STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009161	A. BUILDING: _____ B. WING _____	C 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEPHENSON NURSING CENTER	2946 SOUTH WALNUT ROAD FREEPORT, IL 61032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Final Observations Statement of Licensure Violation: 1 of 1 Violation 300.610a) 300.682b) 300.690c) 300.1210b) 300.3240a) 300.3240b) 300.3240c) 300.3240d) 300.3240e) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.682 Nonemergency Use of Physical Restraints b) A physical restraint may be used only with	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009161	A. BUILDING: _____ B. WING _____	C 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEPHENSON NURSING CENTER	2946 SOUTH WALNUT ROAD FREEPORT, IL 61032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1	S9999		

the informed consent of the resident, the resident's guardian, or other authorized representative. (Section 2-106(c) of the Act) Informed consent includes information about potential negative outcomes of physical restraint use, including incontinence, decreased range of motion, decreased ability to ambulate, symptoms of withdrawal or depression, or reduced social contact.

Section 300.690 Incidents and Accidents

c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009161	A. BUILDING _____ B. WING _____	C 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEPHENSON NURSING CENTER	2946 SOUTH WALNUT ROAD FREEPORT, IL 61032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2	S9999		

care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)

c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act)

d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009161	A. BUILDING: _____ B. WING _____	C 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEPHENSON NURSING CENTER	2946 SOUTH WALNUT ROAD FREEPORT, IL 61032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		

e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act)

These Requirements are not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure a resident (R1) on the dementia unit was not physically abused. The facility also neglected to intervene to keep a resident safe from abuse. The facility failed to ensure the facility abuse policies and procedures were implemented by the administrator (abuse coordinator) after the physical abuse of R1. These failures resulted in R1 being abused for over 20 minutes by V8 CNA (Certified Nursing Assistant) as V5 CNA looked on and did nothing. R1 sustained extensive bruising to the neck, nose, arms, chest and back after being held against her will and repeatedly abused by V8.

This applies to 1 of 5 residents (R1) reviewed for abuse in the sample of 5.

The findings include:

R1 is a 73 year old female admitted to the facility's dementia unit on April 5, 2019 at 1:50 PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009161	A. BUILDING _____ B. WING _____	C 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEPHENSON NURSING CENTER	2946 SOUTH WALNUT ROAD FREEPORT, IL 61032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4	S9999		

from home. R1's face sheet shows diagnoses of Dementia with behavioral disturbance, Hypertension, Asthma, Osteoarthritis, Cardiac murmur, History of Transient Ischemic Attack and Liver Transplant. R1's Brief Interview for Mental Status (BIMS) dated April 14, 2019 shows a score of 99 which indicates R1 was unable to complete the interview (cognitively impaired).

Review of the video recording from April 6, 2019 (day after admission) captured the incident as follows:
At 8:16 PM, R1 was sitting in the vestibule at the dementia unit entrance. R1 flipped the light switch turning the hallway lights off.

At 8:17 PM, V8 CNA (Certified Nursing Assistant) walked behind R1 and attempted to lift the resident and her four wheeled seated walker as the resident was sitting in it. R1 resisted, pushing her feet on the ground and leaning into V8. V8 put R1 into a choke hold-put his left arm around R1's neck and his right arm under her right arm extending it backwards. V8 then released the choke hold and grabbed R1 by both wrists and pulled them behind her back.

At 8:18 PM, V5 CNA brought a wheelchair as R1 continued struggling with V8.

At 8:19 PM, V8 took R1 by the right arm (as R1 attempted to back away). R1 stood up and V5 stepped in to assist R1 from the left side and R1 is forcibly sat into the wheelchair. R1's feet kicked up from the force of being sat in wheelchair. R1 continued to struggle against V8. V8 placed R1 in a choke hold with his left arm across her chest. V8 then grabbed R1's arms from behind and placed his arms in front of hers and held onto the arms of the chair, restricting her arm movement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009161	A. BUILDING _____ B. WING _____	C 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEPHENSON NURSING CENTER	2946 SOUTH WALNUT ROAD FREEPORT, IL 61032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5	S9999		

During this struggle, R1's eyeglasses were knocked to the floor. V8 attempts to push R1 down the hallway in the wheelchair. R1 put both feet down and V8 then tilted the wheelchair on its back two wheels (R1's feet are now off the floor) and R1 is kicking both feet. R1 threw her arm back to strike V8 and V8 lost control of the wheelchair causing V8 to fall to the floor on his knees. R1 and the wheelchair landed on top of V8. R1 continued to strike at and struggle with V8. V5 steadied the wheelchair and V8 was able to stand up.

