STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING: _____ B. WING _____	C 05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF FREEPORT	2170 WEST NAVAJO DRIVE FREEPORT, IL 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) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 2313587/IL159309	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.3210t) 300.3240b) 300.3240e) 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.	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING: _____ B. WING _____	C 05/03/2023

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

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S9999	Continued From page 1 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 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. 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. Section 300.3240 Abuse and Neglect b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act)	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING: _____ B. WING _____	C 05/03/2023

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

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S9999	Continued From page 2 e) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These Requirements Were Not Met as evidenced by: Based on interview and record review the facility failed to ensure residents were free from physical abuse for 2 of three residents (R1, R3) reviewed in the sample of three. This failure resulted in R2 physically abusing R1 and R3 on 4/20/23 when R2 twisted R1's arm and caused a skin tear to her left hand. R2 sat on R3 while she was in bed and hit her. On 4/28/23 R2 hit R3 repeatedly with a call light. The findings include: 1. The Event Documentation dated 4/20/23 at 1:28 AM for R1 showed she was called into a resident's room by a CNA (Certified Nursing Assistant). R1 was lying in bed with a bloody gown covering her left hand. R1 had a skin tear on the top of her left hand that measured 4.5 cm. The edges were approximated, cleansed, (Brand) thin adhesive wound closure strips placed, and covered. When I asked what happened R1 stated, "She squeezed my hand with her hands and told me to leave her house; she pushed on my chest really hard." The CNA stated around	S9999		

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	IL6016133	A. BUILDING: _____ B. WING _____	C 05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF FREEPORT	2170 WEST NAVAJO DRIVE FREEPORT, IL 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) COMPLETE DATE
S9999	Continued From page 3	S9999		

1:00 AM he redirected R2 back to her room after he found her standing in the doorway of R1's room. R1 complained of pain; Ibuprofen given.

On 5/2/23 at 9:00 AM, V1 (Administrator) stated on Thursday (4/27/23) V16 (R1's daughter/Power of Attorney) came in to visit R1 and reported to us that R1 had bruises and a skin tear from another resident. V16 asked what we were going to do about her mother's situation, and I had no idea what she was talking about until she told me. V1 stated V2 took over this incident. V1 stated that the incident was resident to resident abuse.

On 5/2/23 at 11:01 AM, V4 (Registered Nurse/RN) stated she was called to the dementia unit. The CNA told her that R2 was standing in the doorway of R1's room. The CNA did not think to check R1 at that time or to tell her about it. V7 (Certified Nurse Assistant/CNA) went to do a bed check and came back saying R1 was bleeding. V4 stated R1 had a skin tear to her hand that she cleaned, applied (Brand) thin adhesive wound closure strips and a dressing to. V4 stated R1 told her someone pushed her on her chest.

On 5/2/23 at 11:22 AM, V7 (CNA) stated, "R2 was by R1's room and I told her to go back to her room. I called the nurse. I went to change R1 at bed check, and there was blood on the sheets. I screamed for my co-worker and the nurse. R1 had a skin tear to her left arm. The nurse talked to R1, and R1 told her that the lady (R2) was trying to fight her. R2 wanders in rooms and is difficult. R2 is very difficult to watch. R2 goes in other rooms thinking she is in her house. R2 constantly moves around. R2 gets irritated when you talk to her. R2 is hard to re-direct."

On 5/2/23 at 11:38 AM, V6 (Certified Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING: _____ B. WING _____	C 05/03/2023

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

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S9999	Continued From page 4	S9999		

Assistant/CNA) stated that she was in a resident's room when V7 (CNA) found R2 in the doorway of R1's room. At bed check, V7 screamed for her and V4 (RN) and said that R1 was bleeding. R1 said a lady came in and grabbed her. V6 stated that was all she knew.

On 5/2/23 at 1:03 PM, V9 (Certified Nurse Assistant/CNA) stated R2 is a resident who wanders and can be combative. V9 stated R2 goes into other residents' rooms. V9 stated staff can redirect R2 unless she is really worked up. If R2 is worked up, they have to back off her and make sure no residents are around her. When R2 gets into her moods, she can be out of control.

On 5/2/23 at 1:41 PM, V10 (Certified Nurse Assistant/CNA) stated she found out about R2 and R1 in report after the incident happened. R2 went into R1's room and caused a skin tear to her arm. V10 stated that all R1 said was that some lady did it. V10 stated after the incident with V2 and other residents on 4/20/23, the facility did not tell them to do anything different with R2. V10 stated no education was given and nothing was done.

