| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 145895 | A. Building<br>B. Wing | 02/26/2026 |

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| Stephenson Nursing Center | 2946 South Walnut Road<br>Freeport, IL 61032 |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a safe mechanical lift transfer for a resident (R11) dependent upon staff for transfers. This failure resulted in R11 sustaining a right fracture. The facility also failed to ensure a stable chair was provided for a resident (R16) to prevent falls. These failures apply to 2 of 5 residents reviewed for safety and supervision in the sample of 38. The findings include:1. R11's face sheet showed she was admitted to the facility 11/27/2017 with diagnoses to include spastic hemiplegic cerebral palsy, major depressive disorder, hypertension, and primary generalized osteoarthritis. R11's facility assessment dated [DATE] showed she has moderate cognitive impairment and is dependent upon staff for transfers. R11's care plan initiated 1/27/26 showed, Resident wears sling to right arm due to right arm injury. Will wear sling to improve pain. R11's care plan initiated 11/28/2017 showed, Resident is at risk for falls. Approaches. Date Initiated: 1/24/26, Ensure resident is all the way back in the wheelchair before unhooking the (mechanical lift) sling. On 2/25/26 at 2:30 PM, R11 was lying in bed with her arm in a sling. R11 said, I'm wearing this sling because I broke some bones. They were putting me in a sling thing to get me out of bed; I just slid down and right onto the floor. It doesn't hurt very much, and the doctor said it should be healed up by Easter. They came in here and took some x-rays, that is how we found out it was broken. It's never happened like that before. There was just one girl was in here working the machine and there is supposed to be two to use it. They came right in and asked me questions; I told them there was only one girl when it happened. R11's Fall Report dated 1/24/26 at 11:30 AM showed, Resident was sliding out of her wheelchair and that was unsuccessful. Resident was lowered to the floor with two CNAs. (Certified Nursing Assistants). Resident does not have any noted injuries. Stated she was lowered to the floor. CNA reported that resident was sliding out of her wheelchair. She called for another CNA to assist her and the two of them lowered her to the floor.Witnessed by [V7 CNA] . Notes 1/26/26 (entered by V2 Director of Nursing): Resident experienced a fall after sliding out of her wheelchair. Has a diagnosis of CP (cerebral palsy), generalized osteoarthritis, edema of right arm, and obesity. After investigation with staff working that day, it was determined that the fall was unavoidable. She has poor trunk control and despite appropriate interventions her positioning in the wheelchair contributed to a loss of stability causing the fall. R11's Radiology Reported showed, . Date of Service: 1/24/26. Shoulder Complete. Right. Conclusion: . Acute anterior medial lateral humeral shoulder dislocation. This document showed it was reported to the facility 1/25/26 at 1:14 AM. R11's Post Fall Observation dated 1/24/26 showed, . she was sliding, and the CNA was unable to lift her back into the chair and she just kept sliding so it was safer to lower her to the floor. R11's Orthopedic Physician Note dated 1/27/26 showed, . Closed fracture of proximal end of right humerus. This is an elderly lady unfortunately had a fall out of a (mechanical lift) lift at the nursing home on Saturday (1/24/26). She was taken to the emergency room on Monday x-rays were taken yesterday which showed a proximal humerus fracture. She was put in a sling. On physical exam she has some pain in around her shoulder, no significant redness or swelling. X-ray show a small crack through the proximal humeral head area, undisplaced. On 2/26/26 at 8:40 AM, V7 CNA (Certified Nursing<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Assistant) said, It wasn't really a fall, she was in a chair, and she needed to be moved up. She wanted me to push her back in the chair. I took the (mechanical lift) sling and (V6 CAN), and I used the (mechanical lift) sling and a pillow and slid her out of the chair onto the floor. Then we used the (mechanical lift) to get her up off the floor. When the situation happened, they said she already complains about that arm. They were saying her arm got sprained because me and the other CNA and sliding her down with the (mechanical lift) sling. This happened in her room. I was getting her up for lunch. It was never a fall; we slid her down. [V6] was not helping me get her up out of the bed. This happened when she was in her chair. She is a lift for transfers. I did that transfer myself. That workload there is pretty heavy. A lot of people there would do that (1 assist lift transfers) because they are so busy. The hall I was working that day with [R11] there were 4-5 residents who were (mechanical lift) transfers. I was on the hall by myself. Some bigger residents I wouldn't do without the help of a second person but [R11] is usually an easier person, I'll be honest with you, I did that plenty of times, but I really don't think her arm has anything to do with