At 8:20 PM, V8 put his hands firmly on R1's shoulders as she grabs at V8's hands. R1 could be seen grimacing and pulling at V8's hands as they exit the camera view in the hallway. In the dining room area, V8 pushes R1 in the wheelchair on the back two wheels. R1's feet are off the ground, hands reaching back towards V8. R1 was kicking.
At 8:21 PM, V8 attempted to place R1 in a choke hold from behind. R1 fought against V8. R1 and V8's hands are locked and pressing on R1's face. V8 pushed R1 and the chair into the dining table. R1 attempted to turn around toward V8 and V8 reclined the wheelchair again restricting R1's movement. V8 put the front wheels of the chair on the ground. R1 grabbed the table and attempted to push it away from her. V8 then restrained R1 from behind by placing his arms on the chair armrests in front of her arms.

At 8:22 PM, R1 attempted to wiggle her arms loose and V8 grabbed R1's left arm and extended it back behind her. V8 continued to stand behind R1 restraining her arms until 8:24 PM.

At 8:24 PM, R1 strikes at V8. V8 grabs both of R1's arms at the bicep area and locked his arms

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009161	A. BUILDING: _____ B. WING _____	C 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEPHENSON NURSING CENTER	2946 SOUTH WALNUT ROAD FREEPORT, IL 61032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 6	S9999		

and crouches, pulling R1 back in the chair with his weight.

At 8:25 PM, V8 locked the brakes of the wheelchair and remained behind her.

Ay 8:26 PM, V8 placed his right foot on the cross bar of the wheelchair from behind holding R1 and the chair against the table.

At 8:29 PM, R1 pushed the table away and leaned forward attempting to stand and V8 tilted the wheelchair and forced R1 back into the wheelchair with his right hand. V8 reached his arm across R1's chest placing her into another hold from behind, keeping the wheelchair in a tilted position. R1 was kicking her legs and trying to free her hands.

At 8:30 PM, V8 changed his position of restraint and placed his hands on the arm of the wheelchair again restraining R1's arm movements.

At 8:37 PM, R1 stood up. V8 grabbed R1 firmly by the shoulders and pushed her back into the wheelchair. R1 attempted to stand again. V8 grabbed her hips and pulled R1 back down into the wheelchair.

At 8:38 PM, R1 stood again. V8 unsuccessfully attempted to use his right hand to sit her down. V8 then grabbed R1's hips and forced her down into the wheelchair. R1 swung her right arm back towards V8. V8 placed R1 in a hold again. V8 used his right arm to push down on R1's neck forcing her head toward the chest while he held her right arm behind her head.

At 8:39 PM, V8 pulled the wheelchair away from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009161	A. BUILDING _____ B. WING _____	C 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEPHENSON NURSING CENTER	2946 SOUTH WALNUT ROAD FREEPORT, IL 61032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 7	S9999		

the table allowing R1 to stand. V8 then pushed the wheelchair back into her knees, bear hugged her from behind and forced her down into the wheelchair. R1 was wiggling side to side and kicking her feet.

At 8:41 PM, V8 walked away from R1. R1 stood and ambulated out of view of the camera with her rolling walker.
During the time the video captured, V5 can be seen looking on, taking a drink, assisting other residents and not intervening in any way to stop the abuse.

On April 12, 2019 at 9:30 AM, R1 had a dark colored bruise to the bridge of her nose and a circular dark bruise to the left side of her neck. There were at least six areas of yellow bruising across the top of R1's upper back. Both of R1's posterior upper arms had large dark purple bruises as well as the underside of R1's arms. There were numerous (at least six) separate bruised areas yellow/green in color across R1's upper chest. Both of R1's lower arms and wrists had various colored bruises.

