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 _____	04/13/2018

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 Annual Health Statement of Licensure Violations	S 000		
S9999	Final Observations 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

These requirements were not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide safe transfers technique to prevent injury for 1 of 5 residents (R59) reviewed for accidents in the sample of 27. This failure resulted in R59 falling and sustaining fractures to the right tibia and fibula.

Findings include:

The Physician's Order Sheet (POS), dated 04/01/18, documented R59 had the following diagnoses, in part as, muscle weakness, fracture to the right tibia and fibula, unsteadiness on feet, lack of coordination and pain.

The Admission Nursing Assessment, dated 09/07/17, documented R59 required assistance with transfers and toileting with an assistive device.

On 09/07/17, the falls risk assessment identified R59 as being a moderate risk for falls.

A Occurrence report, dated 09/07/17 at 3:30 PM, documented R59 fell while being toileted. It documented R59 had fallen during a one person transfer onto the bathroom floor. It documented V22, CNA, had toileted R59 alone without a gait belt and upon standing R59's legs buckled and she fell. It documented R59 was observed by V7, Licensed Practical Nurse (LPN) lying on her back on the floor with right knee bent and right foot behind right thigh. It documented R59 stated "Voiced that the girl wasn't able to hold me that my legs gave out." The immediate actions taken were for ice pack applied, pain when Range of

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S9999	Continued From page 2	S9999		

Motion (ROM) performed and resident kept under continuous supervision.

On 09/07/17 at 3:30 PM, R59's Nurse's Note documented R59 fell and complained of right knee pain. A nurse's note documented V2, Director of Nursing (DON) had massaged a small knot area in the muscle that R59 was voicing pain. It further documented knot disappeared and R59 said some relief. At 4:35 PM, a Nurse's Note documented R59 voicing pain again in right below the knee and area was swollen and Physician was called. At 5:24 PM, a nurse's note documented called physician back and waiting on call. At 5:40 PM, physician called back and said to send to emergency room. At 5:55 PM, ambulance called for transport to the hospital. At 6:26 PM, ambulance arrived and transported R59 to the hospital. At 11:30 PM, a nurse's note documented the hospital called and notified that R59 had fractured right leg.

On 04/11/18 at 9:50 AM, R59 stated she was dropped on the floor by V22, CNA. R59 stated she was unable to ambulate without a lot of assist prior to coming to the facility.

On 04/12/18 at 3:00 PM, V2 Director of Nursing stated R59's fall and fracture was due to poor transfer techniques and that subsequently, V22, CNA was terminated for not following facility policy regarding safe transfers.

On 04/12/18 at 3:30 PM, V7, LPN stated that on 09/07/17, he was asked to come to R59's room for a fall. V7 stated that he saw R59 on the bathroom floor with the right leg bent back behind her leg with full weight on the right leg. V7 said R59 was complaining of pain at the right knee. V7 stated V22 had been transferring R59 from the

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toilet without a gait belt alone. V7 stated V22 should not have tried to transfer without a gait belt.

The Care Plan, dated 09/08/17, documented R59 required extensive assist of two staff per full mechanical lift for transfers. On 09/19/17, the care plan documented R59 required extensive assist of two staff for transfers. On 12/19/17, the care plan documented R59 required extensive assist of two staff per sit to stand mechanical lift. On 04/13/18, the care plan documented R59 required extensive assist of two staff per full mechanical lift for transfers.

The Minimum Data Set (MDS), dated 03/20/18, documented R59 required extensive assist of two staff for transfers with sit to stand mechanical lift and was non-ambulatory.

On 04/11/18 at 3:00 PM, V15 and V16, Certified Nursing Assistants (CNA's) were completing incontinent care and a skin check for R59. When the blanket was removed off R59's legs, there were multiple (more than 10) bruises of varying colors and stage of healing. Most were on bilateral knees and shins. V15 and V16 could not say a reason for the bruising.

On 04/12/18 at 2:50 PM, V10, Certified Nursing Assistant (CNA) and V21 Registered Nurse (RN) were observed during transfer and toileting for R59. R59 was up in the wheelchair and required sit to stand mechanical lift for transfers. V10 and V21 applied the lift sling around the upper back and extending up under each axilla. R59's legs were placed onto the footboard and her knees pushed closely to the pad. As V10 lifted R59 up she immediately started to cry out "ouch, no no, it hurts, it hurts." When V10 was done lifting R59,

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S9999	Continued From page 4 her legs were not supporting any weight on the footboard and the sling was pulling up on both arms and no longer under the axilla's. R59 was in a dangling-like position during this transfer. The bruises on bilateral legs coincided with the position of her legs and the knee board of the sit to stand mechanical lift. After toileting, again R59 was transferred in the same manner with R59 crying out the entire way to the bed. When V21 was asked if R59 cried out in pain and not able to support herself during sit to stand mechanical lift was common she stated "We may have to change that (transfer) again." (B)	S9999		