STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016976	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF ROCHELLE	2203 FLAGG ROAD ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigations: 2514249/IL192352 2514280/IL192392	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)4)A)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016976	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF ROCHELLE	2203 FLAGG ROAD ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1	S9999		

resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:

A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These requirements were not met as evidenced by:

Based on interview, and record review the facility failed to identify a resident with a change in condition resulting in a delay in treatment from 5-11-2025 to 5-12-2025. This applies to 1 of 3 (R1) residents reviewed for quality of care in the sample of 3. This failure resulted in R1 needing to be hospitalized for removal of a denture appliance under anesthesia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016976	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF ROCHELLE	2203 FLAGG ROAD ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2	S9999		

The findings include:

R1's current Resident Face Sheet shows R1 is a 93-year-old male resident with a medical history of Parkinson's, tremor, and vascular dementia with mild behavioral disturbance admitted to the facility on 6/23/2023.

On 5/19/2025 at 2:36PM, V4 Certified Nursing Assistant (CNA) said he took care of [R1] on 5/9/2025 into the morning of 5/10/2025. V4 said he did assist [R1] with oral care and placed [R1's] dentures in this mouth that morning, noting they fit well. V4 said [R1] does require assistance with his dentures as he has Parkinson's and has tremors.

On 5/19/2025 at 10:14AM and 1:47PM, V5 CNA said she was working with [R1] on 5/10/2025 and 5/11/2025 on night shift. V5 said the first day she noticed [R1] didn't have his dentures was Sunday morning [5/11/2025]. V5 said she did not report the missing dentures to anyone. V5 said she thought they had just been misplaced. V5 said [R1] was not in any distress when she worked with him, and he was not clearing his throat. V5 said she got [R1] up in the morning when she worked with him.

On 5/19/2025 at 1:25PM, V12 CNA said he helped put [R1] to bed on Sunday night [5/11/2025]. V12 said he did assist [R1] with oral care that night, brushing his teeth, but didn't see any dentures. V12 said they were very busy that night and he didn't check the report sheet that has patient information such as if they have dentures or not. V12 said he does not normally work that unit and is unfamiliar with the resident. V12 said he did hear some gurgling sounds but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016976	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF ROCHELLE	2203 FLAGG ROAD ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		

thought it was related to brushing [R1's] teeth. V12 said [R1] was breathing normal and did not appear to be in any distress.

On 5/19/2025 at 2:46PM, V13 CNA said she was working on Mother's Day weekend with [R1] but did not provide [R1] with oral care that day because they were really behind that day. V13 said family had approached her regarding the resident having a gurgling sound and she reported it to [V10]. V13 said [V10 assessed [R1]. V13 said [R1] needs assistance with his dentures. V13 said [R1] seemed present on Saturday but was more tired on Sunday during 'lay downs'.

On 5/19/2025 at 8:57AM, 10:44AM, and 12:38PM, V10 Registered Nurse (RN) said [R1's] family had reported he had some gurgling noises on Sunday [5/11/2025]. V10 said she went to see [R1], and he didn't appear to be in any distress or having breathing issues. V10 said [R1's] lung sounds were diminished, and she messaged V14 Physician about a chest x-ray, which was ordered. V10 said the x-ray was not a stat order and the x-ray company said they would be in the following day [5/12/2025] to do the x-ray. V10 said non stat x-rays are done in about 24 hours normally. V10 said [R1] had lost his upper dentures about a month ago and only had his bottom denture which was a partial.

On 5/19/2025 at 1:00PM, V6 RN said on 5/12/2025 [R1's] family approached her about him sleeping in the dining room and asked what the x-ray showed. V6 said she explained she didn't have any x-ray results because it wasn't done over the weekend. V6 said she went to check on [R1] and he was sleeping in the chair. V6 said his lung sounds were diminished with audible congestion. V6 said she called [V14]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016976	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF ROCHELLE	2203 FLAGG ROAD ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4	S9999		

regarding transfer to the hospital for evaluation and [V14] was ok with transfer.

On 5/19/2025 at 4:17PM, V7 Licensed Practical Nurse (LPN) said [R1] was sent out on 5/12/2025 because he was having increased lethargy and some crackles. V7 said [R1's] oxygen saturation was 98% prior to leaving with paramedics on 5/12/2025.

On 5/19/2025 at 3:05PM, V14 (Physician) said [R1] did have a foreign body in his airway or above it that needed to be removed. V14 said he wasn't close to serious harm or death with slightly abnormal breath sounds, stable vital signs, and was still oxygenating.

On 5/20/2025 at 8:36AM, V18 Fire Department Lieutenant read the report for the 5/12/2025 at 9:18AM for [R1]. V18 said [R1] was picked up for difficulty breathing and was classified as emergent, but not critical or unstable. V18 said two oxygen saturations were documented one at 96% on room air and another at 89% and 3 liters of oxygen via nasal cannula was started. V18 said [R1] was arousable with sternal rub initially and then was following commands and tracking with his eyes. V18 said [R1] had bilateral rhonchi noted and difficulty breathing. V18 said they gave [R1] a GCS (Glasgow Coma Scale) of 10. V18 said if someone can follow commands, they would still have a gag reflex and artificial airway placement would be contraindicated. V18 said a GCS of 8 or less would indicate intubation would be appropriate. V18 stated [R1's] vitals were listed as 97.9 temperature, 95 heart rate, 154/76 blood pressure, 22 respiratory rate.

On 5/20/2025 at 10:15AM, V2 Director of Nursing (DON) said [R1] requires assistance with oral

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016976	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF ROCHELLE	2203 FLAGG ROAD ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5	S9999		

care and would not be responsible for them himself. V2 said staff should report missing dentures. V2 said abnormal breath sounds should be followed up on and assessed by nursing staff.

R1's Search Vitals Results 5/5/2025 to 5/20/2025 show vitals of 98.1 temperatures, 68 heart rate, respiratory rate of 22, blood pressure of 105/51, and an oxygen saturation of 97% on 5/12/2025 at 8:34AM.

R1's current care plan shows [R1] has generalized muscle weakness, fatigue, poor activity tolerance, and decreased mobility [dated 11/8/2024] . . . and approach of mouth care: staff will assist with oral care as needed. [R1] has top and bottom dentures. . ."

R1's hospital records shows resident was transferred from the facility to [a local area hospital] for foreign body aspiration on 5/12/2025. Hospital records state the resident has been gurgling over the past couple of days and CT chest showed the dental denture within the pharynx. Therefore, the patient was transferred to [another local area hospital] to receive a higher level of care.

R1's hospital procedure notes state on 5/12/2025 [R1] was brought to the operating room and monitoring anesthesia care with sedation was administered. Time out performed. The pharynx was examined with a Glide laryngoscope and thick secretions were suction. The intact dental appliance was visible in the hypopharynx, and it was removed without trauma with a McGill forceps. The hypopharynx and larynx were inspected and found to be free of mucosal trauma or other foreign bodies. The patient was turned over to anesthesia to transport back to his room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016976	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF ROCHELLE	2203 FLAGG ROAD ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 6 There were no complications. The dental appliance was given to the patient's son who verified that it was fully intact. R1's 5/12/2025 hospital records show [R1] was noted to have pneumonia and was started on antibiotic therapy related to pneumonia. (A)	S9999		