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	03/19/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to honor a residents (R1) Advanced Directive, resulting in (R1) being resuscitated against her wishes. This failure applies to 1 of 3 residents reviewed for Advanced Directives in the sample of 3.The findings include:R1's electronic face sheet, printed on [DATE], showed R1 had diagnoses of COVID-19, rib contusion, chronic kidney disease, depression, and venous insufficiency.R1's physician's orders, dated [DATE], showed, Do Not Resuscitate (DNR).R1's banner on her electronic medical record, created [DATE], showed, Full Code.R1's Physician's Orders for Life Sustaining Treatment (POLST) form, dated [DATE], showed, No CPR (Cardiopulmonary Resuscitation): Do not attempt Resuscitation. R1's POLST form was not scanned into her electronic medical record until [DATE].R1's nursing progress notes, dated [DATE], showed, This nurse called to residents' room regarding a fall. Went to resident's room and she was on the floor facing down, her arms tucked in and she was bleeding. Printed paperwork and shortly 911 responders came. Resident on her way to local emergency room for evaluation. Received a call from local hospital that resident did not make it. Stated while Emergency Medical Services (EMS) was helping her she became unresponsive.R1's local EMS report, dated [DATE], showed, (Ambulance Crew) dispatched to extended care facility for a (resident) who fell and is COVID positive. Upon arrival, crew found patient lying prone on the floor next to her bed with a small amount of blood coming from her nose. Patient breathing normally. Patient was moaning in pain, and crew attempted to communicate with the patient, but she did not have her hearing aids in. Staff member was standing next to the patient and told the crew that the patient was a full code. Manual C-Spine precautions were taken. Patient was log rolled onto a full body splint. C-collar was applied on the patient. Patient was secured to the full body vacuum splint. Patient was carried to the cot and secured. Crew noted the patient started to have agonal breathing. Crew checked patients' carotid pulse and no pulse was felt. Manual chest compressions were started while moving. Manual chest compressions were continued. Patient was placed on cardiac monitor via pads. Patient was showing PEA (Pulseless Electrical Activity) on the cardiac monitor. CPR was continued at a rate of 30:2 with ventilations done BVM (Bag valve mask). BVM was attached to oxygen at 15 liters. Intraosseous (IO) line was placed in left proximal tibia. Patient was given 1:10 Epinephrine via IO and followed with rapid 10mL saline flush. [NAME] device (mechanical CPR system) applied on patient. Compressions were changed to a continuous rate, and ventilations were done at a rate of every 5-6 seconds. Second 1:10 epinephrine was given via IO. Crew noted patient was still in PEA on the monitor. Patient was given a third 1:10 Epinephrine via IO. Upon arrival to the emergency department, patient was showing asystole on the monitor. Patient was taken to room, and verbal report was given to nursing staff. CPR was continued by EMS and hospital staff. CPR was discontinued due to hospital staff having a valid DNR on file that was signed 5 days ago.On [DATE] at 8:25AM, V7 (Registered Nurse) stated, I remember telling the EMS provider that (R1) was a full code because that's what her chart said. I was made aware of the issue with (R1's) code status. There just isn't the management support that I feel we need as nursing staff. There should be someone doing a double check of code status and I don't think the floor nurses have time to (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be doing that. I went by what was on her banner at the top of her chart and I feel terrible that she was resuscitated and shouldn't have been. It's how we have always done it. Whatever their banner says is what their code status is and we've never questioned it.On [DATE] at 9:36AM, V2 (Director of Nursing) and V9 (Wound Care Nurse) stated, Advanced Directives are usually shared in report with a new admission. Everyone is a full code until we have the paperwork showing otherwise. Once we have the paperwork we change the code status. We do not enter the order or change any code status until we have the POLST form. Sometimes the POLST is faxed ahead of time. The hospital that (R1) came from is kind of a mess right now with the new ownership. Sometimes they will fax the paperwork and sometimes they will send the paperwork with the resident. It is definitely a concern that (R1) was resuscitated and shouldn't have been. The admitting nurse would not have put the order in for DNR unless she saw the