

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146102	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/23/2026
NAME OF PROVIDER OR SUPPLIER  Manor Court of Freeport		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>Based on observation, interview, and record review, the facility failed to ensure there were staff available to administer resident medications according to schedule administration times for 5 of 5 residents (R1, R2, R3, R4, R5) reviewed for staffing in the sample of 5. The findings include: On 4/23/26 at 8:50 AM, V4, Licensed Practical Nurse (LPN), said she had worked this past weekend (4/18/26-4/19/26). V4 said on Saturday, 4/18/26, one of the 3 scheduled nurses for day shift called off, so they were short. V4 said at 10:00 AM, she found out an entire hallway still had not received their morning medications. V4 said R1 and R2 (who live down that hallway) were very upset. V4 said when there are 3 scheduled nurses, 2 of the nurses split the memory care unit so there isn't a nurse in that unit all the time. 1. On 4/23/26 at 11:05 AM, R1 was in his wheelchair sitting at the dining room table. R1 said on Saturday, they were short nurses, and he didn't get his sugar checked or his morning medications until almost 10:45 AM. V4 said he is supposed to get his morning medications (including insulin) before breakfast at 7:30 AM. R1's Medication Administration Record (MAR) shows on 4/18/26, R1 received Depakote at 10:27 AM (scheduled time 7:00 AM), furosemide 10:27 AM (scheduled time 6:00 AM-10:00 AM), gabapentin at 10:27 AM (scheduled time 7:00 AM) and lispro insulin at 10:27 AM (scheduled at 7:00 AM). 2. On 4/23/26 at 9:38 AM, R2 was in his room, sitting in his wheelchair. R2 said his medications were so late on Saturday (4/18/26), he had to run down the hall to find the nurse to get them. R2 said he takes his medications before breakfast, but on Saturday it was way past breakfast before he finally got them, and his lunch medications were late as well. R2's MAR shows on 4/18/26 R1 received carbidopa-levodopa at 1:07 PM (scheduled time 11:00 AM) and his gabapentin at 9:52 AM (scheduled time 7:00 AM) and at 1:07 PM (scheduled time 11:00 AM). 3. On 4/23/26 at 11:40 AM, R3 was sitting in a recliner in her room with her family at the bedside. R3 said she felt there weren't enough nurses scheduled. R3 said she often gets her medications late and has to wait a long time to get her pain medications. R3's MAR shows on 4/18/26, R1 received hydralazine at 8:54 AM (scheduled time 7:00 AM) for her blood pressure of 172/68. 4. On 4/23/26 at 11:00 AM, R5 was in his room watching TV. R5 said he was not sure what was going on this past weekend; it seemed like there were only two nurses working. R5 said they didn't give him his insulin until after breakfast and they didn't check his blood sugar before lunch. R5's MAR shows on 4/18/26, R1's blood sugar was checked at 12:36 PM (scheduled time 10:00 AM) and his insulin was given at 9:20 AM (breakfast is served at 7:30 AM). 5. On 4/23/26 at 11:50 AM, R4 was sitting up in his wheelchair in the dining room. R4 said the nurses were really busy this weekend; the staff was telling us there were only 2 nurses on most of the shifts. On 4/23/26 at 9:15 AM, V6, LPN, said on Saturday 4/18/26, one of the scheduled day shift nurses called off and so there were just two nurses. V6 said the night nurses stayed for awhile to help but no one passed one whole hallway. V6 said the morning medications pass is very heavy and it is stressful, even when there are 3 nurses working. V6 said it is a huge responsibility when you have that many residents to care for, there is so much to do, so much to remember and that's when you can start making mistakes. V6 said sometimes she administers medications for 38 residents. V6 said on her weekend they are lucky to have 3 nurses. On 4/23/26 at 12:15 PM, V2, Director of Nursing, said staffing is based on census and usually there are 4 nurses (continued on next page)</p>

