STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145895	A. BUILDING _____ B. WING _____	**03/11/2020**

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

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 0744 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide interventions to a resident with dementia that exhibited behaviors for one of three residents (R1) reviewed for dementia care in the sample of nine. The findings include: The facility's Allegation Investigation Involving an Employee and Resident dated 2/29/2020 for R1 showed, On 2/26/2020 at 7:10 PM it was reported by a certified nursing assistant (CNA) that she accidentally hit a resident when the resident grabbed her arm and tried to bite her. V8 (CNA) stated she reported her action to the nurse who immediately called the abuse coordinator. According to V8, R1 typically has a place located in the hall outside of the dining room where she likes to wait for staff. V8 asked R1 if she would like to get ready for bed and R1 did. V8 pushed R1 to her room, R1 removed her beads and put them in her drawer as this is her routine. R1 showed no behavior symptoms until reaching her room. At this time R1 began complaining about items on the shelf and why does her roommate have things on R1's side. R1 started throwing those things on the floor. R1 was verbally calling her roommate names and stated that she will get the shelf taken care of. V8 proceeded to assist R1 with removing her clothes and putting on her nightgown and then the belt for the mechanical transfer. R1 was moved from the wheelchair to the bed and continued to act out by swearing and swinging her hands and arms. V8 stated R1 was sitting on the bedside and she felt the need to prevent R1 from sliding so she put her knee against R1 while she removed the transfer belt for the mechanical lift. While doing this R1 grabbed V8's left arm with both hands and pulled it towards her open mouth. V8 said when she felt her teeth on her arm she tapped R1 on the side of her head, trying to get her attention to stop the biting. V8 stated she did get R1's attention because R1 stopped and looked up at her. R1 did not say anything to V8. V8 assisted placing R1's legs on the bed and covered her so she would not be exposed, left the room and went directly to the nurse. The facility's Interview with V8 on 2/26/20 was signed by V8 and showed that she explained the incident. V8 stated R1 had been incontinent and V8 had went to assist in cleaning R1 up and getting her ready for bed. R1 was in the room throwing things on the floor, calling her names and was agitated about her roommate. V8 stated she was talking to R1 and that she thought it made it worse so she stopped talking. V8 said when she was undoing the mechanical lift belt, R1 grabbed her left arm with both hands and went to bite her. R1's mouth was open and she felt teeth on her arm. V8 stated she tried to get R1's attention and with her right hand she tapped R1 on the left side of her head. V8 was asked if she had considered backing off or walking away when she observed that R1 was already agitated and she said she knew that's what she should have done. On 3/11/2020 at 8:24 AM, V2 (Director of Nursing - DON) stated, I received a call around 7:00 PM that a CNA reported to the nurse that she accidentally hit a resident in the head. The phone was handed to V8 and she was asked what happened. V8 said R1 was trying to bite her arm and she accidentally hit her. I sent V8 home. The nurse assessed R1 and R1 never said anything about being hit. R1 denied any pain, had no red marks or signs of injury. R1 was angry when she came into her room. R1 saw something on the dresser and started throwing things on the floor. V8 proceeded to get R1 ready for bed. All staff are told to walk away when a resident is agitated as long as the resident is safe. R1 wasn't agitated until she got to her room and saw the things sitting there. V2 stated she would not have transferred or provided care for R1 at that point. V2 stated she would have let the resident calm down and then she would have tried again later. V2 stated, Maybe someone else needs to try. I give the example that a resident doesn't have to be taken to the bathroom if the don't want to go. Wait ten minutes and try again. This was not handled appropriately by the CNA and she admits that and that is why she went to the nurse. No one has even taught me how to get away from a resident that is biting. I would never let the resident close enough to bite me. I would pull away. On 3/11/2020 at 8:55 AM, V14 (Registered Nurse - RN) stated if a resident is agitated she would let the resident calm down, ensure the resident's safety. Try to distract the resident and then re-approach the resident. V14 stated she has received dementia training at the facility. On 3/11/2020 at 9:40 AM, V3 (CNA) stated she has received dementia training at the facility. V3 stated if she had a resident with dementia that was exhibiting behaviors she would try to keep the resident calm. V3 stated she would redirect the resident if she can or leave the resident alone and come back to the resident later when the resident is calm. V3 stated she could also get another staff member to see if they can handle the situation better. On 3/11/2020 at 9:51 AM, V4 (CNA) stated she has had dementia training at the facility. V4 stated if she had a resident that was agitated or having behaviors she would walk away and try later. On 3/11/2020 at 10:07 AM, V5 (CNA) stated she has had dementia training at the facility. V5 stated if she had a resident that was agitated, upset or having behaviors she would try to figure out why; maybe the resident needed to go to the bathroom or is in pain. V5 stated she would get another coworker because maybe a different face may calm the resident down. V5 stated if a resident became aggressive she would walk away from the resident. V5 stated she would report the behavior to the nurse and document in the behavior book. On 3/11/2020 at 3:36 PM, V9 (CNA) stated, I was working with V8 and then she went home. Something happened with V8 and R1. I had no idea anything happened at the time. V9 denied seeing any marks on R1. R1's Care Plan dated 12/16/19 showed, Resident has a history of verbal, physical, and other behavioral symptoms related to anxiety disorder. Assess whether the behavior endangers other resident. Intervene if necessary. Avoid a power struggle. Maintain a calm, slow, understandable approach. Redirect R1 to prevent an occurrence. Convey an attitude of acceptance towards the resident. Maintain a calm environment and approach to the resident. The Resident Face Sheet dated 3/11/2020 showed [DIAGNOSES REDACTED]. The facility's Behavioral Policy and Procedure (1/2019) showed, Staff need training to identify potential triggers for a resident's behavioral and emotional symptoms such as agitation, mood change, expression of pain. When staff recognize these triggers, they can use environmental and behavioral strategies to modify the triggers impact and document them in the behavioral tracking log. The facility's In-service Sign in Sheet dated 10/2019 showed V8 attended training on [MEDICAL CONDITION] and related disorders for CNA's. Attached to the facility's In-service Sign in Sheet dated 10/2019 was the in-service education materials that showed, Agitation: Remove upsetting things when agitation is apparent. Keep things simple. Get help as agitation turns to violence. You may need to give the resident an outlet for anger, but make sure he/she is in a safe place. Remember anger can turn to violence. Caregivers taking care of elderly people who may become violent or abusive should be advised: Do not be confrontational. Do not take personal offense. Stay calm, do not raise your voice. Do not attempt to steer a resident away by touching (action could easily be misunderstood). Do not corner the agitated person as this will increase feelings of threat/alarm. It is important to muse appropriate responses for effective behavior management. Stay calm, speak slowly and clearly. Respect the person's space. Everyone has a different personal space. Remember to give the hostile person plenty of room (so you will not get hurt). Attempt to redirect the hostile behavior. When assisting a resident with activity of daily living, remember to go slowly and do not expect the resident to be complacent with all aspects of care. If the resident refuses care, do not argue, stop what you are doing and come back later. Always be aware of the resident's anger and anxiety levels.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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.

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