 7/16 documents in part that this nursing facility emphasizes and expects respectful, mature conduct from each resident both within the facility and the outside community. Some individuals admitted to the facility have history of psychiatric problems. Because of a combination of mental health, physical problems and irresponsible behavior certain residents may not be fully capable of negotiating safely in the community. Procedure listed includes but not limited to persons who demonstrate consistent maladaptive and problematic behaviors may not be candidates for independent privileges. Decisions regarding pass privileges, including, independent privileges or being accompanied by responsible individual are determined by physician orders and social services assessments. As appropriate, pass privileges may be discussed at care plan meetings which the resident is encouraged to attend. The resident is responsible for making staff aware of his/her desire to receive an independent pass privilege. Pass privilege levels listed, Level1 (Supervised Pass), Level 2 (Restricted Pass), Level 3 (Independent Pass) and resident may only move up one level at a time. Facility policy titled Unauthorized Absence dated 8/14 documents that the purpose of the policy is to ensure the ongoing health and safety when a resident has eloped/ and or is otherwise unable to be accounted for during occurring times of the day. An “unauthorized absence” is one that the resident is unable to be accounted for upon the scheduled return from home pass, while out on community pass, at a day treatment program and/or other similarly situated times. If a resident has eloped and / or otherwise absent from the facility without prior permission of notification, the facility is to take the following measures. 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	S9999		

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S9999	Continued from page 9 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. Facility Incident/Accident Reports presented dated 9/14 documented in part that all accidents or incidents where there is potential for injury the report must be completed. An accident is defined as any happening, unintended event not consistent with the routine operation of the facility, that can result in bodily injury other than abuse. Listed incident / accident that report will be completed includes all accident/ incidental unusual occurrences , all unexpected events that occur that cause actual or potential harm to a resident and leaving premises without authorization (elopement).the administrator, Director of nursing, Assistant Director of nursing or Nursing supervisor must notify the following The incident/accident report is to be completed by RN (Registered Nurse) or LPN (Licensed Practical Nurse) and is to include date and time of the incident or accident., and the IDPH (Illinois Department of Public Health) The facility Supervision and Safety policy dated 3/15 presented documents that "our policy strives to make environment as free from hazards as possible. Resident safety and supervision are facility-wide priorities. Our facility -oriented approach to safely addresses risk for groups residents such as wanderers, behavior, aggressiveness, confusion etc. (And so on). Staff to make visual rounds on residents minimally every two hours and more often I necessary based on resident's assessment. (CNA) saw R1 standing in the front lobby at 8:00pm, R1 told the (CNA) that he was waiting for his ride, re-directed R1 back into the facility without making the staff on 3-11pm aware on the 1st floor. The facility Discharge Against Medical Advice (AMA) documented that the purpose of the policy is to define the facility's responsibility when a resident and /or	S9999		

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S9999	Continued from page 10 legal guardian voluntarily discharges him/herself from the facility without the consent of or an order from the attending physician. It is the policy of the facility to acknowledge the right of a resident to sign him/herself out of the facility without the consent of or an order from the attending physician providing that the resident has the decisional capacity to do so. If it has been determined that the resident is able to make his/her own decisions and chooses to exercise this right, he/she will be discharged from the facility Against Medical Advice (AMA). Procedure listed includes but not limited to prior to leaving the facility, the resident and/or guardian will be provided with explanation of the potential risks of such a discharge and alternatives to the same, any resident or legal representative choosing to discharge or be discharge without the consent of or an order from the attending physician is expected to sign AMA form. In the event the resident is signing him/herself out AMA, his /her legal representative and/or family member will be notified by facility personnel. (A)	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **0051318**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/07/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE CREST HEALTH CARE	**3300 WEST 175TH STREET , HAZEL CREST, Illinois, 60429**

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