STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145895	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stephenson Nursing Center	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39543 Based on interview and record review the facility failed to apply a narcotic pain patch in an inaccessible location for a resident with a history of removing narcotic pain patches. This applies to 1 of 3 residents reviewed for medications in the sample of 5. The findings include: R1's Face Sheet showed she was admitted to the facility on [DATE] with diagnoses including scoliosis and dementia. R1's 1/23/25 Minimum Data Set (MDS) showed the resident was not able to complete the Brief Interview for Mental Status and she had both short and long-term memory problems. R1's MDS showed she was dependent upon staff for functional abilities except eating which she required substantial/maximal assistance. R1's MDS showed she had frequent pain. The facility's 3/1/25 incident report submitted to the state health department showed R1's fentanyl (schedule II narcotic pain medication) patch, which was on her body, had gone missing. The report showed a replacement patch was applied. R1's fentanyl order history showed she had been on varying doses of fentanyl beginning on 11/19/24. The order history showed the patches are to be changed every 72 hours. R1's fentanyl order history showed a change beginning on 2/18/25, which her previous orders did not show. The change on 2/18/25 was, Place patch on res (resident) back only and cover with [transparent film dressing]. This change carried through to her most recent order as of 4/3/25. R1's current fentanyl patch order (started on 3/9/25) was for a 25 microgram per hour patch to be applied to R1's back every 72 hours. R1's February 2025 and March 2025 Medication Administration History (also known as Medication Administration Record, or MAR) showed an order to verify the placement of R1's fentanyl patch once a shift (every 8 hours). The MAR showed, beginning on 2/27/25 for the 3:00 PM to 11:00 PM shift, the nurse documented the fentanyl patch was on R1's chest. (At this time, R1's fentanyl order showed it should be applied to her back.) Prior to this entry, R1's patch was documented as being on her back. The nurses continued to document R1's fentanyl patch was on her chest until 3/1/25 during the 3:00 PM to 11:00 PM shift. The entry for this shift showed R1's patch was missing. (continued on next page)

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145895	A. Building B. Wing	04/03/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's 3/1/25 9:06 PM nursing note, (Authored by V6 Registered Nurse) showed, At bedtime, unable to find the resident's fentanyl patch. I asked for assistance from another CNA (Certified Nursing Assistant) to put her in bed, change her clothes, and do a skin check. Patch still missing .sweep of the room done with 2 CNAs, unable to find the detached patch . On 4/3/25 at 12:25 PM, V6 Registered Nurse stated she was the nurse who noted R1's fentanyl patch was missing from R1's body. V6 said herself and a CNA performed a head-to-toe skin assessment to try and find the patch; however, they were unsuccessful. V6 said, R1 had a linen change earlier in the shift and they were unable to locate the patch in any of the laundry; however, they were not certain if all laundry had been searched. V6 said R1 does have a history of picking at dressings and pain patches. R1's March 2025 MAR showed, on 3/7/25, R1's patch was applied to her chest. R1's MAR showed the fentanyl patch verification entries, beginning on 3/7/25 for the 11:00 PM to 7:00 AM shift, showed R1's patch was on her chest. The nurses continued to verify patch placement to R1's chest until the 3:00 PM to 11:00 PM shift on 3/9/25. During this shift the nurse documented in the MAR, Found in resident's mouth. R1's 3/9/25 9:22 PM nursing note showed, Resident found with fentanyl patch in her mouth at 5:15 PM. Removed by CNA and given to myself to dispose of . On 4/3/25 at 10:10 AM, V2 Director of Nursing stated R1 has a history of picking at her dressings and fentanyl patches. V2 stated R1's order was changed to have it placed on her back and covered with a dressing to prevent the patch from coming off and to make it inaccessible to R1. V2 said, while reviewing R1's MAR in the electronic charting, the nurse documented the patch was placed to R1's chest on 2/27/25. V2 said the patch should have been applied to R1's back. V2 said the patch applied to R1's chest on 3/7/25 should have been applied to her back. V2 said fentanyl is a potent narcotic and can be dangerous if ingested. Medication Administration policy (effective 4/2020) showed, Medication preparation/Administration .Follow special directions .