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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)2) 300.1210d)5) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.	S9999		

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 1 Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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: 2) All treatments and procedures shall be	S9999		

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 2 administered as ordered by the physician. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. 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 REQUIREMENTS ARE NOT MET AS EVIDENCED BY: Based on observation, record review and interview, the facility failed to follow policies, accurately and timely assess; turn and reposition residents; monitor for drainage and intact dressings; follow physician orders for treatment; notify physician and power of attorney of declining condition, timely identify and failed to follow intervention for prevention and promote healing of pressure sores for 6 of 8 residents (R1, R2, R3, R4, R11 and R13) reviewed for pressure sores in the sample of 16 and 1 resident (R28) in the supplemental sample. R2 developed an unstageable pressure sore in house with no treatment change on decline and was receiving	S9999		

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 3	S9999		

incorrect treatment. R3 developed 4 unstageable pressure sores in house that were avoidable. R4 developed an unstageable in house pressure sore that facility was not aware and had a decline in a stage 4 pressure sore and failed to follow Physician orders for the treatment of the stage 4 pressure sore.

Findings include:

1. R3's MDS (Minimum Data Set) of 2/8/14 documents R3 has severe cognitive impairment; requires extensive assistance of 2 or more for transfer and hygiene; extensive assistance of 1 for bed mobility; and is at risk for pressure sores.

R3's Care Plan of 11/26/13 documents R3 is at risk for potential impairment to skin integrity r/t (related to) fragile skin, medication use (warfarin). "She requires total assist for incontinence care, requires assistance with nutritional intake, demonstrates contracture of left hand, has had history of distal fibula fracture, requires total assist for transfers with a mechanical sling lift, is wheel chair bound, demonstrates potential risk for shearing and friction injuries and has decreased sensory perception as manifested by profound cognitive deficits and advanced dementia. Braden Scale: 12 high risk." Care Plan goal is R3 will be free from skin breakdown. It is documented under interventions, "11/04/2013 abrasion buttocks. Re-evaluate sling usage, turn reposition every 2 hours...11/26/2013 Daily skin checks with all incontinent episodes and with all showers. Report any changes to the nurse. Nursing notify MD (Medical Doctor)/POA (Power of Attorney) of any changes...11/26/2013 Keep skin clean and dry. Use lotion on dry skin. 11/26/2013 Monitor/document location, size and treatment of skin injury. Report abnormalities,

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 4	S9999		

failure to heal, s/sx (sign/symptoms) of infection, maceration etc. to MD...Resident requires pressure relieving cushion to protect the skin while up in chair. Resident requires pressure relieving/reducing mattress to protect the skin while in bed..."

R3's March 2014 Physician Order Sheet, POS, documents an order to turn and reposition every 2 hours.

Physician Correspondence form of 3/11/14 documents 4 cm x 2.5 cm reddened and excoriate area on left buttock as well as 2.2 x 1.3 cm area on coccyx. Areas cleansed with wound cleanser, dried and hydrocholloid protective dressing applied. Z1, R3's Physician, responded, "Do you have a decubitus ulcer protocol or P.T. (Physical Therapy) need to eval for prevention so this heals and doesn't get worse?"

During a skin check on 3/11/14 at 4:35PM, E11, Certified Nurse Aide, CNA,, stated he had just given incontinent care to R3 and was going to get another CNA to assist with the mechanical lift transfer. During the skin check, R3 was observed to have dried feces smeared on her left lower buttock. E12, Licensed Practical Nurse, LPN, confirmed and washed the area with disposable wipes. R3 had an hydrocholloid dressing dated 3/11/14 on her coccyx and left upper thigh. R3 had a light brown area on her mid left outer mid foot 1 cm in diameter. E12 stated she didn't know what it was.

R3 was observed every 10 to 15 minutes on 3/12/14 from 8:15AM to 2:45PM sitting up in a wheel chair with a mechanical sling under her and her legs extended out in front of her. At 8:15AM, R3 was in her wheel chair in the Dining

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 5	S9999		

Room waiting for breakfast. At 9:12AM, E17, CNA, started to feed R3 and R3 ate over 75% of food served. R3 was taken from the Dining Room to Activities at 9:45AM by E17. At 9:55AM, R3 was taken to the beauty shop. At 10:10AM, R3 was taken out of the beauty shop by Z3, Hairdresser, to get her hair washed and then back to the beauty shop. R3 was observed to be in the beauty shop until 11:25AM and was taken to the 100 Hall Nurses Station by the Dining Room and remained there until 12:15PM when E18, Nurse Aide, took her into the Dining Room for lunch. R3 remained up in her wheel chair in the Dining Room until 1:40PM when R3 was taken from the Dining Room by E17 still in her wheel chair by the Nurses Station. At 1:40PM, E13, LPN, was informed that R3 had been up in her wheel chair since breakfast and requested to do a skin check. At 2:03PM, E15, CNA, took R3 from the Nurses Station to her room. R3 remained up in her wheel chair in her room until 2:45PM. E13, E14, LPN's and E15, CNA transferred R3 from her wheel chair to bed using the mechanical sling lift. R3 did not have a pressure relieving cushion on her wheel chair. R3's incontinent brief was saturated with urine and had an area that was blood tinged. R3's back of thighs and buttocks were deep creased and red. R3 had hydrocholloid dressings on her coccyx and left upper thigh. E13 stated the blood was coming from a wound on R3's coccyx. E13 removed the dressing from the coccyx. R3 had 3 open pressure sores. E13 and E14 stated the open sores were from pressure. E15 was observed to give incontinent care and failed to wash all areas that were soiled with urine. E15 wiped R3's anal area with disposable wipes and then wiped the pressure sores without changing his soiled gloves. E13 and E14 identified 3 pressure sores and stated one was the size of a

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 6	S9999		

dime and two were the size of a nickel and stated all 3 pressure sores were stage 2. Observation showed all pressure sores were unstageable with eschar and/or slough. When asked about the dark section on the top pressure sore, E13 stated yes it was getting dark. E13 placed a new hydrocholloid dressing on the pressure sores without cleansing the pressure sores first. E15 stated R3 was already up in her wheel chair when he came on duty at 7AM and confirmed she had not been out of her wheel chair until the time of the observation.

