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 03/04/2017

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

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S 000	Initial Comments Complaint #1741182/IL92106 Statement of Licensure Violations	S 000		
S9999	Final Observations 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 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 300.1210 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	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE
03/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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

These requirements were not met as evidenced by:

Based on interviews, observations and record review, the facility failed to assess/identify causative factors contributing to falls, implement interventions based on those causative factors, monitor/modify the interventions if needed and provide adequate supervision to prevent falls for 3 of 3 residents (R1, R2, and R3) reviewed for falls in the sample of 7. This failure resulted in R1 falling and sustaining a depressed fractured nasal bone on the left and R3 falling and sustaining an acute non displaced fracture of the left superior pubic ramus.

Findings include:

1. R1's Admission Record documents R1 was admitted to the facility on 1/16/17 with diagnoses of muscle weakness, unsteadiness of feet, and Myocardial Infarction in part.

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On 3/1/17 at 10:30 AM, R1 was sitting at the nurses' station in her wheelchair. Her left eyebrow area and upper cheek were bruised greenish/yellow and purple with a dressing present over her left temple area. R1 had foot pedals on with a foot buddy to prevent her feet from falling to the floor behind the pedals.

R1's Minimum Data Set (MDS), dated 2/13/17, documents R1 to have a Brief Interview of Mental Status (BIMS) score of 11 - moderately cognitively impaired. The MDS identifies R1 requires extensive assist of one staff for transfers and mobility on and off the unit and in hallway. The MDS documents she uses a wheelchair and has balance deficits during transfers and walking being only able to stabilize with the help of staff. The MDS documents no falls prior to admission.

R1's Fall assessment, dated 1/16/17, documents R1 to be at high risk for falls.

An Occurrence Report, dated 2/18/17 at 7:30 AM, documents R1 "planted feet as wheelchair was being moved and fell forward out of wheelchair." Resident statement at the time was "I fell and hit my face." Witness statement from E3, Certified Nurse's Aide (CNA), documents "Resident placed feet down and fell forward out of chair." Recommendations written in at the bottom of the first sheet documents "Leg rests - with foot buddy for positioning." Injuries documented on the Report was two areas on left forehead, one measuring 4.5 centimeters (cm) by (x) 3.5cm. knot of left eyebrow and the second small 0.5 cm in length bruise to left cheek. The Report section identified as "Root cause analysis" is marked "N/A (Not Applicable)" as was conclusion and care plan update.

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On 2/19/17 at 18:05 (6:05 PM), an Occurrence Report documents R1 to have another fall. The Nurse's Notes on the report document "At 1800 (6:00 PM) the resident began yelling help. CNA (E4) asked resident what she needed and resident stated to lay down." The Report documents E4 "was wheeling resident to her room and resident put her foot down refusing for CNA to help her. Resident fell face foreward out of w/c (wheelchair) landing on her right side w/ (with) legs bent." The Report documents bruising from prior fall but that R1 had a nose bleed, "Right nostril bleeding moderate amount of blood. Residents nose slightly bent towards right side." The witness statement documents E4 told writer "He was taking resident to room for bed as she requested." The Report does not document leg rests with foot buddy were on R1's wheelchair at the time she fell. The report documents the facility requested a facial X-ray.

The X-ray report, dated 2/19/17 documented R1 sustained a depressed fractured nasal bone on the left.

R1's Care Plan, dated 1/17/17, documents R1 to be at risk for falls due to confusion and psychoactive drug use with the goal being to have no falls thru next review. Interventions include educating her and family/caregivers about safety reminders and what to do if a fall occurs, leg rest with foot buddy for positioning (added 2/20/17) and provide safe environment with even floors free from spills and/or clutter, adequate glare free lights, bed in low position at night, handrails on the walls and personal items within reach.