On 5/2/23 at 3:32 PM, V12 (Certified Nurse Assistant/CNA) stated she was not aware of anything happening between R2 and any other residents. V12 was not aware of R2 being a wanderer or needing any closer supervision.

On 5/2/23 at 3:40 PM, R1 was sitting in a chair in the common area of the dementia unit. R1 had a long, curved, scabbed red line across her left hand. R1 had several bruises to her left arm and a bruise to her right hand. R1 stated, "She cut me with her nail across here" and pointed to her left hand. R1 stated, "She was squeezing me" and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING: _____ B. WING _____	C 05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF FREEPORT	2170 WEST NAVAJO DRIVE FREEPORT, IL 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) COMPLETE DATE
S9999	Continued From page 5	S9999		

grabbed her left arm with her right hand to show how she was being squeezed. R1 stated it hurt when the lady did that. R1 stated that the lady hit her in her shoulder. R1 pointed to her right shoulder. R1 stated it was scary when the lady grabbed her arm and hit her.

On 5/3/23 at 7:47 AM, V2 (Director of Nursing/DON) stated someone told her the next day that R2 had given R1 a skin tear. V2 stated the nurse on the night shift did not tell her that it happened. V2 stated she was not told about it until 4/21/23. V2 stated it was resident-to-resident abuse. V2 stated abuse training is done when staff are hired and annually.

On 5/3/23 at 9:05 AM, V15 (Nurse Practitioner/NP) stated she has received paperwork about R2's behaviors, and for a while she was increasing R2's medications. V15 stated she was leery of increasing the medications too much because there needs to be some time in there to see how the medications are working. V15 stated sometimes residents with dementia will have behaviors because they are not being attended to. Residents will wander and get upset. V15 stated that for R2, she would expect staff to redirect R2 and spend more time with her. If R2 becomes aggressive then back off, remove other residents from the area if they can't move R2. V15 stated she would expect staff to keep other residents safe. They should be monitoring R2 closer and the types of behaviors she has. V15 stated she reviews the progress notes when she comes in. If there isn't any documentation of what was happening for the resident, then she would not know about it.

On 5/3/23 at 9:16 AM, V16 (R1's daughter/Power of Attorney) stated, last Thursday, on 4/27/23, I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING: _____ B. WING _____	C 05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF FREEPORT	2170 WEST NAVAJO DRIVE FREEPORT, IL 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) COMPLETE DATE
S9999	Continued From page 6	S9999		

came into the facility for my weekly visit. R1 was lying down, and I saw her arms and hand. R1's left forearm was swollen and bruised to her fingertips. R1 had a large cut that was nasty looking to her left hand. R1 had a bruise to her right hand. I asked R1 what happened, and she said someone came in her room in the middle of the night, squeezed her arms and it hurt really bad. I went out of the room and asked V10 (CNA) about R1's arms. She said I should talk to V5 LPN (Licensed Practical Nurse). I asked V5 what happened. She looked in the computer and said R1 was attacked by a resident. V5 said it happened on 4/20/21 between 1-1:30 AM. V5 said I should talk to V1 (Administrator) or V2 (DON). We just want our mom to be safe, feel safe, and be content. R1 is 97 years old and doesn't have much time left. If R1 didn't have dementia she would be horrified and have trauma. R1 maybe wouldn't be able to sleep because she would be worried it would happen again. R1 would probably want to leave.

R2's Face Sheet dated 5/3/23 showed medical diagnoses including dementia, anxiety, type 2 diabetes mellitus, chronic kidney disease, post-traumatic stress disorder, unsteadiness on her feet, pain, fall, and disorientation.
The Physician Order's for R2 dated 4/3/23 - 5/3/23 showed, walk with assistance and walker.

The Progress Notes for R2 showed she was admitted to the facility on 3/6/23.

The MDS (Minimum Data Set) Assessment dated 3/12/23 for R2 showed severe cognitive impairment; physical, verbal, and other behaviors; and no assessment of her functional status.

The Care Plan for R2 dated 4/28/23 showed she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING: _____ B. WING _____	C 05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF FREEPORT	2170 WEST NAVAJO DRIVE FREEPORT, IL 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) COMPLETE DATE
S9999	Continued From page 7	S9999		

has diagnoses of anxiety, dementia, and post-traumatic stress disorder. Due to these she is displaying physical behaviors, verbal behaviors and wandering. At times she wanders the unit or into other resident's rooms disturbing them. At times, it is difficult to redirect R2. The Care Plan was updated on 5/2/23 and did not show frequent monitoring.

