STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0046839	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF FREEPORT	2170 WEST NAVAJO DRIVE , FREEPORT, Illinois, 61032

(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	Initial Comments Facility Reported Incident of July 26, 2025 2576216	S0000		08/27/2025
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)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 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.	S9999		08/27/2025

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

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S9999	Continued from page 1 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 requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide safe mobility for residents by not ensuring footrests were on wheelchairs when pushing residents for 4 of 6 residents (R1, R4, R5, & R6) reviewed for safety in the sample of 6. This failure resulted in R1 falling out of the wheelchair and sustaining a laceration that required 3 sutures to close. The findings include: 1.R1's Face Sheet, dated 8/19/25, showed diagnoses including vascular dementia, moderate, with psychotic disturbance, encephalopathy, type 2 diabetes mellitus, nutritional anemia, atherosclerotic heart disease, hyperlipidemia, hypokalemia, hypothyroidism, vitamin D deficiency, anxiety disorder, depression, idiopathic gout, pain, overactive bladder, diarrhea, constipation, dysuria, and muscle weakness. The Minimum Data Set (MDS) dated 6/3/25 for R1 showed moderate cognitive impairment; substantial/maximal assistance needed for toileting, shower/bath, and lower body dressing; partial/moderate assistance needed for upper body dressing, personal hygiene, and wheeling 50 feet in manual wheelchair. R1's Current Care Plan, dated 6/11/25, showed Resident at risk for falling related to poor safety awareness and generalized muscle weakness (start date 9/13/25); last reviewed 8/5/25. The care plan was updated on 8/4/25 and showed staff assist of two with mechanical lift for transfers. Keep foot pedals in place if staff is providing transport assist. If R1 is self-propelling through the unit, allow her to self-propel (updated 7/28/25). The Nurses note, dated 7/26/25 at 9:32 PM for R1, showed, "resident exhibiting behaviors this shift.	S9999		

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S9999	Continued from page 2 Screaming, crying, running into things/people with her wheelchair, setting off the door alarm and going into others resident's rooms. At approximately 8:30 PM, (V3, Certified Nursing Assistant/CNA) began to push (R1) to her room when (R1) planted her feet firmly on the floor and fell face first onto the floor. Blood was noted on the floor and a small laceration to her forehead was observed. Pressure was applied to the wound and the resident was made comfortable while the nurse called 911. (R1) was transported to the emergency department (ED). Husband/power of attorney (POA) notified. Medical Doctor (MD) notified. Director of Nursing (DON) notified." The Long-Term Care Facility & IID - Serious Injury Incident and Communicable Disease Report for R1, dated 7/30/25, showed it was the final report for an incident that occurred on 7/26/25. The report showed R1 has multiple diagnoses including a history of vascular dementia and encephalopathy. R1 takes medications including Lexapro and risperidone. On 7/26/25 at approximately 8:30 PM, R1 was observed having a loss of plane. Upon notification the nurse immediately completed an assessment and noted a small laceration to R1's forehead with a small amount of blood loss noted. Mild discomfort to her head. Range of motion x 4 with no shortening, rotation, or deformity noted. Neuros within normal limits at baseline. Maintained position. At approximately 8:35 PM, the on-call physician was notified with orders to send to the emergency department (ED) to evaluate and treat. Power of attorney (POA) was phoned. 911 was phoned and arrived to transport R1 at 8:50 PM and left the building to the hospital ED. At approximately 12:36 AM on 7/27/25, resident returned to the facility with orders to cleanse forehead with soap and water. Three sutures noted and a hematoma formed. Upon investigation, it was determined that when R1 was being transported in her wheelchair, she had firmly placed her feet on the floor, which resulted in her falling forward out of her wheelchair. On 8/19/25 at 8:47 AM, V1 (Administrator) stated, "(V2, Director of Nursing/DON), did the incident investigation. (R1) was going to pull the fire alarm and (V3, Certified Nursing Assistant/CNA) went to stop her. (V3) moved (R1), and when she did this, the resident planted her feet on the floor. This caused a forward motion. (R1) fell out of her wheelchair and hit her head. (R1) had a laceration to her head." V1 stated when he came to the facility in September 2024, he did training/in servicing with the staff about using foot pedals when pushing a resident in their wheelchair. V1 stated it is his rule for resident safety. "(V3) did	S9999		

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S9999	Continued from page 3 not follow the rule for resident safety. (V3) didn't follow the procedure. When someone plants their feet, then staff should stop immediately right there and call for help, and put the foot pedals on. It is done for the resident's safety." On 8/19/25 at 9:17 AM, V3, CNA, stated, "(R1) was having behaviors all day, and she was exit-seeking. (R1) did not have foot pedals on her wheelchair because she moves around in her chair on her own. (R1's) wheelchair is reclined in back a little, but she doesn't sit all the way back in it; she never does. I went to move (R1) away from the door and when I turned (R1) around, she planted her feet. (R1) fell out of her wheelchair. (R1) did not have any foot pedals assigned to her." 2.R4's Face Sheet, dated 8/19/25, showed vascular dementia, parkinsonism, atherosclerotic heart disease, long term use of antithrombic/antiplatelets, hyperlipidemia, overactive bladder, retention of urine, pain, vitamin deficiency, abdominal pain, depression, anticoagulant use, elevation of levels of lactic acid dehydrogenase, constipation, shortness of breath, vomiting, and hypoxemia. R4's MDS, dated 7/3/25, showed severe cognitive impairment; partial/moderate assistance needed for toileting, upper body dressing, personal hygiene, and wheeling in a manual wheelchair 50 feet. R4's Care Plan, dated 6/27/25, showed resident is at risk for falling related to need for staff assist with daily activities and well as safety reminders. Staff assist of one with walker or grab bar for pivot transfers. Instruct resident to call for assist before getting out of bed or transferring. Encourage resident to stand slowly. Orientate resident to room, surrounding areas, and use of call light system. Encourage resident to use side rails/enablers as needed. Provide resident with specialized equipment i.e. walker and wheelchair. Assist resident with activities of interest. On 8/19/25 at 11:31 AM, V4, CNA, brought R4 into the dining room. V4 was pushing R4 in his wheelchair without any foot pedals in place. On 8/19/25 at 11:39 AM, V4 stated when pushing residents in the wheelchair, they should have the footrests on their chairs. V4 stated there is a blue bag on the back of the chair that holds the footrests. V4 she is supposed to use them, "just got in the moment", and forgot. All residents should have a bag on	S9999		