On April 12, 2019 at 9:35 AM, R1 was asked how she got the bruising and replied "I had a check up with a doctor, an assistant. He grabbed at ya. I think he was a young guy who didn't know much about what he was doing".

On April 12, 2019 at 8:20 AM, V1 Administrator said she became aware of the bruising on R1 the morning of April 9, 2019. V1 said V11 CNA reported the bruising to V4 Dementia Unit Director. The video showed V8 restraining R1 with his arms behind her back and restraining her with his arms. The more R1 tried to scratch and claw, the more V8 held R1 down. R1 was turning

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009161	A. BUILDING _____ B. WING _____	C 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEPHENSON NURSING CENTER	2946 SOUTH WALNUT ROAD FREEPORT, IL 61032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 8	S9999		

the lights on and off. V8 persisted against R1's will. The nurse assigned to the dementia unit that evening was on another unit at the time of the incident.

At 9:35 AM, V1 Administrator said I didn't see any reason why R1 had to be moved from the vestibule area on April 6, 2019. The door was secure. R1 would have been safe even if she exited the wing door. In discussing the video footage of the April 6, 2019 incident, V1 said, R1 was resisting being moved from inside the vestibule. R1 was struggling and fighting down the hallway. V8 had the wheelchair tilted on two wheels which is not safe. I don't think it's the resident's fault the wheelchair fell backwards. V8 did not allow R1 to do as she pleased. V8's foot was behind the wheelchair preventing R1 from getting up. V8 used force to keep R1 seated. The acceptable thing to do would be to supervise her. She was safe.

At 10:20 AM, V14 RN (Registered Nurse) said if abuse is suspected you should call the Administrator right away and remove the employee from working and send them home. This removes the suspected cause of harm from the residents and protects them. I would consider it physical abuse if a resident was physically restrained to the point of bruising.

At 10:25 AM, V9 RN said she was responsible for the dementia unit the evening of April 6, 2019. V9 said on April 6, 2019 around 9-9:15 PM, she was told by V5 that V8 was being rough with R1. I had my coat on and was headed toward the door when she told me. V9 said she did not assess R1, did not remove V8 from resident care or tell the oncoming nurse. V9 said she left the building.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009161	A. BUILDING: _____ B. WING _____	C 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEPHENSON NURSING CENTER	2946 SOUTH WALNUT ROAD FREEPORT, IL 61032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 9	S9999		

At 10:42 AM, V10 CNA said if a resident is combative you should walk away, notify the nurse, and reapproach later. I would not force a resident to do something; it may cause them to lash out, punch or scratch you. It's never okay to physically restrain a combative resident. That's how you cause behaviors. If a resident was restrained to the point of causing bruising, I'd consider it abuse.

At 2:12 PM, V2 DON (Director of Nursing) said R1's bruising could be explained by the actions from the video on April 6, 2019.

V5 CNA said on April 6, 2019, R1 was between the double doors on the dementia unit and kept turning the lights off. V8 asked her to stop doing it, which she did for a short time. R1 started turning the lights out again and that's when everything started. V8 should have left R1 go after she was out from the double doors. V8 was aggressive with R1. V8 physically restrained R1. I told V9 about V8 putting his arm around R1's mouth and aggressive behavior toward R1.

On April 16, 2019 at 9:10 AM, V4 Dementia Unit Director said V8 didn't back off and leave R1 alone. V8 should have backed off right from the start. V8's actions would be considered abuse based on my knowledge and my teaching abuse here. The incident between V8 and R1 happened on April 6, 2019 and we were not aware of it until April 9, 2019. At 10:40 AM, V4 Dementia Unit Director said R1's extensive bruising could be explained by the actions of V8 recorded on the video on April 6, 2019. When asked if V8 did anything wrong in the video, V4 said, V8 had R1's arms behind her back, put R1 in a wheelchair when she didn't want to be put there and tipped the wheelchair backwards. It looked like V8 used

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009161	A. BUILDING: _____ B. WING _____	C 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEPHENSON NURSING CENTER	2946 SOUTH WALNUT ROAD FREEPORT, IL 61032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 10	S9999		

force and restrained her. This is not appropriate and normally causes a resident to be more upset.V8 should have backed off. V8 was making R1 do what he wanted not what R1 wanted. By continuing this R1 got more upset, combative and was striking out.