that. Look at this, I got her in the chair, but she slid out. On 2/26/2026 at 12:39 PM, V6 CNA said, [V7] asked for help because [R11] was almost sitting on her wheelchair pedals. She was positioned with her butt on the pedals, so I don't know if she was trying to scoot or something. The sling was up behind her above her head, and she was sliding down. Her arms were up in the air; she was not holding onto anything. She was not complaining of pain at that time. We lowered her to the floor. I knew we couldn't get her back up because she is too big of a person, so we used the (mechanical lift) to get her back up off the floor. We slid her down using the (mechanical lift) sling then used the (mechanical lift) to get her back up. She is too heavy we could have never picked her up to get her back in the chair without the lift. [V7] was getting her up for lunch by herself. There should always be two people to use the (mechanical lift) so one can run the lift, and the other one can assist the resident into the chair. We use the lift because it is easier. We use the thing on the (mechanical lift) to scoot them up and get them positioned decent in the chair. It just works better when there is two, they just sit better. On 2/26/26 1:26 PM, V2 DON (Director of Nursing) said V7 was an agency CNA, and she would not have her back. I was informed shortly after she fell. The nurse called me and said that she had a fall, she told me that she slid out of the wheelchair. Everything seemed fine at that point but later in the afternoon. I got a phone call stating that [R11] was making a comment that she was transferred with one aide. I came in early that evening to speak with her and she told me that she had been transferred with just one person. The investigation was started then. [V7] was supposed to work the next day again so I called the agency and told them I was investigating and to DNR (do not return) her. I continued with the investigation, she contacted me and asked why she was DNR'ed (sic) and she swore up and down that she didn't do it by herself. I asked [V6] who was working that same day and she said she did not help her. [V6] had gone in with her when she had fallen to see what the positioning was. [V6] that she was right in front of the wheelchair but the whole thing was how did she get into the wheelchair in the first place? There was a (mechanical lift) in the room per [V6]. [V7] gave me the name of an employee who said she helped her, and that employee denied helping. [R11] was complaining of some discomfort to her right arm, which was not abnormal for her, but we did an x-ray that showed a dislocation. When that report came back, we let [R11's physician] know and he sent her to the ER. When [R11] came back she had a sling and an order to follow up with orthopedics, which we did. Orthopedics said there was a questionable subtle nondisplaced fracture. The aides are supposed to use two people when doing transfers with the (mechanical lift), and an in-service was completed afterwards. The reason they have to use two is for safety reasons, safety of the resident, for positioning, and for prevention of falls. The facility's undated policy and procedure showed, Safe Resident Handling/Transfers. Policy: It is the policy of this facility to ensure that residents are handled and transferred safety 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. Policy Explanation: All residents require safe handling when<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | transferred. Compliance Guidelines: . 10. Two staff members must be utilized when transferring residents with a mechanical lift. 2. R16's face sheet showed she was admitted to the facility 6/24/25 with diagnoses to include encephalopathy, lack of coordination, hypothyroidism, Type 2 Diabetes, dementia with other behavioral disturbance, bipolar disorder, major depressive disorder, obstructive sleep apnea, chronic pain, muscle weakness, disorders of muscle, fibromyalgia, unsteadiness on feet, and abnormalities of gait and mobility. R16's facility assessment dated [DATE] showed she has moderate cognitive impairment and requires supervision and touch assistance for most cares. R16's Care Plan initiated 10/7/25 showed, Resident is at risk for falls. The resident has impaired cognition and impaired safety awareness. Approaches. Date Initiated 12/18/25 Provide new stable dining chair. R16's Care Plan initiated 10/7/25 showed, Is above ideal body weight range and confounding factors include Diagnoses Diabetes and arthritis with weight gain making mobility more difficult. R16's Fall Report showed, . Patient fell after the chair broke while sitting down. Patient sat in the chair which broke making the patient fall to the floor. On 12/16/25, resident [R16] had a fall in the dining room. Contributing factors include BMI 40-44.9. dining room chairs were inspected immediately. R16's medical record showed, 12/16/25 at 1:36 PM, Patient fell after the chair broke while sitting down for dinner. Patient fell landing on the left side of her body. Patient denies any distress; however, she voiced pain to her lower back 3/10. Patient voiced that she hit her head. On 2/26/26 at 8:16 AM, V8 CNA said, I witnessed it (R16's fall), she was going to sit down in the chair, and it broke. She flopped back and hit the floor. It was one of our dining room chairs and she is a wider lady. When she was sitting in those chairs it was a tight fit.On 2/26/2026 at 1:39 PM, V2 DON said, [V1] and I went down to check the rest of the chairs to make sure they were stable, and we gave her a different chair to use. Her weight with the other chair was just too much. I don't think it was that the chair was in disrepair, I think all chairs down there would have done the same thing. Staff help her into the chair that is for her. she doesn't have safety awareness.The facility's policy and procedure dated 9/1/25 showed, Fall Prevention Program. Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to ensure dietary staff covered their facial hair while preparing food for the residents, and while cleaning dishes. The facility failed to ensure staff used chemical sanitation to disinfect a food preparation table and equipment; failed to ensure staff were knowledgeable about the concentration level that was needed when testing the chemical sanitation; and failed to ensure cold desserts were maintained below 41 degrees Fahrenheit. This failure has the potential to affect all the residents in the facility.The findings include:The CMS 671 form completed by the facility on 2/24/26 showed 70 residents resided in the facility on 2/24/26.The document provided by the facility on 2/26/26, showed the only resident residing in the facility that does not receive nutrition by mouth is R21.On 2/24/26 at 9:17 AM, In the dish washing area of the facility, V17 (Dietary Cook) was doing the breakfast dishes. No gloves and no hair net covering his beard. V17 went across to the kitchen area to the hand washing station, to wash his hands. At 9:23 AM, V16 (Dietary Manager-DM) told V17 to make sure he puts his hair net on to cover his beard before doing the food. V17 said he only took it off to do the dishes because it was so hot in there. V17 had sweat dripping down his face and wiped the sweat off with his right arm. V17 was asked if facial hair could fall onto the clean dishes, and he said yes. Both V16 and V17 agreed that he should have been wearing the hair net over his beard in the dish wash area. On 2/24/26, between 10:35 AM-11:05 AM, this surveyor observed V17 do the pureed food for the lunch meal. V17 checked the consistency of the pureed spaghetti with meat sauce several times, pulling his hair net below his chin and resting in his facial hair. V17 continued this process several times until the spaghetti was the correct consistency. At 10:55 AM, V17 poured the food from the food processor into a smaller pan. V17 pulled the hair net under chin to taste, nodded his head, left the hair net under his chin while he took the pan across the kitchen and placed it in the oven. After putting the food in the oven, V17 pulled the hair net back over his beard. V17 put the cooked carrots into the food processor to puree them for the residents that required a pureed diet. V17 poured the pureed carrots into a smaller pan and pulled the hair net down under his chin (again resting on his facial hair) to test the consistency. V17 did not cover his facial hair again when he carried the pan over to the oven and placed the pan in the oven. At 11:13 AM while watching V17 do the pureed foods, V18 (dietary aide) was wiping down a large mixing bowl machine with a cloth used from green bucket. V18 covered the equipment with plastic, then cleaned the prep counter across from where V17 was working. V18 placed paper down on the prep table, laid out several slices of bread and started putting cheese on the bread. V18 was asked what was in the green cleaning bucket. V18 said dawn dish soap and water. V18 was asked if the prep areas should be cleaned with sanitizer instead of soap and water. V18 said she cleans them with soap and water. V16 (DM) was present during the conversation and said the prep areas should be cleaned with sanitizer and not soap and water. V18 grabbed a red bucket and filled it with quaternary solution from the three-sink area. V18 was asked to test the chemical solution. As she was dipping the test strip into the red bucket, V18 was reading the container the test strips were in. V18 held the strip next to the container to see what the results were. V18 said she thinks it should be between 400-500 ppm (parts per million). V16 said it should be 200 ppm. V16 said the facility does not keep any logs to record the results for testing the sanitation buckets. At 11:40 AM, V16 tested the temperature of some of the desserts in the roll in cooler. V16 said the pumpkin dessert was made last night and put in the cooler. The pureed pumpkin desserts temperatures were 51degrees Fahrenheit, 50 degrees Fahrenheit, and 51 degrees Fahrenheit. The regular pumpkin dessert was 46 degrees Fahrenheit, and the cottage cheese was 41.1 degrees Fahrenheit.On 2/26/26 at 10:47 AM, V15 (Registered Dietitian) said dietary staff should be wearing a hair net to cover facial hair when preparing foods. V15 said it is possible for facial hairs to fall onto clean dishes, so staff should probably wear one to cover their facial hair while doing the dishes. V15 