STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146083	A. Building B. Wing	06/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor Court of Princeton	140 North Sixth Street Princeton, IL 61356

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to investigate an alleged allegation of physical abuse. This applies to 1 of 3 residents (R1) reviewed for physical abuse in the sample of 4. The findings include:On 6/13/26 at 11:10 AM, V8 Certified Nursing Assistant (CNA) stated, she came into work and was receiving report from V6 CNA. V6 CNA told V8 that R1 was acting crazy on her shift and that it was so bad, she had to pin him down. V8 asked V6 what she exactly meant by that. V6 demonstrated to V8 that she grabbed R1 by his hands and was holding him down. V8 reported that to V7 Registered Nurse (RN). On 6/13/26 at 10:49 AM, V7 RN stated, V8 CNA reported to her during CNA to CNA report, V7 reported R1 was wound up that shift and she had to hold him down to keep him in bed. V8 reported that she questioned what that meant and asked V6 CNA to demonstrate what she did. V8 reported to V7 that V6 showed her, she held him down in bed. V7 RN stated, V6 CNA was already gone for the night from her shift. She tried to call V1 Administrator and V2 Director of Nursing with no answer, so she messaged them both on the facility's secure messaging system. No one responded to her message until 5:00 AM. She stated, V2 Director of Nursing responded at 5:00 AM saying she received the message and would investigate the incident. V7 RN stated, V6 CNA was not suspended and continued to work with R1 after she reported that to V1 and V2. She was confused because normally they suspend the employee until they investigate the incident but V6 CNA was never suspended and they did not investigate the incident. R1's electronic medical record shows, he was admitted on [DATE] and passed away 5/30/26 on hospice. On 6/13/26 at 12:00 PM, V2 Director of Nursing (DON) stated, she had never heard of any incidents with R1. She would have to check the messaging system but she didn't recall anything ever being said about V6 CNA holding R1 down in bed.On 6/13/26 at 9:45 AM, V1 Administrator stated, she didn't have any abuse allegations for the past three months. At 12:06 PM, it's the first time I'm hearing anything about R1. She was not aware of any incidents with V6 CNA and R1. At 12:39 PM, she stated, V2 DON looked through all of her messages on their secure messaging system and couldn't find anything. On 6/13/26 at 1:01 PM, V1 Administrator stated, she was opening a physical abuse allegation for R1. V6 CNA would be suspended until they investigated the incident. The facility's abuse prohibition and reporting dated 11/28/19 shows, Policy: The facility actively prohibits resident abuse including neglect, corporal punishment, involuntary seclusion, misappropriation of property, injuries of unknown source, exploitation and use of any physical or chemical restraint not required to treat resident's symptoms. Purpose: To protect 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. Staff responsible: 1. Administrator, 2. Director of Nursing, 3. HR (human resources) manager, 4. Department Heads/Employees, 5. Shift Coordinators, 6. Shift Nurses. Procedure: .B. Initial steps and reports of alleged abuse or neglect- 1. Facility employees or agent who becomes aware of alleged abuse or neglect of a resident should immediately report the matter to the facility Administrator or designee. If allegation involves the Administrator, then the facility employee or agent should immediately report the matter to the facility DON. 6. If the incident involves alleged abuse and substantiated evidence indicates that another resident of the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility is the perpetrator of the abuse, then the Administrator shall immediately suspend the employee suspected the employee suspected to be involved in the alleged abuse without pay pending investigation of the incident. C. Investigation- 1. Interviews with all involved parties or potential witnesses will be completed. If possible, at least two interviewers shall be present for each witness interview. At least one interviewer shall take notes. 2. Signed statements from those persons who saw or heard information pertinent to the incident shall be obtained. Statements shall be taken from the suspect, the person making the accusations, the resident abused or neglected (if cognitive level permits), other staff of residents who may have witnessed the incident, and any other person who may have information related to the incident. 3. The Administrator shall keep copies of all notes from the interviews conducted by the Administrator or other facility interviewer in the course of the investigation. 4. The Administrator shall be responsible for supervising the investigation and reporting the results of the investigation to the Illinois Department of Public Health. 5. The Administrator shall be responsible for resident's protection from retaliation during and after the investigation. 6. Investigation checklist will be utilized when necessary.