

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145895	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2025
NAME OF PROVIDER OR SUPPLIER Stephenson Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2946 South Walnut Road Freeport, IL 61032	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506</p> <p>Based on interview and record review, the facility failed to ensure misappropriation of residents' property did not occur for two of four residents (R41, R11) reviewed for misappropriation in the sample of 13.</p> <p>The findings include:</p> <p>1. R41's Physician Order Report dated January 3, 2025-February 3, 2025 shows he was admitted to the facility on [DATE] with diagnoses including heart disease, dementia with agitation, dehydration, anxiety disorder, and urinary tract infection. There is an order for hydrocodone-acetaminophen (Norco) 5-325 one tablet for pain every four hours as needed.</p> <p>The facility's Preliminary Incident Investigation Report dated February 1, 2025 shows, January 31, 2025, during the shift to shift narcotic count it was noted that five Norco 5-325 tablets were missing from the bottle. Name of resident allegedly abused or neglected: [R41].</p> <p>R41's Norco 5-325 Controlled Substance Record shows R41's bottle of Norco was not counted on the night shift of January 30, 2025. On January 31, 2025 at 3:00 AM, there were Norco 60 tablets signed by two nurses. On January 31, 2025 at 3:00 PM, there were 55 Norco tablets.</p> <p>V2 DON (Director of Nursing) investigation report shows she received a call from V19 LPN (Licensed Practical Nurse) stating that [R41's] pill bottle that contained Norco 5/325 was off by five tablets. V19 stated to V2 that V18 RN (Agency Registered Nurse) wanted to do a corrected count, but V19 said no and called V2. Upon speaking with V19 further, V19 told V2 that she counted the narcotic on January 29, 2025 (prior day that V19 worked) and the counted showed 60 Norco pills in R41's bottle.</p> <p>On February 4, 2025 at 11:18 AM, V19 said on January 31, 2025, she was counting the narcotics with an agency nurse [V18] that worked before her. V19 said that when she went to retrieve R41's bottle of Norco 5-325, V18 immediately said 'We didn't count that.' Meaning the previous shift did not count R41's bottle of Norco. V19 said she reached for a cup and a spoon and proceeded to count R41's bottle of Norco. V19 said she counted 55 when it should have been 60. V18 said, Oh I should have counted with the previous nurse to V19. V19 said V18 said this statement twice. V19 said she double counted and still got the same number. V19 said that V18 told V19 to sign the narcotic count sheet and to correct the narcotic count. V19 told V18 that V19 is not authorized to do that. V19 said V2 the director of nursing does that. V19 said that V18 kept saying, I should have counted it, I don't want anyone to think I took anything. V19 said that V18 was acting strange.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On February 4, 2025 at 9:46 AM, V2 DON said she received a phone call shortly before midnight on Friday January 31, 2025 from V19. V2 said V19 told her that R41's bottle of Norco was missing five tablets. V2 said R41's family had brought in a bottle of Norco to the facility. V2 said 41 also had a bingo card of Norco from the facility's pharmacy. V2 said staff are supposed to count both the bottle of Norco and the bingo card of Norco at the end of every shift and at the beginning of every shift. V19 told V2 that V18 wanted V19 to just correct the count. V2 said she came in early the next morning on February 1, 2025 to begin the investigation. V2 said she reviewed the facility's cameras. The only thing that V2 noted from the cameras was V18 may have opened the narcotic box at 3:46 PM, 7:20 PM, and 7:41 PM. V2 said the actual narcotic box was obscured by another medication cart, but V18 made the arm motion like she was opening the narcotic box. V2 said V18 gave residents a narcotic medication during the 7:20 PM time and 7:41 PM time but could not find where V18 would have given a narcotic at 3:46 PM. V2 said she called and made a report to the local police department and called the agency where V18 worked. V2 said she did not talk with V18 after the incident but that V18 emailed V2 an unsigned statement. V2 said she still has not accounted for the Norco yet. V2 said the police came to the facility and they are doing their investigation.</p> <p>2. R11's Face Sheet shows she was admitted to the facility on [DATE] with diagnoses including anxiety disorder, Alzheimer's disease, depression, scoliosis, delusional disorder, and encounter for palliative care.</p> <p>R11's Physician Order Report dated December 1, 2024-December 31, 2024 shows an order for fentanyl patch 25 mcg every 72 hours.</p> <p>R11's Progress Note dated December 21, 2024 done by V24 RN (Registered Nurse) shows, Resident is due to have new fentanyl patch administered per order. This writer unable to locate current patch on left chest as indicated in electronic medical record. New patch applied early to right back related to no current transdermal pain relief present on resident body.