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	03/26/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interviews and record review, the facility failed to protect a resident from abuse. This applies to one of three residents (R2) reviewed for abuse in the sample of three.The findings include:A facility reported incident, dated 3/19/26, shows R2 was found at around 5:30AM on 3/11/26, in her bed, with R1 standing over her placing a pillow over R2's head area. R1 was removed from the room by the two Certified Nursing Assistants (CNA). R2 did not seem in any distress.The facility face sheet for R2 shows she was admitted to the facility with a diagnosis of dementia. The facility assessment for R2, dated 2/17/26, shows her to have severe cognitive impairment and required supervision with her mobility. A progress note, dated 3/11/26, shows communication with R2's Power of Attorney (POA) that R2 had been awakened by her roommate who had held a pillow to her face.The facility face sheet for R1 shows she was admitted to the facility with a diagnosis of Alzheimer's Disease. The facility assessment, dated 3/12/26, shows her to have severe cognitive impairment and requires supervision for her mobility. A progress note, dated 3/11/26 at 3:56PM, shows the writer of the note (V3, Memory Care Unit Director) was notified by staff that R1 was found to be holding a pillow over R2's face. The staff removed R1 from the room. R1's POA was notified and R1 was given a room change. The note shows the Director of Nursing (DON) was notified at that time.On 3/25/26 at 8:43 AM, V5, Certified Nursing Assistant/CNA, said she was working the night of the incident with R1 and R2. V5 said R1 had been up during the night wandering around the unit like she sometimes does. V5 said she redirected her back to her room and told her to lie down. V5 said about 10 minutes later she went to do a bed check on R2, at around 5:30 AM, and when she and another CNA (V4) entered R1 and R2's room, they saw a couch pillow over R2's face. V5 said she removed the pillow and V4 took R1 out of the room. V5 said R2 was sleeping and when she woke her up, she was agitated and asked V5 what she was doing and grabbed V5's arm. V5 said she told R2 who she was, and she calmed down. On 3/26/26 at 8:55 AM, V4, CNA, said she was working the night R1 and R2 had their incident. V4 said R1 had been up wandering on the unit like she sometimes does and R1 was redirected to go lie down. V4 said she and V5 went into R1 and R2's room to do a bed check on R2 at around 5:30 AM, and she saw R1 standing over R2 holding a gray pillow over R2's face. V4 said she immediately removed the pillow and took R1 from the room. V4 said R2 was not reacting in any way at the time. On 3/25/26 at 10:45 AM, V3, Memory Care Director, said she was notified at around 3 PM by V4 about what had happened that morning. V3 said she was told during a bed check they saw R1 holding a pillow over R2's face. V3 said she made a room change to separate R1 and R2 and called the POA for R1 to tell her a room change had been made. V3 said she then told the DON what she had discovered. V3 said the information about the incident was supposedly passed through in report, but she was not made aware.On 3/25/26 at 11:46 AM, V2, Director of Nursing/DON, said she was notified around 4:20 PM by V3 about the incident between R1 and R2. V2 said she was told V4 and V5, CNA's, saw R1 holding a pillow over R2's face at around 5:30 AM. V2 said she immediately notified the Administrator and began her investigation into the matter. V2 said this should have been reported when it occurred.On 3/25/26 at 12:08 PM, V1, Administrator, said he was notified by the nurse consultant at around 4 PM on 3/11/26. V1 said this should have been reported immediately for the safety of the residents.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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility abuse investigation into this incident on 3/11/26 at 5:30AM shows V4 stating they entered the room of R1 and R2 and saw R1 holding a pillow over R2's face. V5 stated when they entered the room of R1 and R2 she saw a large pillow over the face of R2. In the investigation, R3 stated she spoke with both V4 and V5 and was told R1 was standing over R2 holding a pillow over her face. She also stated the CNAs could not find the nurse to report the incident and they both thought the third CNA had gone to report it. (The third CNA could not be reached by phone and was not present in the facility at the time of investigation.) A telephone statement made by V13 during the investigation shows she was on the unit between 5 and 5:30 AM, the rest of her shift she was on another hall she was also assigned to. V13 stated she was not told of the incident, but the staff are good at reporting things to her. The facility abuse policy, with a revision date of 11/28/19, shows the purpose is to protect residents from any kind of abuse such as verbal, sexual, mental, physical. A facility employee or agent who becomes aware of alleged abuse or neglect of a resident should immediately report the matter to the facility administrator.