| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145515 | A. Building<br>B. Wing | 10/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Freeburg Care Center | 746 Urbanna Drive<br>Freeburg, IL 62243 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 [DATE] 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 [DATE] 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. 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 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 |