The Facility's Abuse Prohibition and Reporting policy (11/28/19) showed the purpose of the policy was to protect the residents from any kind of abuse such as verbal, sexual, mental, physical, including corporal punishment, involuntary seclusion, neglect, misappropriation of property, exploitation and any physical or chemical restraint not required to treat the resident's symptoms. Special attention will be given to identifying behavior that increases the resident's potential for abusing self or others or being a victim of abuse. These behaviors would include residents with a history of aggressive behaviors, residents who have behaviors such as entering other resident rooms, residents with self-injurious behaviors, residents with communication disorders, and those who require heavy nursing care and/or are totally dependent on staff. Appropriate interventions to address identified behaviors will be included on resident care plans and reviewed as/when change occurs. These interactions will be communicated to the direct care staff. If another resident is the suspected perpetrator of abuse, then the suspected resident shall be supervised 1:1 or kept physically separate from other residents until further orders.

2. The Nurse's Note dated 4/20/23 at 1:21 AM for R3 showed the nurse was called into R3's room by the CNA. The CNA stated she entered R3's

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	IL6016133	A. BUILDING: _____ B. WING _____	C 05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF FREEPORT	2170 WEST NAVAJO DRIVE FREEPORT, IL 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) COMPLETE DATE
S9999	Continued From page 8	S9999		

room and her roommate (R2) was sitting on top of R3. R3 stated R2 was yelling at her; telling her to get out of her bed. R3 stated R2 punched her. R3 was pointing to the area just below her right clavicle. R3 stated she told R2 that it hurt and reached for her call light. R2 was removed from the room.

On 5/2/23 at 11:01 AM, V4 (RN) stated she was called to the dementia unit on 4/20/23 around 1:00 AM or 1:30 AM by the CNAs. V4 stated she went to R3's room and R2 was sitting on top of R3. V4 stated she wasn't sure if she notified V1 (Administrator) or V2 (DON). V4 stated "Sure" and "I don't know" when she was asked if V1 (Administrator) and V2 (DON) are supposed to be notified of resident-to-resident abuse.
On 5/2/23 at 11:22 AM, V7 (CNA) stated R2 was sitting on top of R3 and was trying to fight her. R2 was screaming to get R3 out of there. The nurse went in and talked to R2.

On 5/2/23 at 11:38 AM, V6 (CNA) stated at some point in the night R2 was sitting on R3. V6 stated her and V7 saw it and told the nurse. V6 couldn't remember if R2 stated R3 had hit her or not. V6 stated R2 said that R3 talks and talks and wants to fight.

On 5/2/23 at 1:51 PM, V1 (Administrator) stated he did not know anything about R2 sitting on R3 or hitting her on 4/20/23. V1 stated it was never reported to him and it should have been. V1 stated it was resident to resident abuse.