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report an allegation of physical abuse of a resident in a timely manner. This applies to one of three residents (R2) reviewed for abuse in the sample of three.The findings include:A facility reported incident, dated 3/19/26, shows R2 was found at around 5:30AM on 3/11/26, in her bed, with R1 standing over her placing a pillow over R2's head area. R1 was removed from the room by the two Certified Nursing Assistants (CNAs). R2 did not seem in any distress.The facility face sheet for R2 shows she was admitted to the facility with a diagnosis of dementia. The facility assessment for R2, dated 2/17/26, shows her to have severe cognitive impairment and required supervision with her mobility. A progress note, dated 3/11/26, shows communication with R2's Power of Attorney (POA) that R2 had been awakened by her roommate who had held a pillow to her face.The facility face sheet for R1 shows she was admitted to the facility with a diagnosis of Alzheimer's Disease. The facility assessment, dated 3/12/26, shows her to have severe cognitive impairment and requires supervision for her mobility. A progress note, dated 3/11/26 at 3:56PM, shows the writer of the note (V3, Memory Care Unit Director) was notified by staff that R1 was found to be holding a pillow over R2's face. The staff removed R1 from the room. R1's POA was notified and R1 was given a room change. The note shows the Director of Nursing (DON) was notified at that time.On 3/25/26 at 8:43 AM, V5, CNA, said she was working the night of the incident with R1 and R2. V5 said R1 had been up during the night wandering around the unit like she sometimes does. V5 said she redirected her back to her room and told her to lie down. V5 said about 10 minutes later, she went to do a bed check on R2 at around 5:30 AM, and when she and another CNA (V4) entered R1 and R2's room, they saw a couch pillow over R2's face. V5 said she removed the pillow and V4 took R1 out of the room. V5 said R2 was sleeping and when she woke her up, she was agitated and asked V5 what she was doing and grabbed V5's arm. V5 said she told R2 who she was, and she calmed down. V5 said she never told the nurse about what she had witnessed.On 3/26/26 at 8:55 AM, V4, CNA, said she was working the night R1 and R2 had their incident. V4 said R1 had been up wandering on the unit like she sometimes does and R1 was redirected to go lie down. V4 said she and V5 went into R1 and R2's room to do a bed check on R2 at around 5:30 AM and she saw R1 standing over R2 holding a gray pillow over R2's face. V4 said she immediately removed the pillow and took R1 from the room. V4 said R2 was not reacting in any way at the time. V4 said she did not report the incident at the time but did call the Memory Care Director that afternoon when she woke up. V4 could not remember what time that was. On 3/25/26 at 10:45 AM, V3, Memory Care Director, said she was notified at around 3 PM by V4 about what had happened that morning. V3 said she was told during a bed check they saw R1 holding a pillow over R2's face. V3 said she told V4 that this type of behavior needs to be reported right away and was told by V4 she fell asleep after her shift and called when she woke up. V3 said she made a room change to separate R1 and R2 and called the POA for R1 to tell her a room change had been made. V3 said she then told the DON what she had discovered. V3 said the information about the incident was supposedly passed through in report, but she was not made aware.On 3/25/26 at 10:50 AM, V6, CNA, said she worked the morning shift on 3/11/26 and was not told anything about the incident in report regarding R1 and R2.On 3/25/26 at 11:34 AM, V7, Registered Nurse (RN), said she worked the morning of 3/11/26 and she was not given any information regarding the incident between R1 and R2.On 3/25/26 at 11:46 AM, V2, Director of Nursing/DON said she was notified around 4:20 PM by V3 about the incident between R1 and R2. V2 said she was told V4 and V5, CNA's, saw R1 holding a pillow over R2's face at around 5:30 AM. V2 said she immediately notified the Administrator and began her investigation into the matter. V2 said this should have been reported when it occurred.On 3/25/26 at 12:08 PM, V1, Administrator, said he was notified by the nurse consultant at around 4 PM on 3/11/26. V1 said this should have been reported immediately for the safety of the residents.The facility abuse investigation into this incident on 3/11/26 at 5:30AM shows (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V4 stating they entered the room of R1 and R2 and saw R1 holding a pillow over R2's face. V5 stated when they entered the room of R1 and R2 she saw a large pillow over the face of R2. In the investigation, R3 stated she spoke with both V4 and V5 and was told R1 was standing over R2 holding a pillow over her face. She also stated the CNAs could not find the nurse to report the incident and they both thought the third CNA had gone to report it. (The third CNA could not be reached by phone and was not present in the facility at the time of my investigation.) A telephone statement made by V13 during the investigation shows she was on the unit between 5 and 5:30 AM, the rest of her shift she was on another hall she was also assigned to. V13 stated she was not told of the incident, but the staff are good at reporting things to her. The facility abuse policy, with a revision date of 11/28/19, shows the purpose is to protect residents from any kind of abuse such as verbal, sexual, mental, physical. A facility employee or agent who becomes aware of alleged abuse or neglect of a resident should immediately report the matter to the facility administrator.