On 3/13/14 at 11:20AM, R3's Pressure Sores were assessed by E5, LPN/Wound Nurse and E2, Director of Nursing, at the request of the Surveyor. E13 also was present. R3 was laying in bed on her back and was laying on 3 quilted bed pads and a folded sheet. E5 removed the hydrocholloid dressing from R3's coccyx. The adhesive to the dressing was directly on the pressure sores and the skin pulled and R3 cried out in pain when the dressing was removed. E5 stated she had not seen the pressure sore on R3's left upper thigh and stated she had seen the coccyx that was a stage 2. E5 stated she had not measured the pressure sores and had no documentation of the areas. E5 stated it would be on the Incident Report of 3/11/14 by E24, LPN. R3 had 3 pressure sores on her coccyx. E5 measured and staged the pressure sores. Coccyx: #1 measured 2.7 x 3 x .1 cm and was identified as a stage 2. The pressure sore was observed to have yellow slough. #2 measured 1.5 cm x 1.5 cm. and staged unstageable. E5 stated it had a dark area but may be from the hydrocholloid dressing. There was eschar observed. #3 measured 2 cm x 1 cm x 0.1 cm and was identified as a stage 2. There was necrotic tissue and slough. The pressure sore on

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 7	S9999		

the upper left thigh measured 6 cm x 2 cm x 0.1 cm and was identified to have serosangous drainage. E5 stated the pressure sore had a black area through the middle and that part is unstageable and the rest of the pressure sore is a stage 2. E2 was asked how he would stage the pressure sores and E2 stated all the pressure sores are unstageable.

On 3/13/14 at 2:50PM, E14, LPN, stated E5 did not document the measurements for R3's pressure sore and asked if the Surveyor had the measurements. At 2:45PM, E13 stated she had not contacted Z1, R3's Physician, of the 3 pressure sores observed on 3/12/14. At 4:15PM, E5 stated she did not know if Z1 had been notified of R3's pressure sores being unstageable and increased in size.

On 3/14/14 at 8:40AM, Z2 (Z1's Nurse) stated they got a fax from the facility last night after the office was closed. Z2 stated Z1 was not in the office today but she had contacted Z1 that morning of the fax information. Z2 stated the fax did not identify pressure sores. Record review showed the fax "Physician Correspondence" was not in R3's medical record. At 9AM, E1, Administrator was asked where the fax could be located and he stated to check with E14 she is taking care of that. At 9:10AM, E14 stated she did not know about a fax sent to Z1's office yesterday evening. E14 looked in R3's medical record stating it should be there. E14 was unable to locate the fax in R3's medical record or at the Nurses Station where the fax machine is located. At 11:20AM, Z2 provided the above fax that documents, "In addition to the prior fax sent for wounds on coccyx and thigh I just wanted to clarify that the wound on the thigh is on the R (right) side not the L (left) side & a new area was

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 8	S9999		

noticed today current measurements are coccyx - top 2.7 x 3 x 1.1, (L) 1.5 x 1.5, (R) 2 x 1, (R) thigh 6 x 2 x 0.1. Serosangous drainage from area & sloughing. Any new orders?"

In an interview with Z1, R3's Physician, on 3/14/14 at 11AM, Z1 stated the facility faxes concerns to her office after 5PM and no one is there to receive the fax. Z1 stated that is inappropriate. Z1 stated the facility sent another fax last night (3/13/14) after the office was closed and they did not get until this morning. They did not identify R3 as having pressure sores. The information the facility gives is incomplete. Z1 stated the first correspondence that Z1 received from the facility identified the pressure sores as being an excoriation. Z1 stated she looks at excoriation as red dried skin, not open pressure sore. Z1 stated R3 had never had a pressure sore in the past. Z1 stated R3 needs turning and repositioning and she is concerned the facility is not following her orders. Z1 stated the lack of turning and repositioning and timely incontinent care would contribute to development of pressure sores. R3 is dependent on staff for care. Z1 stated someone is wiping R3's bottom, they should have seen the pressure sores when they were red before they were open with slough. Z1 stated that putting 3 pads and a folded sheet on the pressure relieving mattress takes away from the effectiveness of the pressure relieving mattress stated it makes it into a regular mattress. Z1 stated she was concerned that the facility would put the adhesive over the pressure sores stating it had to hurt when they removed it. Z1 stated she considered this as neglect. "Very neglectful." Z1 stated she does not see patients in the Nursing Homes but planned to go to the Nursing Home today to see R3.

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 9 At 1:11PM, Z1 was at the facility and stated she looked at R3's pressure ulcers. Z1 stated she had placed an order for a cushion for R3's wheel chair and asked Therapy to evaluate R3's positioning. Z1 stated they have R3's legs extended out in front of her when she is in her wheel chair which adds pressure to her coccyx. Z1 stated they have R3's legs extended out for a fractured hip that healed a long time ago. Z1 stated R3's positioning is a problem and increases the risk of pressure sores. Z1 stated she is sending R3 to the wound clinic. 2. According to the Minimum Date Set, MDS, dated 12/19/13, R2 is totally dependent on staff for all activities of daily living. The MDS indicates she is frequently incontinent of bowel/bladder with no toileting plan in place. The MDS identifies no pressure ulcers present at that time. The care plan dated 3/12/14 identifies R2 to have actual skin integrity with the goal to have no skin breakdown by next review and will have no complications due to the pressure ulcer on right hip through the next review. Interventions include pressure relieving device bed and chair, padding such as pillows/sheepskin, encourage good nutrition and hydration in order to promote healthier skin, identify causative factors and eliminate/resolve where possible, keep skin clean and dry, monitor/document locations, size and treatment of skin injury, report abnormalities, failure to heal, s/sx of infection, maceration to MD (Medical Director), and Hospice care. The Physician's Order Sheet (POS) for March 2014 includes an order dated 11/28/13 for Butt paste to be applied to bony or reddened areas up to four times a day. There are no current labs for Protein and/or albumin. The POS also reflects orders for Health Shakes three times daily dated 12/2/09. Braden Scale for Predicting Pressure sore risk last done 6/3/13 identifies R2 as being at high	S9999		

