

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6011373</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/29/2021</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>REGENCY CARE OF STERLING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>612 WEST ST MARY'S STREET STERLING, IL 61081</b>
---	--

(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:  2116988/IL138449	S 000		
S9999	Final Observations  Statement of Licensure Violations:  300.610a) 300.1010h) 300.1210b) 300.1210d)3)  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 300.1010 Medical Care Policies  h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident,	S9999	<b>Attachment A</b> <b>Statement of Licensure Violations</b>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6011373</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/29/2021</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>REGENCY CARE OF STERLING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>612 WEST ST MARY'S STREET STERLING, IL 61081</b>
---	--

(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	<p>Continued From page 1</p> <p>injury or change in condition at the time of notification.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>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:</p> <p>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on interview and record review the facility failed to ensure a resident with skin tears was monitored for signs and symptoms of infection, failed to assess and document an initial wound assessment and weekly wound assessments for a skin tear, and failed to ensure treatment orders were obtained for a skin tear for 1 of 3 residents</p>	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6011373</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/29/2021</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>REGENCY CARE OF STERLING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>612 WEST ST MARY'S STREET STERLING, IL 61081</b>
---	--

(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	<p>Continued From page 2</p> <p>(R1) reviewed for skin tears in the sample of 3.</p> <p>This failure resulted in R1 being transferred to an acute care hospital on 9/12/21 and requiring debridement of her left lower extremity and intravenous antibiotic treatment for a bacterial infection.</p> <p>The findings include:</p> <p>R1's face sheet showed she was admitted to the facility on 6/30/21 with diagnoses to include but not limited to chronic kidney disease, diverticulitis of intestine, hyperlipidemia, hypertension, dementia without behavioral disturbance, magnesium deficiency, glaucoma, and generalized muscle weakness. R1's facility assessment dated 7/7/21 showed R1 had severe cognitive impairment and required the physical assistance of two staff members for cares.</p> <p>R1's nursing progress note dated 9/12/21 showed, "Resident in recliner after lunch and received a phone call. She was speaking to her son and wasn't making sense as she normally does. Assessment completed, paged [On Call NP] ...Received order to send to ER (Emergency Room). Notified 911."</p> <p>R1's acute care hospital Infection Disease Consultation dated 9/13/21 showed, "... She was noticed to have change in mental status with fever yesterday. Therefore, she was brought to the emergency room. In the emergency room, temperature was 102.6 degrees.... Her left lower extremity showed big bullae [large fluid filled blister] from her malleolus [bone on ankle] up to almost the middle of her leg. There is tenderness in that area... There is redness and bluish discoloration... Assessment/Recommendations:</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6011373</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/29/2021</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>REGENCY CARE OF STERLING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>612 WEST ST MARY'S STREET STERLING, IL 61081</b>
---	--

(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	<p>Continued From page 3</p> <p>1. Sepsis. Patient presented with fever and leukocytosis. Source will be her bacteremia and necrotizing fasciitis. 2. Inflammatory change in her left lower extremity with big bullae with Group A Strep and sepsis. This is highly compatible with necrotizing fasciitis. Patient needs to be seen soon by surgery service... In the meantime, I am going to change her antibiotic to penicillin-G 4 million units every 4 hours, in addition to clindamycin 900 mg IV (intravenous) every 6 hours. 3. Group A Strep bacteremia. Source will be her left lower extremity... 4. Bilateral pleural effusion probably related to her sepsis.... Please note that I called her son, [V5 R1's Power of Attorney] and I updated him about my assessment and plan. He is in agreement to do surgery tonight..."</p> <p>R1's Incident Note dated 9/7/21 at 12:40 AM showed, "reported to this nurse that resident had obtained a skin tear to left outer leg while residents' legs were being put back up on the bed..."</p> <p>R1's September 2021 Treatment Administration Record showed no documentation of monitoring R1's left lower leg skin tear. R1's physician order sheet showed no orders to monitor or treat R1's left lower leg skin tear.</p> <p>There was no documentation found in R1's medical record of initial measurements of R1's skin tear or an initial assessment of R1's skin tear.</p> <p>R1's care plan initiated on 7/26/21 showed, "Skin Tear/Potential for skin tear... Interventions: ... If skin tear occurs, treat per facility protocol and notify MD, family."</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6011373</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/29/2021</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>REGENCY CARE OF STERLING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>612 WEST ST MARY'S STREET</b> <b>STERLING, IL 61081</b>
---	--

