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 06/04/2025

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
S 000	Initial Comments Complaint Investigation 2514794/IL193540	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)4)A) 300.1210d)6) 300.1220b)3) 300.3210t) 300.3300j) 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. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary 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	S9999		

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 06/04/2025

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		

resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

4) Personal care shall be provided on a 24-hour, seve
n-day-a-week basis. This shall include, but not be limited to, the following:

A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and

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 06/04/2025

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		

modified in keeping with the care needed as indicated by the resident's condition.

Section 300.3210 General

t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.
Section 300.3300 Transfer or Discharge

j) The planned involuntary transfer or discharge shall be discussed with the resident, the resident's representative and person or agency responsible for the resident's placement, maintenance, and care in the facility. The explanation and discussion of the reasons for involuntary transfer or discharge shall include the facility administrator or other appropriate facility representative as the administrator's designee. The content of the discussion and explanation shall be summarized in writing and shall include the names of the individuals involved in the discussions and made a part of the resident's clinical record. (Section 3-408 of the Act)

These requirements were not met as evidenced by:

Based on interview and record review the facility failed to ensure discharge services were in place prior to discharging a resident to independent senior housing who requires assistance with activities of daily living. This failure resulted in R1 being found in her apartment soiled in urine and feces and unable to get out of bed. This applies to 1 of 3 (R1) residents reviewed for discharge in the sample of 3.

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 06/04/2025

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		

The findings include:

R1's face sheet shows she is a 77 year old female with diagnosis including osteoarthritis left hip, abnormalities of gait and mobility, type 2 diabetes unspecified dementia and cognitive communication deficit. R1's face sheet shows she was admitted to the facility on 3/8/25 and discharged on 5/30/25.

R1's care plan initiated March 17, 2025 shows R1 has difficulty understanding others, hard of hearing, cognitive and memory deficits. R1 is a fall risk and requires staff assistance with ambulation, has urinary incontinence and requires staff to provide incontinence care. R1's current care plan does not show a discharge plan.

On 6/4/25 at 9:33 AM, V3 (Social Service Director) said prior to discharge home health services should be set up and medical equipment should be delivered to their home prior to discharge. If the resident needs a caregiver, V3 facilitates this process through the senior resource center prior to discharge. The day of R1's discharge V3 found out that R1's apartment was independent living. V3 said, V10 (Property Manager of Senior Housing) said she would let V11 (Social Service Manager of Senior Housing) know of R1's discharge. V11 came to the facility the day before R1's discharge and talked to R1. V3 said, V11 asked V3 how R1 was doing in therapy and asked if R1 was more independent. The following day after R1's discharge, "everything fell apart." V3 said V11 expressed concerns that R1 was not stable enough to return to her apartment and R1 should have not been discharged because R1 needed long term care and was not appropriate for independent living.

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 06/04/2025

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		

V3 said, "This is the first time that this problem has come up." R1 is her own decision maker, and she is still at her apartment. If V3 knew R1 had a case worker she would have reached out to her prior to R1's discharge. V3 said today V3 was going to call the senior resource center to see if the caregiver services were set up for R1 as R1 had this service prior to coming to the facility and it should have been set up prior to discharge. V3 said, "Our staff assisted R1 back to her apartment, and it was discovered R1 lost her cell phone when R1 arrived in her apartment." V3 delivered the walker to her apartment on 5/30/25. V3 said R1's apartment does not have caregivers and V3 was not aware of the type of setting where R1 was being discharged to. V3 said, "During the discharge meeting, we only talked about how R1 was doing in therapy, and we did not discuss her discharge needs. R1 was alert, had periods of confusion, she was a standby assist with ambulation. R1 was referred to home health services for therapy." V3 said V3 sent the referral but is not sure if R1 is receiving those services. V3 said R1 was calling her throughout the weekend. R1 reported she was doing okay, and V3 has not heard from her since Monday.

On 6/4/25 at 9:59 AM, V4 (Restorative Nurse) said she was part of R1's discharge meeting. V3 coordinates the equipment and home health services, and V4 coordinates with therapy and assesses a residents mobility prior to discharge. V4 said, "R1 was alert with forgetfulness. By the time of discharge, she (R1) could walk with her walker and required supervision with transfers and was incontinent." V4 said the day of R1's discharge V4 felt uncomfortable about R1's discharge. V4 asked V1 (Administrator) if she could meet R1 at her apartment. V4 said R1 had the facility's walker and did not have her own

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 06/04/2025

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		

walker with her prior to discharge. A senior bus picked up R1 to transport her to her apartment and V4 met R1 at her apartment. V4 said she was concerned about R1 getting to her apartment safely so that's why V4 met R1 there. V4 said she assisted R1 off the bus and sat her on a bench and went to get a wheelchair because it was a long walk to her apartment and R1 did not have her walker. V4 said before she left R1's apartment, V4 asked the facility about visiting hours and was told visitors are buzzed in on the phone. R1 did not have a phone with her. V4 said she left R1 and bought a cell phone for her and dropped it off at her apartment. V4 said she was told the independent living center does not have any staff to assist with any care needs. V4 said V11 expressed concerns about R1's discharge but stated, "well she (R1) was already there, what are we supposed to do." V4 said she reassured V11 that R1 is capable of doing what she needs to do. R1 can transfer herself, ambulates with walker, and was incontinent of urine.