said it is important to use chemical sanitation to wipe down the<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | equipment and clean food prep areas to prevent food-borne illness. V15 said it is important for staff to be aware of the chemical concentration level needed for sanitation. V15 said the cold dessert temperatures should be under 41 degrees Fahrenheit if came out of the cooler to puree and cold milk was added.The facility's 2025 Dietary Employee Personal Hygiene policy showed 4. Hair Restraints. A. All dietary staff must wear hair restraints (e.g. hairnet, hat and/or beard restraint) to prevent hair from contacting food.The facility provided the information for the (Broad Range Quaternary Sanitizer). The document showed it was an EPA-registered broad range, liquid quaternary sanitizer. The document showed it was EPA approved for food contact sanitizing from 150-400 ppm. The document also showed the target range was 200 ppm. |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure resident dignity was maintained during personal care for 2 of 2 residents (R13, R48) reviewed for dignity in the sample of 38. The findings include:1. R13's face sheet printed on 2/26/26 showed diagnoses including but not limited to traumatic subdural hemorrhage, speech and language deficits, autistic disorder, and left side paralysis. R13's facility assessment dated [DATE] showed moderate cognitive impairment. The same assessment showed total staff assistance required for bathing, dressing, personal hygiene, and transfers. On 2/25/26 at 9:10 AM, V6 (CNA-Certified Nurse Aide) performed morning hygiene care for R13. V6 removed R13's clothing and did a bed bath. R13's face, chest, groin area, and buttocks were washed during the process. R13 was rolled repeatedly from side to side during the process. The window curtain was not closed and R13 was visible to the neighboring wing windows. R13 was dressed and transferred to the wheelchair. At no time was the window curtain closed. 2. R48's face sheet printed on 2/26/26 showed diagnoses including but not limited to transient cerebral attack, chronic heart failure, palliative care, and anxiety. R48's facility assessment dated [DATE] showed severed cognitive impairment. The same assessment showed staff assistance required for bathing, dressing, and personal hygiene. On 2/24/26 at 10:56 AM, V5 (CNA) removed R48's incontinence brief and began peri care. During the process, V5 exited the room to get more gloves. R48 was naked from the waist down and the room door was left open. R48 was visible to the hallway. On 2/26/26 at 9:49 AM, V2 (Director of Nurses) stated resident room doors and window curtains should be closed during personal care. It is to ensure privacy and dignity. It is required for all residents, regardless of mental cognition or level of alertness. The facility's Promoting/Maintaining Resident Dignity policy revision dated 12/1/25 states under the compliance section: 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. 12. Maintain resident privacy. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a care plan for a resident with a diagnosis of post-traumatic stress disorder (PTSD) for 1 of 1 resident (R79) reviewed for PTSD in the sample of 38.The findings include:R79's admission Record, provided by the facility on 2/26/26, showed she had diagnoses including post-traumatic stress disorder, unspecified, bipolar disorder, in partial remission, major depressive disorder, and generalized anxiety disorder. All of these diagnoses had an onset date of 12/29/23. R79's facility assessment dated [DATE] showed she has moderate cognitive impairment and partial to moderate assistance from staff for dressing, bathing, and toilet hygiene. The assessment showed R79 is independent with bed mobility and transfers.On 02/24/2026 at 12:51 PM, R79 was alert, oriented. Cognitively intact. Well-groomed. R79 was smiling and pleasant. No signs of withdrawal, anger, depression. R79 interacted with staff and other residents. R79 said she likes it in the facility. Staff are nice. They take good care of me. R79 said she feels her needs are being met.On 2/26/26 at 12:06 PM, V11 (RN) said R79 had some relationship issue in the past that caused her PTSD. Emotional and Verbal abuse. V11 said she knows this from working with R79 previously and talking with R79 and her family. V11 was asked to look in R79's electronic medical record for a PTSD care plan. V11 said she did not see a care plan for R79's PTSD diagnosis and does not know where to reference the cause of her PTSD diagnosis. V11 said R79 has been stable. V11 said it is important for staff to know the cause of a resident's PTSD, what the triggers are and how to manage the resident's symptoms.On 2/26/26 at 1:03 PM, R79 said she talks with someone that comes to the facility twice a week about how she feels and things that make her sad. She does not know what the person's name is, or who she works for. R79 said she feels her emotional needs are being met at the facility.On 2/26/26 at 1:30 PM V1 (Administrator) verified that there was no care plan for R79's PTSD prior to this surveyor asking. V1 said it is important to have a care plan in place, so staff know how to take care