On 5/3/23 at 7:47 AM, V2 (DON) stated no one told her about what happened between R3 and R2 on 4/20/23. V2 stated she was reading a note and R2 had hit and sat on R3. V2 stated she read about it the next day when she was looking at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING: _____ B. WING _____	C 05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF FREEPORT	2170 WEST NAVAJO DRIVE FREEPORT, IL 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) COMPLETE DATE
S9999	Continued From page 9 R2's information. V2 stated it was resident to resident abuse. The Facility's Abuse Prohibition and Reporting policy (11/28/19) showed the purpose of the policy was to protect the residents from any kind of abuse such as verbal, sexual, mental, physical, including corporal punishment, involuntary seclusion, neglect, misappropriation of property, exploitation and any physical or chemical restraint not required to treat the resident's symptoms. Special attention will be given to identifying behavior that increases the resident's potential for abusing self or others or being a victim of abuse. These behaviors would include residents with a history of aggressive behaviors, residents who have behaviors such as entering other resident rooms, residents with self-injurious behaviors, residents with communication disorders, and those who require heavy nursing care and/or are totally dependent on staff. Appropriate interventions to address identified behaviors will be included on resident care plans and reviewed as/when change occurs. These interactions will be communicated to the direct care staff. These interactions will be communicated to the direct care staff. If another resident is the suspected perpetrator of abuse, then the suspected resident shall be supervised 1:1 or kept physically separate from other residents until further orders. 3. On 5/3/23 at 1:03 PM, V9 (CNA) stated she saw R2 hit another resident. On Friday, 4/28/23, she stated she came into work in the morning and got report. At around 6:30 AM, there was a call light going off and she went to answer it. When she went into the room R2 had the call light and was hitting R3 with it. R3 was trying to get out of bed on her own to get away. V9 stated	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING: _____ B. WING _____	C 05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF FREEPORT	2170 WEST NAVAJO DRIVE FREEPORT, IL 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) COMPLETE DATE
S9999	Continued From page 10 she yelled for help and V10 (CNA) came down. On 5/3/23 at 1:18 PM, V10 (CNA) stated on Friday 4/28/23 R3's call light went off and V9 (CNA) caught R2 whipping the call light at R3's back. R2 was in the first bed and R3 was in the second bed. V10 stated they cleaned R3 up and removed her from the room. On 5/3/23 at 2:35 PM, V1 (Administrator) stated V2 (DON) sent him a text message on Friday, 4/28/23 at 6:31 AM, that we needed to do something with R2 because she had been hitting people with a call light. It didn't get reported to IDPH. V1 stated it was abuse. V1 stated he thought it didn't get reported because they were busy with R1's daughter and what happened to R1. A review of R3's medical record did not show any documentation of her being hit by another resident on 4/28/23. The last Progress Note for R3 was dated 4/26/23. On 5/2/23 at 3:50 PM, V1 stated the last Progress Note in R3's chart was dated 4/26/23. V1 stated he asked V2 (DON) why the incident on 4/28/23 between R3 and R2 was not documented in the progress notes. V2 said V5 (Licensed Practical Nurse/LPN) should have documented it in the progress notes. On 5/3/23 at 7:47 AM, V2 (DON) stated the morning (4/28/23) that they said R2 hit R3 with a call light she sent a message to V1 (Administrator) and V14 (Social Services). V2 stated she told them R2 needed to be put in a different room, so they were aware of what happened. V2 stated V5 (LPN) should have put a note in the resident's medical record. V2 stated	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF FREEPORT	2170 WEST NAVAJO DRIVE FREEPORT, IL 61032

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S9999	Continued From page 11	S9999		

the incident was reported to her and she reported it to V1. V2 stated it was resident-to-resident abuse.

On 5/3/23 at 8:45 AM, V5 (LPN) stated she was the nurse on duty on 4/28/23 on the dementia unit. V5 stated a CNA went to answer R3's call light. V5 stated she was told that R2 was over R3's bed, hitting R3 with the call light. V5 stated they got R3 dressed and out of the room. V5 stated she asked V14 (Social Services) to ask V1 (Administrator) how to chart the incident. V5 stated no one got back to her on charting. V5 stated another nurse had told her they wanted things charted a certain way. V5 stated she could have documented, but the day got away from her and she didn't do it. V5 stated she reported what happened to V2 (DON) because it was resident-to-resident abuse.

The Facility's Abuse Prohibition and Reporting policy (11/28/19) showed the purpose of the policy was to protect the residents from any kind of abuse such as verbal, sexual, mental, physical, including corporal punishment, involuntary seclusion, neglect, misappropriation of property, exploitation and any physical or chemical restraint not required to treat the resident's symptoms. Special attention will be given to identifying behavior that increases the resident's potential for abusing self or others or being a victim of abuse. These behaviors would include residents with a history of aggressive behaviors, residents who have behaviors such as entering other resident rooms, residents with self-injurious behaviors, residents with communication disorders, and those who require heavy nursing care and/or are totally dependent on staff. Appropriate interventions to address identified behaviors will be included on resident care plans and reviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING: _____ B. WING _____	C 05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF FREEPORT	2170 WEST NAVAJO DRIVE FREEPORT, IL 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) COMPLETE DATE
S9999	Continued From page 12 as/when change occurs. These interactions will be communicated to the direct care staff. These interactions will be communicated to the direct care staff. If another resident is the suspected perpetrator of abuse, then the suspected resident shall be supervised 1:1 or kept physically separate from other residents until further orders. The following will be documented in the resident's medical record: a. The nature and extent of any injuries sustained or the condition resulting from the alleged incident. b. Whether the resident was sent to the hospital. c. Whether the resident's physician was called. (B)	S9999		