</p> <p>An attempt was made to talk to V24 via phone on February 4, 2025. A message was left with no call back.</p> <p>On February 4, 2025 at 9:46 AM, V2 DON said she has not investigated any potential for misappropriation in the last three months regarding a missing fentanyl patch. V2 said she was not aware of the missing fentanyl patch on R11. V2 said V24 no longer works for the facility due to attendance issues. V2 said staff are supposed to notify her right away if they see that a fentanyl patch is missing off a resident.</p> <p>On February 4, 2025 at 11:18 AM, V19 LPN said she calls the director of nursing and administrator if a fentanyl patch is missing off a resident because it is a controlled substance and it could mean that someone took it.</p> <p>The facility's Medications-Controlled policy effective April 2020 shows, A count of controlled drugs is maintained by nurses of the off-going and oncoming shifts.</p> <p>The facility's Abuse policy effective April 2020 shows, This facility affirms the right of our residents to be free from verbal, physical, sexual, mental abuse, neglect, exploitation, misappropriation of property, involuntary seclusion, or mistreatment.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506</p> <p>Based on interview and record review, the facility failed to ensure their abuse policy was implemented for one of four residents (R11) reviewed for abuse policy and procedures in the sample of four.</p> <p>The findings include:</p> <p>R11's Face Sheet shows she was admitted to the facility on [DATE] with diagnoses including anxiety disorder, Alzheimer's disease, depression, scoliosis, delusional disorder, and encounter for palliative care.</p> <p>R11's Physician Order Report dated December 1, 2024-December 31, 2024 shows an order for fentanyl patch 25 mcg every 72 hours.</p> <p>R11's Progress Note dated December 21, 2024 done by V24 RN (Registered Nurse) shows, Resident is due to have new fentanyl patch administered per order. This writer unable to locate current patch on left chest as indicated in electronic medical record. New patch applied early to right back related to no current transdermal pain relief present on resident body.</p> <p>An attempt was made to talk to V24 via phone on February 4, 2025. A message was left with no call back.</p> <p>On February 4, 2025 at 9:46 AM, V2 DON said she has not investigated any potential for misappropriation in the last three months in regard to a missing fentanyl patch. V2 said staff are supposed to notify her right away if the see that a fentanyl patch is missing off a resident.</p> <p>On February 4, 2025 at 11:18 AM, V19 LPN said she calls the director of nursing and administrator if a fentanyl patch is missing off a resident because it is a controlled substance and it could mean that someone took it.</p> <p>The facility's Abuse Policy effective April 2020 shows, The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of residents. This will be done by: orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of abuse, neglect, exploitation, and misappropriation of property.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506</p> <p>Based on interview and record review, the facility failed to report a missing controlled substance for one of four residents (R11) reviewed for reporting abuse in the sample of four.</p> <p>The findings include:</p> <p>R11's Face Sheet shows she was admitted to the facility on [DATE] with diagnoses including anxiety disorder, Alzheimer's disease, depression, scoliosis, delusional disorder, and encounter for palliative care.</p> <p>R11's Physician Order Report dated December 1, 2024-December 31, 2024 shows an order for fentanyl patch 25 mcg every 72 hours.</p> <p>R11's Progress Note dated December 21, 2024 done by V24 RN (Registered Nurse) shows, Resident is due to have new fentanyl patch administered per order. This writer unable to locate current patch on left chest as indicated in electronic medical record. New patch applied early to right back related to no current transdermal pain relief present on resident body.</p> <p>An attempt was made to talk to V24 via phone on February 4, 2025. A message was left with no call back.</p> <p>On February 4, 2025 at 9:46 AM, V2 DON said she has not investigated any potential for misappropriation in the last three months in regard to a missing fentanyl patch. V2 said she was not aware of the missing fentanyl patch on R11. V2 said V24 no longer works for the facility due to attendance issues. V2 said staff are supposed to notify her right away if the see that a fentanyl patch is missing off of a resident.</p> <p>On February 4, 2025 at 11:18 AM, V19 LPN said she calls the director of nursing and administrator if a fentanyl patch is missing off a resident because it is a controlled substance and it could mean that someone took it.</p> <p>The facility's Abuse Policy effective April 2020 shows, The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of residents. This will be done by: Identifying occurrences and patterns of potential mistreatment. Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property the observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator or to a compliance hotline or compliance officer.</p>		