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	03/17/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review the facility failed to supervise a resident at risk for falls. This applies to 1 of 3 residents (R1) reviewed for falls in the sample of 6. This failure resulted in R1 sustaining a left hip fracture. This past compliance occurred from 2/22/26 to 2/23/26. Past noncompliance-no plan of correction required. The findings include:R1's admission Record (Face Sheet) showed an Original admission date of 11/18/25 with diagnoses to include but not limited to Alzheimer's dementia, unsteadiness of feet, weakness, and rheumatoid arthritis. R1's 2/28/26 Minimum Data Set (MDS) showed she was unable to complete the Brief Interview for Mental Status test, and she has both short and long-term memory problems. R1's 2/10/26 Restorative Note from 9:08 AM showed, On 2/5 (2/5/26) staff in (locked memory care) unit informed me that occasionally when [R1] is tired or not walking well in general she tends to walk too far behind her rollator (walker). I observed her ambulating (walking) with it and did not notice any concerns at that time. I called her husband. to discuss this with him. He said at night when he is visiting, he has noticed the rollator ?gets away from her sometimes.' R1's 2/22/26 Post Fall Observation showed, This nurse was off unit to complete scheduled facility treatments. At appx 1320 (1:20 PM), [V5 Certified Nursing Assistant, CNA] gestures from down the hall to come quick. When asked, resident states there's someone on the floor down here. This nurse responds immediately. Upon entering common area of unit, observed this resident lying on her back, LLE (left lower extremity) is bent at the knee, external rotation observed. Affected area immobilized. (Note was authored by V4 Registered Nurse, RN) R1's 2/22/26 Nurses' Note from 3:40 PM, showed R1 was admitted to the local area hospital with a left hip fracture. On 3/17/26 at 8:54 AM, V5 (CNA) stated she was taking R1 (a locked memory care unit resident) to the toilet shortly after lunch on 2/22/26. V5 stated the other CNA was in a room providing care for a resident and the nurse was off the unit. V5 said, I noticed she was getting away from the walker and her butt was sticking out. I asked if she was okay, so I went for a chair a few steps away and when I stepped away and turned around, she fell. She was using a 4-wheel walker. Her walker being away from her, that means her arms were stretched out and her butt was sticking out. I was trying to get her to stand upright with the walker, so I did what I thought was right and grabbed the chair, and as soon as I saw her leaning, she started to fall. I was holding the walker steady and put my hand on her back and trying to coach her to move towards the walker and she didn't understand, she was confused. I went to get the chair because she was so far from the walker, and I didn't think she was going to make it to the bathroom. Sometimes her hips go out, but I was told that afterwards; I didn't know that at the time. I thought she needed the chair, she would sit down, collect herself, then we would try again. I did not have gait belt on her. She needs some help going from seated to standing with the walker. She was in a lot of pain. I should have stayed side by side with her and called for help instead of leaving her. If I had stayed with her and called for help instead of leaving, and I had a gait belt on her, I could have possibly lowered her to the floor. On 3/17/26 at 10:56 AM, V4 (RN) stated, I was her (R1) nurse that day (2/22/26). V4 stated at that time, the memory care nurse was responsible for wound care on the other units, and she was attending those duties at the time of R1's fall. V4 stated V5 had called for her to come to the unit. V4 said she could tell right away it was (continued on next page)

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	03/17/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	broken. V4 stated she believed the leg was broken based on R1's pain and the rotation of the leg. V4 said she knows R1, and she doesn't typically have pain, and she was experiencing a significant amount of pain, especially when her left leg was touched. V4 said, I have never seen her this uncomfortable before. V4 said R1 requires assistance with ambulation, transfers, and a gait should be used. V4 said the assistance with ambulation and gait is for safety. V4 said the CNA should have stayed with R1 and not left for the chair. V4 said the CNA should have called for help and then if no help came and it was needed, she should have lowered R1 to the floor with the gait belt. On 3/17/26 at 9:55 AM, V8 (CNA) stated R1 requires assistance with ambulation as well as a gait belt. V8 said if R1's walker was getting away from her, she would call for help, and if there was a chair within reach, she would grab it. V8 said she would not take her hands off R1, and if needed, she would utilize the gait belt to lower R1 to the floor. On 3/17/26 at 10:03 AM, V9 (RN) (memory care) stated R1 requires assistance with ambulation, and she is definitely a fall risk when walking by herself. V9 said R1 can be weak when walking. V9 said if R1's walker was getting away from her, she would call for assistance, and if a chair was nearby, she would grab it. V9 said, If the chair was several steps away, I would not go get the chair. V9 said, if needed she would use the gait belt and lower R1 to the floor. On 3/17/26 at 1:55 PM, V2 (Director of Nursing) stated R1 had a tendency of getting away from her walker, which required her to have assistance and gait belt when she walked. V2 said, The gait belt is due to the unsteadiness, it will assist with steadying her. V2 stated V5 said, .she was assisting her (R1) and she (R1) was unable to advance her left leg forward, she (V5) went to grab the wheelchair and she went down on her left side. My understanding is she was walking her to the bathroom, and the wheelchair was right there. V5's description of the sequence of events leading to R1's fall was relayed to V2; R1's walker getting in front of her, R1's buttocks sticking out, V3 leaving R1 to get a chair, then R1 falling. In response, V2 stated V5 should not have left R1, she should have called for assistance, and if needed use a gait belt to lower R1 to the floor. On 3/17/25 at 12:25 PM, V11 (R1's Physician) stated, R1 has dementia, and she requires assistance with care. V11 stated if person is standing and their hip breaks because of a medical condition and not a fall, the person will typically fall immediately after the fracture occurs. V5's description of the sequence of the events leading to R1's fall was relayed to V11; R1's walker getting in front of her, R1's buttocks sticking out, V5 leaving R1 to get a chair, then R1 falling. V11 stated, based on V5's sequence of events, he couldn't say for certain; however, it sounds likely that the fall did cause the fracture. The facility's Safe Resident Handling/Transfers policy (Reviewed/Revised 11/1/25) showed, It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. The policy continued, Compliance Guidelines:. 5. Proper hands-on assistance during ambulation. 8. Never leave a resident unsupported when balance is compromised or when the resident stops walking. Prior to the survey date of 3/17/26, the facility had taken the following action to correct the noncompliance:On February 22, 2026 the facility conducted gait belt training.On February 23, 2026 the facility conducted Safe Handling of Resident training.The facility terminated the offending employee.