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 _____	08/29/2024

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 Annual Health Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610 a) 300.1010 h) 300.1210 b) 300.1210 c) 300.1210 d)2) 300.1210 d)3) 300.1210 d)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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or	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 _____	08/29/2024

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 1	S9999		

manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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.

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.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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

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 _____	08/29/2024

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 2	S9999		

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 observation, interview, and record review, the facility failed to identify a pressure wound prior to becoming advanced stages, failed to identify deterioration of an existing pressure ulcer, failed to perform weekly wound assessments, failed to perform accurate wound assessments for 2 residents (R75, R63), failed to provide wound treatments, failed to maintain documentation of wound assessments for 1 resident (R16), and failed to ensure pressure ulcer prevention measures were in place for 1 resident (R63). These failures resulted in R75 experiencing sepsis requiring hospitalization, surgical debridement of his necrotic wound, and placement of a colostomy due to an infected wound. These failures also resulted in R63's bilateral heel wounds not being identified until they were unstageable wounds and becoming necrotic. These failures apply to 3 of 6 (R75, R63, R16) residents reviewed for pressure ulcers in the sample of 23.

The findings include:

1. R75's electronic face sheet, printed on 8/29/24, showed R75 has diagnoses including but not limited to
pressure ulcer stage 4, infection following sacral debridement, Parkinson's disease, Alzheimer's disease, dementia without behaviors, and colostomy.

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 _____	08/29/2024

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		

R75's care plan, dated 6/23/24, showed, "Resident is at increased risk for pressure ulcers related to decreased mobility, generalized muscle weakness following recent illness and hospitalization..."

R75's admission nursing assessment, dated 7/17/24, showed R75 had no skin alterations upon admission.

R75's care plan, dated 7/18/24, showed, "(R75) has a colostomy related to sacral wound infection and need to keep the area clean."

R75's facility assessment, dated 8/22/24, showed R75 has no cognitive impairment, has one stage 4 pressure ulcer, and utilizes and ostomy.

R75's wound assessment report, dated 6/26/24, showed, "dermatitis-7x6cm (centimeters). Red, open blisters to inner natal cleft. Scar tissue to coccyx and buttocks. Wound bed 50% slough and 50% granulated. Not recorded as pressure injury due to between skin folds."

R75's wound assessment report, dated 7/3/24, showed, "dermatitis-10x5cm-declining-macerated and excoriated scar tissue, grey in color."

R75's nursing progress notes showed, "7/4/24 Writer was taking resident to supper and noted his face appeared red and flushed. Writer took temperature and temperature was 101.2. Resident had some confusion to what time it was and seemed a bit slower than usual to respond. (Physician on call) notified gave order to restart cefdinir 300mg (milligrams) bid (twice per day) x 5 more days and if resident worsens tonight may send to emergency room. 7/5/24 Power of

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 _____	08/29/2024

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 4	S9999		

Attorney here and concerned that (R75) has confusion and was not acting like himself. Vitals taken temperature was 101.4. He is on antibiotic for UTI (urinary tract infection)...911 called and took resident to local emergency room..."

R75's local hospital records, dated 7/5/24, showed, "...brought in for evaluation from nursing home after developing fever and altered mental status again yesterday. Daughter states he appeared to have some labored breathing from time to time as well...evidence of sepsis with urinary catheter has a large unstageable sacral decubitus foul-smelling necrotic wound that requires debridement....sepsis criteria likely secondary to wound to coccyx."

R75's operative note, dated 7/6/24, showed, "Reason for operation: sepsis with necrotic decubitus ulcer...findings: necrotic decubitus involving skin and subcutaneous tissue with purulence (drainage)...scalpel was used to excise necrotic infected tissue..."

R75's surgery progress note, dated 7/8/24, showed, "May need to consider diverting ostomy as patient seems to be intermittently incontinent of stool...wound is approximately 8-9cm in diameter and 5-6cm in depth..."

R75's surgery progress note, dated 7/9/24, showed, "Discussed with patient and daughter that we suggest additional debridement of wound as well as construction of diverting ostomy for stool incontinence. They are in agreement...surgery within 24-48 hours." (R75's ostomy surgery was completed on 7/10/24)

R75's hospital physician note, dated 7/10/24, showed, "Sacral ulcer: wound cultures reporting

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 _____	08/29/2024

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		

prevotella and morgnella (bacteria)."

