

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0025098		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/21/2025	
NAME OF PROVIDER OR SUPPLIER FREEBURG CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 746 URBANNA DRIVE , FREEBURG, Illinois, 62243			
(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		S0000				
	Facility Reported Incident of 10/13/25/2645013						
S9999	Final Observations		S9999				
	Statement of Licensure Violations:						
	300.610a)						
	300.1210b)						
	300.3210t)						
	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.						
	Section 300.3210 General						
	t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to prevent abuse for 1 of 3 (R2) residents reviewed for abuse in the sample of 6. This failure resulted in R2 being cut on his face by another resident (R3) with a butter knife, falling from his wheelchair, subsequently requiring transfer to the local hospital for evaluation and treatment. Findings include: R2's face sheet documents an admission date of 4/7/2022. Diagnosis include Sepsis due to Streptococcus Pneumoniae, Dementia, Contracture of Left and Right Knees, Acute Respiratory Failure, Cerebral Infarction, Chronic Pain Syndrome. R2's Minimum Data Set, MDS, dated 10/6/2025 documents R2 is moderately cognitively impaired. R2's care plan updated 9/14/2025 documents R2 has a behavior problem: Attempting to make others feel sorry for him. Pretending to be sick related to diagnosis of Major Depressive Disorder. Attention Seeking. Upset about diagnosis of Dementia and fixates due to diagnosis of General Anxiety Disorder. R3's face sheet documents an admission date of 9/25/2025. Diagnosis include Anxiety Disorder, Dementia, Chronic Atrial Fibrillation, Benign Prostatic Hypertrophy. R3's MDS dated 10/3/2025 documents R3 has no cognitive deficits. R3's care plan dated 9/26/2025 The resident has an alteration in neurological status. Interventions include cueing, reorientation as needed. Facility provided incident report dated 10/15/2025 Incident: At approximately 12:30PM residents R2 and R3 were sitting in the dining room at separate tables eating lunch. Per camera footage R3 grabbed a butter knife off the table and stood from wheelchair and moved it towards R2's face, contacting R2's cheek and creating a laceration approximately 2 cm (centimeters) long. R3's and R2's altercation continued for about 35 to 40 seconds. R2 slid from wheelchair during the altercation landing on his bottom. R3 walked from the dining room immediately following. Staff made V8 (LPN-Licensed Practical Nurse), V2 (DON-Director of Nursing), and V1 (Administrator) aware immediately.		S9999				

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S9999	Continued from page 2 Immediate assessment was given to R2. Vitals obtained; neuro checks initiated. POA (Power of Attorney) and V9 (Nurse Practitioner) made aware as soon as possible. V8 did full body assessment and first aid given to R2. New order to send to hospital for evaluation and treatment given. Staff stayed with R2 until Emergency Medical Services, EMS, arrived and transported to local hospital. POA did not express desire to make police report. R3 was under 1 on 1 supervision immediately following incident and until leaving facility. V2 and V4 (SSD-Social Services Director) present. First aid was attempted, and R3 refused all care. Attempting to strike staff when attempting to give care. POA and ombudsman made aware of the order to send R3 out to hospital for psychological evaluation. R3 left facility with EMS and was transported to hospital. On 10/21/2025 at 8:45AM facility provided video surveillance of incident with R2 and R3. Video dated 10/13/2025 showed R2 and R3 sitting at dining tables next to each other. R3 stood up, took a step over to R2 and stabbed a butter knife into R2's right cheek below the right eye. R2 began struggling and trying to grab knife and then fell out of wheelchair. R3 then dropped the knife and walked out of frame of video. Staff members came into frame and began assisting R2. On 10/21/2025 at 9:00AM R2 sitting up at dining room table in wheelchair. Surveyor asked R2 about incident with R3. R2 stated "I was sitting here and this guy I didn't know clocked me. I thought he punched me, but he used a knife. I only saw his fist. I fell out of my chair. He's gone now." Surveyor asked R2 if he felt safe and R2 stated "I guess so." On 10/21/2025 at 9:15AM V6, CNA (Certified Nurse's Assistant), stated I was at a table close by R2's table assisting another resident and heard R2 scream "My eye my eye." I ran over and R3 was walking away with a glazed look in his eyes. He said, "Get out of my face #####." I started helping R2 and getting his vitals. R3 left the dining room with other staff. R3 had never acted this way before. On 10/21/2025 at 8:10AM V5, RN (Registered Nurse) stated I was in V2's office when I heard someone yell "Help me Help me." I saw R3 walking away out of the dining room. Staff members that were in the dining room were already there and walking with R3 and staff were already assisting R2. R2 was on the floor. R2 thought he had gotten hit. We laid R2 on the ground flat. R2 had a very small laceration under his right eye on his			S9999			

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S9999	Continued from page 3 cheekbone area. There was a very small amount of blood. We started neuro checks and vitals on R2 and helped him up. R3 was sent out to the hospital first and then R2. R2's vitals and neuro checks were all fine. On 10/21/2025 at 8:33AM V2, DON, stated I was in my office the time of the incident with R2 and R3. I heard "Ouch, Ouch" and went running out of office. I saw R2 on the floor and his head was on the foot pedals of his wheelchair. I asked R2 what happened, and he said, "That guy clocked me." We then laid R2 flat and started getting vitals and neuro checks. One of the CNAs had walked out of the dining room with R3. I went to see about R3, and he was away from all other residents. He was talking crazy. He was saying his wife was cheating on him and his son was stealing from him. He was irate. We stayed with him and kept him away from residents until EMS came. On 10/21/2025 at 10:40AM V8, LPN, stated I was walking back into the dining room on 10/13/2025 during lunch and heard R2 yelling help and that his eye hurt. V2 was already there by R2 and some other staff were with R3 keeping him away from other residents. We started vitals and neuro checks. I then called and got orders to send both residents out. Facility abuse policy updated 12/13/2023 states "This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of property, corporal punishment and involuntary seclusion. This facility therefore prohibits mistreatment, neglect or abuse of its residents, and has attempted to establish a resident-sensitive and secure environment. The purpose of this policy is to assure that the facility is doing all that is within our control to prevent occurrences of mistreatment, neglect or abuse of our residents." (B)		S9999				