At 9:00 AM, V11 CNA said she noticed bruising on R1's arms the night shift of April 8, 2019. The bruising looked like hand and finger prints to both arms. I have never seen so much bruising on anyone. I knew something happened. I thought, who did this? Who could have done this? I asked R1 how she got the bruises and she said she didn't know. I asked if someone grabbed her and she said she didn't know. I asked if someone hit her and she said she didn't know.

At 11:19 AM, V1 Administrator said (while viewing the video and asked to describe V8's actions)) I believe that's where the other CNA said, he was "choking her out".

At 12:52 PM, V1 was asked if there was additional video footage. V1 replied R1 and V8 went outside the building and there is no video from the outside. V1 said she has viewed the video a few times and it's just hard to watch.

At 1:09 PM, V4 said based on the video and R1's bruises "it was really inappropriate as we all know". V4 answered "yes" based on the seven kinds of abuse, this was abuse.

At 1:18 PM, V4 said R1 wasn't hurting anybody. They should have backed off and given her some time and space.

At 2:05 PM, V5 said I didn't attempt to intervene on R1's behalf to stop V8. It was wrong on my

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009161	A. BUILDING: _____ B. WING _____	C 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEPHENSON NURSING CENTER	2946 SOUTH WALNUT ROAD FREEPORT, IL 61032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 11	S9999		

part. I was shocked by what was going on. V8 should have just let her go. V8 had his arm around R1's mouth.

At 3:25 PM, V1 Administrator said some of the bruises found on R1 looked like hand prints and fingerprints.

At 12:30 PM, V6 CNA said I helped the nurse do the skin check on R1 when she was admitted. There wasn't any bruises. On April 9, 2019 at 2:00 AM, R1 was up and walking on the unit. I tried to give her a shower. R1 took her top off in the shower room and I saw all the bruises on her. I don't know if it was the look on my face but R1 refused the shower. R1 had bruises to the neck, chest, bridge of her nose, back, back of her arms and shoulders. I thought, "What the hell", "Who body slammed her?" She didn't have those bruises on April 5th. There were finger type bruising on her arm. I thought, "Why is there a spot on her neck? Is that from someone's thumb?" I was upset. R1 had a change in behavior since April 5, 2019. On April 5th, R1 was bossy and now (on April 9, 2019) R1 is scared and anxious.

R1's admission skin assessment dated April 5, 2019 shows there were no issues.

R1's skin assessment dated April 9, 2019 shows at least 29 bruised /reddened areas to her arms, wrists, hands, chest, neck, nose and thigh. This assessment does not include at least six bruises noted to her back on April 12, 2019.

The facility's final investigative report into this event showed "the events of 4/6/2019 and the actions of V8 have been substantiated as a factor in the subsequent development of bruises to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009161	A. BUILDING _____ B. WING _____	C 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEPHENSON NURSING CENTER	2946 SOUTH WALNUT ROAD FREEPORT, IL 61032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 12	S9999		

resident". "V8 chose to physically redirect the resident (R1) away from the exit door; this resulted in an observable escalation in the resident's (R1's) agitation including swinging her arms, striking out, etc".

This resulted in V8 continuing to work 10 more hours on the dementia unit and another 16 hours the next day on the dementia unit after witnessed aggressive behavior towards a resident was reported. Twelve of these hours, V8 was the only CNA assigned to provide care on the unit.

On April 16, 2019 at 3:25 PM, V1 Administrator said it's important to (suspend) the accused abuser to protect the resident and other residents from harm. Staff should make sure the resident is safe.

On April 16, 2019 at 2:57 PM, V2 DON reviewed the assignment schedules for April 6 and 7, 2019. V2 said V8 worked as the only CNA on the dementia unit from 11:00 PM until 3:00 AM on April 6, 2018. V8 also worked as the only CNA on the dementia unit from 11:00 PM until 7:00 AM on April 7, 2019.

Time card reports from April 6, 2019 show V8 worked from 2:38 PM until 7:24 AM on April 7, 2019 and on April 7, 2019 from 2:45 PM until 7:32 AM on April 8, 2019.

V5's time card shows V5 continued to work on April 12, 13 and 15, 2019.