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S9999	Continued from page 4 the back of their wheelchair with the footrests in them. V4 stated they are supposed to use them for the resident's safety. 3.R5's Face Sheet, dated 8/19/25, showed diagnoses including Peripheral vascular disease, unspecified hypertensive urgency, dysphagia, left sided weakness, type 2 diabetes mellitus with foot ulcer, non-pressure chronic ulcer of other part of left foot with necrosis of muscle, laceration without foreign body, left foot, subsequent encounter, atrial septal defect, unspecified, hypomagnesemia, left wrist contracture, hypertension, abnormal posture, dysarthria and anarthria, benign prostatic hyperplasia with lower urinary tract symptoms, anxiety disorder due to known physiological condition, constipation, long term (current) use of antithrombotic/antiplatelets, and cognitive communication deficit. R5's MDS, dated 7/8/25, showed severe cognitive impairment; dependent for toileting, shower/bath, upper body dressing, lower body dressing, persona hygiene, and wheeling in a manual wheelchair 150 feet; partial/moderate assistance wheeling in a wheelchair 50 feet. On 8/19/25 at 11:33 AM, V5, Licensed Practical Nurse (LPN), pushed R5 into the dining room in his low padded wheelchair. R5's foot was sliding across the floor when she was pushing him. There wasn't a footrest in place. V5 stated she did not know why there wasn't a footrest on his chair; his chair would not have footrests like a regular wheelchair. V5 stated when residents are pushed in their wheelchairs, the foot pedals are supposed to be on the chair. V5 stated there is a blue bag on the back of the wheelchairs that holds the foot pedals. V5 stated the foot pedals should be used for residents' safety. 4.R6's Face Sheet, dated 8/19/25, showed diagnoses including cerebral infarction, spinal stenosis, dysarthria following cerebral infarction, muscle weakness, unspecified fall, subsequent encounter, aphasia following cerebral infarction, dysphagia following cerebral infarction, hypertension, other abnormalities of gait and mobility, hyperlipidemia, benign prostatic hyperplasia without lower urinary tract symptoms, (osteo)arthritis, pain, insomnia, constipation, and long term (current) use of antithrombotic/antiplatelets. R6's Care Plan, updated on 8/4/25, showed: Resident at risk for falling related to generalized muscle weakness and need for staff assist with daily cares. Staff	S9999		

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S9999	Continued from page 5 assist of two with stand aid for transfers with arm sling on right arm, high-profile toilet to aid in rest room use. Provide resident with specialized equipment, wheelchair, walker. Instruct resident to call for assist before getting out of bed or transferring. Encourage resident to stand slowly. Orientate resident to room, surrounding areas, and use of call light system. Encourage resident to use side rails/enablers as needed. Assist resident with activities of interest. R6's MDS, dated 7/8/25, showed moderate cognitive impairment; substantial/maximal assistance needed for toileting and lower body dressing; Partial/moderate assistance needed for shower/bath, upper body dressing, personal hygiene, and wheeling in a manual wheelchair 150 feet. On 8/19/25 at 11:37 AM, R6 did not have footrests on his wheelchair when V4, CNA, was pushing him into the dining room for lunch. On 8/19/25 at 11:39 AM, V4 stated when pushing residents in the wheelchair, they should have the footrests on their chairs. V4 stated there is a blue bag on the back of the chair that holds the footrests. V4 she is supposed to use them, "just got in the moment", and forgot. All residents should have a bag on the back of their wheelchair with the footrests in them. V4 stated they are supposed to use them for the resident's safety. On 8/19/25 at 12:23, V1 (Administrator) stated he did not have a policy for footrests being on wheelchairs when he did the in-service and training. V1 stated corporate told him there was a policy; so he did the in servicing. V1 stated he ordered the blue bags for the back of the wheelchairs to hold the footrests. At 12:26 PM, V1 stated V2, Director of Nursing (DON), contacted the corporate nurse who told her there wasn't a policy related to footrests, but all wheelchairs should have them. The In-Service Education/Meeting Report, dated 7/28/25, showed, "this is our policy and for their safety. All residents that are using a wheelchair must have wheelchair peddles. If for any reason you need to push a resident in a wheelchair, they must have pedals on at all times. If you don't have pedals, you don't push them." The facility's Safe Resident Handling policy (11/2012) showed the facility is dedicated to providing quality care to residents who have entrusted their lives to us and provide a work environment that is safe and	S9999		

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S9999	Continued from page 6 enjoyable to staff. Our Safe Resident Handling Program is designed to meet the following goals: Protect staff and residents from injury. All residents will be assessed for safe resident handling and moving. The assessment will consider: Staff and resident safety. The facility's Geriatric Chairs policy (2/2004) showed, adjust foot pieces. On 8/19/25, the facility did not have a policy regarding the use of foot pedals on wheelchairs. (B)	S9999		