

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 06/04/2025
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 0628</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure discharge services were in place prior to discharging a resident to independent senior housing who requires assistance with activities of daily living. This failure resulted in R1 being found in her apartment soiled in urine and feces and unable to get out of bed. This applies to 1 of 3 (R1) residents reviewed for discharge in the sample of 3.</p> <p>The findings include:</p> <p>R1's face sheet shows she is a [AGE] year old female with diagnosis including osteoarthritis left hip, abnormalities of gait and mobility, type 2 diabetes unspecified dementia and cognitive communication deficit. R1's face sheet shows she was admitted to the facility on [DATE] and discharged on 5/30/25.</p> <p>R1's care plan initiated March 17, 2025 shows R1 has difficulty understanding others, hard of hearing, cognitive and memory deficits. R1 is a fall risk and requires staff assistance with ambulation, has urinary incontinence and requires staff to provide incontinence care. R1's current care plan does not show a discharge plan.</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 0628</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/4/25 at 9:33 AM, V3 (Social Service Director) said prior to discharge home health services should be set up and medical equipment should be delivered to their home prior to discharge. If the resident needs a caregiver, V3 facilitates this process through the senior resource center prior to discharge. The day of R1's discharge V3 found out that R1's apartment was independent living. V3 said, V10 (Property Manager of Senior Housing) said she would let V11 (Social Service Manager of Senior Housing) know of R1's discharge. V11 came to the facility the day before R1's discharge and talked to R1. V3 said, V11 asked V3 how R1 was doing in therapy and asked if R1 was more independent. The following day after R1's discharge, everything fell apart. V3 said V11 expressed concerns that R1 was not stable enough to return to her apartment and R1 should have not been discharged because R1 needed long term care and was not appropriate for independent living. V3 said, This is the first time that this problem has come up. R1 is her own decision maker, and she is still at her apartment. If V3 knew R1 had a case worker she would have reached out to her prior to R1's discharge. V3 said today V3 was going to call the senior resource center to see if the caregiver services were set up for R1 as R1 had this service prior to coming to the facility and it should have been set up prior to discharge. V3 said, Our staff assisted R1 back to her apartment, and it was discovered R1 lost her cell phone when R1 arrived in her apartment. V3 delivered the walker to her apartment on 5/30/25. V3 said R1's apartment does not have caregivers and V3 was not aware of the type of setting where R1 was being discharged to. V3 said, During the discharge meeting, we only talked about how R1 was doing in therapy, and we did not discuss her discharge needs. R1 was alert, had periods of confusion, she was a standby assist with ambulation. R1 was referred to home health services for therapy. V3 said V3 sent the referral but is not sure if R1 is receiving those services. V3 said R1 was calling her throughout the weekend. R1 reported she was doing okay, and V3 has not heard from her since Monday.</p> <p>On 6/4/25 at 9:59 AM, V4 (Restorative Nurse) said she was part of R1's discharge meeting. V3 coordinates the equipment and home health services, and V4 coordinates with therapy and assesses a residents mobility prior to discharge. V4 said, R1 was alert with forgetfulness. By the time of discharge, she (R1) could walk with her walker and required supervision with transfers and was incontinent. V4 said the day of R1's discharge V4 felt uncomfortable about R1's discharge. V4 asked V1 (Administrator) if she could meet R1 at her apartment. V4 said R1 had the facility's walker and did not have her own walker with her prior to discharge. A senior bus picked up R1 to transport her to her apartment and V4 met R1 at her apartment. V4 said she was concerned about R1 getting to her apartment safely so that's why V4 met R1 there. V4 said she assisted R1 off the bus and sat her on a bench and went to get a wheelchair because it was a long walk to her apartment and R1 did not have her walker. V4 said before she left R1's apartment, V4 asked the facility about visiting hours and was told visitors are buzzed in on the phone. R1 did not have a phone with her. V4 said she left R1 and bought a cell phone for her and dropped it off at her apartment. V4 said she was told the independent living center does not have any staff to assist with any care needs. V4 said V11 expressed concerns about R1's discharge but stated, well she (R1) was already there, what are we supposed to do. V4 said she reassured V11 that R1 is capable of doing what she needs to do. R1 can transfer herself, ambulates with walker, and was incontinent of urine.