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	06/30/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure accuracy of medical records for 1 of 3 residents (R1) reviewed for medical records in the sample of 3.The findings include:On 6/30/26 at 9:22 AM, R1 was on the locked memory care unit. R1 could not recall the events of her fall on 6/20/26 or even that she had fallen. R1's facility Fall Investigation for 6/20/26 indicated R1 was unable to be interviewed. R1's progress note, dated 6/20/26 at 2:28 PM, showed R1 was in her room walking to the bathroom with V8 (Certified Nursing Assistant- CNA), tripped backwards, and landed on her buttock. The progress note indicated staff were present and the fall was witnessed. On 6/30/26 at 10:11 AM, V8 said he was providing care to R1's roommate in the bathroom with the bathroom door closed when he heard R1 yell. V8 said he opened the bathroom door and saw R1 had fallen next to her bed. V8 said he was not walking with R1 when she fell and did not witness R1 fall. V8 said when he opened the bathroom door there were no other staff present to witness the fall. V8's interview indicated there were no staff present when R1's fell and the fall was unwitnessed. On 6/30/26 at 9:43 AM, V2 (Director of Nursing) confirmed V8 was the CNA in R1's progress note dated 6/20/26 at 2:28 PM that was allegedly walking R1 at the time of the fall. V2 said she reviewed R1's progress note dated 6/20/26 at 2:28 PM and interviewed V8. V2 was asked why there was a discrepancy between the progress note of 6/20/26 at 2:28 PM and the interview that V8 gave. V2 said V3 (Registered Nurse), who entered the progress note for 6/20/26 at 2:28 PM, said she saw R1 follow V8 into R1's room and that is why she documented what she did. On 6/30/26 at 12:05 PM, V1 (Administrator) said he based his initial report to IDPH on the progress note dated 6/20/26 at 2:28 PM. V1 added that during the investigation they interviewed V8 and found out that the progress note dated 6/20/26 at 2:28 PM was not accurate. V1 said when V8 was interviewed V8 stated he was providing care to R1's roommate and was not with R1 when she fell as the progress noted indicated. The facility's Resident Documentation policy, with a revised date of 12/03, showed the facility shall maintain accurate documentation on all nurses' notes.

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