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 11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREEBURG CARE CENTER	**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 Annual Licensure Survey	S0000		12/10/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 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 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	S9999		12/10/2025

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

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S9999	Continued from page 1 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 were not met as evidenced by: Based on interview and record review the Facility failed to provide proper supervision to prevent a fall for 1 of 15 (R1) residents reviewed for supervision of falls in the sample of 42. This failure resulted in R1 being sent to the hospital on 11/18/2025 for a fall which resulted in a facial laceration on her scalp and required her to have her scalp glued back together. Findings include: R1's Physician Order Sheet (POS) for November 2025 documents a diagnosis of anxiety, restlessness, and agitation, unsteadiness on feet, a history of falling and weakness. R1's Facesheet documents she was admitted to the facility on 4/3/2025 for therapy then transitioned to a long-term resident. R1's Minimum Data Set (MDS) dated 8/29/2025 documents she is severely impaired. Toileting hygiene, Substantial assist: the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement helper does more than half the effort. Helper lifts or holds trunks or limbs and provides more than half the effort." R1's Care Plan under intervention task dated 4/3/2025, "Resident has a history of falls. Applied chair and bed pad alarm. 5/29/2025, "Moved resident to a room that is closer to the nurse's station. 11/13/2025. Bed against the wall and floor mat x 1. 11/18/2025 fall off toilet re-educated staff on not leaving resident unsupervised. R1's Care Plan documents, "Resident at risk for falls 5/29/25 Fall in room out of bed 11/13/25 Fall out of bed." R1's Progress Notes dated "Late Entry:11/18/2025 at 7:50 PM, "Note Text: CNA (certified nursing assistant) notified this writer that resident had fell while sitting on the toilet in her bathroom. CNA reported that she heard resident yelling and stating that she needed to "poop". CNA states they assisted resident to	S9999		

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S9999	Continued from page 2 her bathroom. CNA states resident was weak and had another CNA assist her with transferring resident to the restroom. CNA states that after assisting resident to her restroom both CNA's stood in resident's bathroom doorway. CNA reports resident leaned forward and fell forward while sitting on the toilet. CNA states they tried to rush and catch resident but were unable. Resident noted with a one-inch laceration to her mid to left forehead. Pressure/cloth applied to forehead. No other injuries noted. ROM (range of motion) and neuro checks are within normal limits." On 11/26/2026 at 11:23 AM, V11, Certified Nurse Assistant (CNA), stated, "I was assisting another resident when I got called by (V12, CNA) asking for help because (R1) was screaming that she had to go poop and she is weak and needs two assistance. We used a gait belt and safely transferred (R1) to the toilet and waited outside the door but the door was open but (R1) leaned forward and fell. She went out to the hospital. I did get written up for it for not being closer to her." R1's Incident Report dated 11/18/2025 documents, "Incident: CNA's who witnessed fall states that resident, (R1) leaned forward while sitting on the toilet, lost balance, and fell forward off toilet, lost balance, and fell forward off toilet. (sic) (V7, Licensed Practical Nurse - LPN) assessed resident immediately. Noted lacerations to forehead, above left eyelid. (V8), Physician and V9, Nurse Practitioner made aware of fall. Orders obtained to send (R1) to the emergency room for evaluation and treatment. Staff stated with (R1), applying pressure to laceration until EMS (Emergency Medical services) arrived. V11's (CNA, Certified Nursing Assistant) Employee Warning Notice dated 11/18/2025 at 7:50 PM, "This aid with assist of other aid (V12) transferred resident to toilet. Resident wears personal safety alarm. Resident not watched at full attention resulting in resident falling off toilet and hitting head face on floor." V12's CNA Employee Warning Notice dated 11/18/2025 at 7:50 PM, "This aid with assist of other aid (V12) transferred resident to toilet. Resident wears personal safety alarm. Resident not watched at full attention resulting in resident falling off toilet and hitting head face on floor." On 11/26/2025 at 11:42 AM, V12, CNA stated, "I heard (R1) yelling out and she said she had to go to the bathroom and when I went to put the gait belt around her, I could tell she was weak. I called out for help	S9999		

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S9999	Continued from page 3 (V11) came and help me and we stood her up with the gait belt and we placed her on the toilet, and she was sitting on the toilet, and it happened so fast she fell. I did get written up they said I was not close enough to her. I was in the doorway of the bathroom, and they said I was too far away." On 11/26/2025 at 11:50 AM, V2, Director of Nursing (DON) stated, "We did write up (V11) and (V12) for (R1's) fall because we felt because R1 has alarms and a history of falls they should have been closer to her and not in the doorway with her history." R1's Hospital Report dated 11/19/2025 documents R1 was seen at the ED (Emergency Department) for a facial laceration on her scalp. The hospital glued back together and did CT scans which showed no brain bleeds or skull fracture. The Facility Fall Policy undated documents, "Purpose: To prevent resident falls, reduce injuries, and ensure timely assessment, response, and documentation." (B)	S9999		