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 10 risk. The facility Skin Condition Report for week 1/3/14 identifies R2 has a newly identified in house developed pressure ulcer right hip on 1/2/14 which measured 3.5cm x 1.5cm Unstageable with Eschar, hydrogel dry dressing treatment. In the documentation, there is no explanation as to why the area was not identified until it was necrotic unstageable pressure ulcer even though treatment records for January 2014 show barrier cream to be applied to bony and reddened areas four times a day prior to 1/2/14. The POS does not reflect any additional supplements and/or nutritional supports ordered to aid in wound healing. The Nurses Noted dated 1/2/14 document Hospice was called regarding the pressure ulcer when identified but nothing in regards to notifying the physician and/or representative. A dietary progress note dated 1/21/14 written by E30 Registered Dietician (RD) documents the pressure ulcer right hip as unstageable measures 5.7 cm x 4.5cm. The January 2014 TAR shows the treatment ordered daily but not initialed as done on 2/3, 2/5 or 2/11. On 1/13/14, Hospice ordered a Hydrocolloid dressing to be applied and changed every three days and was only applied on 1/13/14 then discontinued. On 1/14/14, the treatment was then documented as "Cleanse with NS (Normal Saline) apply hydrogel cover with foam dressing every day and was documented thru 1/22/14. The TAR shows Solosite to wound bed and cover with foam dressing twice daily. Documentation of the treatment being done is absent on 7-3 shift for 1/23 and 1/25, 3-11 shift on 1/30 and 1/31/14. According to the weekly wound reports, the measurements remained the same until 1/16/14 when its was documented as	S9999		

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 11	S9999		

measuring 5.7cm x 4.5 cm outer perimeter, inner 2.4cm x 1.5cm x 1, unstageable, dark purple with 100% slough. The order was changed to Santyl and foam boarder change daily. On 1/21/14, the nurses notes (no time) document that the Hospice nurse was called regarding R2's right hip wound having "extra drainage and change in color of wound". But again, no notification to the Physician and/or representative.

A Physician's Progress note dated 1/31/14 documents R2's "status appears unchanged. She recently has been treated for a decubitus with resolution."

The February weekly skin condition reports on 2/7/14 and 2/10/14, R2's right hip ulcer measured 2.8cm x 3.1 identified as necrotic unstageable. On 2/17/14, R2's pressure ulcer shows another decline measuring larger at 3cm x 3.5cm. There is no indication that the physician was notified of the decline and a different treatment was sought. On 2/27/14, the ulcer measurements remained the same but description documented necrotic moderate. The February 2014 TAR documents an order to cleanse with NS, pat dry, apply therahoney and cover with foam dressing BID (twice daily.) The treatment was not documented as done for 7-3 shift on 2/2, 2/5, 2/12, 2/23, and 2/28/14. 3-11 shift shows no treatments documented on 2/3, 2/12, 2/21, 2/23, 2/24, and 2/26/14.

The Registered Dietician note dated 2/20/14 documents that R2 has an unstageable press ulcer with health shakes three times daily had no suggestions for supplements due to the wound improving.

The Weekly skin report dated 3/7/14 identified

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 12	S9999		

R2's right hip ulcer as a stage IV measuring 3cm x 3cm x 1cm, with 20% slough and 80% granulation. The March TAR shows no treatment documented to R2's pressure ulcer on 7-3 on 3/7 shift, 3/10, 3/11 and 3/12/14.

On 3/11/14 at 11:10am, R2 was laying in her bed. She had three padded incontinent briefs under her. She had a foam dressing on her right hip dated 3/11/14. She had an air cushion on her wheelchair. Her water pitcher was full of warm water and there was no straw/cup. R2 was transferred to her wheelchair and taken to lunch. No fluids were offered from her her. At lunch, she was noted to eat less than 25% taking in very little fluids.

On 3/14/14 at 10am, R2 was transferred to bed by E3 and E20, CNA's. E3 stated in aninterview that R2 was up when she came in at 7am. R2 had deep white/red creases throughout her upper thighs, hips, and buttocks. She had a foam dressing on dated 3/13/14 that had visual drainage throughout the dressing. E5, LPN came in with the treatment cart. E5 removed the foam dressing exposing a packed wound underneath. The packing was pink/grey tinged drainage with no odor. E5 stated that the treatment did not call for packing and had been done wrong. E5 stated the wound was suppose to be cleansed, then have therahoney applied to the base of the wound with a foam dressing applied. E5 removed the packing exposing a golf ball size wound. The wound had slightly rolled edges, was covered with a thin film of slough. There was grey stringy tissue at 5 o'clock with dark areas surrounding it from 2 to 6 o'clock. There was no beefy red tissue. E5 changed her gloves and after putting some wound cleansing on a two 4 x 4 gauze pads, patted the base of the wound but did

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 13	S9999		

not cleanse the wound. She measured it for the weekly skin report at 4cm x 3cm x 1.5cm at the deep point 4 O'clock. E5 did not check for tunnelling and denied that the wound currently has any. E5 applied therahoney gel with a gauze pad and covered it with a foam dressing.

On 3/14/14 following the treatment, E5 was asked why no treatment change had been done since 1/22/14 since the ulcer had showed a change and decline stated she thought it looked better since the "plug" came out. E5 stated the facility wound consultant had been in on Monday 3/10/14 and made a recommendation for the treatment to be changed to Tenderwet but that she hadn't had time yet to contact Hospice to see if they covered that treatment or not. E5 stated she would have preferred a specific debridement agent but Hospice did not cover it. E5 was asked if she notified the physician and stated she would notify Hospice first. The weekly wound skin report includes the above measurements but fails to include any documentation about the drainage observed that saturated the packing and foam dressing.