paperwork so that means we had the POLST here somewhere so the banner should have been changed to DNR as well to avoid any confusion.The facility's policy titled, Advance Directives, dated 02/2018, showed, To ensure that the resident and/or representative has been informed and educated about the right to formulate an Advanced Directive, and the facility's policy regarding these rights; the resident has been assisted in exercising these rights; and the residents choices regarding these rights have been incorporated into the treatment, care, and services. Documentation of the resident's Advance Directives shall be present within the medical record and specified on the individual's face sheet. All Advanced Directives shall be uploaded into (medical record system) and stored in the resident's clinical record .

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on interview and record review, the facility failed to perform weekly skin assessments, failed to identity a pressure ulcer prior to late stages for 1 resident, failed to obtain physician's orders for treatment of a pressure ulcer for 1 resident. This failure resulted in R3 obtaining a Stage 3 pressure ulcer that required surgical debridement and advanced to a Stage 4 pressure ulcer. These failures apply to 1 of 3 residents reviewed for pressure ulcers in the sample of 3.The findings include:R3's electronic face sheet, printed on 3/19/26, showed R3 has diagnoses including but not limited to dementia without behaviors, pain in right hip, stage 3 pressure ulcer to right hip, and depression.R3's facility assessment, dated 12/13/25, showed R3 has moderate cognitive impairment, requires partial/moderate assistance to roll left and right, and is at risk of developing pressure ulcers.R3's care plan, dated 6/10/25, showed, Resident is at increased risk for pressure ulcer related to decreased mobility, generalized muscle weakness, and need for staff assist with transfers .assist resident with turning and repositioning.R2's care plan, dated 6/10/25, showed, Skin checks each shift.R3's physician's orders showed no orders for weekly skin assessments from December 2025-January 2025.R3's pressure injury event, dated 1/2/26, showed, 1/2/26 Resident has what appears to be an unstageable pressure injury, measuring 2 x 2 cm (centimeters), to the right ischial protuberance. The wound bed is completely dry. The edges are indurated. Bordered foam placed for protection. Will contact primary for treatment orders. Endorsed to next shift.R3's physician's orders, dated 1/6/26, showed, Right hip: clean and pat try. Skin prep to peri wound then apply hydrogel with silver and a bordered gauze. No treatment orders or documentation of any treatments were present in R3's medical record from 1/3-1/5 for her pressure wound.R3's wound physician notes, dated 1/5/26, showed, Stage 3 pressure wound of the right hip, full thickness >1 day. Wound size 1.9cmx2.0cmx0.2cm. Light serous (clear) exudate.R3's wound physician notes, dated 1/12/26, showed, Necrotic tissue: 20%, Slough: 20%, Granulation tissue: 20% .Surgical excisional debridement procedure: remove necrotic tissue and establish margins of viable tissue. Post-Stage: Stage 4 pressure wound of the right hip, full thickness.As of 3/19/26, R3 continues to have a Stage 4 pressure ulcer to her right hip as evidenced by continued wound physician visits on a weekly basis and continued treatment to R3's pressure ulcer.On 3/17/26 at 10:21AM, V4 (Registered Nurse) stated, Whatever I charted is what the wound looked like. I can't remember that long ago to tell you anything about it. You'll just have to look at the documentation.On 3/19/26 at 9:08AM, V8 (Registered Nurse) stated, Skin assessments are done weekly on every resident. In our computer system, you go into the treatment record, and it will show you whether or not they have skin assessments or treatments or anything. We don't really have a check system, we put in a progress note that the resident had a skin assessment and whether or not their were findings. On 3/19/26 at 9:36AM, V2 (Director of Nursing) and V9 (Wound Care Nurse) stated, Every resident gets a skin assessment on their shower days. The aides report anything out of the ordinary to the nurse. If there are no skin alterations, then the nurse doesn't do a skin assessment. No shower sheets are done for residents. Some residents do have skin assessments that are done by the nurse. (R3's) wound was identified on 1/2/26 and was unstageable to her right hip. (V10, Wound Care Physician) saw her on the 5th and staged it at a stage 3 and initiated treatment. It's an issue that is was found at a stage 3 because that means the wound has been going on for a while and should have been identified earlier.On 