(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED		
		IL6008239	B. WING		03/1	3/2025		
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
REGENO	Y CARE		ST WASHING IELD, IL 627					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE		
S 000	Initial Comments		S 000					
	Licensure and Certi	fication Survey						
S9999	Final Observations		S9999					
	Statement of Licens	sure Violation:						
	300.610a) 300.1210b) 300.1210b)3							
	Section 300.610 a)	Resident Care Policies						
	procedures governi facility. The written be formulated by a Committee consisting administrator, the a medical advisory conformation of nursing and othe policies shall complete the facility and shall	dvisory physician or the ommittee, and representatives r services in the facility. The y with the Act and this Part. shall be followed in operating the reviewed at least annually documented by written, signed						
	Section 300.1210 (Nursing and Persor	General Requirements for nal Care						
	care and services to practicable physical well-being of the research resident's complan. Adequate and care and personal coresident to meet the	shall provide the necessary of attain or maintain the highest land, and psychological sident, in accordance with aprehensive resident care properly supervised nursing care shall be provided to each e total nursing and personal esident. Restorative						

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 04/07/25

TITLE

STATE FORM 6899 YRTD11 If continuation sheet 1 of 4

PRINTED: 05/22/2025 FORM APPROVED

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		IL6008239	B. WING		03/1	3/2025
					1 00/1	0.2020
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
REGENO	Y CARE		ST WASHING			
		SPRINGFI	ELD, IL 627	02		
(X4) ID	_	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		COMPLETE DATE
TAG	TREGOEATORY OR EX	SO IDEIVIN TING IN CINIMATION)	IAG	DEFICIENCY)	10/11	
S9999	Continued From page 1		S9999			
	measures shall incl	ude, at a minimum, the				
	following procedure	es:				
		personnel shall assist and				
		s so that a resident who is I and/or bladder receives the				
		ent and services to prevent				
		ons and to restore as much				
		ction as possible. All nursing				
		ist residents so that a resident				
		ity without an indwelling				
		eterized unless the resident's				
	clinical condition demonstrates that catheterization was necessary.					
		vere not met as evidenced by:				
		and record review, the facility				
		ident's call lights to address				
		mote resident dignity for 6 of 6				
		R25, R30, R33 and R285)				
		in the sample of 42. This				
	failure resulted in R285 becoming incontinent and feeling humiliated.					
	reening numinated.					
	Findings include:					
	1. R285 was admitted on 1/22/2025 with					
	diagnosis of, in part, fracture of left fibula, left tibial fracture, fracture around internal prosthetic					
	left knee joint, and i					
	in in its joint, and i					
	R285's Care Plan d	ated has an ADL Self Care				
		t requires substantial/maximal				
	assistance from sta	ff participation for toileting				
	hygiene and transfe	ers and requires				
		l staff participation with				
		nd set up help from staff with				
	oral care.					
	On 3/10/25 at 12:50) PM_R285 stated she will				

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wait a minimum of 30 minutes or more to have

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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6008239	B. WING		03/1	3/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
REGENO	CY CARE		ST WASHING IELD, IL 627			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 2	S9999			
		red. R285 stated, "I've had to cidentally soiled myself wait any longer. It's				
	The facility policy Call Light dated 8/1/05 documents it is the policy of this facility to maintain the highest quality of care for its residents. The policy documents to answer call light promptly. The policy documents if you are unable to meet resident request or need, leave call light on and obtain assistance from charge nurse. 2. During the resident council meeting held on 3/12/2025 at 2:30PM, R9, R16, R25, R30, and R33 all stated call lights are not answered timely. All stated could take up to 30 minutes to get light answered.					
	R9's Minimum Data documents R9 is co	a Set (MDS) dated 1/16/2025 ognitively intact.				
	R16's MDS dated 1 cognitively intact.	/2/2025 documents R16 is				
	R25's MDS dated 2 cognitively intact.	2/21/2025 documents R25 is				
	R30's MDS dated 1 cognitively intact.	/3/2025 documents R30 is				
	R33's MDS dated 1 moderate cognitive	/10/2025 documents R33 has impairment.				
	2/27/2025 documer unresolved issues s state Certified Nurs	t council minutes dated ints under old business any since last month "residents ing Assistants (CNAS) still ver call lights. Resident council				

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minutes dated 1/31/2025 documents old business

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STATEMENT OF DEFICIENCIES (X1) PROVIDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION		BENTI IO MIONINOMBEN.	A. BUILDING:		OOWI ELTED		
		IL6008239	B. WING		03/1	3/2025	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
REGENC	Y CARE		ST WASHING IELD, IL 627				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
\$9999	taking a long time to business residents out the reason the	ues last month CNAs are still o answer call lights, new state the CNAs come to find light is on and leaves without esidents stated CNAs are very	S9999	DEFICIENCY			

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