On 3/1/17 at 11:10 AM, E2 Director of Nurses (DON) stated they identified that E4 needed

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additional transfer training following the incident but was unable to state why R1 did not have the foot pedals on that were recommended the day before as a result of the first fall. E2 did not realize R1's first fall occurred as she was being pushed by E3, CNA. When asked if she considered the rate at which the CNA's were pushing R1 as a factor, stated she did which resulted in her recommending E4 get additional training in transfers. E2 was unaware if R1 used her feet to propel herself prior to placement of the pedals but stated she thought she did.

No revision was done to R1's care plan to reflect her dropping her feet during a wheelchair transfer when foot pedals are not in place.

2. The Admission Record for R3 documents she was admitted to the facility on 12/9/16 following hospitalization for a non-displaced intertrochanteric fracture of the left femur and pathological fractures in part.

R3's MDS, dated 12/23/16, documents her to have a BIMS score of 7 - severe cognitive impairment. The Section entitled "balance during transfers and walking" documents she is unsteady and can only stabilize with staff assistance.

R3's Care Plan, dated 12/20/16, documents R3 to be at risk for falls due to gait/balance problems and incontinence. The goal documents R3 is to be injury free from falls thru the next review on 3/29/17. The care plan reflects no falls as occurring since admission.

An Occurrence Report dated 1/23/17 documents R3 was "sitting in her w/c she moved forward in the seat and lunged forward gently landing on her

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knees she had no injury." The Witness statement documented R3 lunged forward and landed gently on her knees. The root cause analysis is documented as "n/a" and a recommendation for a pommel cushion was made by therapy.

Progress Note, dated 2/13/17 at 1700 (5:00 PM), documented R3 was walking unassisted in her room and falling before staff could reach her. The Nurse's notes document "resident was stumbling backwards." The Nurse's Note documented the Certified Nurse's Aide (CNA) and R3 fell to the floor.

The Occurrence Report, dated 2/13/17, documents therapy was discontinued, root cause analysis was documented "n/a" with no conclusion, and "none noted" written for recommendations following the fall. The report includes copies of medication administration records that document on 1/18/17, R3's Paxil, Remeron and Tramadol was changed and/or discontinued. R3 sustained no injuries. There were no revisions made to the care plan following this fall.

Progress note, dated 2/14/17 16:01 (4:01 PM) document resident trying to ambulate self, transfer and ambulate self without staff assistance stating "I'm leaving."

Progress note, dated 2/15/17 4:02 AM document resident very confused with increased behaviors in the evening and night time, difficult to redirect.

The Occurrence Report, dated 2/17/17 at 2235 (10:35 PM), documents R3 was found on the floor in the bathroom following her sister's visit. It was an unwitnessed fall. The report documents R3 asking where her sister was. The

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recommendation written on the bottom of the report is to "monitor to see for behaviors of sitting on the floor." No root cause analysis was documented and no conclusion written. No staff interviews were conducted according to the report.

Progress note, dated 2/17/17 at 23:05 PM document that 15 minutes before incident, resident had come to the nursing station looking for her sister. There is no explanation as to why the intervention of monitoring sitting on the floor would have been added since she was in the bathroom and there was no indication she sat herself down or had a history of doing so.

The Occurrence Report, dated 2/18/17 at 9:30 AM, documents R3 was again found on the floor in her room. The report documents R3 stated "I was walking tried to leave and I'm leaving no matter what you say." The recommendation was for a perimeter mattress even though the report documents R3's lights were on, slippers on, wheelchair in use along with a low bed. The report documents no staff interviews done and no information as to where R3 was prior to the fall was recorded in the report. No root cause was identified or conclusion documented.

On 2/24/17 at 10:38 AM, the Progress Note documents "Quetiapine (Seroquel) 12.5 mg (milligrams) at HS (bedtime) was started for sleep, mood liability, behaviors aggression - verbal, delusions, and dementia with behaviors." At 1732 (5:32 PM) Progress notes documents R3 "behaviors started at 9 this morning, Resident began standing up from w/c walking w/o (without) staff assistance and poor gait stating "I'm trying to go downstairs". Resident continues to stand up from bed with staff assistance."