Nurses notes from 1/2/14 thru 3/14/14 fail to include any documentation of R2's pressure ulcer except the two above mentioned calls to Hospice.

On 3/14/14 at 2:10pm, Z5 Certified Medical Assistant for Z6, R2's physician stated in interview that Z6 was called on 2/24/14 regarding the order for Therahoney every 3 days and that Z6 saw R2 on 2/26/14 writing a note "worsening progress with skin breakdown." When asked about the facility nurses doing R2's treatment twice daily when she had it documented as every three days, Z5 stated perhaps the order changed. Z5 was told the facility's wound consultant saw

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 14	S9999		

R2 on Monday 3/10 and made recommendations for a treatment change with no documentation that the physician was notified. Z5 stated the physician has had no communication from the facility or Hospice since 2/24/14.

Hospice notes reviewed showed no documentation of this pressure ulcer since 2/24/14 when notes written by Z8, Hospice Nurse documented "Wound base yellow/white center, pulling away from edge (outer) - outer surrounding tissue red + intact, wound odorous" There is no measurements documented.

On 3/14/14, Z7 Hospice Registered Nurse was interviewed and asked about the pressure ulcer. Z7 stated she was not aware that the facility wound consultant made recommendations for a treatment change and stated "what the wound consultant gives is just a recommendation. It's all about billing, all about medicare and what will get paid for" when asked about a treatment change. Z7 stated she wouldn't expect the home to call as they usually take care of their own wounds adding that Hospice has their own wound nurses. Z7 stated they see R2 on a weekly basis with the CNA's coming in twice weekly. Z7 stated they would expect R2 to be turned and repositioned every 2 hours and that is does concern her that R2 was up for three hours. There is no documentation including a wound assessment by Hospice since 2/24/14.

On the evening of 3/14/14, the facility did a house skin sweep and remeasured R2's pressure ulcer to be different with what E5 had done earlier in the day. New measurements were recorded on the Weekly skin report as: 2.8cm x 4cm x 1.5cm, pink wound bed, low odor, serous drainage, tunneling at 4 o'clock 2.5cm in depth with slough

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 15	S9999		

plug noted. E5 had not identified the drainage or tunneling.

According to a documentation provided by the facility dated 3/14/14, the Hospice Nurse (Z7) declined the facility wound consultants recommendations from 3/10/14 on 3/14/14, explaining to the facility that "in her opinion the wound was actually improving with the current treatment being used on" R2. Based on the wound measurements, R2's wound has shown marked deterioration as evidenced by 2.5cm of tunnelling since Hospice last assessed it on 2/24/14

3. On 03/11/14 at 10:00 AM, R4 was observed lying in bed on his back with the head of bed at a 30 degree angle with knees bent up toward his abdomen and his bottom directly on two incontinent pads. On 03/11/14 at 2:00 PM, R4 was observed in bed in the same position on his bottom. On 03/12/14 from 8:35 AM to 10:45 AM, R4 was observed sitting in a wheelchair with his lower extremities elevated approximately 30 degrees. A mechanical lift sling was under R4's buttocks. At 10:45 AM, E15 and E23 (CNA's) were observed during transfer of R4 and incontinent care. When R4 was transferred from the wheelchair to bed per mechanical lift, he had facial grimacing and moaned, as if to be in pain. The bed was observed to have two incontinent pads with a draw sheet folded into eights. E23 stated that R4 had pain in his legs, especially when wearing the heel protecting boots, because the boots are heavy. E15 stated that staff got R4 up in the wheelchair at 7:30 AM. R4 was log rolled to the right side lying position, as E15 removed the incontinent brief, a heavily soiled dressing was hanging off a large gaping open pressure ulcer located on the sacral area. R4's

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 16	S9999		

buttocks, scrotum, lower back and back of the thighs were all deeply reddened and heavily creased from sitting. A heavily soiled bloody, brown packed dressing the size of a 4 x 4 gauze was observed to fall out of the ulcer onto the soiled incontinent brief. E15 was observed to put the gauze back into the large ulcer and attempted to replace the adhesive part of the bandage to take hold. The adhesive did not stick. There was a small amount of feces observed at the anus and smeared into and on the dressing. E15 used wet wipes to wipe cleanse the anal area, but did not cleanse the scrotum or surrounding buttocks. No catheter care was performed. E15 then placed a new incontinent brief on and repositioned him with the head of the bed at a 30 degree angle and knees bent, essentially sitting on his buttocks. A dressing was observed on the left hip, dated 3/10, with a large brown area of drainage 3 cm in circumference. Neither CNA knew why.

On 03/12/14 at 10:55 AM, E21, LPN stated that R4 was admitted with a stage IV decubitus ulcer on the coccyx and a pressure ulcer on the right heel both with daily dressing changes. E21 stated that R4 had a pressure ulcer of the left hip, but said it had healed. E21 stated that she could not do the dressing changes at this time because R4's Santyl ointment for the pressure ulcers was currently out of stock and she would have to call the physician to get a refill. E21 did not assess R4's pain level prior to performing dressing changes.

On 03/12/14 at 2:00 PM, E21, LPN was observed during dressing changes for R4 on the coccyx/sacral area and right heel. E17, CNA was observed to remove the coccyx/sacral dressing while removing the incontinent brief. Two small

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 17	S9999		

areas between the ulcer and the anus were observed to be under the taped part, not protected by the 4 x 4 gauze. E21 stated that the areas were probably caused by the CNA's wiping during incontinent care. There was feces at the anus and smeared up into the ulcer. The ulcer was observed to be large gaping hole 8 cm x 6 cm x 3 cm with macerated rolling edges and undermining. The ulcer had a foul smell with at least four areas of black necrotic tissue measuring 2.5 cm each and 80 % slough throughout. E21 was observed to cleanse the area around the ulcer with a wet wipe then used wound cleanser spray to moisten the inside of the ulcer. E21 then gently pressed a dry 4 x 4 gauze into the ulcer and patted gently. Bloody, brown serosanguineous drainage was noted on the 4 x 4 gauze. E21 then applied a small amount of Santyl ointment to a dry 4 x 4 gauze and smear together to spread the ointment then placed in inside the ulcer. E21 then covered the ulcer with a dry 4 x 4 dressing and taped. Tape was applied over the two small areas between the anus and ulcer and were not addressed.

