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
	IL6011381	A. BUILDING: _____ B. WING _____	R 03/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE OF MORRIS	1095 TWILIGHT DRIVE MORRIS, IL 60450

(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 Follow up survey to Annual health & Complaint 1776573/IL98027 of 1/10/18	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)6) 300.3240a) 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. Restorative measures shall include, at a minimum, the following procedures: 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on observations, interviews and record review the facility failed to provide supervision during personal care for one resident with a history of falls. As a result, R47 fell and sustained a fracture. This applies to one resident (R47) reviewed for supervision. The Finding includes; 03/07/2018 and 03/08/2018 R47 observed throughout the days self-propelling wheel chair around the unit in wheel chair with a soft neck brace on. 03/07/2018 at 12:19PM, V8 (nurse), stated R47 is wearing a neck brace due to fracturing her neck due to an un witnessed fall incident on 02/23/2018. R47 stood up from the wheel chair was brushing her teeth and fell. R47 had a right forehead laceration with sutures and a fractured neck from that fall. R47 is alert and oriented with some confusion, is a heavy (extensive assist) of 1-2 staff with care. Last month (01/2018), R47	S9999		

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had a urinary tract infection requiring antibiotics. R47 is incontinent of bowel and bladder at times, requires staff assist with toileting and activities of daily living (ADL's).

Face sheet and diagnosis sheet document that R47 was admitted to facility with diagnosis to include decreased mobility, lack of coordination, hypotension, Parkinson disease, difficulty walking and "needs assist with personal care." The MDS (Minimum Data Set) Assessment dated December 4, 2017 documents that R47 requires extensive assistance with toileting and all activities of daily living (ADL), except eating. The MDS also documents the use of chair and bed alarms due to R47 being assessed as a high fall risk. R47's 02/13/2018 fall risk assessment scored a 55 (greater than 45 is high risk), on this assessment.

R47's physician orders include administer diuretics, Parkinson's disease medications and as needed anti-anxiety medications.

R47's medical records and incident reports include three fall incidents between 01/13/2018 and 02/22/2018:

1) 01/13/2018, R47 had a witnessed fall after a shower, the nurse aide was assisting to pull up residents pants while R47 was standing and holding onto a grab bar in the bathroom near toilet. R47's knees gave out and fell to the floor.

2) 02/13/2018, while self-propelling wheel chair out of the bathroom, the resident's wheels got caught on the threshold between the doorway and R47's wheel chair tipped over and R47 fell forward on to the floor.

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3) 02/22/2018 at 7:37AM, V7 (nurse aide), left R47 alone in bathroom in wheel chair by the sink. R47 stood up from wheel chair unassisted to brush her teeth and fell to the floor. R47 sustained a large laceration to the right forehead requiring sutures and lower lip laceration and a "C5" fracture (neck fracture). R47 required hospitalization 02/22/2018 through 02/23/2018 with diagnosis of syncope and C5 fracture.

The 02/22/2018 incident report documents predisposing physical factors that could have resulted in the fall included:
History of falls, previous CVA (stroke), gait imbalance, incontinent and confused and forgetful. The incident report also notes no history of seizures but on anticoagulant medications at the time of this fall.

The incident report states "responded to alarm sounding in R47's bathroom and found resident on bathroom floor, the whole body was shaking. R47 was face down with head lying on the right side of face, arms at her side and legs stretched out and under wheel chair at the feet. Blood noted under face, resident did not answer questions initially, pulse was bounding, color pale/ blue and respirations were shallow. After about 30 seconds R47 started to answer questions for staff and reported not knowing what happened. R47 complained of neck pain, towels placed under head, left R47 on the floor and 911 called."

R47's 10/2016 fall risk care plan include:
At risk related to history of falls, weakness and Parkinson's disease.
Interventions include 02/13/2018 anticipate care needs; encourage to ask staff for assistance with transfers.

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R47's 02/23/2018 hospital discharge notes include:
Problem/Diagnosis:
Vasopressor syncope, orthostatic hypotension due to diuretics causing a fall at nursing home, laceration to forehead from traumatic head injury causing fracture of spinous process of cervical vertebra (C5).