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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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>scheduled for day shift. V2 said they did have a call off on Saturday 4/18/26, but she was able to get a nurse to come in at 10:00 AM to work. V2 said she did not come in to help. The facility's Nurse 1st shift schedule 6A-2:30 P shows there was only 3.5 nurses on 4/18/26. The facility's Resident Council Minutes from March 2026 shows, Nurses on second shift are not getting the pills passed out to certain residents on time at night some residents don't get their pills until 9:00 PM and they feel it is not fair.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on observation, interview, and record review, the facility failed to administer resident medications according to Physician Orders for 4 of 5 residents (R1, R2, R3, R5) reviewed for medications in the sample of 5. The findings include: On 4/23/26 at 8:50 AM, V4, Licensed Practical Nurse, said she had worked this past weekend (4/18/26-4/19/26). V4 said on Saturday, 4/18/26, one of the 3 scheduled nurses for day shift called off, so they were short. V4 said at 10:00 AM, she found out an entire hallway still had not received their morning medications. V4 said R1 and R2 were very upset. 1. On 4/23/26 at 11:05 AM, R1 was sitting in his wheelchair in the dining room. R1 said on Saturday they were short nurses, and he didn't get his sugar checked or his morning medications until almost 10:45 AM. V4 said he is supposed to get his morning medications (including insulin) before breakfast at 7:30 AM. R1's Medication Administration Record (MAR) shows on 4/18/26, R1 received Depakote at 10:27 AM (scheduled time 7:00 AM), furosemide 10:27 AM (scheduled time 6:00 AM-10:00 AM), gabapentin at 10:27 AM (scheduled time 7:00 AM) and lispro insulin at 10:27 AM (scheduled at 7:00 AM). 2. On 4/23/26 at 9:38 AM, R2 was sitting in his wheelchair in his room. R2 said his medications were so late on Saturday (4/18/26) he had to run down the hall to find the nurse to get them. R2 said he takes his medications before breakfast, but on Saturday it was way past breakfast before he finally got them, and his lunch medications were late as well. R2's MAR shows on 4/18/26 R1 received carbidopa-levodopa at 1:07 PM (scheduled time 11:00 AM) and his gabapentin at 9:52 AM (scheduled time 7:00 AM) and at 1:07 PM (scheduled time 11:00 AM). 3. On 4/23/26 at 11:40 AM, R3 was sitting in a recliner in her room with her family at the bedside. R3 said she felt there just weren't enough nurses scheduled. R3 said she often gets her medications late. R3's MAR shows on 4/18/26, R1 received hydralazine at 8:54 AM (scheduled time 7:00 AM) for her blood pressure of 172/68. 4. On 4/23/26 at 11:00 AM, R5 was sitting in his room watching TV. R5 said he was not sure what was going on this past weekend, it seemed like there were only two nurses working. R5 said they didn't give him his insulin until after breakfast and they didn't check his blood sugar before lunch. R5's MAR shows on 4/18/26, R1's blood sugar was checked at 12:36 PM (scheduled time 10:00 AM) and his insulin was given at 9:20 AM (breakfast is served at 7:30 AM). On 4/23/26 at 12:20 PM, V2, Director of Nursing, said medications are to be given following the scheduled time or time frame on the MAR. V2 said resident blood sugars should be checked prior to meals and insulin given as ordered prior to meals. The facility's Medication Administration Policy, dated 2/04, shows, All medications must be administered to the resident in the manner and method prescribed by the physician.