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	11/25/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure proper cooling techniques were utilized, failed to maintain cleanliness of unit food storage areas, and failed to maintain facility freezer in proper working condition. These failures have the potential to affect all residents in the building. The facility roster, dated 11/23/25, showed 110 residents residing in the facility.On 11/23/25 at 11:00AM, the initial tour of the kitchen was conducted. The thermometer reading on the facility's walk-in cooler registered at 0 degrees Fahrenheit. V25 (Cook) stated the temperature should be higher than that. A container of Salisbury steak inside the cooler appeared frozen. A previously cooked pork roast was loosely covered in a pan with aluminum foil and showed a use by date of 11/27/25. V25 stated the roast was cooked on Thursday (11/20/25). The facility's walk-in freezer had a thick layer of ice from water that dripped on food items on the top shelf and on top of ice cream cups and popsicles. Additionally, a layer of thick frost/ice was on the top left shelf on top of bagged items. V25 stated ice builds up and they have to defrost it.On 11/24/25 at 10:30AM, the Resident Council meeting was held with 17 residents in attendance. All residents agreed with R102 when she stated tthe kitchenette areas on the hallways were filthy and needed a good cleaning.On 11/24/25 at 1:00PM, all resident dining areas and cupboards were observed. All drawers with coffee, utensils, and condiments had crumbs and spilled coffee grounds inside of them. One of the unit cupboards that were unlocked had a 3/4 full bottle of glass cleaner located inside of it.On 11/25/25 at 9:10AM, the facility's freezer was observed and continued to have ice buildup on the ceiling of the freezer and on top of foods on the left and right top shelves. V3 stated, We try to keep an eye on that but it's hard to have to defrost it all the time. It's better than it used to be, but it still shouldn't be like that. The cooler should be kept at 40 degrees or less and if it's reading 0 I would get a different thermometer and check the temperature. If it's still reading low, then I would have maintenance come check it and do an adjustment.On 11/25/25 at 9:36AM, V3 stated, We haven't done any cooling logs recently and we don't have one for the pork roast that was cooked last week that's in the cooler. Honestly, we have had a lot of new cooks and changeover in the kitchen. Housekeeping and Dietary staff clean the kitchenette areas, but we don't have anyone specifically going through the cupboards and cleaning them; I guess that's something I should implement because I've never thought about it. The facility's policy titled, Food Storage and Labeling Procedure dated 9/22 showed, Store food at the proper temperatures.Refrigerator 41 degrees or below, Freezer 0 degrees or below.The facility's recipe for Ginger & Honey Pork Roast showed, Cool- Product must reach 70*F or less within 2 hours and 41*F or below within 4 hours. Total cooling time should not exceed 6 hours. Separate into shallow pans as needed for proper cooling.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident with dysphagia received thickened liquids and was supervised when eating to prevent her from eating another resident's food and large amount of food at once for 1 of 1 resident (R33), and the facility failed to ensure the hot water and coffee in 3 of 4 dining rooms were at safe temperatures, for residents reviewed for safety and supervision in the sample of 50. This failure has the potential to affect residents in 3 of 4 dining areas.The findings include: 1. On 11/23/25 at 12:32 PM, R33 was sitting in her wheelchair at a dining room table, with three other residents and a resident's wife for the noon meal. R33 was sitting next to R22, who had a grilled cheese that was quartered. R33 had taken a quarter of R22's grilled cheese sandwich, used it like a spoon, put meat on top of it, and then shoved it in her mouth. There were no staff at the table at this time. V19 (R115's wife) was at the table and alerted staff R33 somehow got R22's sandwich. V11, Certified Nursing Assistant, walked over to the table, looked at the residents, then walked away. On 11/24/25 at 11:58 AM, V6, Licensed Practical Nurse – LPN, stated R22 is on a SB 6 diet and stated it is a mechanical soft diet that she had questioned, and was told it meant small bites, but she did not know what the 6 meant. V6 stated R33 has thickened liquids and is on the SB 6 diet. V6 stated R33 wanders around a lot, takes things including other people's food. V6 stated the grilled cheese should