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 01/23/2023

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
S 000	Initial Comments Complaint Investigation: 2310502/IL155525	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2): 300.1210b) 300.1210d)6) 300.3240a) 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 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. Section 300.3240 Abuse and Neglect	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the safety of a resident (R1) during incontinence care. This applies to 1 of 3 (R1) residents reviewed for safety in the sample of 6. This failure resulted R1 sustaining a bruising/hematoma to the left forehead. The findings include: R1's Final Abuse Investigation dated 1/20/23 documents on 1/16/23 while care was being provided, his left forehead bumped the siderail sustaining injury as evidenced by hematoma to the left forehead. R1 reported to V15 (Physician) that R1 had been pinned by the "black CNA" identified as V9 (CNA) against the side rail. When the second CNA (V8) was questioned, V8 stated she did not witness any unusual occurrence. R1 informed V15 he was forcibly turned to be cleansed and isn't certain if he hit his head against the bed rail... R1 explained to police he had been "held down" while being changed .... We can't substantiate abuse occurred; however, the CNA's providing care were terminated due to providing care less than facility standards. Interviews with both CNA' (V8 & V9) deny any unacceptable practice occurred. R1's Physician Progress note dated 1/16/23	S9999		

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S9999	Continued From page 2 documents problem- "traumatic ecchymosis of the forehead." R1 is seen for a bruise on the forehead. R1 was seen yesterday by me (V15) at that point R1 did not have a bruise on the forehead. According to R1 either last night or early this morning the patient was forcibly turned to be cleansed and suffered an injury to the forehead .... R1 is uncertain how this happened ...He has a bruise on his forehead approximately 3 inches in length. R1's face sheet shows he is a 78-year-old male with diagnoses including congestive heart failure, COPD, hypertension, major depressive disorder on receiving hospice services. R1's Minimum Data Set assessment dated 1/5/23 shows he's cognitively intact, no behaviors, has no indicators of psychosis, requires extensive two person assist with bed mobility, total dependent on staff for toileting, and has limited range of motion affecting both lower extremities. On 1/19/23 at 8:58 AM, R1 was lying in his bed. A large dark purple bruise was observed from the left side of his forehead above his left eyebrow down to his temple. R1 said "I remember they were changing me." He was turned on his side and V9 was being rough. On 1/19/23 at 2:22 PM, V9 (CNA) said she and V8 (CNA) were the only two CNAs on 2nd shift on 1/15/23. They went room to room to change residents. V9 said her and V8 went to change R1 about 9:00 PM, and she did not notice a bruise on him. V9 said they changed him and that was it, she said during cares she did not press his head on the rail. On 1/19/23 at 12:14 PM, V8 (CNA) said V8 and	S9999		

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S9999	Continued From page 3 V9 were the only two CNA's working 2nd shift on 1/15/23 on R1's wing. R1 needs help repositioning. They went in his room to provide incontinence care. She did not notice anything happen during care. V8 said she did not see R1's head hit the side rail. On 1/19/23 at 7:00 AM, V7 (RN) said she was R1's nurse on 1/15/23 for 2nd and 3rd shift. V8 and V9 were the only two CNA's working on 2nd shift. V7 said she did not notice a bruise on R1's forehead until the next day on 1/16/23. On 1/16/23 there was a large bruise on the left side of his forehead. V7 said V8 and V9 did not report any occurrence during cares. If something happened, I'm not aware of it. On 1/19/23 at 10:00 AM, V10 (CNA) said she was R1's CNA on 1/16/23 during the day shift. She went into his room and noticed a very large bruise on his forehead. I asked him what happened, and he said some girls were cleaning him up and one of the girls was holding him down. V10 said R1 asked to speak to a manager on duty and she reported the bruise to V3 (Infection Control Nurse). V10 said R1 is alert and a total care with his activities of daily living. On 1/19/23 at 9:44 AM, V3 (ICP Nurse) said she was the manager on duty on 1/16.23. V10 reported to R1 wanted to talk to me. V10 said when she entered the room, she noticed a large bruise to the left side of his forehead. He said a couple of CNAs were rough with him the night before. On 1/19/23 at 10:18 AM, V11 (CNA) said R1 is alert and oriented he can communicate his needs and needs assistance with rolling in bed. He's pleasant. He said some CNA's he does not get	S9999		

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S9999	Continued From page 4 along with because they are rough with him but did not tell me who. On 1/19/23 at 1:18 PM, V2 (DON) said R1 makes his needs own, he has not made any false allegations. On 1/15/23 there was only two CNA's (V8, V9) working on 1/15/23 during second shift. Something is not adding up on what caused the bruise to his forehead. On 1/19/23 at 1:45 PM, V1 (Administrator) said she went to talk to R1 again on 1/20/23. R1 said when during care he was being turned by V9 and she placed her hand under his knee and her other hand near his head, and he may have hit the rail but does now know what happened. He was very adamant he did not want V9 taking care of him. The way V9 had positioned R1 could have caused the bruise. V1 said V9 and V8 were both terminated for lack of facility standards. V6 (Police Officer) typed email submitted to the state agency dated 1/17/23 documents he was escorted to see R1. When asked R1 what happened he said V9 (CNA) was being rough with him but could not recall how he sustained the injury to his forehead. R1's nurses note dated 1/16/23 documents a 6.1 cm (centimeters) x 6.1 cm red/purple hematoma on the left outer side of his forehead. R1's care plan updated October 2022 documents R1 is unable to complete bed mobility independently, has weakness, diagnosis of CHF, on hospice services, needs training and skill practice in bed mobility. Interventions include for the CNA to cue the resident that staff need to assist him with repositioning. Ask R1 to reach and grab onto the side rail as staff turn him side to	S9999		

