

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0004259		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/26/2026	
NAME OF PROVIDER OR SUPPLIER STEPHENSON NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2946 SOUTH WALNUT ROAD , FREEPORT, Illinois, 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) COMPLETION DATE	
S0000	Initial Comments		S0000			03/06/2026	
	Annual Health Licensure survey						
S9999	Final Observations		S9999			03/06/2026	
	Statement of Licensure Violations (1 of 2):						
	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.						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 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 a safe mechanical lift transfer for a resident (R11) dependent upon staff for transfers. This failure resulted in R11 sustaining a right arm 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 2/3/26 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			S9999			

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S9999	Continued from page 2 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,			S9999			

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S9999	Continued from page 3 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 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		S9999				

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S9999	Continued from page 4 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 safely 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 transferred... Compliance Guidelines: ... 10. Two staff members must be utilized when transferring residents with a mechanical lift..."	S9999					

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S9999	Continued from page 5 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 1/22/26 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			S9999			

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S9999	Continued from page 6 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..." (B) 2 of 2: 300.615e) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5 (a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act) The regulation was not met as evidenced by: Based on interview and record review, the facility failed to perform background checks on residents within 24 hours of admission for 4 of 5 residents (R71, R61, R86, R30) reviewed for criminal background checks in the sample of 38. The findings include: On 2/26/26 at 8:50 AM, V3 (Social Service Director) stated resident background screening should be done within 24 hours of admission to the facility. V3 stated the CHIRP reports (Criminal History Information Response Process) were not done on time for R71, R61, R86 and R30. V3 said "they were ran (sic) late" because the facility credit card did not have any money on it to pay for the reports. V3 said it is important to have reports done in time to check for any hits or criminal history.		S9999				

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S9999	Continued from page 7 On 2/26/26 at 9:16 AM, V1 (Administrator) stated resident background checks include running a CHIRP report at admission. The reports check for any history of dangerous activity. The reports ensure a safe environment for the residents and staff. V1 said there was room on the credit card for the charges, and she could not speak as to why the reports were run late. R71's face sheet printed on 2/26/26 showed an admission date of 2/11/26. R61's face sheet printed on 2/26/26 showed an admission date of 2/11/26. R86's face sheet printed on 2/26/26 showed an admission date of 2/11/26. R30's face sheet printed on 2/26/26 showed an admission date of 2/10/26. The CHIRP reports for the residents showed a search date of 2/24/26 (day of survey). The facility's undated Central Intake Program Policy and Procedure policy states: "2.6 The Admission Director will run a background check before admission and complete the CHIRP upon admission." (C)			S9999			