STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146144	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Nursing & Rehab	902 South McLeansboro Benton, IL 62812

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure sufficient staff to meet the needs of the residents timely. This has the potential to affect all 58 residents currently residing at the facility. Findings include: 1. R13's admission Record documents an admission date of 2/9/25 with diagnoses including in part: altered mental status, anxiety disorder, diabetes, disorder of muscle, unsteadiness on feet, other lack of coordination, and unsteadiness on feet. R13's MDS dated [DATE] documents a BIMS of 14, indicating R13's cognition is intact. On 8/26/25 at 11:54 AM, R13's was sitting in his wheelchair in the doorway to his room with his call light on, this surveyor asked if his call light had been on a while, and he stated yes it has been. The call light was already on when the observation began. During constant observation, R13's call light was answered by V3 (Corporate Nurse) at 12:16 PM. 2. R8's admission Record documents an admission date of 9/11/23 with diagnoses including in part: diabetes, anxiety, chronic obstructive pulmonary disease, chronic pain syndrome, nicotine dependence cigarettes, and difficulty in walking. R8's MDS dated [DATE] documents a BIMS of 15, indicating R8's cognition is intact. R8's current Care Plan documents R8 uses tobacco with interventions including in part: orient R8 to smoking times and procedures. On 8/26/25 at 10:57 AM, R8's call light was on, and he stated he turned his call light on about 30 minutes ago about 10:30 AM because that was the smoking time for residents. There was a digital clock with large print that was next to R8's bed that he looked at when he stated what time he put his call light on. R8 stated it can take an hour at times to get his call light answered because there isn't enough help. On 8/26/25 at 11:49 AM, R8 is still in bed, stated he is still waiting for someone to get him up. V1 (Administrator) came to the room to answer the call light and stated he would go find the sit to stand to get him up. On 8/26/25 at 12:31 AM, R8 was still in bed. R8 stated V1 told him again that he was going to get the sit to stand and find the Certified Nursing Assistants (CNA) to get him up. R8 stated he has now missed the 10:30 AM smoke break. R8 said he thinks the next one is after lunch around 1:00 PM. 3. R3's admission Record documents an admission date of 8/7/25 with diagnoses including in part: cellulitis of buttock, muscle weakness, unsteadiness on feet, cognitive communication deficit, reduced mobility, need for assistance with personal care, and dementia severe. R3's MDS dated [DATE] documents a BIMS of 13, indicating R3's cognition is intact. R3's current Care Plan documents R3 has a selfcare deficit with interventions including in part: assist with meals as needed. On 8/26/25 at 12:38 PM, R3 was lying in bed with her lunch tray sitting on the bedside table, next to the bed. The tray was untouched. This surveyor asked R3 if she was hungry and she said yes, this surveyor told R3 her lunch was sitting beside the bed for her. On 8/26/25 at 1:33 PM, R3 was lying in bed with her lunch try sitting on bedside table next to bed, tray is untouched. On 8/26/25 at 1:38 PM, This surveyor asked R3 if she needed assistance eating and she replied Yes. On 8/26/25 at 1:42 PM, R3's V7 (Family Member) and V6 (Speech Pathologist/Director of Rehab) went into R3's room and V6 told V7 that R3 wasn't having a very good day today. On 8/26/25 at 1:47 PM, V6 stated R3 doesn't usually need assistance eating but she isn't having a very good day today, so she was going to try and get her to eat some. On 8/26/25 at 2:02 PM, V8 (CNA) stated R3 usually feeds herself but she has been struggling lately and hasn't been eating much. V8 stated she hasn't checked on her since her tray was delivered because she has been shaving 3 other residents and hasn't had time. 4. R11's admission Record documents an admission date of 12/5/23 with diagnoses including in part: fracture of lower end of right tibia, obesity, chronic pain syndrome, primary osteoarthritis, muscle weakness, other abnormalities of gait and mobility, unsteadiness son feet, and need for assistance with personal care. R11's MDS dated [DATE] documents a BIMS of 15, indicating R11's cognition is intact. The same MDS documents R11 is dependent for chair/bed-to-chair transfers. The MDS documents depends as, helper does all the effort and resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. On 8/26/25 at 9:20 AM, R11 stated she is a mechanical lift now because she fell about 2 months ago while being transferred and broke her knee. R11 stated she usually has a long wait for her call light to be answered, sometimes 30 minutes or longer and stated she has urinated on herself before because she had to wait so long. On 8/26/25 at 12:40 PM, R11 said the CNAs usually get her up with one assist using the mechanical lift. On 8/26/25 at 12:40 PM, V4 (CNA) stated she got R11 up today with the mechanical lift by herself. This surveyor asked V4 why she did it by herself and V4 stated because there wasn't anyone else to help. 5. R12's admission Record documents an admission date of 7/18/25 with diagnoses including in part: displaced