be bite sized and it should have been taken away and replaced. On 11/24/25 at 12:10 PM, R33 was given a regular glass of water with ice cubes in it; the water was not thickened. On 11/24/25 at 12:22 PM, V17, Dietary, stated she did not give R33 the regular water; she had her thickened water sitting here for her. V10, CNA, stated she gave the water to R33 and that a different resident was sitting in that spot earlier. On 11/24/25 at 3:22 PM, V2, Director of Nursing, was updated on the dining observations and stated what happened was not okay. V2 stated her first concern was about the diet. V2 also stated she was concerned with cross contamination by eating someone else's food and for the risk of aspiration. V2 stated staff know what a resident eats because the resident has a diet slip at mealtime, and it shows what their diet is with diet and type of liquids. V2 stated staff should follow the diet order. V2 stated R33 is a resident that wanders, and she was not aware R33 was taking other resident's food. On 11/25/25 at 9:26 AM, V12, Registered Dietician, stated, SB6 is part of the International Dysphagia Diet Standards Initiative (IDDSI) diet program. SB means small bite sized food at a level 6. There are different levels. It is like the old mechanical soft, chopped diet. Typically bread and bread products are not typical on this, but the Speech Yherapist at the facility has okayed the use of bread and bread products. The bite size for the SB6 would be 1/2 inch or smaller. The grilled cheese may or may not be okay; it depends on the size of the pieces. Thin liquids given to (R33) is not in line with the physician prescribed diet. (R33) receiving water with ice is a safety concern; she has dysphagia and is a choking risk. The Registered Dietician Note, dated 11/16/25 at 11:55 AM for R33, showed she has diagnoses including Alzheimer's dementia; her diet is soft, and bite sized with slightly thickened liquids. R33 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was evaluated by Speech Therapy in September due to coughing/choking during oral intake and her diet was downgraded to slightly thickened liquids. The Minimum Data Set, dated [DATE] for R33, showed supervision or touching assistance needed when eating, severe cognitive impairment. The Speech Therapy Discharge summary, dated [DATE] for R33, showed she was seen for Alzheimer's disease and dysphagia. A soft, bite sized diet and slightly thick liquids were recommended. Supervision at mealtime due to swallow safety was needed 26-49 % of the time. On 11/24/25 at 4:30 PM, V2, DON, stated the facility uses the medication Administration policy for all orders including following diet orders because the policy stated they should follow physician orders. The Medication Administration policy (11/2011) showed all medications must be administered to the resident in a manner and method prescribed by the physician. The policy did not state anything related to diet orders. The facility's Resident Diet: IDDSI policy (2/2021) showed the purpose of the policy.to provide residents with a safe diet as prescribed by the physician. Nursing will enter each new diet or diet change into computer as ordered by the physician. IDDSI diets are as follows: dysphagia level 6: soft and bite sized. Liquid level 1: slightly thick. 2. On 11/24/25 at 1:00PM, 3 of the 4 resident dining areas had a pot of hot coffee and pot of hot water located on the counter, on top of the hot plate of the machine and the machine turned on. On 11/25/25 at 10:42AM, R33 was in the resident dining area, unattended. The hot coffee and hot water pots were full, and the machine was turned on. R33's facility assessment, dated 10/21/25, showed R33 has severe cognitive impairment. On 11/25/25 at 11:16AM, V3 (Food Service Supervisor) obtained the temperatures of the hot liquids. The hot coffee was 175.8 degrees Fahrenheit and the hot water was 168.8 degrees Fahrenheit. V3 stated that is how hot he would expect the liquids to be and that would probably cause a burn if a confused resident spilled it on them. On 11/25/25 at 11:26AM, R2 was in the resident dining area, unattended. The hot coffee and hot water pots were full, and the machine was turned on. R2's facility assessment, dated 11/18/25, showed R2 has severe cognitive impairment. The facility was unable to provide a policy regarding hot liquids.