</p> <p>On 6/4/25 at 10:35 AM, V6 (Registered Nurse-RN) said prior to discharge there should discharge planning in place to ensure a resident's needs are set up, the floor staff gets a discharge list about one week prior to discharge. V6 said R1 was alert with forgetfulness. R1 could get up and transfer herself, she self-propelled in the wheelchair and was incontinent. V6 said sometimes R1 would refuse therapy or assistance from staff at times. V6 said V6 thought R1 was being discharged to assisted living setting. V6 said, I don't know if R1 was safe to be discharged to independent living.</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/4/25 at 12:47 PM, V5 (Director of Therapy) said R1 had multiple refusals with therapy and was non-compliant, R1 was strong-willed and worked with therapy when she allowed us to. V5 said R1 made progress initially in therapy and then she flat lined. R1 lacks safety awareness of her deficits, poor safety, she could ambulate with the walker with standby by assist and would self-propel herself in the wheelchair. V5 said R1 had not practiced going up and down stairs, R1 would refuse services to work with stairs. V5 said, We had concerns about her safety to go home to an independent setting. I'm not sure if any staff reached out to her (R1's) family. R1 would be more appropriate for assisted living or long term care.</p> <p>On 6/4/25 at 1:06 PM, V3 (SSD) said she did not communicate with home health services of R1's new phone number so they could call R1 to set up the service. She does not know if R1's caregiver service has been reinstated and did not know she needed assistance with meals.</p> <p>On 6/5/25 at 10:00 AM, V10 said senior housing apartments are for elderly residents ages [AGE] years old and above. V10 said, They should be independent for all their activities of daily living, including cooking, dressing, transfers, ambulating, and housekeeping needs. V11 (Senior Housing Social Worker) expressed concerns to the facility regarding R1 not being fully independent with activities of daily living. The facility asked if we could pick up R1 to transport her home, we explained we do not provide transportation services. They asked if we could assist R1 off the senior bus, we explained we do not have caregivers to assist with cares. We do not have staff or provide services for residents we only provide housing. V11 re-instated R1's caregiver service through the senior center and the caregiver arrived on 6/3/25. On 6/3/25, R1 would not answer the door so she (V11) went to open R1's door with the caregiver and found R1 soiled in bed (appeared to be in bed from the previous day).</p> <p>On 6/5/25 at 10:15 AM, V11 (Senior Housing Social Worker) said she went to the facility on 5/28/25 (two days prior to R1's discharge) to talk to R1. V11 asked R1 how therapy was going and how R1 was doing with her activities of daily living. V11 said she spoke with V3 and told V3 the senior housing facility does not offer any assistance with activities of daily living. There are no staff to assist R1 with ADL's, cooking or housekeeping services. V11 asked V3 about R1's transfer status and was told R1 was being discharged on Friday 5/30/25. V11 said the facility was aware of R1's home setting. V11 reminded V3 they only offer housing and no other services. Residents should be independent, and any outside services should be set up prior to discharge. V11 said V3 asked if someone one could assist R1 off the bus the day of discharge and V11 questioned R1's ability getting in and out of the bus. V11 said the day of R1's discharge, the facility asked for assistance to get R1 into her apartment and V11 told the facility again they cannot provide hands on assist with cares. V11 said the facility was well aware of R1's living situation and expressed V11's concerns to V3. On 6/3/25, R1 was found in her apartment soiled with urine and feces (appeared she had been in bed from the previous day) and unable to get out of bed. V11 said the facility should communicate with us the services a resident needs and should be set up prior to discharge. V11 said R1 required meals on wheels, caregiver services and had not been seen by PT/OT.</p> <p>R1's Communication/Order Sheet dated 5/23/25 shows orders including discharge home with current medications, in home PT (Physical Therapy)/OT (Occupational Therapy) services, and four wheeled walker.</p> <p>R1's Discharge Meeting Care Plan Record dated 5/29/25 shows V3 (Social Service Director), V4 (Restorative Nurse) and R1 in attendance.</p> <p>(continued on next page)</p>		

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