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 05/27/2025

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

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S 000	Initial Comments Facility Reported Incident of 5/5/25/IL192177	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 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 resident to meet the total nursing and personal care needs of the resident.	S9999		

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c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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:

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.

These requirements were not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure staff applied a gait belt for a resident who is high risk for falls. This failure resulted in R1 falling on the floor while ambulating without a gait belt and sustained a left femur fracture requiring surgical repair. This applies to 1 of 3 (R1) residents reviewed for falls in the sample of 3.

The findings include:

R1's Final Serious Injury Incident Report dated 5/8/25 shows R1 is an 88-year-old female, alert and oriented x3. On 5/5/25 at 10:00 PM, (R1) sustained a fall while exiting the bathroom. V5 (Certified Nursing Assistant-CNA) was assisting (R1) back to the recliner after toileting. (R1) became weak and began to fall ...(R1) complained of leg pain and was assessed by the nurse and sent out to the local hospital. R1

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S9999	Continued From page 2	S9999		

sustained a left femur fracture requiring surgical repair.

R1's Fall Risk Assessment dated 5/3/25 shows she is high risk for falls. R1 has balance problems while standing and walking, requires the use of assistive device, impaired mobility requires assist with toileting, and has a history of three or more falls in the last three months.

On 5/27/25 at 9:05 AM, R1 was observed in her room lying in her bed. Dark and light purple and greenish bruising noted to R1's left forehead and bruising throughout her left forearm to above her elbow. A leg brace and ace wrap was in place to her left lower leg. R1 said she was coming out of the bathroom and fell down trying to get into her wheelchair. R1 said staff was with her but could not recall who. R1 said her "legs gave out" and once in a while her legs give out. R1 said she did not have a gait belt on and does not remember if she was lowered to the floor. R1 said she has a broken femur and cannot bear weight on her left leg; she is getting therapy in her room and now the staff use a mechanical lift to transfer her out of the bed.

On 5/27/25 at 10:37 AM, V3 (Licensed Practical Nurse-LPN) said on 5/5/25, she was alerted by V5 (CNA) R1 fell after toileting. When she entered the room, R1 was laying on the floor outside of the bathroom, her head was partially under the wheelchair touching the top left wheel. R1 did not have a gait belt on, she had a hematoma on the outer side of her left knee with bruising. V5 asked me for a gait belt to assist R1 off the floor. R1's gait is not the greatest, she transfers with one person, walker, and gait belt. V3 does not recall where R1's walker was located.

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On 5/27/25 at 10:43 AM, V6 (CNA) said she was in another resident's room when V5 reported R1 was on the floor, and she needed help with transferring her. When she entered R1's room, R1 was lying on the floor in between the bathroom and her recliner chair. R1's wheelchair was positioned behind her, and she does not recall seeing R1's walker. R1 was not wearing a gait belt and V5 was trying to find a gait belt to use to assist R1 from the floor. R1 is a one person assist and transfers with a gait belt and walker. R1's gait is unsteady and uses her walker when up. R1 is a fall risk, staff should use a gait belt on residents when transferring and ambulating. "Anybody who walks should have a gait belt on." V5 reported to her, R1 said she thinks her leg is broken.

On 5/27/25 at 9:28 AM, V4 (Registered Nurse-RN) said R1 is alert and oriented but can be forgetful at times. She was recently admitted from home after having falls at home. R1 was admitted to the facility with bruising to her face and body. Prior to the fall R1 transferred with one person assist, gait belt and walker. Staff should ensure R1 has a gait belt on and walker because her gait is unsteady.

On 5/27/25 at 11:51 AM, V2 (Director of Nursing-DON) said V5 (CNA) reported she was assisting R1 from the bathroom and R1 seemed a little off and tired while ambulating. V5 went to get the wheelchair and placed it behind R1 and when she tried to sit sat on the edge of the wheelchair and was lowered to the floor. V3 (LPN) and V6 (CNA) both said R1 did not have a gait belt on when they entered the room. V2 said when she questioned V5 about the gait belt and V5 said she removed the gait belt after R1 fell

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and she was sticking to her statement. V2 said it does not make sense to remove a resident's gait belt after falling. Staff should ensure to use gait belts when transferring and ambulating residents.

R1's X-ray report dated 5/5/25 shows "acute markedly displaced and angulated fracture mid shaft femur." (Severe break in the femur where the fracture pieces are significantly shifted and angled away from their normal position. These types of fractures are caused by trauma, like a fall).

R1's current care plan initiated on 5/2/25 shows R1 is at risk for falls due to history of falling at home and general weakness. R1's interventions include observe for fatigue when ambulating, offer and provide toileting assistance, encourage to assume a standing position slowly, and personal items within reach.

R1's Fall Program Policy dated 2020 states, "All residents will be evaluated for falls ...Upon completion of the fall evaluation; if the resident is identified at risk for falls; the following may occur: a care plan is developed or updated, new fall interventions are reviewed ...education regarding the resident's risk for falls and interventions to prevent falls is provided." (A)