Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008239	A. BUILDING: ______ B. WING ______	C 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE	2120 WEST WASHINGTON SPRINGFIELD, IL 62702

(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: 2246146/IL149780	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.690a) 300.1210b) 300.1210d)3 300.1210d)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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.	S9999	**Attachment A** **Statement of Licensure Violations**	

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

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S9999	Continued From page 1 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. 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: 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. 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 interview and record review, the facility failed to notify Adminsitrator and medical doctor, failed to document incident, failed to ensure provision of assessment, and monitoring for	S9999		

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Continued From page 2

change of condition after a fall for 1 of 4 residents (R2) reviewed for quality of care in the sample of 4. This failure resulted in a delay in treatment for a fractured femur.

Finding include:

On 8/9/22 at 11:30AM, V2, Director of Nursing (DON), stated R2 had a visit to see Orthopedics on 8/1/22, for preparedness of clearance for prophylactic bilateral hip pinning, due to the metastasis to both of her hips, and the greater chances of developing a left hip fracture, without having the pinning hardware to her hips.

R2's Orthopedic consult note, dated 8/1/22, documented, "Resident is a 74 year old resident with diffuse osseous metastatic disease including bilateral proximal femurs, notably to the left femoral head, bilateral iliac bones, sacrum and multiple vertebrae with plans for prophylactic pinning of bilateral hips.

R2's Hospital History and Physical report, dated 8/3/22, documented, R2 presents, for altered mental status and a recent fall in bathroom found to have left femur fracture. Plan for surgical intervention.

R2's Hospital History of Present Illness, dated 8/3/22, documented a Chief Complaint of, "fall at nursing home yesterday. Shortening and rotation of left lower extremity, presents to the emergency department today for altered mental status and a recent fall in the bathroom found to have left femur fracture. Plan for surgical intervention."

V2 Director of Nursing (DON) stated, on 8/3/22, V4 was assigned to work and cared for R2, without mention of R2's fall. On 8/3/22 late

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S9999	Continued From page 3 morning, R2 developed a change in condition with her respiratory status. V2 stated at that time while assisting R2 to be transported out for evaluation and treatment, R2 had stated she had fallen in the bathroom yesterday afternoon. V2 stated after R2's transport, she notified the physician, R2's family representative and requested V4 to complete the appropriate Fall Incident Forms prior to ending her work shift, R2 was delayed because R2's fall was not reported. V2 stated, R2 was admitted with a left femur fracture with plans of surgical interventions. V2 stated on 8/2/22, after V4 left her working shift at 3:00PM, there was no documentation in R2's medical records. On 8/8/22 at 2:10PM, V2, Director of Nursing (DON), stated R2 remains in the hospital due to sustaining a left femur fracture. V2 stated R2 had an increased cough, diminished lung sounds, poor oral intake, and c/o (complained of) generalized pain late morning on 8/3/22. V2 stated she was in R2's room for the preparation of R2's transport to the local hospital, when R2 stated she had fallen in the bathroom yesterday. V2 stated V4, Licensed Practical Nurse (LPN), who was providing care for R2 that day, notified R2's son (V6) of R2's transport to hospital for changes in her respiratory condition. V2 stated she was not aware of this fall, therefore she initiated the telephone call to V6 to explain that R2 had a fall on 8/2/22. V2 stated she discussed this issue of R2's fall with V4. V2 stated that V4 had told her she did not know that R2 had fallen until late the evening of 8/2/22 when V3, Certified Nurse Aide (CNA), called her at her residence because he was worried about R2's condition after her fall. V2 stated V4 did not follow facility protocol, as V4 did not complete a Fall Occurrence Report, as	S9999		

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S9999	Continued From page 4 this includes: a set of vitals, a full skin and pain assessment and notification to R2's Physician and V6. V2 stated there was no documentation from the nurses who followed after V4's work shift from 8/2/22 through 8/3/22. V2 stated V4 was assigned to work 8/2/22 from 7:00AM to 3:00PM and returned to work on 8/3/22 for 7:00AM to 3:00PM, and still there was no documentation of R2's fall. On 8/8/22 at 2:20PM, V1, Administrator, stated the facility managers get together every morning to discuss issues, concerns and Fall reporting's and on 8/3/22, no one thing was mentioned of R2 having a fall that occurred on 8/2/22 at 1:00PM. On 8/9/22 at 10:10AM, V3, CNA, stated he was assisting R2 to the toilet on 8/2/22. V3 stated as he was standing at the bathroom doorway, watching R2 toileting, R2 had raised herself up to cleanse herself, leaned forward and fell onto the floor on her right side, did not hit her head. V3 stated this happened so fast he could not get to R2 to prevent the fall. V3 stated R2 was then assisted back onto the toilet and he called out to V4. V3 stated he explained to V4 that R2 had fallen and was assisted back onto the toilet. V3 had stated V4 came into the bathroom had done a body skin assessment and checked R2's vital signs. On 8/10/22 at 9:20AM, V4, LPN, stated that V3 reported that R2 needed assistance with toileting, with no mention of a fall. V4 stated that she entered R2's bathroom, R2 was sitting on the toilet, helped V3 clean her up from having a large bowel movement, felt her body all over for any abnormalities, R2 had stated she hurts all over, but this her normal base line every day. V4 stated the evening of 8/2/22 at around 7:00PM,	S9999		

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V3 had called her at home, with a statement that he was concerned for R2, due to her fall she had early in the afternoon. V4 stated, she was not aware of this fall, got wrapped up in events occurring at home and did not notify the facility, the On-call nurse nor V2 of this concern. V4 continued to state, she did not complete, nor document R2's fall event, as she thought she would take care of it the next day when she came into work.

On 8/9/22 at 3:50PM, V2 stated she would expect the licensed nursing staff, to document and complete the appropriate forms as required per facility policy and procedure, provide notification of an incident to the physician and family and report such incident to the Director of Nursing.

The facility's Fall Assessment and Management policy and procedure, dated 4/2019, documented, Post fall assessment - immediately after a fall the resident will not be moved from their position until a licensed nurse determines it is safe to do so, A license nurse will immediately assess the resident, document a description of how the resident is observed, notify the physician, responsible party, complete a Risk Watch Occurrence Report immediately and a Licensed Nurse will continue to document post fall occurrence for 72 hours regarding the resident's status and note any change in condition. A fall occurrence will be presented and reviewed at the Quality Assurance meeting.

(A)