of R79. V1 provided the updated care plans with the PTSD included.R79's 2/26/26 PTSD care plan showed her PTSD was due to past falls that caused injuries.On 2/26/26 at 3:28 PM, V2 (Director of Nursing) was asked where the information was obtained regarding the cause for R79's PTSD. V2 said R79's PTSD was probably because she had a fall with a fracture in the past. V2 said R79 is receiving psychiatric services from a (behavioral health service). V2 was informed of the information provided to this surveyor by V11 (RN). V2 said she (V2) was not sure that R79's falls caused her PTSD or if it is due to something else. V2 said she called the behavioral health service that sees R79 and has not received a return call yet. V2 agreed that it is important to identify the reason for the diagnosis and make sure a care plan is in place.The facility's 2025 Comprehensive Care Plans policy showed It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality.Trauma-informed care is an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact, and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization. The policy showed the care plan will be developed within 7 days after the completion of the comprehensive assessment.The comprehensive care plan will describe, at a minimum, the following: A. The services that are to be furnished are to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. B. Any services that would otherwise be furnished but are not provided due to the resident's exercise of his or her right to refuse treatment. C. Any specialized services or specialized rehabilitation services<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the nursing facility will provide as a result of screening recommendations.f. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. G. Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated. Trigger-specific interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident. Identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure pressure relieving interventions were in place for 1 of 5 residents (R26) reviewed for pressure ulcers in the sample of 38. The findings include: R26's face sheet printed on 2/26/26 showed diagnoses including but not limited to paralysis of upper limb following cerebral infarction affecting right dominate side, right hip/buttock stage 3 pressure ulcer, right and left knee stiffness, and muscle weakness. R26's facility assessment dated [DATE] showed partial to moderate staff assistance required for bed rolling. The assessment showed total staff assistance required for putting on footwear. The same assessment showed R26 had no cognitive impairment. R26's pressure ulcer risk assessment dated [DATE] showed risk for pressure ulcer development. R26's most recent weight dated 2/12/26 showed 193.4 pounds. On 2/24/26 at 2:25 PM, R26 was seated in a wheelchair in his room. R26 wore black socks and both feet were resting directly on the floor. Blue heel protectors were lying on the bottom shelf of his nightstand. R26 had a low air-loss mattress on his bed, and the dial was set to the firmest level, way beyond the 400-level mark. This surveyor pushed on the mattress and R26 stated, That is super hard, right? R26 said he had a sore on his hip, and the mattress is supposed to help. R26 said the mattress is hard and he can't get comfortable on the hard ridges. On 2/25/26 at 9:40 AM, R26 was seated in a wheelchair in his room. The heel protectors were still on the bottom shelf of the nightstand, and his heels were directly on the floor. The air mattress setting was still set beyond the 400-level mark. At 2:27 PM, R26 was in the wheelchair in his room. The boots and bed setting were the same. His feet were flat on the ground. R26 stated the boots come off when he is in bed and staff do not attempt to put them back on him. On 2/26/26 at 10:13 AM, R26 was seated in a wheelchair in his room. The boots and bed setting were the same. His feet were flat on the ground. R26 stated staff do not float his heels or reposition him in bed. R26 repeated, That bed is so hard I can't move around on it. The ridges on the mattress make it hard for me to roll. R26's care plan showed a focus area related to stage 4 pressure of right hip. Interventions included: Apply pressure relieving device as ordered by MD (SPECIFY: pressure relieving device/reducing device) on (SPECIFY: bed/chair). Date initiated 10/6/25. Encourage turn and repositions every 2 hours and as needed. Date initiated 1/9/26. R26's wound report dated 2/23/26 showed a stage 4 right lateral hip wound measuring 1.5 x 0.4 x 1.0 centimeters. The report showed the wound was chronic and greater than 364 days in duration. The report showed it was decreasing in size and surface area. The report showed the objective was to prevent deterioration. Recommendations included limit sitting to 60 minutes, offload wounds, turn side-to-side in bed and reposition per facility protocol. On 2/26/26 at 10:29 AM. V2 (Director of Nurses) stated pressure ulcer air mattresses are based on resident weight. Settings are monitored by both the aides and nurses. The dial is set per each resident's weight. The settings are monitored every shift. It is reflected on the physician order report