Illinois Department of Public Health						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6007447	B. WING		C 10/11/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS. CITY. S	TATE, ZIP CODE		
414 SOUTH WESLEY AVENUE						
PINECREST MANOR 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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	ULD BE COMPLETE	
S9999	Final Observations		S9999			
	Statement of Licens 1 of 1 violation	sure Violation:				
	300.610a) 300.1030a)2) 300.1210b) 300.1210c) 300.3240a)					
	Section 300.610 R	esident Care Policies				
	procedures governifacility. The written be formulated by a Committee consisti administrator, the a medical advisory cof nursing and othe policies shall comp The written policies the facility and shall	dvisory physician or the ommittee, and representatives or services in the facility. The ly with the Act and this Part. It is shall be followed in operating I be reviewed at least annually documented by written, signed				
	Section 300.1030	Medical Emergencies				
	advisory committee procedures to be for medical emergenci time in long-term ca	ry physician or medical shall develop policies and ollowed during the various es that may occur from time to are facilities. These medical de, but are not limited to, such		Attachmer Statement of Licensu		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING IL6007447 10/11/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **414 SOUTH WESLEY AVENUE PINECREST MANOR MOUNT MORRIS, IL 61054** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL *(EACH CORRECTIVE ACTION SHOULD BE)* **PREFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 Continued From page 1 S9999 things as: Cardiac emergencies (for example, ischemic pain, cardiac failure, or cardiac arrest). Section 300.1210 General Requirements for Nursing and Personal Care 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. Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. Section 300.3240 Abuse and Neglect An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced by:

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E4 said R1 appeared to be fine and made a

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on the MAR (Medication Administration Record).

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