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 _____	03/03/2022

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

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)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 resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 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 observation, interview, and record review the facility failed to implement interventions to prevent a resident with a history of falls from experiencing a fall with major injury for 1 of 2 residents (R7) reviewed for falls in the sample of 16. This failure resulted in R7 being left unsupervised in her wheelchair and experiencing a fall on 1/21/22. R7 sustained a facial laceration which required treatment at an acute care hospital and received 7 sutures to her left forehead. The findings include: R7's face sheet showed she was admitted to the facility on 11/17/21 with diagnoses to include congestive heart failure, Alzheimer's disease with late onset, dehydration, hypertension, fatigue, personal history of transient ischemic attack, and cerebral infarction without residual deficits. R7's facility assessment dated 11/25/21 showed R7 to be cognitively impaired and staff assistance for all cares.	S9999		

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S9999	Continued From page 2 R7's care plan started 10/20/18 titled Falls showed, "Resident at risk for falling related to history of falls, vision impairment, cognitive and memory deficits, history of noncompliance with care, history of refusal to wear gait belt and eyeglasses at times. Fall and safety precautions diminished due to diagnosis of dementia... Approach start date: 11/23/20 Apply sensor pad in char and bed and ensure they are working at all times... Approach start date: 4/16/21 Place resident in Falling Star Program... Approach start 10/3/21 Place resident on visual supervision when she is up in chair and when having increased behavioral symptoms..." R7's fall record reviewed and showed R7 experienced falls 8/11/21, 8/30/21, 9/15/21, 9/21/21, 10/7/21, 10/16/21, 11/11/21, 11/22/21, 12/31/21, 1/21/22, and 2/19/22. R7's 8/30/21 fall event report showed R7 experienced an unwitnessed fall in her room when she got up out of her wheelchair and attempted to ambulate without assistance. R7's 9/21/21 fall event report showed R7 experienced an unwitnessed fall in her room when attempting to transfer herself from her wheelchair into her bed without assistance and was found sitting on the floor. R7's 9/15/21 fall event report showed R7 experienced a fall in the hallway when she attempted to transfer herself from her wheelchair without assistance. R7's care plan showed a new intervention on 10/3/21 to place resident on visual supervision when she is up in chair. R7's nursing progress notes showed a late entry entered on 10/9/21 at 5:15 PM which documented an unwitnessed fall for R7 which	S9999		

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S9999	Continued From page 3 occurred on 10/7/21 and showed, "Patient was noted to be sitting on the dining room floor in front of her wheelchair next to the dining room chair with her legs extended out in front of her. Patient attempted to transfer herself from the wheelchair to the dining room chair without assistance." R7's 10/16/21 fall event report showed R7 was in her wheelchair at the nurse's station when she attempted to transfer alone and fell. R7's nursing progress note dated 10/16/21 at 2:46 PM showed, "Resident at nurse's station in wheelchair. Heard noise. Resident seen on floor on her back. Chair alarm did not go off, broken, replaced..." R7's 11/22/21 fall event report showed R7 experienced an unwitnessed fall in the dining room when she leaned too far forward and fell out of her wheelchair. R7's 12/31/21 fall event report showed she attempted to get up from bed and take herself to the bathroom without assistance. The same report showed the alarm pad was in place but not plugged in. R7's 1/21/22 fall event report showed R7 experienced an unwitnessed fall from her wheelchair when she attempted to transfer without assistance. The same report showed R7's alarm was in place but not sounding. R7's nursing progress note dated 1/21/22 at 11:40 AM showed, "Resident noted to be on floor in front of wheelchair. Moderate amount of blood noted next to head. Upon assessment noted laceration to left forehead above eye brow active bleeding present, direct pressure applied. Able to move extremities, noted left hip rotated outward."	S9999		

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S9999	Continued From page 4 R7's nursing progress note entered 1/21/22 at 11:45 AM showed, "...order received to send to [Acute Care Hospital Emergency Department] ..." R7's nursing progress note dated 1/22/21 at 4:05 PM showed, "A call from [acute care hospital] stating that resident is coming back with stitches on her left forehead..." R7's acute care hospital paperwork dated 1/21/22 showed R7 was seen for a fall, blunt head trauma, and a facial laceration. The same paperwork included instructions for caring for R7's sutures. The same packet from the acute care hospital included results of a CT Scan (diagnostic scan of R7's head to identify any injuries) which showed, "... Moderate scalp hematoma is seen in the left lateral upper frontal region." R7's 2/19/22 fall event report showed R7 experienced another unwitnessed fall from her wheelchair in her room. On 3/03/22 at 1:36 PM, V3 RN (Registered Nurse Manager) said she is the one who handles the fall program at the facility. V3 said upon admission they do a fall risk assessment and then again quarterly. These assessments determine if a resident is in the "fall star program". V3 said, "Residents in the falling star program would get a little bit closer monitoring, safe positioning, stuff like that. We used to do fall meetings more regularly but that has kind of got put to the wayside. The nurse filling out the fall report at the time of the event should be putting a new intervention on a care plan. [R7] has had a lot of falls and was on the falling star program. She is a resident who should be in a supervised area, within arm's reach. She is someone you would have to have right next to you. She should not be	S9999		

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S9999	Continued From page 5 in her wheelchair and unsupervised. She has been declining in the last few months though so maybe the nurse thought she was sleeping. We do not have a process to check the to ensure the alarms are working. The alarms are supposed to blink when the batteries are low, and the nurses would need to watch for that and replace the batteries. The facility's fall policy titled "Falling Star Program Policy and Procedure" with review date of 1/2022 showed, "Purpose: The Falling Star Program is designed to prevent falls in our facility... Assessment: To identify residents on the Falling Star program a blue falling star is placed at the head of the bed, on their care plan, and on any wheelchairs or walkers. This alerts the staff to a potential risk for falls and interventions that may prevent the resident from falling.... 3. Implement a plan of care including the potential risk for falls, goals, and appropriate interventions based on the resident's assessment. If a fall occurs: ... 8. IDT (interdisciplinary team) to meet daily in clinical meeting regarding any falls. Safety interventions will be reviewed, and the plan of care updated..." (B)	S9999		