3/19/26 at 11:39AM, V10 stated, In general, if a wound is necrotic then that is a problem to be identified as a stage 3. I wouldn't have debrided a wound that wasn't necrotic. It would have remained as an unstageable wound and we would have treated it as such. If I stated in my note that it was full thickness, then that means there was loss of skin and the wound was open. That would not have occurred within a few days. I was able to stage it better after debridement and it was moved to a stage 4 wound. It is the responsibility of the facility staff to ensure and encourage offloading measures. If a resident is not compliant, that should be documented. There are many residents who are noncompliant and facility's are able to (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	identify a wound at early stages. At the end of the day, skin assessments should be completed on all residents to ensure even the smallest wound alterations are identified and treated immediately to prevent wound progression.On 3/19/26 at 12:32PM, V1 (Administrator) and V2 (Director of Nursing) provided documentation to surveyor of unavoidable pressure injury for R3 following surveyors interview with V10. V2 stated, (R3) does refuse interventions but we don't have it documented like we should. Perhaps if we would've had that in place, we could have thought of alternative interventions. I do not see documented weekly skin assessments for her and she is one that should have them as she is noncompliant with interventions. I understand where you are explaining the late stage finding, and again, this is a learning experience for me and my nurse's.The facility's policy titled, Bath (Shower), revised 01/04, showed, Objectives .2. To observe the skin .15. Report any reddened areas, skin discolorations, or skin breaks to the nurse .The facility's policy titled, Pressure Injury/Pressure Ulcer Prevention and Treatment, revised 10/24/22, showed, Objective and Purpose: To ensure that measures are taken to prevent skin breakdown and to provide guidelines for treatment of any pressure injury or pressure ulcer that might develop. Pressure Ulcer/Injury (PU/PI) refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. A pressure ulcer will present as an open ulcer, the appearance of which will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Soft tissue damage related to pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities and condition of the soft tissue .Principles: 2. An individualized plan of care will be developed for the resident following the guidelines of the assessment .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, the facility failed to ensure a resident (R2) was free from significant medication errors. This applies to 1 of 3 residents reviewed for medications in the sample of 3.The findings include:R2's electronic face sheet, printed on 3/19/26, showed R1 has diagnoses including but not limited to Parkinson's Disease, pressure ulcer of sacral region stage 4, Alzheimer's disease, and dementia without behaviors.R2's care plan, dated 3/10/26, showed, (R2) has a wound infection. Antibiotic therapy to be completed 4/22/26.R2's CT (Computed Tomography) scan, dated 3/4/26, showed, Correlate for cellulitis and sinus track at the natal cleft with induration extending centrally to the coccygeal segments with significant posterior bone loss and erosions in the mid and lower coccygeal segments. Osteomyelitis has similar appearance. Correlate for surgical debridement .R2's wound physician note, dated 3/9/26, showed, Investigations recommended and/or reviewed: CT scan of Stage 4 pressure wound sacrum demonstrates osteomyelitis. Similar finding on 3/4/26 Prescription recommendations: Ciprofloxacin 500mg (milligrams) twice daily for 42 days, Linezolid 600mg twice daily for 42 days.R2's physician's orders, dated 3/9/26, showed, Linezolid 600mg twice daily.R2's medication administration record for March 9th-17th showed R2 received 4 of the 16 scheduled doses of his Linezolid.On 3/17/26 at 8:53AM, V11 (R2's daughter) stated, The only thing the facility has allowed us to do regarding my dad's linezolid is to call the VA (Veterans Administration) and now it's being covered. They just told me rules and regulations do not allow us to bring his medications in that would be cheaper. I called (V10-Wound Physician) and he said he would sign the prescription for me so that it could be covered with a different pharmacy. I contacted the Ombudsman, but they told me to call you. My dad has a wound on his foot, neuropathy, edema, and a pressure sore that is causing the osteomyelitis. He was prescribed the medication and then 2 days later is when it was started. It would have been longer if I wouldn't have said something about