The facility's record of warning showed V5 was disciplined on April 22, 2019 (16 days after the incident) for failing to follow the facility's abuse prevention and reporting policies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009161	A. BUILDING: _____ B. WING _____	C 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEPHENSON NURSING CENTER	2946 SOUTH WALNUT ROAD FREEPORT, IL 61032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13	S9999		

The facility's record of warning shows V8 was discharged from employment on April 22, 2019 for physically containing a resident causing multiple bruises to the resident (16 days after the incident).

On April 12, 2019 at 2:40 PM, V7 (R1's physician) said the facility notified him R1 tipped back in her wheelchair (R1 is ambulatory) and fell onto a CNA. V7 said he was not notified there was an abuse investigation regarding R1.
R1's Physician Fax Communication form dated April 9, 2019 showed the facility notified V7 that R1 was in a wheelchair which was tipped backward onto a CNAs lap and it was being considered a fall. The time stamp on the fax communication form actually showed April 10, 2019 at 9:54 AM as the time the fax was sent (a day after the videotaped incident was reviewed by Administration).

R1's Physician Fax Communication form dated April 9, 2019 showed the facility informed V7 of bruising on both arms, chest, neck and nose via fax and not by phone. This fax communication has a time stamp that showed the fax was actually sent April 12, 2019 at 2:25 PM. The facility received acknowledgement back from V7 on April 12, 2019 at 4:36 PM. V7 did not assess R1's bruising until after this surveyor notified him of the extent of the injuries and video evidence of what really occurred on April 6, 2019.

R1's physician progress note dated April 14, 2019 showed R1 is not on any blood thinners and has had no abnormal bleeding issues in the past. This note showed R1 has had no other trauma (other than incident of April 6, 2019).
R1's care plan started April 11, 2019 showed R1 is at risk for abuse/neglect. If/when R1 exhibits

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009161	A. BUILDING: _____ B. WING _____	C 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEPHENSON NURSING CENTER	2946 SOUTH WALNUT ROAD FREEPORT, IL 61032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 14	S9999		

physical/verbal behaviors, provide her with a safe/secure environment and walk away until she calms down (monitor from a distance).

On April 25, 2019 at 9:35 AM, V26 (Facility Medical Director) said V1 did not notify him of an abuse allegation. V26 said V7 "unofficially mentioned it to me." I assumed that since they (the facility) did not say anything to me that it did not occur.

On April 19, 2019 at 2:30 PM, V22 (R1's spouse) said he was notified about a week ago that "something" happened between a CNA and his wife. "I don't know if she was trying to get out or if a CNA grabbed her but she (R1) scratched him." V22 said he has not been notified of the investigation results. (The facility investigation was finalized on April 17, 2019).

On April 25, 2019 at 8:30 AM, V22 said the facility notified him a CNA was fired after he held R1's hands down on the floor. "They didn't give me any details or say the CNA abused my wife. They didn't give me much detail at all." I noticed she had bruises.

The facility's Abuse Prevention Program Policy dated February 2017 showed employees of this facility who have been accused of abuse, neglect or mistreatment will be removed from resident contact immediately. Abuse is defined as any physical or mental injury inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident...The resident or resident's representative will be immediately informed of the occurrence of potential abuse, neglect or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009161	A. BUILDING: _____ B. WING _____	C 04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEPHENSON NURSING CENTER	2946 SOUTH WALNUT ROAD FREEPORT, IL 61032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 15 mistreatment and that an investigation is being conducted. Neglect means "the failure to provide goods and services to a resident that are necessary to avoid physical harm, pain, or mental anguish...The resident or resident's representative will be informed of the conclusions of the investigation... The facility shall also contact local law enforcement authorities if there is physical abuse involving physical injury inflicted on a resident by a staff member and when there is reasonable suspicion that a crime has been committed in the facilty by a person other than the resident... The facility's Nursing Home Administrator job description dated 2003 showed to ensure that all employees follow the facility's established policies and procedures. This job description shows the Administrator will inform the Medical Director of all suspected or known incidents of abuse. This also showed to make routine inspections of the facility to assure that established policies and procedures are being implemented. The Nursing Home Administrator must possess the ability to implement policies and procedures necessary for providing quality care and maintaining a sound operation. (A)	S9999		