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to provide privacy to a resident during a blood sugar check and insulin administration. This applies to three of three residents (R28, R42, R90) reviewed for privacy in the sample of 50.The findings include:The face sheet for R28 shows a diagnosis of Type 2 Diabetes Mellitus. The POS (Physician Order Sheet), dated 11/2025, for R28 shows an order for blood glucose monitoring before meals and at bedtime. The face sheet for R90 shows a diagnosis of Type 2 Diabetes Mellitus. The POS, dated 11/2025, for R90 shows an order for blood glucose monitoring four times a day and an order for insulin injections to be given at breakfast, lunch and dinner.The face sheet for R42 shows a diagnosis of Type 2 Diabetes Mellitus and the POS shows an order for blood glucose testing for before meals and at bedtime. The POS also shows orders for insulin injections four times a day as needed. On 11/23/2025 at 11:32 AM, V28, RN (Registered Nurse), performed a blood glucose test on R28 while she was sitting at the dining room table with other residents around her. At 11:46 AM, V28 again checked a blood glucose test on R90 while she was sitting at the dining room table with other residents around her. V8 then administered an injection of insulin into R90's arm while at the table. At 11:50 AM, V28 performed a blood glucose test on R42 while he was at the dining room table surrounded by other residents. V28 then gave R42 an insulin injection at the table with other residents in the dining room watching. On 11/23/2025 at 12:00 PM, V28 said she was not able to get the residents blood sugar testing and insulin administration done before the residents were moved to the dining room.On 11/25/2025 at 11:19 AM, V7, RN (Registered Nurse), said blood glucose test and insulin administration should not be done in the dining room. V7 said to provide privacy for the resident, they should be taken out of the dining room. On 11/24/2025 at 3:30 PM, V2, DON (Director of Nursing), said the residents should always be removed from a public area to have a blood glucose test and insulin administration. V2 said it's a HIPAA (Health Insurance Portability and Accountability Act) violation. V2 said the facility does not have a policy regarding privacy.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident received assistance to eat (R79) and failed to ensure showers were provided (R22) for 2 of 3 residents reviewed for activities of daily living in the sample of 50. The findings include: 1. R79's face sheet, printed on 11/24/25, showed diagnoses including but not limited to cerebral infarction, dementia, and depression. R79's facility assessment, dated 7/28/25, showed severed cognitive impairment. The assessment showed R79 is completely dependent on staff for oral hygiene, toileting, dressing and hygiene. The same assessment showed substantial to maximal staff assistance required for eating. On 11/23/25 at 12:35 PM, R79 was in bed with her lunch over her, on the bedside table. R79 was alone in the room and was picking at the blueberry pie. R79 was confused and repeatedly tried to bring the pie to her mouth, without realizing nothing was in her fingers. At 12:40 PM, V22 (CNA-Certified Nurse Aide) entered the room, dropped a fork and spoon onto the bedside table, then exited the room. On 11/23/25 at 12:39 PM, R79 was using both her hands to bring a cup to her mouth. All the cups on the table had been drunk and were empty. R79 continued to repeatedly raise the cup to her mouth and was confused. This surveyor remained in the room continuously while interviewing R79's roommate family member. At no time did staff enter the room to offer cueing, encouragement, or feeding assistance. This surveyor exited the room at 1:05 PM. On 11/23/25 at 1:10 PM, V21 (CNA) was pushing a garbage can past R79's room. V21 glanced into the room and said, She (R79) is still in there picking at that plate. V21 did not enter the room and continued on. At 1:16 PM, V22 (CNA) removed R79's lunch tray. Less than one-fourth of the meal had been eaten. On 11/24/25 at 12:44 PM, R79 was in bed and alone in the room. Her lunch tray was over her and none of the food had been eaten. All three cups on her tray had been completely drunk. R79 was staring into space and holding a stuffed animal. At 12:51 PM, V20 (CNA) verified the lunch trays had been delivered to the unit approximately 40 minutes ago. On 11/24/25 at 12:45 PM, V23 (Registered Nurse) stated, (R79) can only say simple yes or no words. She is not able to use the call light and does not get out of bed. A CNA or a family member has to feed her. All meals need to be fed to her. (R79) can reach for a cup and use a spoon or fork on some days but needs encouragement with dining. On 11/25/25 at 12:41 PM, V2 (Director of Nurses) stated the aides should be assisting R79 with meals. It is important to ensure she get the adequate nutrition and good food intake. The facility's Feeding Assistance policy, revision dated 