the VA.On 3/17/26 at 10:21AM, V4 (Registered Nurse) stated, (R2's) linezolid was discontinued this morning. I didn't discontinue it; I don't know who did. It looks like we didn't have it so I'm not sure what is going on with it.On 3/19/26 at 9:36AM, V2 (Director of Nursing) and V9 (Wound Care Nurse) stated, (V10-wound physician) ordered linezolid for (R2) for osteomyelitis and also ordered cipro. The pharmacy sent the pricing to say that it was a high-cost medication. I didn't know it was a high-cost medication until family reacted because he's private pay and would have to pay for it. I tried to figure out how to get it paid for; tried to get a prior authorization through our pharmacy and then I found out he has the VA too. I was trying to make sure I could get it at a lower price for them. They are not able to bring it in from an outside pharmacy; they already signed paperwork that they would go through (facility pharmacy). He already has the benefits through the VA so that wouldn't be considered an outside pharmacy. His medication normally goes through (facility pharmacy). When (facility pharmacy) found out it was high cost they sent me a few days' worth of the medication. On Tuesday (3/17) I let (V10) know that we were working on getting the medication and asked if we could put it on hold. We looked into an alternative medication to see if there was something that would give the same coverage but there isn't. (V10) didn't know if there was anything else that would give the same coverage either. He just said to keep giving cipro until linezolid came in. The VA has not contacted me yet to let me know if it's covered or not.On 3/19/26 at 10:20AM, V1 (Administrator) stated, (R2's) daughter informed me that he had VA benefits because this actually came up in conversation with his daughter about otic medications. (V9) is working on getting the antibiotic he needs as well. Private pay medications that are high cost are handled by me. I contact the family and let them know what the cost is. I informed the daughter that insurance wasn't going to cover it. Whenever pharmacy sends me the sheet then that's how I know it's over our threshold. We have to maintain our contract with Medicare and go through a specific pharmacy. The VA is different because they are a federally funded medication. Even though he is here under private pay we still have to go through Medicare guidelines on medications. He can't bring them in from anywhere other than our pharmacy or the VA.On 3/19/26 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 11:39AM, V10 stated, It is important for (R2) to receive the linezolid to treat his suspected osteomyelitis. We are not seeing bone exposure or clear infection at this point. I would like to see him on the linezolid soon. He has subacute to chronic osteomyelitis. That's the only oral antibiotics recommended for treating osteomyelitis. We have a number of alternatives that can be given IV (Intravenously) but some of those come with different things like having an RN available to be in house, so that's why we are trying to get the linezolid because there was uncertainty about having an RN available to care for intravenous medications. I told the facility if it's impossible to get the linezolid then let's just convert it to IV. It's hard to know if the 4 doses were even beneficial or not, we would have to do another CT scan. Based on recommendations and current guidelines it wouldn't make much of difference just getting a few doses.On 3/19/26 at 12:32PM, V2 (Director of Nursing) stated, (R2's) son/Power of Attorney told us not to treat him after he heard the cost of the medication. We discussed it with (V10) and he said we could hold the medication. I didn't document any conversation with (V10) about the medication, but we did discuss doing an intravenous medication and (V10) didn't want to do that. It was never us as a facility denying the IV medication. I don't know where that came from. I know that if I didn't document it, I can't prove it so that's a learning experience for me. We have many conversations with him that don't get documented and they probably should. Either way, I agree that (R2) needs treatment, we can't keep holding it off. He has an infection that needs to be treated. No documentation was present in R2's progress notes regarding a conversation with V10 regarding R2 not receiving treatment until 3/17/26. The facility's policy titled, Medication Administration, revised on 02/04, showed, Objective: To provide the resident with those medications deemed necessary by the physician to improve and/or stabilize specified diagnosis of the resident .6. All medications must be administered to the resident in the manner and method prescribed by the physician .