STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003321	A. BUILDING: _____ B. WING _____	C 05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREEBURG CARE CENTER	746 URBANNA DRIVE FREEBURG, IL 62243

(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 Investigation 2544532/IL192728	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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 resident to meet the total nursing and personal care needs of the resident.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003321	A. BUILDING: _____ B. WING _____	C 05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREEBURG CARE CENTER	746 URBANNA DRIVE FREEBURG, IL 62243

(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 These requirements were not met as evidenced by: Based on interview and record review the facility failed to honor care directives for 1 of 5 (R2) residents reviewed for quality of care in the sample of 8 and failed to follow physician orders to send a resident (R3) to the emergency room for further evaluation and follow hospice agreement that a resident (R2) is not to be transferred to the hospital for treatment without first notifying hospice for 2 of 4 residents (R2, R3) reviewed for quality of care in the sample of 8. This failure resulted in R2 being sent out to the hospital and having unnecessary diagnostic testing initiated before discovering (R2) was not the intended resident and R3 not being sent out to the hospital as ordered. This failure also puts R2 at risk to incur unnecessary medical bills. This past non-compliance occurred 5/10/25 to 5/23/25. Findings include: 1. R2's Face sheet undated documents that resident was admitted to the facility on 12/31/2024. R2's Physician Order Summary (POS) dated 12/31/2024 documents diagnosis of Cerebral infarction, unspecified and Facial weakness following cerebral infarction. R2's MDS (Minimum Data Set) dated 4/7/2025 documents a BIMS (Brief Interview for Mental Status) score of 3 out of 15. R2's MDS dated 4/7/2025 documents that resident is dependent with toileting hygiene,	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003321	A. BUILDING: _____ B. WING _____	C 05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREEBURG CARE CENTER	746 URBANNA DRIVE FREEBURG, IL 62243

(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		

putting on/taking off footwear and lower body dressing and needs substantial/maximal assistance with shower/bathe self and upper body dressing.

R2's MDS dated 4/7/2025 document resident needs substantial/maximal assistance with mobility.

R2's Nurse Progress Note dated 5/10/2025 at 11:47 PM documents resident mistakenly sent to ER for eval and treat of low BP and low 02 sats. When the hospital noticed the mistake, POA and MD made aware. Resident returned to facility with no further incident.

R2's Hospital medical records dated 5/10/25 documents "Patient arrives per EMS, wrong patient sent from facility. Pt being sent back to nursing home, Emergency Room Charge RN attempted to call pt family with no answer.

Emergency Room Physician notes dated 5/11/24 at 12:26 AM documents Wrong patient sent by nursing home, patient is hospice, Do Not Resuscitate (DNR), Do Not Intubate (DNI), comfort care, and family did not want this patient seen. I did (?) evaluate or treat the patient.

No facility physician order documented for R2 to be sent to hospital as of 5/27/2025.

On 5/28/2025 at 11:22 AM, V1 Administrator states "we dodged a whole lot of bullets with this one", so many things could have gone wrong. V1 states V19, Licensed Practical Nurse (LPN) was terminated the following Monday after incident.

On 5/27/2025 at 1:46 AM V9, daughter of (R2), stated the emergency medical technicians

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003321	A. BUILDING: _____ B. WING _____	C 05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREEBURG CARE CENTER	746 URBANNA DRIVE FREEBURG, IL 62243

(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		

(EMT's) went to the wrong room. She states her mother (R2) was in room 08 and the other resident was 06. She states the EMT's took the patient in room 08 as the patient needing to be transported to the hospital. She states no one notified the family that (R2) had been taken to the hospital and they had no idea that it had happened. She states the hospital called at 11:58 PM to advise that our mother (R2) was at the hospital. She states (R2) had a series of strokes and was not alert. She states (R2) was receiving hospice services and had only been with hospice for 1 week. She states she did speak with a nurse and Dana in admissions who admitted that her mother (R2) had been sent to the hospital by mistake and the nurse had been fired. She states she has hospital records but not the ambulance records, mother (R2) did not receive any treatment but if they had provided treatment, it would have been for the wrong person. She states the patient they were supposed to transfer to the hospital had diabetes and questions what if they would have given (R2) insulin. She states anything that the hospital would have done would been unnecessary treatment and that her mother was not supposed to be transported.

R2's medical records dated 5/10/25 documents R2 was seen in an area hospital for a complaint of Shortness of breath (SOB). Diagnostic testing was initiated before discovering (R2) was not the intended resident.