Upon request, E21 then removed the left hip dressing, dated 03/10/14, and said that she did not know about it and other staff must of noticed it on the weekend. E21 pointed out a scarred area above the current ulcer and stated that's where the old ulcer was located and had healed. A foam bordered dressing was removed with brownish yellow drainage measuring 4 cm x 6 cm was observed. The left hip ulcer was observed to be completely covered with yellow eschar and surrounded by red swollen skin measuring 3 cm x 4 cm, depth could not be determined. E21 was observed using wound cleanser spray and pat the skin dry, then placed a small amount of Santyl ointment on a 4 x 4 gauze folded into 2 x 2 shape

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 18	S9999		

and an foam dressing placed on top. E21 could not determine when this ulcer was first observed by staff. E21 removed the dressing to the right inner heel ulcer. The soiled dressing was observed to with brownish yellow serosanguineous drainage. The ulcer was covered with red swollen tissue and yellow slough throughout. The ulcer was observed to have an area from 9 o'clock to 3 o'clock of denuded white skin edges. E21 stated this is caused from too much moisture. E21 was observed to spray wound cleanser onto the ulcer and pat dry, add a small amount of Santyl ointment on a cut to size 4 x 4 gauze and place onto ulcer then covered with a folded dry 4 x 4 gauze and taped.

The Telephone Order (TO), dated 01/24/14, documented "change to sacral ulcer to Puracol silver hydrogel and cover with border foam. Change daily and as needed (prn)." On 03/12/14, E21, LPN stated that Santyl ointment was ordered for all ulcers. E21 was observed to apply Santyl to the sacral ulcer. However, the Treatment Record, dated March 1-31, 2014, documented daily dressing changes for the sacral ulcer was to "Apply Puracol, then Silvasorb and cover with bordered foam to sacral ulcer every day and as needed." The treatment records for the month of February, 2014 could not be located. The treatment record documented staff initials each day during the month of March, 2014 as being done for the sacral ulcer.

There were no physician's orders documented for the treatment of the new facility acquired pressure ulcer on the left hip as of 03/16/14. There were documented treatments for the month of March, 2014 for left hip pressure ulcer. There were no nurses notes that documented an assessment of initial date of when the left hip

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 19 ulcer was identified. On 03/13/14 at 11:20 AM, R4 rated his pain level at a 10 on a scale of 0-10. R4 stated that the pain was in his bottom and lower back. Treatment record for March, 2014, documented R4 was given Tylenol 650 mg on 03/12/14 at 11:50 AM on 3/14/14. On 03/13/14 at 11:25 AM, E5, LPN/Wound Nurse, stated that all of R4's ulcers were currently being treated with Santyl and covered with 4 x 4 dressings. E5 further stated that the coccyx ulcer was previously changed from using a "Puracol Silver Hydrogel" type dressing and was being changed twice per day and as needed. She did not know why or when the orders had changed. However, during a dressing change on 03/13/14, E5 stated that due to the uncertainty of the undermining/tunneling and the multiple areas of necrosis and slough, the wound could be assessed as unstageable. E5 also stated that both the left hip and right heel ulcers were considered unstageable. E5 further stated that R4's ulcers of the coccyx and right heel were also being treated by the wound clinic every two weeks. She also stated that R4 was going to the wound clinic once every week, but had been recently changed to every other two weeks. On 03/14/14 at 10:55 AM, E5, LPN was observed during dressing change and measurements for R4's coccyx and right heel pressure ulcers. E5 stated that R4 was given pain medications earlier in the morning. Treatment record documented on 03/14/14 at 8:00 AM, Tylenol 650 mg was given. R4 stated his pain level was a 5/10 on the pain scale. When the covers were pulled back off of R4, R4's pants were pulled down to his knees and the urinary catheter tubing was tucked	S9999		

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 20	S9999		

between R4's legs and wrapped around underneath the right leg. When R4's pants were removed, R4's bilateral legs were heavily creased and the buttocks and testicles were deeply reddened. The coccyx dressing was hanging on by only one side of the adhesive tape and saturated with bloody yellow/brown drainage and soiled with feces. E5 measured the coccyx wound at 6 cm x 6.7 cm x 2.5 cm. However, R4 was turned onto his right and the positioning of his buttocks was not optimal for a true measurement due to the left side of the buttocks sagging down toward the center of his body. E5 stated she could not determine the exact measurement of the undermining due to position of R4.

The POS, dated March 1-31, 2014, documented R4's diagnoses, in part, as Urinary Tract Infection/Sepsis on three different hospitalizations and VRE infection, Stage II Sacral Decubitus Ulcer with MRSA infection, mild Dementia and Diabetes Mellitus.

The MDS, dated 02/05/14, documented R4 was totally dependent on at least two staff for bed mobility, transfers, dressing, toilet use, personal hygiene and bathing. It also documented that R4 is incontinent of bowel and bladder occasionally. However, R4 has a urinary catheter and E15 (CNA), E23 (CNA) and E21 (LPN) stated R4 is always incontinent of bowel, he does not toilet.

The Care Plan, dated 02/07/14, documented R4 as being admitted with Stage IV pressure ulcer to the coccyx, unstageable to right inner heal and unstageable to left hip. On 03/12/14, E21, LPN stated that the left hip wound had healed. A scar was observed above the newly acquired hip ulcer. The Care Plan documented interventions, in part, as assess, record and monitor wound healing,

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 21	S9999		

report improvements and declines to the MD, requires staff assist with turning and repositioning every two hours or more often as needed, inform family/caregivers of any new area of skin breakdown, treat pain as per orders prior to treatment to ensure his comfort and treatment per order.