and TAR (treatment administration record). R26 is high risk for more skin breakdown and he already has a wound on his hip. V2 said staff should be attempting to get R26 to wear heel protectors or floating his heels in bed. V2 stated there is the potential for slower wound healing and more open areas to develop if interventions are not done correctly. At 10:40 AM, V2 and this surveyor observed R26's air mattress settings and feet directly on the floor. V2 said nurses should be documenting in the medical record that they are checking for both interventions. R26's February 2026 TAR showed documentation of the heel boots in place on 2/24, 2/25 and 2/26 (start dated 10/1/25). The same TAR showed to check air mattress for correct weight setting every shift (start dated 2/26/26-day of survey). The facilities Pressure Ulcer Prevention and Management policy dated 9/1/25 states: 4.c. Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure ulcer injury present. |

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| | 145895 | A. Building<br>B. Wing | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Stephenson Nursing Center | 2946 South Walnut Road<br>Freeport, IL 61032 |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to ensure catheter tubing was positioned in a manner to prevent it from dragging across the floor as a resident was propelling his wheelchair for 1 of 1 resident (R46) reviewed for catheters in the sample of 38.The findings include:R46's admission Record provided by the facility on 2/26/26, showed he had diagnoses including, but not limited to chronic kidney disease, stage 3A, disorder of prostate, unspecified, urine retention, benign prostatic hyperplasia with lower urinary tract symptoms, obstructive and reflux uropathy (urine flow is blocked or flows backward into the kidneys), vesicoureteral-reflux with bilateral reflux nephropathy with hydroureter (the backward flow of the urine from the bladder to the kidneys leads to scarring, infection, and potential chronic failure). R46's facility assessment dated [DATE] showed he had moderate cognitive impairment, Requires supervision or touch assistance for toileting, bathing, bed mobility and transfers. The assessment showed R46 uses a wheelchair for mobility and has a urinary drainage catheter.On 2/24/2026 at 1:33 PM, R46 was observed propelling himself down the hall in his wheelchair. R46 had a urinary drainage bag placed inside a privacy bag that was attached to the wheelchair. The tubing for R46's urinary drainage bag was dragging on the floor as R46 was propelling down the hallway. On 2/25/26 R46 was seen propelling himself down a hall with the tubing to his urinary drainage device dragging on the floor at 8:30 AM, at 9:34 AM, and at 9:46 AM. As he was propelling his wheelchair past the nurses' station at 9:34 AM, he went past V14 (RN) and a Certified Nursing Assistant that was sitting at the nurses' station documenting in the facility's electronic medical system.On 2/26/2026 at 8:45 AM R46 was observed propelling himself down the hall. Again the tubing for R46's urinary drainage device was dragging on across the floor as he was propelling down the hall. On 2/26/26 at 11:41 AM, V2 (Director of Nursing-DON) was informed about the daily observations of R46's catheter tubing dragging across the floor as he propelled through the facility. V2 said the tubing should not be touching the floor for infection control reasons. To prevent infection.On 2/26/26 at 12:38 PM, V11 (Registered Nurse-RN) said a resident's catheter tubing should not be dragging on the floor for infection control reasons and dignity reasons. R46's care plan initiated 12/4/25 showed he had a indwelling urinary catheter. Position catheter bag and tubing below the level of the bladder. Collection bags have backflow prevention devices which are effective for short periods such as during transfers and bed mobility.The document provided by the facility on 2/26/26, titled (R46) UTI dates showed since his admission on [DATE], R46 has had 3 urinary tract infections.The facility's 2025 Indwelling Catheter Use and Removal policy showed Indwelling urinary catheters are catheters that remain in the bladder to assist with urinary elimination.and increase the risk of urinary tract infections. The policy showed 7. Additional care practices include.e. Securement of the catheter to facility flow of urine, prevention of kinks in the tubing and position below the level of the bladder. The policy does not address ensuring the tubing does not come into contact with the floor.The facility's 9/1/2025 Catheter Care policy does not address ensuring the catheter tubing does not come in contact with the floor. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a gradual dosage reduction was attempted for a resident prescribed multiple psychotropic medications. This applies to 1 of 5 residents (R16) reviewed for unnecessary medications in the sample of 38.The findings include:R16's face sheet showed she was admitted to the facility 6/24/25 with diagnoses to include encephalopathy, lack of coordination, hypothyroidism, Type 2 Diabetes, dementia with other behavioral disturbance, bipolar disorder, major depressive disorder, obstructive sleep apnea, chronic pain, muscle weakness, disorders of muscle, fibromyalgia, unsteadiness on feet, and abnormalities of gait and mobility. R16's facility assessment dated [DATE] showed she has moderate cognitive impairment and requires supervision and touch assistance for most cares. This same assessment showed R16 exhibited no behaviors. On 2/24/26 at 12:00 PM, R16 was in the common area during the lunch meal. On 2/25/26 at 9:30 AM, R16 was in the common area during an activity. On 2/26/26 at 8:11 AM, R16 was in the common area sitting at the dining table. No behaviors were observed. R16's February 2026 Physician Order Sheet showed orders for psychotropic medications as follows: clonazepam (antianxiety medication) 0.25 mg every evening; duloxetine (antidepressant medication) 60 mg daily; Quetiapine Fumarate (antipsychotic medication) 200 mg every evening; Quetiapine Fumarate 50 mg every afternoon; Quetiapine Fumarate 100 mg daily (scheduled in the morning). R16's complete Care Plan was reviewed with no mention of resident exhibiting behaviors. R16's Care Plan initiated 7/6/25 showed, Resident is at risk for adverse consequences related to receiving antipsychotic, antidepressant, antianxiety medications. History of behavioral symptoms. Access if the resident's behavioral symptoms present a danger to the resident and/or others. Attempt to give the lowest dose possible. Monitor for effectiveness.R16's last 3 months of CNA Behavior Charting was reviewed and showed no behaviors exhibited. R3's last 3 months of nursing notes showed no documentation of resident adverse behaviors. On 2/26/26 at 8:16 AM, V8 CNA said, [R16] does not really have behaviors. She can get kind of snippy maybe, she has no yelling out, she is not combative at all, she does not refuse care for me.On 2/26/26 at 8:11 AM V 9 CNA said, [R16] doesn't have behaviors really, maybe trying to walk by herself when she needs assistance, otherwise, not really.On 2/26/26 at 8:40 AM, V7 CNA said, I worked regularly on [R16's] hall for 5 months until last month, so I'm very familiar with her. [R16] has no behaviors. She would try and tell other residents what they need to do sometimes, but she has never had a bad behavior. She had no yelling out, no combative behaviors at all.On 2/26/2026 at 9:54 AM, V2 DON (Director of Nursing) provided R16's behavior monitoring documentation. V2 said R16's behaviors include being easily irritated. V2 said this behavior is exhibited by swearing at times and using a different tone of voice. V2 said R16 will also at times kind of push her walker away. R16's Pharmacy Consultation Report signed 2/28/26 showed, The resident has been receiving duloxetine 60 mg every day since 6/24/25; clonazepam 0.25 mg every day since 6/24/25; Quetiapine 100 mg at 9:00 AM, 50 mg at 12:00 PM, and 200 mg at 6:00 PM since 6/24/25. Per CMS guidelines if used to manage behavior, stabilize mood, or treat a psychiatric disorder, thee medications are subject to dose reduction regulations twice within the first year in two separate quarters and annually thereafter, unless clinically contraindicated. If appropriate at this time, may I suggest the following GDR: QUETIAPINE 100 MG AT 9:00 AM, 50 mg AT 12:00 PM, and 150 mg AT 6:00 PM. If a gradual dose reduction is contraindicated, please review the following and check if appropriate: 1. The resident's target symptoms returned or worsened after the most recent attempt at a tapering dose. 2. Past reduction attempts have resulted in problematic behavior and/or staff inability to provide care. 3. Past reduction attempts have resulted in psychiatric instability by exacerbating an underlying medical or psychiatric disorder. 4. Past reduction attempts have caused the resident to post danger to self or others. Please provide in the space below a CMS required patient specific rationale describing why a Gradual Dosing Reduction attempt is clinically<br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | contraindicated. (R16's physician wrote in) ?No change due to continued behaviors'. The facility's policy and procedure implemented 9/1/25 showed, Gradual Dose Reduction of Psychotropic Drugs. Policy: Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless, clinically contraindicated, in an effort to be managed at a lower dose or to discontinue these drugs. For any individual who is receiving a psychotropic medication, a GDR may be considered clinically contraindicated for reasons that include, but that are not limited to, the following: a. The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or exacerbate an underlying medical or psychiatric disorder; or b. The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at this time would be likely to impair the resident's function, exacerbate an underlying medical condition or psychiatric disorder or increase distressed behavior. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, interview, and record review, the facility failed to ensure staff wore the required personal protective equipment when providing high-contact resident care activities for 1 of 7 residents (R9) reviewed for infection control in the sample of 38.The findings include:R9's admission Record, provided by the facility on 2/26/26, showed diagnoses of moderate protein-calorie malnutrition, muscle weakness, paraplegia, cachexia (a complex, progressive syndrome characterized by severe weight loss, muscle atrophy, and fat depletion), ataxia (a lack of muscle coordination affecting gait, speech, eye movements, and swallowing), degenerative disease of nervous system, neuropathy, stage 4 pressure ulcers on his buttocks sacrum, left and right lower back, and an unstageable pressure ulcer right heel. All the pressure ulcers were present on admission. The admission Record showed R9 had a colostomy on admission, and a gastrostomy tube was initiated on 12/26/25. R9's 1/31/26 facility assessment showed he is cognitively intact, is dependent on staff for all activities of daily living.R9's care plan initiated on 11/26/26, showed he requires Enhanced Barrier Precautions due to wounds and catheter. The care plan showed, Sign will be posted outside resident door to notify staff and visitors of protocol for enhanced barrier precautions. The care plan showed, Staff will wear gown and gloves when performing activities listed on posted signage.On 2/24/26 at 12:09 PM, V12 (staffing coordinator/scheduler) was in R9's room. V12 let R9 know she needed to reposition him in bed. V12 was only wearing gloves, no gown. V12 was touching R9's blankets, pillow, R9, and his catheter bag. R9 was agitated and said he wanted his pants on first. V12 put R9's sweatpants on him. At 12:18 PM, V13 (Certified Nursing Assistant-CNA) entered R9's room and let R9 know she informed the nurse that his colostomy bag needed changed. V13 told R9 they (V12 and V13) need to reposition him in bed. V13 did not have gloves or a gown on. V13 touched R9's bed frame, his wheelchair, then his bed remote to raise the bed. After raising R9's bed, V13 said she needed to put gloves on. V13 put gloves on. V12 and V13 repositioned R9 in bed. At 12:24 PM, V14 (Registered Nurse-RN) entered R9's room. Both V13 and V14 were only wearing gloves. V14 (RN) touched R9's colostomy bag, then touched the tubing on R9's feeding tube to move it to the side. V14 removed R9's colostomy bag. Both V13 and V14 cleaned stool from around R9's stoma site. Both only had on gloves. V13 wiped stool from stoma because it was still coming out. While leaning over resident to perform care both V13 and V14's clothing was touching R9's bedding. V14 put a new colostomy pouch on R9, then helped V13 roll R9 onto right side. V13 informed V14 that R9's dressing needed changed on his bottom. V14 removed one of the large dressings, looked at R9's wound and said she would be right back with supplies. V14 returned and informed R9 that V1 (Administrator/RN) would be right in to do the dressing change so she could finish the medication pass. At 12:50 PM, V1 entered R9's room, washed her hands and put clean gloves on. V13 (CNA) was still in R9's room to assist with wound care. This surveyor observed 5 pressure wound dressing changes for R9. No gown was worn by V1 or V13 during the wound care for R9. During the wound care, both V13 and V1's clothing were touching the resident and his bedding. V1 and V13 applied a brief to R9 after care.On 2/25/26 at 9:24 AM, V14 (RN) was in R9's room with the door closed. This surveyor knocked on the door. V14 was flushing R9's feeding tube after stopping the feeding. V14 was only wearing gloves and no gown.On 2/26/26 at 9:59 AM, V2 (Director of Nursing-DON) said if a resident is on Enhanced Barrier Precautions and staff are going in to provide care, they should have a gown and gloves on to prevent the resident from getting an infection. V2 said this includes doing anything with the feeding tube and during wound care.On 2/26/26 at 12:38 PM, V11 (RN) said if a resident is on enhanced barrier precautions and staff are going in to do direct care such as repositioning, toileting, wound care, V11 would wear a gown and gloves for infection control reasons.The signage posted outside R9's room showed, Stop. Enhanced Barrier Precautions. Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and Staff Must also: Wear gloves and a gown for the following High-Contact resident care activities: Dressing, Bathing/showering, Transferring, changing linens, providing Hygiene, (continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | changing briefs or assisting with toileting, Device Care or use: Central line, urinary catheter, feeding tube, tracheostomy. Wound Care: Any skin opening requiring a dressing.The facility's 2025 Enhanced Barrier Precautions policy and procedure showed It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDROs).Enhanced barrier precautions refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown, and gloves use during high-contact resident care activities.1. a. All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions.2. B. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g. chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous statis ulcers) and/or indwelling medical devices (e.g. central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO. The policy showed 4. High contact resident care activities include dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters, and Wound care: Any skin opening requiring a dressing. |