On 5/28/2025 at 10:12 AM, V27, Hospice Nurse, states she was notified on 5/12/2025 at 9:00 am by V19, Licensed Practical Nurse (LPN), (R2) was having difficulties that day. V19 mentioned to V27 that (R2) had been sent to the ER on 5/10/2025 by ambulance and they had taken the wrong resident. V27 states V19 told her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003321	A. BUILDING: _____ B. WING _____	C 05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREEBURG CARE CENTER	746 URBANNA DRIVE FREEBURG, IL 62243

(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		

emergency medical service (EMS) grabbed the wrong resident and not sure how this happened. V27 notified Hospice both clinical coordinator and medical director. V27 states she did not receive medical records from the hospital and had prepared a report of the incident. V27 states the Case Manager followed up with (R2's) family. V27 states she has not filed a report but would do so today. V27 states the nursing home told her that no care was provided at the hospital. V27 states her expectation is the facility will call before sending (R2) out to hospital.

On 5/28/2028 at 4:48 AM, V15, certified nurse assistant, (CNA) stated she works nights but was not here at that time of the incident. V15 states she has been trained to accompany EMT's to the resident's room, stay with the resident and get the resident ready for transport. V15 states the nurse provides the information to the Emergency Medical Technicians (EMT).

On 5/28/2025 at 5:00 AM, V16, CNA, states she work both evening and night shifts and has received in-service training on transferring a resident to the hospital and to notify the family representative. V16 states the CNA's duties are to stay with the resident and get the resident ready for transport.

On 5/28/2025 at 4:00 AM, V10, Registered Nurse (RN) stated she works the evening and night shift and did relieve the evening shift nurse. V10 does not recall the events surrounding the wrong resident being sent out. V10 states CNAs that worked that evening were all agency CNA's and did not know names. Have no idea how the wrong person was sent out.

Hospice organization dated December 1, 2008,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003321	A. BUILDING: _____ B. WING _____	C 05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREEBURG CARE CENTER	746 URBANNA DRIVE FREEBURG, IL 62243

(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		

documents regarding Patient Transfer. The Nursing Facility agrees not to transfer any Residential Hospice Patient to another care setting without the prior approval of Hospice. If the Nursing Facility fails to obtain the necessary prior approval, Hospice bears no financial responsibility for the costs of transfer and the costs of care provided in another setting.

Facility Policy for Hospice Services undated documents "Purpose: Provide and promote collaboration and coordination of care and services for the resident receiving hospice care. This facility will immediately notify the hospice provider of the following: Significant change in resident's physical, mental, social, or emotional status; Clinical complications that suggest a need to alter the plan of care; Need to transfer the resident from this facility for any condition and the resident's death."

2. R3's Face Sheet undated documents R3 was admitted 04/22/2025 with pertinent medical diagnoses of Human Metapneumovirus as the causes of diseases classified elsewhere, Systemic Inflammatory of Response Syndrome (SIRS) of Non-infectious origin without Acute Organ Dysfunction.

R3's Nurse's Progress notes dated 5/10/25 documents R3 was experiencing a temperature of 100.2 degrees, abnormal lung sounds and a decrease in blood pressure of 102/64 to 88/46.

R3's Nurse Progress notes dated 5/10/25 documents R3 was experiencing a temperature of 100.2 degrees. The Medical Director ordered (R3) to be transferred to area hospital for further evaluation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003321	A. BUILDING: _____ B. WING _____	C 05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREEBURG CARE CENTER	746 URBANNA DRIVE FREEBURG, IL 62243

(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 R3's Nurse's Progress notes dated 5/10/25 documents by error resident was not sent to hospital. MD was made aware when error was noticed. Resident re assessed and not sent out to ER and resident family made aware. On 5/27/25 at 4:00 AM V10 Registered Nurse stated she work nights and was the on-coming nurse and was made aware that R3 had not been sent out to the hospital. V10 was familiar with R3, re-assessed her and believed her symptoms could be addressed at the facility. V10 did not contact the medial director with that information and did not send R3 as ordered. Prior to survey date, the facility took the following actions to correct the non-compliance: All facility nurses and Certified Nurse Assistants were in-serviced between 5/12/25 and 5/23/25 on the vital importance of resident identification, including Certified Nursing Assistants and/or nurse presence in room with Emergency Medical Service before transporting/transferring resident to the hospital. Additionally, Medical provider or Nurse Practitioner and Hospice company (if applicable) should be notified before any transfers or discharges. The Director of Nursing will Audit all hospital transfers for the next 4 weeks and then monthly for a period of 6 months. (B)	S9999		