On 8/27/24 at 11:40AM, R75 stated, "I have a horrible sore on my bottom. I got it while I was here and needed surgery on it, and then they gave me this (pointing to colostomy) because the sore was so bad."

On 8/28/24 12:30PM, V17 (Wound Care Nurse) stated, "(R75) had dermatitis, but I'm not exactly sure when it started. We were watching it and he had some areas that were red. I guess it broke open. I was doing the wound assessments for (R75) at the time. I don't really recall much about him, but looking at the physician communication notes, he must have had some chapped skin that we were trying to soften up or something. It's strange that there are no wound assessments other than the physician communication forms. I'm not sure where they would be or even how to find them. I would think if the nurse saw a change in the wound, she would notify the physician for new orders and document that. I'm only here one day a week, so if there is something new with the wound, then that is up to the floor staff to notify the physician."

On 8/28/24 at 12:38PM, V2 (Director of Nursing) stated, "There are nursing skin assessments in (R75's) chart, dated 6/18/24 and 6/26/24, but they do not show any open areas. I don't see any full wound assessments documented in (R75's) chart. It is the expectation that (V17) does a full wound assessment including measurements and characteristics of every resident with a wound when she is in the facility. If a new wound is identified when she is not here, then the floor staff do the assessment and initiate orders. It is also the expectation that if a change is seen with a wound, the staff notify the physician for new

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 _____	08/29/2024

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		

orders. We now have a Wound Physician that comes once a week, but he started after all of this with (R75), so he did not start seeing him until 7/22/24."

On 8/29/24 at 11:07AM, V26 (Wound Care Physician) stated, "It's not normal to change from dermatitis to an unstageable wound. It might have started as a stage one and then progressed to a higher stage, but this was never dermatitis. When you have granulation and slough, you don't have dermatitis. There is no broken skin with dermatitis. From the wound assessments that were performed initially, this wound should have been classified as a pressure ulcer and treated as such. It should have been reclassified as soon as his skin broke open. With the slough and granulation present, I would have probably classified this as a Stage 3 pressure ulcer initially. A wound can become necrotic within a few days if not receiving the proper wound care. The nurses should have noticed the wound was necrotic and odorous, and he should have been seen by a Wound Care Physician as soon as possible. When a wound becomes necrotic, it becomes very dark and liquified and very noticeable. He was not receiving the proper treatments for this wound, which led to the complications he had."

The facility's policy titled, "Pressure Injury/Pressure Ulcer Prevention and Treatment Protocol", dated 10/24/22, showed, "6. When a resident is admitted to the facility or develops a pressure injury in the facility, the following will occur: A. Assess the pressure injury for location, size (measure length x width x depth), wound bed, drainage (amount, color, type), odor, tunneling, undermining or sinus tract, wound edges, surrounding tissue and pain at site. B. determine the injury's current stage of

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 _____	08/29/2024

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		

development: Stage 3 Pressure ulcer: full thickness skin loss: Full thickness loss of skin, in which subcutaneous fat is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slouch and/or eschar may be visible but does not obscure the depth of tissue loss...if slough or eschar obscures the wound bed, it is an unstageable pressure ulcer/injury..."

2. R63's face sheet, printed on 8/29/24, showed R63 has diagnoses including but not limited to peripheral vascular disease, pneumonia, pressure-induced deep tissue damage of left hip, atherosclerosis, and anxiety disorder.

R63's facility assessment, dated 6/25/24, showed R63 has mild cognitive impairment and has 1 unstageable pressure ulcer.

R63's care plan, dated 11/22/23, showed, "(R63) is at increased risk for pressure ulcers related to decreased mobility, generalized muscle weakness following recent illness and hospitalization. Pressure areas present to heel, foot and hip. Apply pressure reducing waffle boots to lower extremities when at rest...pressure reducing device in wheelchair and bed."

R63's "wound management detail report", dated 12/13/23, showed, "Right heel pressure ulcer-unstageable 2.5 x 5cm, 100% eschar, dark purple or rusty discoloration." R63 did not have a wound assessment performed 12/20/23 and 12/27/23.

