STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145515	A. BUILDING _____ B. WING _____	C 02/04/2015

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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #1540301/IL74401: No Deficiency Complaint #1540463/IL74569 : F493	F 000		
F 493 SS=C	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to provide a Licensed Administrator to oversee the operation and management of the Facility. This has the potential to affect all 89 residents in the Facility. Findings Include: 1. On 02/03/15 at 3:30 PM, E2, Director of Nursing (DON) stated; "I am the DON and the Administrator. Our Administrator left on December 6, 2014, and we are actively seeking an Administrator. I am not licensed, and I don't want to seek an administrator license." Through out the survey on 02/03/15 and 02/04/15 there was no Administrator available.	F 493		

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

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.

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F 493	Continued From page 1 2. The Facility's Facility Data Sheet dated 02/03/15 documented the Facility had a census of 89 residents.	F 493		