STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0046839	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF FREEPORT	2170 WEST NAVAJO DRIVE , FREEPORT, Illinois, 61032

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S0000	Initial Comments Complaint Investigation 2516120/IL195854	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)1) 300.1620 a) 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. 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	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 300.1620. Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile, or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to administer a resident's (R1) sodium tablets for 12 days following his admission to the facility. This failure resulted in R1 experiencing a critically low sodium level, confusion, hallucinations, and a 15 day hospital stay to correct his sodium levels. This applies to 1 of 3 residents reviewed for medications in the sample of 5. The findings include: R1's electronic face sheet printed on 7/8/25 showed R1 has diagnoses including but not limited to permanent atrial fibrillation, syndrome of inappropriate secretion of antidiuretic hormone (SIADH), chronic kidney disease, and malignant neoplasm of bladder.	S9999		

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S9999	Continued from page 2 R1's census report showed R1 was admitted to the facility on 6/5/25, and discharged to a local hospital on 6/16/25. R1 did not return to the facility. R1's local hospital discharge orders, dated 6/5/25, showed, "NEW: Sodium Chloride 1gm PO (oral) QID (4 times per day) ...Discontinued: sodium chloride 1,000mg PO TID (3 times per day) ..." R1's physician's orders for June 2025 showed no orders for R1 to receive Sodium Chloride 1gm PO QID. R1's medication administration record for June 2025 showed no evidence R1 ever received Sodium Chloride during his stay at the facility from 6/5/25-6/16/25. R1's nurse practitioner visit note, dated 6/9/25, showed: 4. SIADH- chronic- managed with sodium chloride 1gm po qid ..." On 7/8/25 at 10:23AM, V4 (R1's son) stated, "(R1) went to an appointment which required them to draw blood and his sodium level was 115. The facility called my sister to let her know because she was at a different appointment with (R1), and she took him to the emergency room. He went back to (local hospital) where they had to slowly increase his sodium levels back up to normal. When she got him to (local hospital), he was hallucinating and saying he was seeing people outside of his eyes and was completely disoriented. I have no idea how she even handled him at the appointment. He knew he wasn't right, and he told us he felt disoriented, and he knew he was hallucinating. It took 2 weeks in the hospital before they got his levels regulated again. The orders were clearly on his discharge paperwork so I'm unsure why (facility) never gave him his medications." On 7/8/25 at 9:48AM, V5 (R1's Nurse Practitioner) stated, "SIADH is usually the reason we see someone on a sodium replacement and that's what (R1) was getting it for. 10 days without the sodium tabs could have detrimental effects and create a critically low sodium level which would put him at risk for nausea, vomiting, increased confusion, and potentially seizures depending how low his sodium was. I never saw what his labs were because he was out at an appointment at the time, and they drew the labs and got the critical lab value. I	S9999		

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S9999	Continued from page 3 saw him on 6/9/25 and nobody ever reported to me that he wasn't getting his sodium tabs, so I assumed what I saw on the discharge report was being given because I certainly did not discontinue his sodium tabs. I never received any notification that there were any issues with getting the medication or entering it into the system." On 7/8/25 at 9:57AM, V3 (Licensed Practical Nurse) stated, "If my name was next to the orders for admission then I must have been the nurse who admitted (R1), but I don't remember much about him. When I do an admission, I look at discharge paperwork and reconcile the orders. Sometimes the hospital will send the orders before the resident comes but it usually comes with the resident. I don't recall having any issues entering any medications or not being able to find medications. If I was the nurse that put the orders in, then there is another nurse from night shift that checks orders so someone besides me should have caught this. If a resident is not receiving sodium as ordered, they could potentially have cardiac effects. I can't really say much because I'm not a doctor or anything." On 7/8/25 at 10:07AM, V2 (Director of Nursing) stated, "When a resident is admitted, the floor nurse enters the medications. Usually, it is the nurse from that hall but if another nurse is available, they will do it. Third shift nurses are then responsible for double checking the discharge orders from the hospital and reconciling it with our list. I remember (R1) a little bit, but he wasn't here long. He went to the hospital because of low sodium and change in mental status. He was out at an appointment at the time we got the call about his low sodium, so his daughter drove him to the hospital. I'm not even sure when the labs were done or what the level was." On 7/8/25 at 11:42AM, V2 stated, "We were able to get the labs from the hospital and it showed (R1's) sodium levels were 115 when he got to the hospital, which is a critically low level. He was confused and hallucinating which are signs of low sodium. I have no idea how this order was missed when he was admitted to the facility because 2 nurses checked the orders so it should have been caught. This is a perfect example of a significant medication error." R1's local hospital records showed, "6/16/25 Sodium 115 (Critical Lab Value) ....6/17/25 119 (Critical Lab	S9999		

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S9999	Continued from page 4 Value) ..." The facility's policy titled, "Admission of A Resident" revised 01/04 showed, "Objective: 1. To facilitate the transition from prior living arrangement to long-term in a caring, professionally comprehensive manner ...Procedure ...13. Obtain physician's orders ..." The facility's policy titled, "Medication Administration" revised 02/04 showed, "Objective: 1. To provide the resident with those medications deemed necessary by the physician to improve and/or stabilize specified diagnosis of the resident ...Procedure ...5. All physician's orders must be accurately transcribed to the MAR (medication administration record). 6. All medications must be administered to the resident in the manner and method prescribed by the physician. 7. In the event that a medication cannot be given, the reason must be documented in the Nurses Medication Notes on the MAR (Medication Administration Record) ..." (A)	S9999		