R63's "wound management detail report", dated 1/3/24, showed, "Right heel pressure ulcer-unstageable deep tissue 2x5.8cm 100%

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 _____	08/29/2024

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 necrotic eschar." On 8/27/24 at 11:02AM, R63 was laying in his bed with no heel protectors in place, and both of his heels were resting on the mattress. R63's heel protectors were observed on the spare bed in R63's room. On 8/27/24 at 11:26AM, V30 (hospice aide) provided incontinence care to R63, and stated R63 should always have his heel boots on because he has "many wounds" on his feet. V30 then transferred R63 to his wheelchair with no cushion in the chair. V30 stated R63 used to have a cushion, but she is unsure of where it is at. On 8/28/24 at 2:15PM, V2 (Director of Nursing) stated, "All residents that are at risk for pressure ulcers and cannot reposition themselves should have heel protectors on at all times when they are in bed. If (R63) has that many wounds, then it is critical that all of the interventions are in place. I don't really know a lot about his wounds, but any wound should be identified as early as possible to allow for early intervention to try to heal the wounds." On 8/29/24 at 11:07AM, V26 (Wound Care Physician) stated, "A deep tissue injury is intact skin with discoloration underneath. You cannot have a deep tissue injury with necrotic eschar. That is when the wound is open and becomes unstageable, so this assessment is incorrect. I wouldn't be surprised if that developed over a day or 2 without wearing heel protectors. If his skin was being assessed every day, this would have been caught when it was a red area; I would see a stage 1 red area. Wounds with eschar should be caught earlier and are signs that the wound is declining and is now open."	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 _____	08/29/2024

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	S9999		

3. R16's 8/27/24 Wound Clinic assessment showed she had a Stage 3 pressure injury to her left heel and two unstageable pressure wounds to her right foot.

On 8/27/24 at 3:45 PM, R16 stated she has wounds on both of her feet. R16 stated her pressure wounds developed after she fell and sustained a fracture to her right ankle. R16 stated some of the pressure injuries developed while she had the cast on, and were not discovered until the cast was removed. R16 stated the pressure ulcer dressings were changed at the wound clinic on 8/27/24; however, prior to this, they had not been changed since Friday, 8/23/24.

On 8/27/24 at 4:02 PM, V28, R16's daughter, stated she attended R16's wound clinic appointment that day. R16 stated the dressing was dated 8/23/24.

On 8/28/24 at 12:19 PM, V16 (Wound Clinic Registered Nurse) stated she was the nurse who removed R16's dressing. V16 stated the dressings to both of R16's feet were dated 8/23/24. V16 stated the date on the dressing "means the date that it was last changed."

On 8/28/24 at 1:28 PM, V2 (Director of Nursing) stated the facility does not have the assessments for R16's wounds because the assessments are done at the wound clinic. V2 stated she did not believe the facility needed to keep records of R16's wounds if the weekly assessments were done outside the facility.

R16's August 2024 Treatment Administration History (provided on 8/28/24, Commonly referred

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 _____	08/29/2024

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	S9999		

to as a TAR, Treatment Administration Record) showed an order to provide treatment and dressings to the left heel every 3 days. The TAR showed the treatment due on Monday 8/26/24 was left blank.

R16's August 2024 TAR showed an order to treat and dress the wounds to the right foot every other day. The TAR showed the treatment due on Monday 8/26/24 was left blank.

R16's Progress Notes from 8/26/24 (Monday, when the dressing changes were scheduled to be completed.) showed she left for an appointment at an unknown time; however, she returned at 4:30 PM. The progress notes do not show a refusal for dressing change.

On 8/28/24 at 1:20 PM, V17 (Wound Nurse) (facility's wound nurse) stated, "The date on the dressing is the date that it was changed. The purpose of the dressing is to removed exudate, promote healing and prevent infection. After a dressing change is done, they should document in the treatment list that the dressing change is done. The floor nurses do dressing changes when I am not here. I am here Wednesday. The dressings to both heels should have been changed Monday. If she (R16) refused, it should have been documented. I didn't assess them (foot wounds) she went to the wound clinic (the wound clinic assesses the wounds). One of them was pressure the other was due to a cast, I think." V17 stated she does not assess R16's wounds.

