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	08/19/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide safe mobility for residents by not ensuring footrests were on wheelchairs when pushing residents for 4 of 6 residents (R1, R4, R5, & R6) reviewed for safety in the sample of 6. This failure resulted in R1 falling out of the wheelchair and sustaining a laceration that required 3 sutures to close.The findings include:1.R1's Face Sheet, dated 8/19/25, showed diagnoses including vascular dementia, moderate, with psychotic disturbance, encephalopathy, type 2 diabetes mellitus, nutritional anemia, atherosclerotic heart disease, hyperlipidemia, hypokalemia, hypothyroidism, vitamin D deficiency, anxiety disorder, depression, idiopathic gout, pain, overactive bladder, diarrhea, constipation, dysuria, and muscle weakness. The Minimum Data Set (MDS) dated [DATE] for R1 showed moderate cognitive impairment; substantial/maximal assistance needed for toileting, shower/bath, and lower body dressing; partial/moderate assistance needed for upper body dressing, personal hygiene, and wheeling 50 feet in manual wheelchair.R1's Current Care Plan, dated 6/11/25, showed Resident at risk for falling related to poor safety awareness and generalized muscle weakness (start date 9/13/25); last reviewed 8/5/25. The care plan was updated on 8/4/25 and showed staff assist of two with mechanical lift for transfers. Keep foot pedals in place if staff is providing transport assist. If R1 is self-propelling through the unit, allow her to self-propel (updated 7/28/25). The Nurses note, dated 7/26/25 at 9:32 PM for R1, showed, resident exhibiting behaviors this shift. Screaming, crying, running into things/people with her wheelchair, setting off the door alarm and going into others resident's rooms. At approximately 8:30 PM, (V3, Certified Nursing Assistant/CNA) began to push (R1) to her room when (R1) planted her feet firmly on the floor and fell face first onto the floor. Blood was noted on the floor and a small laceration to her forehead was observed. Pressure was applied to the wound and the resident was made comfortable while the nurse called 911. (R1) was transported to the emergency department (ED). Husband/power of attorney (POA) notified. Medical Doctor (MD) notified. Director of Nursing (DON) notified.The Long-Term Care Facility & IID - Serious Injury Incident and Communicable Disease Report for R1, dated 7/30/25, showed it was the final report for an incident that occurred on 7/26/25. The report showed R1 has multiple diagnoses including a history of vascular dementia and encephalopathy. R1 takes medications including Lexapro and risperidone. On 7/26/25 at approximately 8:30 PM, R1 was observed having a loss of plane. Upon notification the nurse immediately completed an assessment and noted a small laceration to R1's forehead with a small amount of blood loss noted. Mild discomfort to her head. Range of motion x 4 with no shortening, rotation, or deformity noted. Neuros within normal limits at baseline. Maintained position. At approximately 8:35 PM, the on-call physician was notified with orders to send to the emergency department (ED) to evaluate and treat. Power of attorney (POA) was phoned. 911 was phoned and arrived to transport R1 at 8:50 PM and left the building to the hospital ED. At approximately 12:36 AM on 7/27/25, resident returned to the facility with orders to cleanse forehead with soap and water. Three sutures noted and a hematoma formed. Upon investigation, it was determined that when R1 was being transported in her wheelchair, she had firmly placed her feet on the floor, which resulted in her falling forward out of her wheelchair. On 8/19/25 at 8:47 AM, V1 (Administrator) stated, (V2, Director of Nursing/DON), did the incident investigation. (R1) was going to pull the fire alarm and (V3, Certified Nursing Assistant/CNA) went to stop her. (V3) moved (R1), and when she did this, the resident planted her feet on the floor. This caused a forward motion. (R1) fell out of her wheelchair and hit her head. (R1) had a laceration to her head. V1 stated when he came to the facility in September 2024, he did training/in servicing with the staff about using foot pedals when pushing a resident in their wheelchair. V1 stated it is his rule for resident safety. (V3) did not follow the rule for resident safety. (V3) didn't follow the procedure. When someone plants their feet, then staff should stop immediately right there and call for help, and put the foot pedals on. It is done for the resident's safety.On 8/19/25 at 9:17 AM, V3, CNA, stated, (R1) was having behaviors all day, and she was exit-seeking. (R1) did not have foot pedals on her wheelchair because she moves around in her chair on her own. (R1's) wheelchair is reclined in back a little, but she doesn't sit all the way back in it; she never does. I went to move (R1) away from the door and when I turned (R1) around, she planted her feet. (R1) fell out of her wheelchair. (R1) did not have any foot pedals assigned to her.2.R4's Face Sheet, dated 8/19/25, showed vascular dementia, parkinsonism, atherosclerotic heart disease, long term use of antithrombic/antiplatelets, hyperlipidemia, overactive bladder, retention of urine, pain, vitamin deficiency, abdominal pain, depression, anticoagulant use, elevation of levels of lactic acid