STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146102	A. Building B. Wing	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor Court of Freeport	2170 West Navajo Drive Freeport, IL 61032

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a physician was notified of a medication error for 1 of 3 residents (R1) reviewed for notifications in the sample of 8. The findings include:R1's face sheet documents she was admitted to the facility on [DATE] and currently resided on the memory unit. The same document list multiple diagnoses including unspecified dementia without behavioral disturbance, and cognitive communication deficit.The 5/23/25, resident and care screening assessment documents R1 to have severe cognitive impairment. Her behaviors included wandering 1 to 3 days of a 7-day observation period.On 7/18/25 at 8:30 AM, R1 was attending activities on the memory care unit, ambulating on her own, alert, but confused. She took herself to the bathroom and washed her hands. She returned to the common area to resume activities. On 7/18/25 at 12:30 PM, V2, Director of Nursing, said V1, Administrator, had reported R1's family found a cup of pills in the room and returned them to the nurse on duty. V2 said she assumed the night shift nurse left them in R1s room the night before on 7/12/25, and V15 (R1s granddaughter) found the cup of pills and gave them to V6, LPN (Licensed Practical Nurse). V2 said she completed a medication error form, including notifying the physician. V2 said V6 should have notified the physician at the time of the occurrence, and complete a medication error form, but none of it was completed. On 7/18/25 at 1:00 PM, V6 stated on the afternoon of 7/13/25, V15 handed her a cup of medication with R1s name written on the side. She reviewed R1s medication orders and determined the pills were R1s evening medications from 7/12/25. V6 said she disposed of the pills, roughly 6 pills total. She did not document the incident and did not report it to anyone. She said she should have notified the physician of the missing dose of medication. On 7/18/25 at 1:44 PM, V2 said the facility has no policy for medication errors. It would be expected in this type of instance, medications not given, a medication error report should be completed. The document requires physician notification.

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
	146102	A. Building B. Wing	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor Court of Freeport	2170 West Navajo Drive Freeport, IL 61032

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were administered when prepared for 1 of 3 residents (R1) reviewed for medication administration in the sample of 8. The findings include:R1's face sheet documents she was admitted to the facility on [DATE] and currently resided on the memory unit. The same document list multiple diagnoses including unspecified dementia without behavioral disturbance, and cognitive communication deficit.The 5/23/25 resident and care screening assessment documents R1 to have severe cognitive impairment. Her behaviors included wandering 1 to 3 days of a 7-day observation period.On 7/18/25 at 8:30 AM, R1 was attending activities on the memory care unit, ambulating on her own, alert, but confused. She took herself to the bathroom and washed her hands. She returned to the common area to resume activities. On 7/18/25 at 12:30 PM, V2, Director of Nursing, said V1, Administrator, had reported R1's family found a cup of pills in the room and returned them to the nurse on duty. V2 said she assumed the night shift nurse left them in R1s room the night before on 7/12/25, and V15 (R1s granddaughter) found the cup of pills on 7/13/25 and gave them to V6, LPN (Licensed Practical Nurse). V2 said she completed a medication error form, as V6 did not complete one when the medications were found.On 7/18/25 at 1:00 PM, V6 stated on the afternoon of 7/13/25, V15 handed her a cup of medication with R1s name written on the side. She reviewed R1s medication orders and determined the pills were R1s evening medications from 7/12/25. V6 said she disposed of the pills, roughly 6 pills total. She did not document the incident and did not report it to anyone. The 7/14/25 medication error report shows the date of error as 7/12/25, and it was a missed dose due to the nurse leaving the pills at the bedside. The medications ordered include alprazolam (anti-anxiety), aspirin, atorvastatin (cholesterol medication) carvediolol (blood pressure), clopidogrel (blood clot prevention) and Seroquel (anti-psychotic). The July 2025 MAR Medication Administration Record shows on 7/12/25, V13, LPN, documented R1's medications as given. There was no indication of missing doses or medication error.On 7/18/25 at 1:44 PM, V2 said the facility has no policy for medication errors. It would be expected in this type of instance, medications not given, a medication error report should be completed. The facility's undated policy for medication administration documents 7. In the event that a medication cannot be given, the reason must be documented in the Nurses Medication Notes on the MAR, and the time frame circled on the MAR. 11. Documentation of meds given will be done in a consistent manner by the nurse placing her initials in the appropriate space on the MAR. Documentation on the MAR will be done at the time of administration of the medication.