The facility's Pressure Injury/Pressure Ulcer Prevention and Treatment Protocol (revised 10/24/22) showed, "...Weekly measurement will be conducted and entered in the chart under

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 _____	08/29/2024

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 11 Wound Management...All treatments and charting of pressure ulcers/injuries will be done by licensed staff..." (A) 2 of 2 300.610 a) 300.1210 b) 300.1210 d)2) 300.1210 d)3) 300.1220 b)3) 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	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 _____	08/29/2024

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	S9999		

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:
2) All treatments and procedures shall be administered as ordered by the physician.
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

These requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to implement interventions for residents with significant weight loss for 3 of 4 residents (R82, R70, R83)

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 _____	08/29/2024

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 13	S9999		

reviewed for weight loss in the sample of 24. These failures caused R82 to experience a 9.91% weight loss in 1 month, R70 to experience a 10.40% weight loss in 1 month, and R83 to experience a 12.18% weight loss in 1 month and a 18.55% weight loss in 3 months.

The findings include:

1. R82's face sheet showed he was admitted to the facility on 5/12/23, with diagnoses to include chronic atrial fibrillation, congestive heart failure, pressure ulcer of sacral region, anxiety disorder, anemia in chronic kidney disease, and obstructive and reflux uropathy.

On 8/28/24 at 9:12 AM, R82 said he has lost weight since he has been at the facility. R82 said he thinks maybe they may want him to lose weight. R82 said he is not on any nutritional supplements.

R82's record showed on 7/11/2024, he weighed 212 lbs. (pounds) and on 8/08/2024, the resident weighed 191 pounds which is a 9.91 % weight loss in 30 days.

R82's record showed the Nurse Practitioner was notified of the significant weight loss on 8/14/24 (6 days after the significant weight loss was identified). R82's Registered Dietitian Note dated 8/20/24 (12 days after the significant weight loss was identified) showed recommendations to complete weekly weights, nutritional shake twice daily, and continue to monitor intakes.

R82's care plan for nutrition was started 8/28/24 (20 days after significant weight loss was identified). R82's care plan showed, "Resident has experienced weight loss... Diet: Regular, high

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 _____	08/29/2024

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S9999	Continued From page 14	S9999		

protein; encourage oral intake of food and fluids; monitor and record intake of food..." There was not nutritional care plan in place prior to 8/28/24.

On 8/28/24 at 3:46 PM, V3, ADON (Assistant Director of Nursing), said there are no meal intakes documented for R82.

On 8/29/24 at 10:39 AM, V6 (Dietary Manager) said they have a few people who get fortified milk as a supplement, but they have no residents on fortified foods. V6 said if V27 (Registered Dietitian) recommends fortified foods, the resident would receive either mashed potatoes, soup, a cookie, or pudding. V6 said the CNAs get the weights and turn them in to him. He enters the weights and generates a report from the electronic health record which he gives to V2 (Director of Nursing), V3 (Assistant Director of Nursing), and V27 (Registered Dietitian, RD). V6 said the report is sent to V27 by email, since the facility does not have a permanent RD at this time. V6 said it has been about 4-6 months since they have had a permanent RD. V6 said the RD responds to let him know she received it and works on it at her convenience, whenever she has time. V6 said if V27 has recommendations, she emails them back to the DON to generate the changes. V6 said the nursing department puts the changes in to place and they change the diet card. V6 said R82 is on a high protein/high calorie diet and has no other nutritional supplements. V6 said the facility usually does an IDT (interdisciplinary team) meeting to discuss weights, but they have not had that meeting for the last few months since the kitchen has been short staffed.

On 8/28/24 at 4:00 PM, V2, DON (Director of Nursing), said the facility does not start any

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S9999	Continued From page 15	S9999		

nutritional supplements without a physician order. V2 said they notify the physician of weight changes, and they give the orders. The facility has no standing orders for nutritional supplements. On 8/29/24 at 12:09 PM, V2 said the RD does all her work remotely and does not come into the facility. V2 said she thinks the Registered Dietitian reviews residents with weight loss, new admissions, and those with their facility assessments coming up. V2 said she is not included in weight monitoring; all weights are given to V6, Dietary Manager. V2 said if the RD has recommendations, she writes it up and sends an email to her and to V6. V2 said recommendations are forwarded to the Nurse Practitioner, the resident's physician, or the Medical Director. V2 said those recommendations should be in place no later than 3 days after receiving them and they try and get them in place the same day or the next day. V2 said after the weight loss is identified, the RD should be reviewing as soon as possible. V2 said they don't monitor and document meal intakes on everyone, but they would do them for residents with weight loss. V2 said monitoring meal intakes would be put into place when the Dietary Manager enters the weight and identifies the weight loss.