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were free of significant errors for 4 of 5 residents (R1, R2, R3, R5) reviewed for medications in the sample of 5. The findings include: On 4/23/26 at 8:50 AM, V4 Licensed Practical Nurse said she had worked this past weekend (4/18/26-4/19/26). V4 said on Saturday 4/18/26 one of the 3 scheduled nurses for day shift called off, so they were short. V4 said the night nurses had to stay to help pass medications. V4 said she said she got busy doing her assigned hallways and was not sure what the night nurses were doing. V4 said at 10:00 AM, she found out an entire hallway still had not received their morning medications. V4 said R1 and R2 were very upset. 1. On 4/23/26 at 11:05 AM, R1 was sitting in his wheelchair in the dining room. R1 said on Saturday they were short nurses, and he didn't get his sugar checked or his morning medications until almost 10:45 AM. V4 said he is supposed to get his morning medications (including insulin) before breakfast at 7:30 AM. R1's Medication Administration Record (MAR) for April 2026 shows R1 has diagnoses of conversion disorder with seizures, type 2 diabetes, intervertebral disc degeneration, low back pain edema, and hereditary and idiopathic neuropathy. R1's MAR shows an order for blood sugar checks four times a day. On 4/18/26 this MAR shows R1's blood sugar checks scheduled for 6:00 AM-10:00 AM was completed at 10:45 AM. This same MAR shows orders for Depakote 500 mg three times a day, furosemide 40 mg twice daily, gabapentin 600 mg three times a day, and lispro insulin sliding scale three times a day before meals. The MAR shows on 4/18/26, R1 received Depakote at 10:27 AM (scheduled time 7:00 AM), furosemide 10:27 AM (scheduled time 6:00 AM-10:00 AM), gabapentin at 10:27 AM (scheduled time 7:00 AM) and lispro insulin at 10:27 AM (scheduled at 7:00 AM). 2. On 4/23/26 at 9:38 AM, R2 was sitting in his wheelchair in his room. R2 said his medications were so late on Saturday (4/18/26) he had to run down the hall to find the nurse to get them. R2 said he takes his medications before breakfast, but on Saturday it was way past breakfast before he finally got them, and his lunch medications were late as well. R2's MAR for April 2026 shows orders for carbidopa-levodopa 25-250 mg, twice a day, for Parkinson's disease with dyskinesia scheduled at 11:00 AM and gabapentin 300 mg twice a day for left hip pain scheduled at 7:00 AM and 11:00 AM. The MAR shows on 4/18/26 R2 received carbidopa-levodopa at 1:07 PM and his gabapentin at 9:52 AM (instead of 7:00 AM) and at 1:07 PM (instead of 11:00 AM). 3. On 4/23/26 at 11:40 AM, R3 was sitting in a recliner in her room with her family at the bedside. R3 said she felt there weren't enough nurses scheduled. R3 said she often gets her medications late. R3's MAR for April 2026 shows an order for hydralazine 25 mg, three times a day for hypertensive heart disease with heart failure. This MAR shows on 4/18/26, R3 received hydralazine at 8:54 AM (instead of 7:00 AM) for her blood pressure of 172/68. 4. On 4/23/26 at 11:00 AM, R5 was sitting in his room watching TV. R5 said he was not sure what was going on this past weekend; it seemed like there were only two nurses working. R5 said they didn't give him his insulin until after breakfast and they didn't check his blood sugar before lunch. R5's MAR for April 2026 shows R5 has a diagnosis of diabetes mellitus. This same MAR shows orders for blood sugar monitoring before meals and at bedtime scheduled for 7:00 AM, 10:00 AM, 5:00 PM, and 8:00 PM, and glargine insulin 30 units twice a day scheduled at 6:00 AM- 8:00 AM, and 7:00 PM-9:00 PM. This MAR shows on 4/18/26 R5's blood sugar was checked at 12:36 PM (instead of 10:00 AM) and his insulin was given at 9:20 AM (breakfast served at 7:30 AM). On 4/23/26 at 12:20 PM, V2 Director of Nursing said medications are to be given following the scheduled time or time frame on the MAR. V2 said resident blood sugars should be checked prior to meals and insulin given as ordered prior to meals. The facility's Meal time document shows Breakfast is at 7:30 AM and lunch is at 12:00 PM. The facility's Medication Administration Policy dated 2/04 shows To provide the resident with those medications deemed necessary by the physician to improve and/or stabilize specified diagnosis of the resident.</p>		