Resident suddenly fell forward while brushing her teeth in bathroom, striking her face on the ground. Resident has no recollection of what happened after brushing her teeth. Sustained larger laceration to right forehead requiring sutures. Cat Scan (CT), showed a non-displaced fracture through the spinous process of C5 with diffuse degenerative spondylosis and disc disease. Complaint of frontal lobe headache and right knee pain after fall.

03/08/2018, 11:15AM, V6 (R47's 02/22/2018 day shift nurse), stated R47 has Parkinson's disease and was slow moving prior to the 02/22/2018 fall. R47 would occasionally be left alone in the bathroom for grooming prior to this fall. On 02/22/2018, V6 responded to R47's chair alarm sounding and observed R47 face down on the floor, body shaking "convulsion" and initially unable to respond to staff questions for approximately 15 seconds. R47 had shallow respirations, was pale and had fixed pupils. After 15 seconds R47 was able to talk. We did not move the residents head but noted small amounts of blood coming from the right side of her face (the side she was lying on), dripping on the floor. R47 had a 1.5 - 2 inch long laceration to the right forehead area and complaint of neck pain. We called 911 and left the resident on the floor.R47 did have a history of falls prior to the 02/22/2018 fall that occurred during transfers and

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S9999	Continued From page 5 does need staff assistance with transfers. 03/08/2018, 1:30PM, V7 (R47's 02/22/2018 day shift nurse aide), stated prior to the 02/22/2018 fall, V7 helped R47 up into wheel chair and placed the resident at the bathroom sink. V7 heard another resident's chair alarm sounding so V7 left R47 alone in the bathroom to check on the sounding alarm. While V7 was out of R47's room, R47's chair alarm sounded and the nurse went to check on it. R47 was on the floor face down with some blood by her mouth. We left the resident on the floor until the paramedics arrived. V7 stated "I usually stay with R47 during grooming in the bathroom; R47 has a problem with her feet and has poor balance when she stands up. {R47's} feet do not move the stumble over each other which cause her to be unsteady alone." 03/09/2018, 9:10AM, V5 (R47's physical therapy aide), stated I have worked with R47 before and after the 02/22/2018 fall incident. R47 has very bad balance, especially standing but she is okay sitting. R47 has declined since last year after her husband passed away, they were roommates. R47's declined in cognition, is forgetful, and has poor insight into what her abilities are. Requires extensive assistance with transfers and used to try and get up without assistance in the past. Someone needs to stay with the resident if there is a chance she will stand up. 03/13/2018, 11:50AM, during a telephone interview V9 (R47's physician), stated V9 became R47's physician on 01/24/2018 and was unaware of her 01/13/2018 fall incident. V9 stated R47 had extended spectrum beta- lactamases (ESBL) urinary tract infection and sepsis that caused a mental status change. We treated her with antibiotics and she improved. R47 has a	S9999		

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diagnosis of Parkinson's disease and orthostatic hypotension which is why she probably fell when she stood up from wheel chair on 02/22/2018. Her blood pressure dropped and she fell to the floor. V9 also said if a resident is known to be a high risk for falls, even when staff is present, staff probably should not have left R47 alone in the bathroom on 02/22/2018. Especially when there is other staff on the unit that could have addressed another residents chair alarm sounding.

03/13/2018, 10:15AM, during a telephone interview, V1 (administrator), said on 02/22/2018 day shift there were two nurse aides and a nurse working on R47's unit (villa). V1 said the two nurse aides were V7 and V10.

03/13/2018, 12:10PM, during a telephone interview, V10 said "I did not come to facility to work 02/22/2018 until around 10:00AM after receiving a call at 8:30AM requesting me to work." V10 was not in the facility at the time of R47's 02/22/2018 fall incident. V10 also stated R47 can take up to 20 minutes in the bathroom grooming in the mornings and sometimes we have to leave her alone to answer chair alarms and other things at times.

(B)