02/04, states: 1. To provide nutrients for the wellbeing of the resident. Encourage resident to assist as much as he is able. 2. The Face Sheet, dated 11/24/25, for R22 showed diagnoses including severe dementia, Alzheimer's (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disease, cognitive communication deficit, diarrhea, and chronic kidney disease. The Minimum Data Set, dated [DATE], for R22 showed she needs substantial/maximal assistance for showers. The Progress Notes for R22 from 11/19/25 – 11/24/25 showed no behaviors, refusal of care. The Care Plan, dated 11/24/25, for R22 showed her shower days are in the PM on Tuesday and Friday. On 11/23/25 at 12:32 PM, R22 was wearing a black and white striped shirt and black pants while sitting in her wheelchair in the dining room. R22 was at the dining room table for the noon meal. R22's hair was greasy. On 11/24/25 at 11:58 AM, R22 was dressed, sitting in her wheelchair at the dining room table for the noon meal. V18 (R22's son) was visiting and assisting her with her meal. On 11/24/25 at 12:53 PM, V18 stated he was at the facility on 11/21/25 or 11/22/25 and her hair was greasy then. V18 stated it looked worse now. V18 stated R22 doesn't know any different, but if she did, she would not like it. V18 stated R2 was very particular about her hair. V18 stated he would like to see it washed. On 11/24/25 at 1:37 PM, V10, Certified Nursing Assistant - CNA, stated she was R22's CNA for the day. V10 stated R22's shower days are in the shower book. V10 pulled the shower book out and stated R22 is supposed to have a shower on Tuesdays and Fridays on the PM shift. V10 stated they document in the computer in the point of care charting when a shower is completed. V10 stated she doesn't havethe ability to see when the last shower was done; they are not able to see the history. V10 stated she would have to rely on report for the information of a shower not being completed. On 11/24/25 at 1:42 PM, V4, Lead Shift Coordinator, stated if R22's hair is greasy then they should attempt a bed bath or dry shampoo. V4 stated they don't have any scanned shower forms anymore. V4 stated they have Duty Sheets that they use. V4 stated R22 should have had a shower on 11/21/25. V4 pulled the Duty Sheet, dated 11/21/25, and stated R22's name was not listed on the form for the day to receive a shower; no shower was given. On 11/24/25 at 3:22 PM, V2, Director of Nursing – DON, stated showers are to be done twice a week and hair is washed at that time. V2 stated a resident's hair can be washed sooner if it is needed. V2 stated, The resident showers for the day are put on the Duty Sheet for the aides. If staff could tell by looking at (R22) that she missed a shower, then they should have followed up on it. There are shift coordinators on every shift for a reason. The facility's Bath (Shower) policy (1/2004) showed the procedure for giving a shower. Documentation: date and shower given. Resident Care Plan: amount of assistance required should be listed on the resident's plan of care.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, the facility failed to ensure pressure relieving interventions were in place for 1 of 3 residents (R47) reviewed for non-pressure wounds in the sample of 50. The findings include: R47's face sheet, printed on 11/25/25, showed diagnoses including but not limited to peripheral vascular disease, cellulitis of left lower limb, type two diabetes mellitus with foot ulcer, right leg atherosclerosis with ulceration of part of foot, and non-pressure chronic ulcer of right foot with exposed fat layer on toes. R47's facility assessment, dated 10/7/25, showed severe cognitive impairment. The assessment showed the presence of five venous/arterial ulcers and the risk of development of pressure ulcers. R47's wound evaluation and management summary report, dated 11/17/25, showed wound physician recommendations including but not limited to float heels in bed and off-load wounds. On 11/23/2025 at 11:09 AM, R47 was in bed and covered with a light blanket. A pair of blue heel protectors were in a box, next to his bed. V20 (CNA-Certified Nurse Aide) removed the blanket and R47's feet were directly on the bed. R47 had a white gauze wrap on his left foot and an anti-skid sock on his right foot. V20 asked R47 why he was not wearing his heel protectors. R47 was confused and did not respond. At 12:26 PM, R47 was in the group dining room, seated in a wheelchair. R47's left foot was directly on the floor. The right foot was directly on the footrest.On 11/24/25 at 9:11 AM, R47 was in a wheelchair in his room Both heels were directly on the wheelchair foot pedals. At 11:47 PM, R47 was seated in