The Admission Nursing Assessment, dated 01/08/14, documented R4 was admitted with a "8 x 5 open area" pointing to the coccyx region on the Skin Condition section of the sheet. It also documented "open area" to bilateral hips and "edema to left heel" and "3 x 3 cm black area."

A Wound Analysis Report (Wound Clinic), documented R4's last visit was on 03/03/14. The report documented "pressure ulcer coccyx - measurements 8.1 cm x 5 cm x 3.2 cm with undermining 2.5 cm wound classification at Stage IV. Wound procedures - open wound/selective debridement, level non-viable tissue." The Wound Analysis Report also documented on 03/03/14 "pressure ulcer right medial foot - measurements 1.7 cm x 2.3 cm x 0.5 cm."

On 03/14/14 at 10:20 AM, Z9, (daughter of R4) stated that when she spoke to the wound clinic doctor in December, 2013, he stated that the pressure ulcers were all "preventable with timely turning and repositioning." Z9 also stated she had not been made of the newly acquired left hip pressure ulcer or the decline in the coccyx ulcer from the facility as of this date.

On 03/14/14 at 12:10 PM, Z4, RN (R4's primary physician's nurse), the physician's office was not notified of the declining nature of the coccyx pressure ulcer, nor a newly developed unstageable pressure ulcer to the left hip, nor any

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 22	S9999		

wound clinic results nor the adding of or changing in ulcer treatments. Z4 also stated that she had tried to call the facility and speak with a nurse to give orders and was told that they are at lunch and to call back in a hour. Z4 also stated that R4's physician wants aerobic cultures of all wounds, wound team to consult, current treatments, frequent repositioning every 2 hours and Tylenol 650 mg every six hours or Tramadol 50 mg every six hours as needed for pain.

On 03/19/14 at 9:50 AM, Z12, (RN, Wound Clinic Nurse) stated that R4 had been seen on 03/17/14 at the wound clinic, she stated R4's coccyx and right heel pressure ulcers have declined and he had developed a new pressure ulcer on the left hip/trochanter. Z12 stated that the stage IV coccyx pressure ulcer most likely has a bone infection and they are awaiting aerobic culture results. Z12 stated that their recommendations are for a wound vac to be applied as soon as possible. Z12 stated that frequent turning and repositioning would prevent such decline and new developments from happening. She stated that the facility is responsible for ordering the vac and then applying it, and the wound clinic will see him in a week. Z12 confirmed that the wound clinic physician signed the order and faxed it back to the facility. The measurements taken on 03/17/14 for the coccyx pressure ulcer were 8.6 cm x 4.0 cm x 3.2 cm with undermining from 7 - 11 o'clock of 3.3 cm, stage IV with probable bone infection. Z12 stated that Santyl dressings ordered to change twice daily and as needed. Z12 also stated that the left hip/trochanter pressure ulcer is a new stage III with 100% slough measurements of 2.7 cm x 2.2 cm x 0.1 cm. Orders for the hip treatments are for Santyl ointment with a foam dressing, change daily and as needed. The right heel pressure ulcer stage III measurements of 1.4

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 23	S9999		

cm x 2.1 cm x 0.3 cm. Z12 stated that the pressure ulcer treatments have not been changed from Santyl since January, 2014. She further stated that at no time did the wound clinic have ordered a Puracol Silver Gel dressing with foam border, because it does not enhance wound debridement. Z12 confirmed that the wound clinic was not aware of the change in wound treatments.

4. R1 has diagnosis' of Muscular Wasting, Malnutrition, Paralysis Agitans, and Dementia with Lewy Bodies. R1's MDS, dated 12/5/14, documented that R1 is "Extensive Assist of one person" for mobility and transfers. R1's Careplan dated 12/10/13 documented R1 uses physical restraints (torso support) while in wheelchair and has a potential for pressure ulcer development. R1's Careplan documented interventions to include: Follow facility policy/protocols for the prevention/treatment of skin breakdown, cueuing to turn/position at least every 2 hours, requires 2 staff assist with sit to stand transfer and check/change resident frequently at least every two hour.

On 3/11/14 at 11:23 AM, R1 was observed, in his wheelchair, being pushed into the sunroom by Z11 (visitor). At 12:05 PM Z11 (visitor) took R1 into the dining room. R1 remained in the dining room until 1:35 PM. At 1:35 PM, R1 was taken from the dining room into the sunroom where he remained until 2:00 PM. At 2:00 PM, E7, CNA and E10, CNA took R1 to his room.

On 3/11/14 at 1:50 PM, E7 stated in an interview that she had gotten R1 up at 8:30 AM. E7 stated that R1 had been out of his wheelchair once to reposition and walk. E7 stated she was unsure of the exact time but it was sometime before R1's visitor took him to the sunroom at 11:23 AM.

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 24	S9999		

5. R28 was admitted to the facility on 9/27/13 with a diagnosis of status post hemiarthroplasty of the left hip. Facility's Skin Condition Report for the week of 3/17/14 documented R28 has an "Unstageable Pressure Ulcer to Left Heel" measuring 2.0 x 1.9 x 1.5 centimeters and that R28 was admitted with this pressure ulcer. The first documentation of R28's pressure ulcer on the Facility's Skin Condition Report is dated 2/7/14 with a measurement of 2 x 1 x .2 centimeters. Admission Nursing assessment dated 9/27/13 did not document any wound, open area or pressure ulcer on R28's heels. Physician's Orders from admission did not address any Pressure Sore to R28's heels. September 2013 Treatment Record did not address any treatments for R28's heels.

E2 (DON) stated during an interview on 3/19/14 at 11:30 am that he was unable to find any documentation that verifies that R28 was admitted with any pressure ulcer to the left heel. E2 was also unable to provide documentation that there was a Physician Order to change treatment for Santyl, which is a debriding agents, to Sivasorb, with is not a debriding agent.