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On 2/25/17 4:07 AM, Progress note documents R3 "up all night standing up from the wheelchair when it is not locked crying and being verbally abusive to staff."

An Occurrence Report, dated 2/25/17 at 1800 (6:00 PM), R3 was found on the floor of her room on the left side of her bed. She was reported to be sitting on the bedside mat with her legs stretched out. The report documents resident's statement as "I slid down out of bed." The report documents R3's confusion with tearfulness and difficulty redirecting. No root cause for the fall was identified and no recommendations were made or revisions made to the care plan.

An Occurrence Report, dated 2/27/17, at 6:00 AM documents R3 was found in hallway on floor on her left side - resident had been sitting in her wheelchair. The report documents R3 stated "I fell down" with no staff interviews done. The report also documents R3 had been up all night and is tearful and confused. R3 was complaining of pain in her left leg and an x-ray was ordered upon physician notification. Root cause was documented as "N/A" as was conclusion.

The X-ray result dated 2/27/17 documents "Acute non displaced left superior pubic ramus fracture." A recommendation was written at the bottom of the report that documented "Medical Workup - since more confused than baseline."

On 3/1/17 at 10:36 AM, E2 stated R3 was very behavioral and continually attempted to get up. E2 stated R3 is currently on bed rest pending an appointment with the orthopedic doctor. E2 stated they have an order now for a lap belt when R3 can get up again. E2 also stated R3 appears

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to be calmer with the Seroquel. E2 confirmed that R3 repeatedly tried to get up unassisted and with her severe cognitive impairment, doesn't realize she is unable to ambulate without assistance and doesn't know to call for help. E2 also stated she was very behavioral and often refused redirection and assistance. E2 was asked if getting up without assistance could be the root cause of most of her falls, E2 stated she thought so given that she thinks she can walk when she can't. E2 confirmed that R3's behaviors or resisting redirection and/or repeatedly getting up unattended are not identified on her plan of care for falls preventions.

R3's current care plan as of 3/3/17 documents R3 to be at risk for falls due to gait/balance problems and incontinence. The goal is to have no injury from falls by next review (3/29/17) with interventions dated 12/20/16 to educate her/family/caregivers about safety reminders and what to do if a fall occurs, and provide a safe environment with even floors free from spills and/or clutter, adequate glare-free light, a working and reachable call light, the bed in low position at night, handrails on the walls, personal items within reach. Provide reacher was added on 1/3/17, Pommel placed per therapy was added 1/24/17 and on 2/20/17, revisions added to include monitoring to see if new behavior of sitting on floor and perimeter mattress. On 2/28/17, fall mats at bedside and therapy screen for positioning in w/c was added. Repeatedly getting up unassisted was not identified as a problem nor was adding additional supervision or keeping her more within visual range added an intervention. Progressive interventions were not developed and/or added following falls on 2/13/17, or 2/25/17 in an effort to prevent R3 from continuing to get up unassisted and falling. The

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care plan also fails to identify R3's poor or lack of safety awareness, her repeated falls and her need for additional supervision due to this behavior.

R3 was in bed on 3/1/17 at 10:00 AM sleeping. She had a scoop mattress and the bed was in low position. R3 remained in bed at lunch and again at 2pm appearing calm making no attempt to get up.

The facility's policy/procedure entitled "Fall Assessment, risk identification and management policy" dated 3/20/12 documents "It is the policy of the facility to assess each resident's fall risk on admission to help facilitate an interdisciplinary approach for care planning to appropriately monitor, assess, and ultimately reduce injury risk. Factors related to the risk will be addressed and care planned." Procedure documents "Post fall care planning will include consulting with the resident's care givers and other disciplinary team members in regards to future intervention, and resident specific risk factors. Interventions will be based on the resident assessment and the circumstances surrounding the risk for injury or actual injury or fall."

3. The Admission Record documents R2 was admitted to the facility on 12/16/16 with diagnoses of muscle weakness, Cerebral infarct, unsteadiness of feet, Dementia and lack of coordination in part.