the group dining room. Both feet were directly on the floor. On 11/24/25 at 11:55 AM, V2 (Director of Nurses) stated, (R47) was admitted with chronic wounds on both feet. He has poor circulation and diabetic issues. He is seen weekly by the wound physician, but the wounds will likely never heal. He has several toe amputations, poor skin integrity, and history of heel wounds. The goal now is infection and pain control. V2 said off-loading is needed for prevention. On 11/25/25 at 12:34 PM, R47 was seated in the group dining room with both feet directly on the ground. At 12:41 PM, V2 stated, (R47) should have heel boots on both feet, especially with all his open areas. I can't say why the staff are not using them. Offloading reduces the pressure and helps with healing the injuries he already has.On 11/25/25 at 12:19 PM, V1 (Administrator) stated there are no facility policies related to non-pressure wounds.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to identify pressure ulcers prior to becoming advanced stages for 2 of 3 residents (R83, R6) reviewed for pressure ulcers in the sample of 50. The findings include: 1. R83's face sheet, printed on 11/25/25, showed diagnoses including but not limited to heart failure, non-pressure chronic ulcer of left heel and midfoot, spinal stenosis, and pain in right leg. R83's facility assessment, dated 9/30/25, showed R83 is cognitively intact. The same assessment showed partial/moderate staff assistance needed for transfers, lower body dressing, and putting on/taking off footwear. R83's pressure score risk assessment, dated 9/30/25, showed R83 was at risk. R83's physician orders showed an order start, dated 11/3/25, for the left foot wound treatments to be done every Monday, Wednesday, and Friday. On 11/23/25 at 11:21 AM, R83 was seated in her room in a wheelchair. R83 stated she cannot dress herself below the waist and needs help with all transfers. R83 stated she has been having right heel pain during the transfers while using the sit to stand mechanical lift. R83 had a blue heel protector lying next to her bed. R83 said she had a sore on her right foot in the past and wears the heel protector at night to prevent another problem. R83 said she has a small sore on her left foot that they treat and change the bandage on every three days. On 11/25/25 at 9:13 AM, R83 stated she had received a shower that morning and the dressing on her left foot needs to be replaced. R83 said the wound doctor and a facility nurse saw her yesterday for the weekly assessment on her left foot wound but did not mention anything about her right heel. On 11/25/25 at 9:19 AM, V23 (Registered Nurse) stated R83 is very alert and knows what is going on. V23 reviewed R83's medical record and stated there were no new orders regarding her right heel. V23 said she had not received any report from the morning aides about any new skin concerns after R83's shower. On 11/25/25 at 9:32 AM, V24 (Registered Nurse) stated she did wound rounds on R83 yesterday and never saw anything on her right heel. V24 said R83 did not voice anything to her and this is the first time she had heard of it. On 11/25/25 at 9:43 AM, V23 replaced the dressing on R83's left foot. V23 and this surveyor observed the area on R83's right heel. A quarter size dark-purple area was noted. V23 said this looks like a bruise that is not open. V23 said the Nurse Practitioner was in the building and will be notified that an assessment needs to be done on it. On 11/25/25 at 10:04 AM, V27 (Nurse Practitioner) and this surveyor observed the area on R83's right heel. V27 pushed on the area and R83 reported pain. V27 measured the dark area at 3.5 x 3.5 centimeters and said it is non-blanchable. V27 said, It can't be staged because it is closed. It is mushy underneath. V27 was asked what a deep tissue injury (DTI) would look like. V27 said, It would start as a stage two then progress from there. A DTI is all the way down to the bone or muscle. I have not seen any of those here. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/25/25 at 12:01 PM, V4 (Lead Shift Coordinator/ CNA Supervisor) stated aides look at resident skin every shift, during all cares. Any bruising, redness, openings, or scratches should be reported. Resident skin is checked at every shower day from head to toe. Any skin changes need to be reported right away. Not reporting can cause a delay in care or treatment. On 11/25/25 at 12:41 PM, V2 (Director of Nurses) stated a DTI would appear as a dark area that is closed and painful to the touch. V2 said R83's heel sounds like a DTI. V2 said, Nothing has been reported regarding (R83's) heel. Nurses do weekly skin checks. Aides do them on shower days and at all care. It is important that skin issues are reported as soon as possible so a plan of care is started, and it doesn't get worse. R83's wound physician was attempted to be reached for interview but did not return the call during the survey. R83's shower sheets showed she received a shower on 11/21/25 and 11/25/25. There was no documentation in R83's progress notes of a wound to her right heel until 11/25/25 by V27 (after the Nurse Practitioner's assessment). R83's care plan showed a focus area related to increased risk for pressure ulcers related to decreased mobility and generalized muscle weakness. A new intervention to: Apply treatment as ordered to the right heel until resolved was start dated 11/25/25 (day of survey). The facility's Pressure Ulcer Prevention and Treatment Protocol policy, last revision date 10/16/24, states: 4. Staff will be trained on pressure injury prevention and safety measures to be taken, including identifying redness that remains when pressure is relieved and proper positioning procedures. The policy states under the Stages of Pressure Injury Definitions: Deep Tissue Injury (DTI): Purple or maroon localized area of discolored intact skin due to damage of underlying soft tissue from pressure or shear. The area may be preceded by tissue that is painful, firm, boggy, warmer or cooler as compared to adjacent tissue. 2. The face sheet for R6 shows diagnoses to include Parkinson's Disease, stage 4 pressure ulcer to the sacral region, stage 2 pressure ulcer to right heel and malnutrition. The facility assessment, dated 9/16/2025, for R6 shows him to be cognitively intact and requires maximum assistance with transfers. The same assessment shows R6 to be at risk for pressure ulcers. The wound management detail, report dated 11/3/2025, shows a new pressure ulcer was found to his right heel measuring 1 by 0.9 by 0.1 cm (centimeters) with a moderate amount of exudate (a fluid that leaks from blood vessels often due to inflammation or injury). The Wound Physicians wound evaluation and management summary, dated 11/3/2025, shows a stage 2 pressure ulcer to R6's right heel measured 1 by 0.9 by 0.1 cm, with a moderate amount of exudate. The report also shows open areas with exposed dermis (thick layer of tissue below the skin). On 11/23/2025 to 11/25/2025, R6 was observed sitting up in his wheelchair attending meals and activities. On 11/24/2025 at 10:38 AM, V8, CNA (Certified Nursing Assistant), said R6 likes to stay up in his wheelchair each day and will only get into bed in the late afternoon. V8 said skin checks are done on the resident's shower day. (continued on next page)

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	146102	A. Building B. Wing	11/25/2025

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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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/24/2025 at 3:30 PM, V2, DON (Director of Nursing), said skin checks should be done every time a resident is given care. V2 said R6 is at high risk for pressure ulcers and the ulcer to his heel should have been found before it became a stage 2. On 11/24/2025 at 1:51 PM, V15, Wound Physician, said R6 is at high risk for pressure ulcers and a good skin check should be completed to find a new area of concern before it advances to a stage 2 or above. The Pressure Ulcer policy, with a revision date of 10/16/2024 shows, 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. 4.Staff will be trained on pressure injury prevention and safety measures to be taken, including identifying redness that remains when pressure is relieved and proper positioning procedures.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to keep the catheter drainage bag of the bed and below the level of the bladder for 1 of 3 residents (R13) reviewed for catheters in the sample of 50.The findings include:On 11/23/25 at 12:01 PM, R13 was in bed on her back and V5, Certified Nursing Assistant - CNA, and V8, CNA, were getting ready to transfer her from the bed to her wheelchair using a mechanical lift. V5 picked the catheter bag up and attached it to the sling laying on the resident's bed. V5 and V8 raised the lift arm up and the bag was attached to the upper loops of the sling. The drainage bag was at the level of R13's head during the transfer. After the transfer, V8 stated the drainage bag should be below the resident's bladder to prevent backflow of urine causing a urinary tract infection. On 11/24/25 at 3:22 PM, V2, Director of Nursing, stated the catheter bag should be kept below the waist to prevent backflow in the tubing and prevent infection. The drainage bag should not be on the