On 8/29/24 at 1:22 PM, V27 (Registered Dietitian) said she has been hired by the facility to cover until they find a permanent RD. V27 said she does all her work for the facility remotely, and was hired to work 8 hours per month. V27 said she lives out of state, and she goes in and enters notes on the residents she was referred to review every 2 weeks. V27 said V6 (Dietary Manager) sends her a list of residents to review, and she does a progress note for those. V27 said if she has recommendations, she writes those down

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S9999	Continued From page 16	S9999		

and sends them to V6, Dietary Manger, and V2, DON. V27 said she would hope they would have those recommendations in place within the week of receiving them, but she would want interventions started right away. V27 said the gap between identifying the significant weight loss and starting interventions (18 days for R82) is too long because the residents could be losing more weight during that time. V27 said residents with a high protein/high calorie diet are supposed to receive fortified oatmeal at breakfast and fortified milk at all meals.

2. R70's electronic face sheet, printed on 8/29/24, showed R70 has diagnosed including but not limited to dementia without behaviors, type 2 diabetes, peripheral vascular disease, and cognitive communication deficit.

R70's care plan, dated 8/28/24, showed, "Resident has experienced weight loss. Monitor and record intake of food."

On 7/11/24, R70 weighed 125 lbs. On 8/10/24, R70 weighed 112 pounds which is a 10.40 % weight loss within 1 month.

R70's progress notes, dated 8/15/24, showed, "(Nurse Practitioner) noted weight loss. No new orders."

R70's Registered Dietician note, dated 8/20/24, showed, "Per nursing note 8/15 (Nurse Practitioner) notified of weight loss with no new orders. Recommend Hi calorie diet. Will continue current nutrition interventions. Will continue to monitor intakes, weight, skin, and plan of care."

R70's meal intake record for July and August 2024 had no documentation of meal intakes.

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S9999	Continued From page 17	S9999		

R70's progress notes, dated 8/27/24, showed, "(Nurse Practitioner) agreed with Dietician's request to change diet to Hi calorie diet due to recent weight loss." (17 days after weight loss identified).

3. R83's electronic face sheet, printed on 8/29/24, showed R83 has diagnoses including but not limited to dementia with behaviors, hypertension, and anxiety disorder.

R83's facility assessment, dated 6/11/24, showed R83 has experienced a weight loss of 5% or more within 1 month or 10% or more within 6 months.

R83's care plan, dated 8/28/24, showed, "Resident has experienced weight loss. Monitor and record intake of food."

On 5/8/24, R83 weighed 124lbs. On 8/8/24, R83 weighed 101lbs, which is a 18.55% loss in three months.

On 7/11/24, R83 weighed 115 lbs. On 8/8/24, R83 weighed 101lbs, which is a 12.17% loss in one month.

R83's progress notes, dated 8/15/24, showed, "(Nurse Practitioner) noted weight loss no new orders."

R83's Registered Dietician note, dated 8/20/24, showed, "Resident continues to drop significant weight. Recommend increasing protein supplement to 8 oz three times a day and weekly weights. Will continue current nutrition interventions. Will continue to monitor intakes, weight, skin, and plan of care."

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S9999	Continued From page 18 R83's meal intake record for July and August 2024 had no documentation of meal intakes. R83's progress notes, dated 8/27/24, showed, "(Nurse Practitioner) agreed with Dietician's request to increase residents' protein supplements and to add weekly weights due to recent weight loss." On 8/28/24 at 3:46PM, V23 (Assistant Director of Nursing) stated, "We do not have meal intakes for these residents. We only chart by exception typically, so the only thing we have documented on them is whether they consume their supplements. I guess it would be helpful to know how much our residents are eating over time, but that's not our policy to document meal intakes on all residents." The facility's policy titled, "Weight Monitoring", dated 06/21, showed, "Objective: To consistently assess residents for significant weight loss or gain...4. Licensed Staff will notify the physician of the following: A. 5% or more gain or loss in a 30-day period B. 7 1/2% or more gain or loss in a 90-day period C. 10% or more gain or loss in a 180-day period. 5. The weight committee will review all residents with significant weight gains or losses and other residents of concern and refer to the Registered Dietician as needed. 6. The Registered Dietician will review significant weight losses and any other residents referred by the weight committee on a monthly basis, and make recommendations to physicians as necessary." (B)	S9999		