On 6/4/25 at 10:35 AM, V6 (Registered Nurse-RN) said prior to discharge there should discharge planning in place to ensure a resident's needs are set up, the floor staff gets a discharge list about one week prior to discharge. V6 said R1 was alert with forgetfulness. R1 could get up and transfer herself, she self-propelled in the wheelchair and was incontinent. V6 said sometimes R1 would refuse therapy or assistance from staff at times. V6 said V6 thought R1 was being discharged to assisted living setting. V6 said, "I don't know if R1 was safe to be discharged to independent living."

On 6/4/25 at 12:47 PM, V5 (Director of Therapy) said R1 had multiple refusals with therapy and was non-compliant, R1 was strong-willed and

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 06/04/2025

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		

worked with therapy when she allowed us to. V5 said R1 made progress initially in therapy and then she "flat lined." R1 lacks safety awareness of her deficits, poor safety, she could ambulate with the walker with standby by assist and would self-propel herself in the wheelchair. V5 said R1 had not practiced going up and down stairs, R1 would refuse services to work with stairs. V5 said, "We had concerns about her safety to go home to an independent setting. I'm not sure if any staff reached out to her (R1's) family. R1 would be more appropriate for assisted living or long term care."

On 6/4/25 at 1:06 PM, V3 (SSD) said she did not communicate with home health services of R1's new phone number so they could call R1 to set up the service. She does not know if R1's caregiver service has been reinstated and did not know she needed assistance with meals.

On 6/5/25 at 10:00 AM, V10 said senior housing apartments are for elderly residents ages 62 years old and above. V10 said, "They should be independent for all their activities of daily living, including cooking, dressing, transfers, ambulating, and housekeeping needs. V11 (Senior Housing Social Worker) expressed concerns to the facility regarding R1 not being fully independent with activities of daily living. The facility asked if we could pick up R1 to transport her home, we explained we do not provide transportation services. They asked if we could assist R1 off the senior bus, we explained we do not have caregivers to assist with cares. We do not have staff or provide services for residents we only provide housing. V11 re-instated R1's caregiver service through the senior center and the caregiver arrived on 6/3/25. On 6/3/25, R1 would not answer the door so she (V11) went to

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 06/04/2025

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		

open R1's door with the caregiver and found R1 soiled in bed (appeared to be in bed from the previous day)."

On 6/5/25 at 10:15 AM, V11 (Senior Housing Social Worker) said she went to the facility on 5/28/25 (two days prior to R1's discharge) to talk to R1. V11 asked R1 how therapy was going and how R1 was doing with her activities of daily living. V11 said she spoke with V3 and told V3 the senior housing facility does not offer any assistance with activities of daily living. There are no staff to assist R1 with ADL's, cooking or housekeeping services. V11 asked V3 about R1's transfer status and was told R1 was being discharged on Friday 5/30/25. V11 said the facility was aware of R1's home setting. V11 reminded V3 they only offer housing and no other services. Residents should be independent, and any outside services should be set up prior to discharge. V11 said V3 asked if someone one could assist R1 off the bus the day of discharge and V11 questioned R1's ability getting in and out of the bus. V11 said the day of R1's discharge, the facility asked for assistance to get R1 into her apartment and V11 told the facility again they cannot provide hands on assist with cares. V11 said the facility was well aware of R1's living situation and expressed V11's concerns to V3. On 6/3/25, R1 was found in her apartment soiled with urine and feces (appeared she had been in bed from the previous day) and unable to get out of bed. V11 said the facility should communicate with us the services a resident needs and should be set up prior to discharge. V11 said R1 required meals on wheels, caregiver services and had not been seen by PT/OT.

R1's Communication/Order Sheet dated 5/23/25 shows orders including discharge home with

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 06/04/2025

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		

current medications, in home PT (Physical Therapy)/OT (Occupational Therapy) services, and four wheeled walker.

R1's Discharge Meeting Care Plan Record dated 5/29/25 shows V3 (Social Service Director), V4 (Restorative Nurse) and R1 in attendance.

R1's Discharge Plan Notice Form dated 5/30/25 shows R1's discharge date of 5/30/25 to her home apartment and a standard walker has been ordered.

R1's Care Conference Report provided on 6/4/25 shows on 5/28/25 faxed documents to set up PT/OT services. On 5/29/25, R1's discharge meeting was held. On 5/29/25, V3 called to inform V10 and V11 that R1 would be discharging on 5/30/25 and asked if they could be looking out for R1 to get off the bus. V10 shared V11 would call V3. On 5/30/25, V4 followed R1 home to assist her off the bus and into her apartment. On 5/30/25, V3 called case manager to inform her R1 had been discharged home in the community so that her care giver service could be reinstated.

The facility's Discharge Instructions Policy states, "Upon admission and throughout the resident admission, the Social Service Representative, with the involvement of the interdisciplinary team, will review the discharge needs of each resident, and develop a discharge plan, and communicate and finalize discharge instructions."

(B)