bed for infection control and cross contamination.The Face Sheet, dated 11/24/25 for R13, showed diagnoses including obstructive and reflux uropathy, retention of urine, and VRE (Vancomycin-resistant Enterococcus- an antibiotic-resistant infection) carrier. The Physician Orders, dated 11/24/25 for R13, showed she is on an antibiotic, cephalexin 500 mg by mouth three times per day for retention of urine. R13 takes a cranberry supplement daily for urinary tract infection. The Care Plan, dated 11/24/25 for R13, showed R13 has a urinary tract infection with her antibiotic therapy to be completed on 12/1/25. The Minimum Data Set, dated [DATE] for R13, showed moderate cognitive impairment; partial/moderate assistance needed for transfers and toileting hygiene.The facility's Catheter care policy (6/2005) did not show any thing regarding keeping the drainage bag below the level of the bladder or infection control to include not placing it on the bed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to provide the physician with the dietician recommendations for a resident with a significant weight loss, and the facility failed to ensure a resident received fluids with her meal and ordered supplements. This applies to 2 of 5 residents (R33 & R8) reviewed for nutrition in the sample of 50. The findings include: 1. R33's Face Sheet, dated 11/24/25, showed diagnoses including Alzheimer's disease, vitamin B12 deficiency, iron deficiency, type 2 diabetes, aortic valve stenosis, atrial fibrillation, atherosclerotic heart disease, hypertensive heart disease with heart failure, hyperlipidemia, congestive heart failure, pain, bursitis, carpal tunnel syndrome, anxiety, depression, and insomnia. The Registered Dietician - RD Note, dated 11/16/25 at 11:55 AM for R33, showed, RD Review. Weight: 11/6 = 116 # (pounds). Weight history: 10/7 = 117.4#, 8/5 = 121#, 5/6 = 129#, significant weight loss -10% x 6 months. Weight on 9/3 = 219.9# clearly an error. Diet: Soft & Bite Sized, slightly thickened liquids. Supplement: protein shake 8oz x 1 daily as provided by family. She was evaluated by speech therapy in September due to coughing/choking during oral intake and her diet was eventually downgraded to slightly thickened liquids. Appetite and intakes are variable. She is at nutrition risk for altered appetite and weight changes related to advanced age and progressive effects of dementia, dysphagia and modified texture diet may impact appetite and meal enjoyment. Recommend add High Calorie/High Protein fortified items to diet for additional kcal/pro. Assist with meals as needed, encourage intakes, honoring preferences as able. Monitor nutritional status and consult RD as needed. The Nutrition Care Report, dated 11/16/25 for R33, showed the same note documented in her chart on 11/16/25 at 11:55 AM. The action portion of the report showed fortified foods: add high calorie/high protein diet. Primary care physician fax attached. The Physician Orders for R33, dated 11/24/25, did not show any orders for High Calorie/High Protein fortified items to be added to her diet. On 11/23/25 at 12:32 PM, R33 was sitting in her wheelchair at the dining room table for the noon meal. R33 took 1/4 of another resident's grilled cheese, used it like a spoon to put meat on it, and shoved it in her mouth. R33 was using her hands to eat meat, diced carrots, and mashed potatoes. Staff were not consistently at the table to assist and/or cue her to eat or use silverware. When R33 was given a fork with meat and potatoes on it, she ate the food. On 11/25/2025 at 9:09 AM, V7, Registered Nurse – RN, stated, There are orders when there is a recommended diet change. A card is filled out and put in (V3, Dietary Manager's) mailbox. V7 stated she has not seen any orders for the fortified foods, high calorie, high protein diet for R33. V7 stated the only thing R33 has is a supplement that is supposed to be brought in by the family, but they have not been bringing them in. V7 stated the RD places the orders for the recommendations. V7 stated she doesn't know what happened to the order for R33. On 11/25/25 at 9:13 AM, V3, Dietary Manager, stated the RD will make a recommendation and emails V,2 Director of Nursing – DON, and then it's given to nurses to follow up on. V3 stated the RD copies him in the email; he reviews it and waits for the nurses to send him an order. V3 stated he saw that the Dietician made the recommendations for R33, and he has been waiting. R33 is not on what is recommended right now. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/25/2025 at 9:26 AM, V12, Registered Dietician, stated she attaches a recommendation to the electronic report that gets sent to the Dietary Manager and the DON. V12 stated she doesn't enter any orders; she makes recommendations and sends them to the facility. V12 stated her recommendation for R33 was based on her weight change and nutritional risk. V12 stated she can verify there is a consultant request report that was done on 11/16/25. The recommendation was High Calorie/High Protein fortified items to her diet and nutritional supplement that the family would bring in. V12 stated the report was sent to corporate, the DON, and the Dietary Manager. V12 stated she did not know what happened to the recommendations after that. On 11/25/25 at 12:52 PM, V2, Director of Nursing - DON, stated when they receive recommendations from the Dietician it is given to the physician to sign off on and agree. The order is put in by the nurses and the physician signs the order. V2 stated the Dietician will send the recommendations, V2 prints off the report, and it is given to the floor nurse to obtain the order. V2 stated the Dietary Manager also receives a copy of the report from the Dietician. V2 stated it is important to follow up on the recommendations and obtain the orders because the resident could be missing out on the nutrition that is needed. The facility did not have a policy regarding the process for dietary recommendations from the RD. No policy for significant weight loss was received. 2. The facility face sheet for R8 shows diagnoses to include Alzheimer's Disease and chronic kidney disease. The facility assessment, dated 9/23/2025, shows severe cognitive impairment and requires set up and clean up assistance with dining. The care plan for R8 shows problems with weight loss and requires house supplements and a high calorie, high protein diet. On 11/23/2025 at the noon meal, R8 was observed being assisted to the dining room table for lunch. There were no drinks in front of R8. R8 was served her plate of food, but no drinks. R8 was observed eating her meal unassisted and ate most of her plate of food. R8 sat at the table until 1:00 PM and was never offered anything to drink. On 11/25/2025 at 9:11 AM, V13, LPN (Licensed Practical Nurse), said all residents should get drinks with their meals. V13 said R8 is to get fortified chocolate milk at lunch. V13 said the nurse and the CNAs hand out the supplements. On 11/25/2025 at 9:17AM, V14, CNA (Certified Nursing Assistant), said all resident get drinks with their meals. V14 said it must have been overlooked that R8 did not get any drinks on Sunday 11/23/2025. V14 said the CNAs don't give out the supplements, the nurses do. On 11/24/2025 at 3:30 PM, V2, DON (Director of Nursing), said there is no reason R8 was not given fluids at lunch. V2 said R8 is at risk for urinary tract infections and should be given extra fluids. On 11/25/2025 at 9:30 AM, V12, Registered Dietician, said the residents should get fluids with all their meals, it provides additional nutrition. V12 said R8 continues to have fluctuations in her weight and it may be due to disease progression and the supplements she has recommended for R8 should be given to keep her from losing to much weight. The Physician orders for R8 dated November 2025 shows orders for a regular diet, 8 ounces of nutritional supplement twice a day, and fortified chocolate milk at lunch and supper. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy for meal service, dated 11/14/2022, shows three beverages should be served at each meal. Serve ice water and 2 additional beverages.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to sanitize the blood glucose testing monitor between residents. This applies to three of eight residents (R28, R42, R90) reviewed for infection control in the sample of 50.The findings include:On 11/23/2025 at 11:32, V28, RN (Registered Nurse), was observed checking blood sugars on three residents R28, R42 and R90. After each blood sugar test, V28 wiped down the blood glucose monitor with an alcohol wipe.On 11/23/2025 at 12:00 PM, V28 said it was fine to use alcohol wipes or the micro kill wipes in the medication cart.On 11/24/2025 at 10:00 AM, V13, LPN (Licensed Practical Nurse), said the blood glucose monitor should be cleaned between each resident with the micro kill wipes.On 11/24/2025 at 3:30 PM, V2, Director of Nursing, said the blood glucose testing monitor must be cleaned with the micro kill wipes to prevent cross contamination between residents sharing the monitor.The blood glucose monitors package instructions for cleaning the meter shows the meter must be cleaned between residents using a EPA registered disinfecting wipe. The disinfection process reduces the risk of transmitting infectious diseases if properly performed.