6. R11's MDS of 2/18/14 documents R11 has severe cognitive impairment and requires extensive assistance for transfers and hygiene.

R11's Care Plan of 2/25/14 documents R11 has the potential/actual impairment to skin integrity r/t fragile skin. Care Plan note of 2/26/14 documents, "work with her on positioning. She is max assist. keep skin clean & dry."

Interview with E15, CNA, on 3/13/14 at 1:25PM,

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 25 E15 stated that R11 is always incontinent. Interview with E27, CNA, on 3/13/14 at 1:29PM, E27 stated R11 is always incontinent. R11 was observed on 3/12/14 every 10 to 15 minutes to be up in her wheel chair from 8:15AM to 1:50PM without being repositioned or checked for incontinency. At 8:15AM, R11 was observed to be in the dining room in her wheel chair through out the breakfast meal. At 9:37AM, R11 was taken from the dining room to the adjoining activity. At 11:15AM R11 was taken from the activity room to her room by E28, Physical Therapy Department. E28 stated she would be doing leg exercises with R11 and that she would not be taking R11 out of her wheel chair. At 11:35AM, E28 took R11 back to the Activity room. At 12:13PM, R11 was taken from the Activity Room by E29, Activity Aide, to her room where E13, LPN gave R11 insulin and then took her to the Dining Room. R11 remained in the Dining Room until 1:28PM, when Z10, R11's husband, took her to her room. At 1:50 PM, E17 transferred R11 from her wheel chair to bed. R11's disposable incontinent brief was saturated with urine and R11's buttocks and back of thighs were deep creased and red. E17 was observed to give R11 incontinent care and failed to cleanse all areas soiled with urine. 7. The MDS dated 12/26/13 identfies R13 as having severe cognitive impairment and requiring extensive assist of one staff for all aspects of mobility. The MDS also indicates R13 is occasionally incontinent of bowel and bladder. The care plan has an intervention added 4/23/13 to reposition every two hours and as needed, peri care with incontinence, lay down between meals.	S9999		

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 26 The care plan identifies a history of pressure ulcers for R13. 3/12/14 at 2:15pm, E3 had just transferred R13 to bed from her wheelchair. R13 had been observed in her chair from 8:18am without being repositioned. E3 stated R13 was up in her chair when she came in and was last toileted at 8:15am. R13 had a saturated brief on which was soiled with bowel movement. R13's bilateral buttocks were deep red and creased, her coccyx had scarring from a prior pressure ulcer, and her upper thighs, hips were also creased. 8. The facility's policy and procedure for the treatment and prevention of the skin breakdown (undated) documents that it is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for ulcers according to industry standards of care. The procedure of pressure ulcer preventions include identifying the risk factors, skin protection (Assess and treat incontinence), provide nutritional support including encouraging fluid intake, and nutritional/protein supplements, observe/assess/treat pain, weekly documentation with the care plan evaluated and revised as necessary based on the needs of the resident, and provide appropriate positioning among others. Under treatment, the facility is to initiate wound care protocols, implement care plan with appropriate interventions, document on weekly wound documentation along with a weekly nurses note, provide protective barriers. Documentation of the wound is to include location, size (length, width and depth), sinus tracts/tunneling, undermining, exudate (amount, color, odor and	S9999		

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 27	S9999		

consistency), odor, wound base characteristics (necrotic tissue, slough tissue, the presence or absence of granulation tissue), wound edge characteristics (epithialization, erythema, edema, induration, crepitus, pain, warmth, and/or maceration) and pain. The policy includes directives to offer pain medication prior to dressing changes if appropriate. Directive: if the wound has a cavity or "dead space", loosely fill all cavities without over packing.

9. The facility's policy entitled "Resident Change of Condition Physician Notification" (undated) documents that attending Physician's, or Physician's on call will be notified of residents change in condition/health status with time of call, physician or nurse practioner or other person spoken to, reason for call and results of call received. The policy for Family/Responsibilible Party Notification documents that they will be notified if there is any change in condition or plan of care.

(A)

300.610a)
300.1210b)4)
300.1210d)2)
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

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 28 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 procedures: 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene 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: 2) All treatments and procedures shall be	S9999		

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 29 administered as ordered by the physician. 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 REQUIREMENTS ARE NOT MET AS EVIDENCED BY: Based on record review, interview and observation, the facility failed to provide timely supplements, adaptive eating utensils and meal assistance/clues for 2 of 6 residents (R2, R12) reviewed for weight loss in the sample of 16. This failure resulted in R12 incurring in a unplanned significant weight loss and below desired laboratory tests. Findings include: 1. R12's Minimum Data Set (MDS), dated 12-19-13, documented severe cognitive impairment and supervision of setup help only with eating and fluids. R12's Care Plan, focus date 1-2-14, documented her ideal body weight as plus/minus 125 pounds. It was also noted that she needed assistance with meals, encouragement, praise her to consume at least 50-100% of each meal offered and provide a divided plate for meals. R12's Hematology lab, dated 1-7-14, documented her hemoglobin as 10.6 gm/dl range of 12.0-16.0 gm/dl, hematocrit 32% range of 37-47%, red blood count 3.69 M/CUMM range of 4.20-5.40 M/CUMM, absolute lymphocytes 0.6 K/CUMM range of 0.9-3.0 K/CUMM, neutrophilas 71%	S9999		

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 30	S9999		

range of 47-67%, lymphocytes 17% range of 25-45%, platelets 113 K/CUMM range of 140-410 K/CUMM and albumin 3.3 gm/dl range of 3.5 0 5.5 gm/dl.

R12's Rehab Addendum Note, dated 1-6-14, documented R12 was issued a spoon with built up handle and was directed to scoop her food and bring it to her mouth.

