

Illinois State Department of Health

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 03/19/2026	
NAME OF PROVIDER OR SUPPLIER MANOR COURT OF FREEPORT				STREET ADDRESS, CITY, STATE, ZIP CODE 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		S0000			03/30/2026	
	Complaint Investigation 2013056/2802838						
S9999	Final Observations		S9999			03/27/2026	
	Statement of Licensure Violations:						
	300.610a)						
	300.1210b)						
	300.1210c)						
	300.1210d)2)5)						
	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						

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 resident care plan. 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: 2) All treatments and procedures shall be administered as ordered by the physician. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to perform weekly skin assessments, failed to identify a pressure ulcer prior to late stages for 1 resident, failed to obtain physician's orders for treatment of a pressure ulcer for 1 resident. This failure resulted in R3 obtaining a Stage 3 pressure ulcer that required surgical debridement and advanced to a Stage 4 pressure ulcer. These failures apply to 1 of 3 residents reviewed for pressure ulcers in the sample of 3. The findings include: R3's electronic face sheet, printed on 3/19/26, showed R3 has diagnoses including but not limited to dementia without behaviors, pain in right hip, stage 3 pressure ulcer to right hip, and depression. R3's facility assessment, dated 12/13/25, showed R3 has moderate cognitive impairment, requires partial/moderate assistance to roll left and right, and is at risk of developing pressure ulcers. R3's care plan, dated 6/10/25, showed, "Resident is at increased risk for pressure ulcer related to decreased mobility, generalized muscle weakness, and need for staff assist with transfers...assist resident with turning and repositioning." R2's care plan, dated 6/10/25, showed, "Skin checks each shift."		S9999				

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S9999	Continued from page 2 R3's physician's orders showed no orders for weekly skin assessments from December 2025-January 2025. R3's pressure injury event, dated 1/2/26, showed, "1/2/26 Resident has what appears to be an unstageable pressure injury, measuring 2 x 2 cm (centimeters), to the right ischial protuberance. The wound bed is completely dry. The edges are indurated. Bordered foam placed for protection. Will contact primary for treatment orders. Endorsed to next shift." R3's physician's orders, dated 1/6/26, showed, "Right hip: clean and pat try. Skin prep to peri wound then apply hydrogel with silver and a bordered gauze." No treatment orders or documentation of any treatments were present in R3's medical record from 1/3-1/5 for her pressure wound. R3's wound physician notes, dated 1/5/26, showed, "Stage 3 pressure wound of the right hip, full thickness >1 day. Wound size 1.9cmx2.0cmx0.2cm. Light serous (clear) exudate." R3's wound physician notes, dated 1/12/26, showed, "Necrotic tissue: 20%, Slough: 20%, Granulation tissue: 20%...Surgical excisional debridement procedure: remove necrotic tissue and establish margins of viable tissue. Post-Stage: Stage 4 pressure wound of the right hip, full thickness." As of 3/19/26, R3 continues to have a Stage 4 pressure ulcer to her right hip as evidenced by continued wound physician visits on a weekly basis and continued treatment to R3's pressure ulcer. On 3/17/26 at 10:21AM, V4 (Registered Nurse) stated, "Whatever I charted is what the wound looked like. I can't remember that long ago to tell you anything about it. You'll just have to look at the documentation." On 3/19/26 at 9:08AM, V8 (Registered Nurse) stated, "Skin assessments are done weekly on every resident. In our computer system, you go into the treatment record, and it will show you whether or not they have skin assessments or treatments or anything. We don't really have a check system, we put in a progress note that the resident had a skin assessment and whether or not their were findings." On 3/19/26 at 9:36AM, V2 (Director of Nursing) and V9 (Wound Care Nurse) stated, "Every resident gets a skin assessment on their shower days. The aides report anything out of the ordinary to the nurse. If there are		S9999				

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S9999	Continued from page 3 no skin alterations, then the nurse doesn't do a skin assessment. No shower sheets are done for residents. Some residents do have skin assessments that are done by the nurse. (R3's) wound was identified on 1/2/26 and was unstageable to her right hip. (V10, Wound Care Physician) saw her on the 5th and staged it at a stage 3 and initiated treatment. It's an issue that is was found at a stage 3 because that means the wound has been going on for a while and should have been identified earlier." On 3/19/26 at 11:39AM, V10 stated, "In general, if a wound is necrotic then that is a problem to be identified as a stage 3. I wouldn't have debrided a wound that wasn't necrotic. It would have remained as an unstageable wound and we would have treated it as such. If I stated in my note that it was full thickness, then that means there was loss of skin and the wound was open. That would not have occurred within a few days. I was able to stage it better after debridement and it was moved to a stage 4 wound. It is the responsibility of the facility staff to ensure and encourage offloading measures. If a resident is not compliant, that should be documented. There are many residents who are noncompliant and facility's are able to identify a wound at early stages. At the end of the day, skin assessments should be completed on all residents to ensure even the smallest wound alterations are identified and treated immediately to prevent wound progression." On 3/19/26 at 12:32PM, V1 (Administrator) and V2 (Director of Nursing) provided documentation to surveyor of unavoidable pressure injury for R3 following surveyors interview with V10. V2 stated, "(R3) does refuse interventions but we don't have it documented like we should. Perhaps if we would've had that in place, we could have thought of alternative interventions. I do not see documented weekly skin assessments for her and she is one that should have them as she is noncompliant with interventions. I understand where you are explaining the late stage finding, and again, this is a learning experience for me and my nurse's." The facility's policy titled, "Bath (Shower)", revised 01/04, showed, "Objectives...2. To observe the skin...15. Report any reddened areas, skin discolorations, or skin breaks to the nurse..." The facility's policy titled, "Pressure Injury/Pressure Ulcer Prevention and Treatment", revised 10/24/22, showed, "Objective and Purpose: To ensure that measures are taken to prevent skin breakdown and to provide			S9999			

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S9999	Continued from page 4 guidelines for treatment of any pressure injury or pressure ulcer that might develop. Pressure Ulcer/Injury (PU/PI) refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. A pressure ulcer will present as an open ulcer, the appearance of which will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Soft tissue damage related to pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities and condition of the soft tissue...Principles: 2. An individualized plan of care will be developed for the resident following the guidelines of the assessment..." (B)			S9999			