R2's MDS, dated 12/29/16, documents R2 as having severe cognitive impairment with a BIMS score of 6. The MDS identifies R2 requires extensive assist of one staff for transfer and has a balance deficit during transfers and walking that requires staff to stabilize.

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R2's Care Plan, dated 12/27/16 identifies R2 to be at risk for falls due to confusion, deconditioning, gait/balance problems, psychoactive drug use and unaware of safety needs. The goal is to have no injuries from falls with interventions being dated 12/27/16 Anti-rollbacks to w/c, Educate him/family and caregivers about safety reminders and what to do if a fall occurs, and provide a safe environment with even floors free from spills and/or clutter, adequate glare-free light, a working and reachable call light, the bed in low position at night, handrails on the walls, personal items within reach. On 12/29/16, fall mats beside bed was added and on 1/12/17, Drop Seat in wheelchair was added. High back w/c with pommel was added and on 1/31/17, perimeter mattress was added.

An Occurrence Report, dated 1/22/17, at 1630 (4:40 PM) documents R2 tried getting out of the wheelchair to pick a shoe up and staff intervened. R2 sat back down and got up again falling to the floor. A high back w/c (wheelchair) with Pommel cushion was recommended. No staff interviews were conducted and the root cause analysis section is documented as "n/a."

An Occurrence Report dated 1/30/17 documents R2 fell again at 2250 (10:50 PM) when staff responded to his call light going off and found him on the floor between the beds. The report documents when asked what he was doing, R2 responded "I do this every night but tonight I couldn't get back into bed." The report documents R2 to have a low bed in place. Root cause analysis is again documented "n/a" with no conclusion. R2 is documented as sustaining a skin tear on his left forearm. No staff interviews

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are documented. Recommendations written at the bottom of the report include perimeter mattress and family wants a room change. The perimeter mattress was added to the care plan. The room change was not reflected on the care plan.

An Occurrence Report dated 2/3/17 at 6:30 AM documents R2 was found sitting on the floor on his bottom beside the bed. The report documents no staff interviews were done. Root Cause analysis and Conclusion was documented as "n/a." Recommendations written on the report documents "Keep bed in lowest position when resident is in it, continue all other current interventions." R2's Care Plan was not revised with progressive interventions to prevent potential future falls.

An Occurrence Report 2/12/17 at 2100 (9:00 PM) documents R2 to have another fall. The report documents resident was found on the floor in his room sitting on his buttocks. Under resident statement, the report documents "He does not have an explanation regarding what he was doing. He states 'I fell down.'" Written at the bottom of the report was "In bed prior - Review of prior intervention - continue all interventions at this time." No staff interviews were done, and root analysis/conclusion is marked "n/a." R2's Care Plan was not revised after this fall with progressive interventions to prevent potential future falls.

On 2/16/17, R2's Occurrence report documents at 1435 (2:35 PM) he was in the bathroom and was found on the floor by a unit aide. R2 had a documented 2.0 cm right elbow skin tear. Witness statement documents resident told staff that he was going home. No root cause analysis

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was documented as being done with no conclusion. Recommendations documented reflect "Toilet diary." R2's Care Plan was not revised at this time to address R2's continued falls.

On 2/27/17 , R2's Occurrence Report documents at 2045 (8:45 PM), R2 was found on the floor beside his bed. Recommendations written in on the report include F/U (follow up) urine but nothing addressing R2's repeated behaviors of getting up unassisted and falling.

On 3/2/17 at 3:00 pm, E2 stated R2 is continually getting up with assistance and can be difficult to redirect. E2 stated R2 is kept at the nurses' station most of the time when he is in his wheelchair for increase visual supervision which she agreed is no reflective in his falls prevention plan. E2 stated R2 repeatedly getting up unassisted could be a causative factor in him falling and she is having a difficult time developing interventions to address this behavior since he does it often. E2 confirmed R2 requires more supervision due to him attempting to get up on his own.

(B)