During observation of R12's breakfast meal on 3-12-14, R12 was served, in part, pureed meat, bread and eggs in a divided plate. A small glass of thin orange juice, two bowls of pureed fruit and a supplement cup were placed around her divided plate. R12 ate her meal with a regular soup spoon and not a spoon with a built up handle. R12 was not assisted or encouraged to eat her meal. She repeatedly dipped her soup spoon in her plate and supplemental cup and without obtaining any food and then lick the spoon. She did not drink her orange juice nor was she offered any fluids, including water, during her meal. R12 only ate bites of her breakfast meal.

R12's Meal Intake Record, dated 3-2014, documented she ate only 25% of her meals on 3-7-14, 3-8-14, 3-9-14 and 3-13-14.

R12's MDS, dated 1-9-14, documented R12's eating/drinking had declined to limited assistance of one person physical assistance.

The facility's Monthly Weight Log, not dated, documented R12's weights as 87 pounds for 1-2014 and 86 pounds for 1-2014.

Interview of E5, Licensed Practical Nurse (LPN), on 3-13-14 at 11:15a.m., E5 stated R12's 3-2014

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 31 weight had declined to 81 pounds. Interview of E25, Dietary Manager, on 3-14-14 at 3:05p.m., E25 said R12's five pound weight loss would be considered a significant weight loss for her. Interview of E2, Director of Nursing (DON), on 3-12-14 at 10:30a.m., E2 stated R12 was not in a restorative program but should be. 2. According to the MDS dated 12/19/13, R2 is totally dependent on staff for all activities of daily living including eating. The Physician's order sheet indicates that R2 is on Hospice and receives a pureed diet with health shakes three times daily (TID) with meals. The weekly pressure ulcer report identifies R2 to have a stage IV pressure ulcer. The care plan dated 12/18/13 includes a goal to consume 50% of each meal with interventions to encourage food and fluids at and between meals, encourage to increase food intake and substitutes dislikes for like foods among others. The monthly weight report sheet documents R2's weight in February (no day) 2014 at 117 pounds. No weights recorded for March as of 3/13/14. The dietary manager last review dated 12/18/13 documents that R2 is fed by staff, skin in intact, health shake tid, diet general puree comfort food. Dietary Progress note dated 1/21/14 written by the Registered Dietician (RD-E30) identifies R2 now with an unstageable pressure ulcer with intake less than 25% to 50%, no sugg (suggestions.) On 2/20/14, the RD documents the same information as 1/21/14 with no suggestions made. On 3/11/14 at 12:40pm, R2 was fed her pureed meal by E3, CNA. She had orange drink, mashed potatoes, meals, fruit and bread. R2 did	S9999		

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 32	S9999		

not receive a health shake. R2 sat in her chair with her eyes shut. Occasionally E3 would touch R2's arm and ask "are you awake". At 12:51pm, E3 got up to assist another table and returned a few minutes later. R2 drank 50% of her orange drink, took bites of potatoes and meat, didn't have any peas, fruit and/or bread offered to her before staff stopped attempting to feed her. No subs were offered or attempted. No health shake was given as ordered.

On 3/12/14 at breakfast meal, R2 was taken to the dining room at 8:27am. At 8:35am, E7 CNA sat down to feed R2. R2 had scrambled eggs, oatmeal, sausage, yogurt, and fruit. R2 remained with her eyes shut as E7 would occasionally shake her arm and ask her to wake up. R2 ate 75% of her fruit but none of her other foods. She drank 100% of her orange juice but none of her orange drink. E7 did not offer any oatmeal, sausage or yogurt to her as she assisted her. No health shake was given to R2 at breakfast. At 9:25am, R2 was propelled out of the dining room after having eaten only a few bites.

On 3/12/14 at the noon meal, R2 was given a health shake after she ate only a few bites of meal, 75% of her ice cream and 100% of her fruit. She drank 100% of her health shake.

Meal Intake Record for March 2014 show no intake recorded for breakfast and lunch 3/1-3/4 and 3/8-3/14 and no intake recorded for supper from 3/13 thru 3/17 when reviewed. For most meals, staff have documented 25% of meal and occasionally 50%. No recorded intake for dates meals were observed. In addition, there is no documentation of the health shakes ordered three times daily.

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 33 On 3/14/14 at 1pm, R2's weight was requested and none was provided. E25, Dietary manager stated she did not have monthly weights for R2 yet. E3 weighed R2 in her wheelchair at 188 pounds then weighed her wheelchair at 78.5 pounds giving R2's weight at 109.5, a decrease of 7.5 pounds (6.4%) loss since recorded weight of 117 pounds in February. E25 stated they do not weigh R2 any more often than monthly and that R2 is on Hospice. 3. Residents will be weighted weekly or more often based upon ongoing assessment of nutritional intake, fluid retention, and other medical factors." 4. The facility's Restorative Programs Log, not dated and presented as the most current log, did not document R12 on the facility's Restorative Programs Log. 5. The facility's Restorative Nursing Therapy Services, dated 11-2013, documented, in part, "Policy: To provide a multifaceted program that seeks to: attain and maintain residents highest level of functioning, to maintain resident dignity or self worth. Restorative therapy is to work in conjunction with skilled therapy services and nursing services." 6. The facility's Eating/Swallowing, not dated, documented, in part, "Purpose: To promote resident independence by providing activities that improves or maintains a residents self performance in feedings one's self food and fluids or maintains resident's ability to ingest nutrition and hydration by mouth. Explain to residents using simple instructions what you want them to do. 14. Provide frequent verbal cues and hand	S9999		

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 _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY NURSING CARE RESIDENCE	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
S9999	Continued From page 34 over hand assist as needed. 16. Provide encouragement and allow the resident to do as much for themselves as they can." 7. The facility's Adaptive Equipment - Eating, dated 1-13, documented, in part, "Policy: Provide adaptive equipment to assist residents and patient at mealtimes for easier, independent eating." 9. The facility's Weight Monitoring - Nursing Services policy and procedure, not dated, documented, in part, "it is the policy of this facility to monitor residents' weights from the time of admission and to provide interdisciplinary support and/or intervention avert adverse trends. (B)	S9999		