Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009161	A. BUILDING: ______ B. WING ______	C 07/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEPHENSON NURSING CENTER	**2946 SOUTH WALNUT ROAD FREEPORT, IL 61032**

(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	Final Observations Statement of Licensure Violations 300.690 b) 300.690c) Section 330.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, " serious " means any incident or accident that causes physical harm or injury to a resident. c) The facility shall by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only " means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. This REQUIREMENT was not met as evidenced by: Based on Observation, Interview and Record Review the facility failed to report two falls with injury (R1,R2) to the Illinois Department of Public Health (IDPH) within 24 hours and failed to send a narrative summary of R1's and R2's fall with specific injuries to IDPH. This applies to 2 of 3 residents (R1, R2) that were reviewed for falls with injury. The findings include: 1. On July 28, 2015 at 8:55 AM, R1 was sitting in a recliner near the nurses station. R1 had a	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE
08/10/15

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S9999	Continued From page 1 hematoma to her forehead On July 26, 2015 at 11:00 PM, R1's Progress Note showed " R1 was taken from dining room, when moving into room (R1's room); R1 leaned to the left, fell forward to the floor, hematoma on left temple, pain, and complained of left shoulder pain. Power of Attorney notified, physician on call notified and gave order to send to emergency room and neurological checks ... left facility at 7:30 PM. " R1's Progress Note dated July 27, 2015 at 1:00 AM, showed the facility staff called local emergency room for an update on R1. R1 was transferred to another hospital for further treatment. On July 27, 2015 at 6:30 PM, R1's Progress Note showed R1 returned to the facility. R1's Discharge Summary dated July 27, 2015, showed a discharge diagnosis of head injury with a follow up appointment with a neurosurgeon in one week. 2. On July 28, 2015 at 9:30 AM, R2 was lying in bed with his eyes closed. There was bruising noted to his eyes and a laceration with staples to R2's forehead. On July 25, 2015 at 2:21 PM, R2's Progress Note showed a " CNA (Certified Nursing Assistant) called the nurse to R2's room. R2 was lying on the floor in a prone position with a " large puddle " of blood under his head and face. R2 yelled " Help, help. " R2 was alert and verbal and able to move arms and legs independently without pain. R2 was rolled onto his back. R2 had a v-shaped laceration to his forehead. The laceration was bleeding and pressure was applied for twenty minutes. R2's pupils were equal and reactive to light. R2's hand grasps were of equal strength. R2 remained conscious throughout process, talking to staff. R2's vital signs were stable. R2 had a skin tear to his left forefinger, which was	S9999		

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S9999	Continued From page 2 also bleeding. Pressure was applied to the forefinger to stop the bleeding. R2 was unable to tell staff what happened, saying " Thanks for your help, thank you, thank you. " R2's bed was in the low position. R2's assigned CNA had been in less than 10 minutes prior and changed R2's brief. R2 was cleaned up and was moved to his bed with a mechanical lift and four staff members. R2's physician was called and an order was received to send R2 to the local hospital. R2's Power of Attorney was called. An ambulance was phoned to transport R2 to the local hospital. R2 left the facility per stretcher ambulance at 2:20 PM " . On July 25, 2015 at 3:15 PM, R2's Progress Note showed R2 returned to the facility with staples to forehead laceration and pressure dressing. R2 also has bruising to left eye. On July 28, 2015 at 2:15 PM, E2 (Director of Nursing) stated that she did not notify IDPH of R1's and R2's falls with injury. E2 stated since there was no fractures she did not believe the falls were reportable. The facility's policy for Accident and Incident Reporting and Investigation dated June 10, 2013, showed, " If the accident/incident involving a resident is serious and requires medical treatment outside of the facility the following will be done: Notify the Director of Nursing Services or designee. The Director of Nursing Services or designee will file a report with the Illinois Department of Public Health " . (B)	S9999		