(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	<p>Continued From page 4</p> <p>On 9/28/21 at 1:20 PM, V3 (Wound Care Nurse) said the nurses let her know if there is a new wound and she completes the weekly wound evaluations. V3 said if there is a skin issue such as a tear or a blister it would be documented on those wound assessments. V3 said if there is a skin tear the nurses document where the skin tear is located. V3 said skin tears are measured by the nurses when it is identified and then it starts the weekly wound assessment form. V3 said skin tears are measured throughout the healing. V3 said if a skin tear occurs the nurses notify the doctor and get orders for treatment. V3 said the purpose of monitoring skin tears is to watch for any signs and symptoms of infections and to make sure the treatment is working. At 2:30 PM, V3 said there are no wound assessments in R1's record for the left lower leg skin tear. V3 said when a skin tear is identified an assessment should be done, it should be measured, and entered in the medical record. V3 said she does not know why this process was not done for R1's left leg wound.</p> <p>On 9/28/21 at 2:11 PM, V2 DON (Director of Nursing) said she was unable to find any monitoring of the left lower leg skin tear or treatments. V2 said the measurements were never documented for the left lower leg skin tear and R1 was sent to the hospital before her first weekly wound assessment would have been due. V2 said the initial assessment should include measurements and then that would trigger the weekly wound assessment to be done. V2 said all wounds are monitored for signs and symptoms of worsening condition, infection, and pain control and overall healing. V2 said the physician should be notified immediately if there are any changes to the wound. At 4:13 PM, V2 said, "If a wound is not monitored it could become infected, worsen,</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6011373</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/29/2021</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>REGENCY CARE OF STERLING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>612 WEST ST MARY'S STREET STERLING, IL 61081</b>
---	--

(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	<p>Continued From page 5</p> <p>and cause pain."</p> <p>The facility's undated policy titled Skin Integrity - Skin Tears showed, "Policy: It is the policy of this facility to provide proper treatment and care to maintain skin integrity. This policy pertains to the prevention and management of skin tears. Policy Explanation and Compliance Guidelines: 1. The facility will utilize a systemic approach for the prevention and management of skin tears including assessment, care planning, monitoring, and modification of interventions as appropriate. 2. Assessment; a. Licensed nurses will conduct skin assessments in accordance with facility policy... c. When a skin tear is discovered, the nurse shall complete an incident report. The following information shall be recorded: i. The resident's name, ii. The name of the employee discovering the skin tear, iii. The site and description of the skin tear... 3. Interventions for Prevention and to Promote Healing; b. Topical treatments in accordance with current standards of practice will be provided for all residents who have a skin tear... 4. Monitoring... b. RNs and LPNs will participate in the management of skin tears and medical conditions by following physician orders, assessment of residents, and reporting changes in condition to the residents' physicians... 5. Modification of Interventions; a. The attending physician will be notified of the presence, progression towards healing, or lack of healing of any skin tears, or any changes in the resident's medical condition. b. Interventions will be modified in a resident's plan of care as needed. Considerations for needed modifications include: i. Changes in medical condition or factors affecting the risk for skin tears. ii. New onset or recurrent skin tear. iii. Lack of progression towards healing..."</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6011373</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/29/2021</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>REGENCY CARE OF STERLING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>612 WEST ST MARY'S STREET STERLING, IL 61081</b>
---	--

(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	<p>Continued From page 6</p> <p>The facility's undated policy for Wound Treatment Management showed, " Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Policy Explanation and Compliance Guidelines: ... 2. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse.... 7. Treatments will be documented on the Treatment Administration Record. 8. The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include a. Lack of progression towards healing. b. Changes in the characteristics of the wound..."</p> <p>(A)</p>	S9999		
-------	--	-------	--	--