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S9999	Continued From page 5 side, once he grabs onto the side rail cue him to hold onto and try to pull himself with staff assist. Then cue him to continue to hold onto the side rail as staff perform care...allow resident rest periods as needed. (B) Statement of Licensure Violations (2 of 2): 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 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	S9999		

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S9999	Continued From page 6 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: 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure staff provided the appropriate care for a resident with a diagnosis of dementia with a history of behaviors. This applies to 1 of 3 (R2) residents reviewed for dementia care in the sample of 6. This failure resulted on R2 sustaining a hematoma and a small abrasion to the right forehead. The findings include: R2's face sheet shows he is a 76-year-old male with diagnoses including encephalopathy, dementia with agitation, delirium, major	S9999		

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S9999	Continued From page 7 depressive disorder, acquired absence of the left leg above the knee and acquired absence of the right leg above the knee. R2's Minimum Data Set assessment dated 12/15/22 shows his cognition is mildly impaired, behaviors of delirium including inattention, disorganized thinking, physical and verbal behaviors towards others, and is total dependent with two people assist for transfers, toileting, and extensive assist with bed mobility. R2's Final Incident Report dated 1/20/23 documents on 1/16/23 while care was being provided R2 became combative and his right forehead bumped the side rail sustaining an injury as evidenced by a hematoma to the right forehead and a small abrasion ....the right siderail has dried blood on it consistent with siderail contact ...R2 stated he was held down by a pillow over his face and was hit with an object ...the CNA's providing care were terminated due to providing care less than facility standards. On 1/19/23 at 9:15 AM, R2 was lying in his bed. A hematoma was observed to his right forehead with a laceration near his eye and diffuse bruising under his right eye. R2 said he wasn't wrestling around with anyone. They said I hit my head on the side rail but I didn't, someone hit me on the head with something. On 1/19/23 at 12:14 PM, V8 (Certified Nursing Assistant) said on 1/15/23 she and V9 were the CNA's working the 2nd shift. They went in to change R2 and he was full of stool, he was being combative, cussing at us, and trying to hit us. We rolled him over too hard causing him to hit his head on the siderail and he started bleeding. We usually re-approach him when he has behaviors	S9999		

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S9999	Continued From page 8	S9999		

and report to nursing but we were in the mix of cleaning him and didn't want to leave him in stool. We should have left the room and came back when he was calmer.

On 1/19/23 at 2:22 PM, V9 (CNA) said she was working on 1/15/23 with V8. They went to change R2, he was being combative and there was stool everywhere, "it was nasty." R2 was in a "rage" it was like a tug of war, he didn't want to get cleaned up, we pushed him over and his head hit the side rail. V9 said she normally does not take of R2. R2 can be combative and has verbal behaviors but has not seen him like that before.

On 1/19/23 at 10:54 AM, V13 (CNA) said R2 has dementia, gets combative and has verbal behaviors. Because of his behaviors we have two staff members go in his room for cares. If he gets combative you should stop providing care, leave the room, and reproach because it could aggravate him more if you continue when he has behaviors.

On 1/19/23 at 10:44 AM, V12 (CNA) said R2 is a handful, he can be hostile and combative. There must be two staff for cares due to his behaviors. He is a total care. When he has behaviors, you should stop what you're doing, re-approach and notify nursing.

On 1/19/23 at 1:18 PM, V2 (DON) said R2 has mental health issues and has accused staff in the past of things. He is a total care assist and has behaviors. When he has behaviors, staff should make sure he is safe and re-approach.

R2's care plan dated through March 2023 shows he is at moderate risk for abuse and may present with physical and verbal behaviors due to his

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S9999	Continued From page 9 condition of health and dementia diagnosis. Interventions include avoid power struggles, continue to care for him with professionalism and dignity, and record behaviors in behavior logbook so departments will know what behaviors have occurred that day. R2's undated Social Services Behavioral Tracking Sheet shows the date, time, staff, behavior, interventions, outcome and care plan/update should be filled out. On 1/15/23 there was no behavior documented for R2. The facility's undated Behavioral Policy and Procedure states, "to provide care for residents living with Dementia which is an integral part of the person-centered environment and necessary to support high quality of life with meaningful relationships and engagement, Fundamental principles of care for the persons living with behavior symptoms associated with Dementia or other mental health issues involve an interdisciplinary approach that focuses on the needs of the resident living with diseases, as well as the needs of the other residents in the facility. We strive to create a quality of life with and for the resident ...The behavior and emotional state of people with Dementia often are the forms of communication because residents may lack the ability to communicate in other ways. Residents need opportunities and sufficient time to express themselves. Staff need training to identify potential triggers for a residents behavioral and emotional symptom such as agitation, mood change ...when staff recognize these triggers, they can use environmental and behavioral strategies to modify the triggers ..." (B)	S9999		