STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

REGENCY NURSING CARE RESIDENCE
I.D. Number: 0036178

2120 WEST WASHINGTON
SPRINGFIELD, ILLINOIS 62702

Date of Survey: 02/05/2004

Complaint Investigation

As a result of a survey conducted by representative(s) of the Department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date by which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

300.690 b) A descriptive summary of each incident or accident shall be recorded in the progress notes or nurse's
notes for each resident involved.

300.1210 b) 6) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven-day-a-week basis: 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.

300.1220b) 2) The DON shall supervise and oversee the nursing services of the facility, including: Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

Based on observation, record review and interview, the facility failed to have individualized assessments on residents for risk of falls. The facility failed to ensure there is a comprehensive investigation and summary for residents who had fallen. The facility failed to ensure that bed rails function properly and/or latched properly to prevent the rail from falling down and residents from falling out of bed. This includes R1, R2, R3, R4, R5, R6, R7 and R8. R1 fell from bed and sustained a subdural hematoma. R3 fell from bed and sustained hematoma on forehead with a small cut and redness to outer knee and calf. R4 fell from bed and sustained a dislocation of 2nd and 3rd digit of left hand with laceration to forehead and bridge of nose requiring sutures.

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Findings include:

1. Record review shows that R1 was deceased at the time of the survey. R1's Care Plan of 9/18/03 states that R1 was at risk for injury related to decreased mobility/confusion. Care Plan states that R1 was alert/oriented, pleasant, quiet uses call light to make needs known. Side Rails x 2 up. Assist with transferring 1 or 2, w/c (wheelchair) ambulates with and without assist. TAB-S unit in place. Fell 9/10/03, 9/14/03, R1's shoulder, upper chest and back bruised.

R1 was admitted to the facility on 9/8/03 and had 4 falls up to 10/21/03. Record review shows that there was no individualized fall assessment for R1. On 10/21/03, R1 was sent to the hospital with a diagnoses of subdural hematoma with Physician Admission note of 10/22/03 stating, "probably terminal".

Record review of maintenance logs showed that there were numerous entries that showed bed rails were not functioning properly. Interview with Z1 (R1's daughter) on 2/4/04 reflected that R1's bed rails would fall down by putting 1 finger on the rail. Z1 stated she had told the facility time and time again about concern of bed rail falling down. Z1 stated they finally put extra springs on the bed rails. Z1 stated that R1 fell in the early morning of 10/21/03. Z1 stated that the nurse told her that they put a chair up against the bed rail after the fall so that the bed rail would not come down. Z1 stated that R1 was to have a TAB-S monitor on when in bed but R9, R1's room mate, stated she did not hear an alarm the night of the fall. Record review shows that R9 put on her call light and informed staff that R1 had fallen.

Interview with R9 on 2/3/04 reflected that she did not remember hearing an alarm the night R1 fell. R9 stated R1's bed rails would come down and that's what happened the night R1 fell. R9 stated that R1 never tried to crawl over the bed rails.

During tour of the facility on 1/17/04, Surveyors found 5 residents who were in bed at the time had bed rails up but came down by running hand along the bedrail. E2 (Administrator) confirmed that the rails were either malfunctioning or latched improperly.

Interview with E7 (LPN/Licensed Practical Nurse) on 2/3/04 reflected that there has been a problem for years with the bed rails malfunctioning. Interview with E5 (CNA/Certified Nurse Aide) on 2/3/04 reflected that if bed rails aren't put up correctly they come down. E5 confirmed that he had cared for R1 and didn't remember R1 ever trying to crawl over the bed rails.

Interview with E6, LPN on 2/3/04 reflected that some side rails would come down by lifting up on the rail. E6 confirmed that side rails have been a problem for years. E6 stated he understands the nursing home is going to take care of the problem with the bed rails. E6 stated that R1 was determined to get out of bed and would force her side rails down. E6 stated that R1 told him she had gotten up to go to the bathroom. E6 stated that R1 also was suppose to have a TAB-S alarm on when in bed. E6 stated that the TAB-S alarm had helped in the past with

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warning staff that R1 was trying to get up. E6 confirmed that R1's bed rail was put up when she went to bed but side rail was down when they found her on the floor. E6 stated her monitor was not on or going off the night of the fall. E6 confirmed that a chair was put up against the bed rail after the fall to ensure that the rail stayed up.

R1's Care Plan of 9/18/03 does not indicate that R1 will try to get bed rails down or that R1 removes the TAB-S monitor.

Interview with E3 (DON) and E4 (ADON) on 2/3/04 confirmed that R1 did not have an individualized fall risk assessment and reflected that the facility does not have fall risk assessments on any residents because all residents are considered to be at risk for falls. On 2/5/04 at 11:20AM E3 (DON/Director of Nursing) and E4 (ADON/Assistant Director of Nursing) stated that the CNA who put R1 to bed the night of
10/20/03 had told them that she had not put the TAB-S alarm on R1. E4 confirmed that the facility did not investigate if the side rail was malfunctioning or not secured properly. E4 did state that they put a chair up against the side rail after the fall to ensure that the bed rail did not come down again. Both E3 and E4 confirmed that an investigation summary was not in R1's progress or nurses notes.

Hospital record review shows that R1's History and Physical Exam dated 10/22/2003 states that R1 had fallen out of bed on the night before her admission. R1's vital signs in the emergency room reflected that blood pressure was 231/154, pulse 113, respirations 14, temperature 98.2 and pulse oximetry 91% with room air. Note states that R1 was initially unresponsive. Computerized tomography scan was done in the emergency room revealing a large intracranial hemorrhage, subdural in origin. Plan, "At this point, she is a do not resuscitate patient and we will make every effort to keep her comfortable."

Facility discharge note of 12/20/03 states that R1 was a hospice resident when readmitted back to the facility after fall.

2. Review of the clinical record identifies R2 as being a 96-year-old female admitted to the facility on 9/5/01 with diagnoses of Deep Vein Thrombosis, Fractured right hip 7/30/01, Dementia secondary to Alzheimer's and Osteoporosis among others. The care plan indicates that R2 is totally dependent on staff for all activities of daily living (ADL's) including mobility. R2 is incontinent and is cognitively impaired. The care plan dated 12/22/03 reflect a "potential for injury R/t (due to) decreased mobility/confusion". The short term goal reads "no fall or injuries/or decreased falls thru 1/2/04". The interventions indicate staff are to keep call light within reach, keep area free from obstruction, side rails up if requested, assist with ambulating, TAB-S unit, wander guard and medication as ordered along with assist with ADL's. The evaluation portion of the care plan indicates R2 is alert but confused, call light used at times, side rails x 2 up, TAB-S unit in place, wander guard on, up in w/c (wheelchair) per staff but frequently gets self out of bed and chair, no falls". It continues to state R2's gait is unsteady and she can become agitated and combative with staff and other residents. The facility failed to assess R2 for fall risk, failed to assess R2 for appropriate use of safety devices, failed to ensure that the side

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rails on R2's bed were functioning properly in order to prevent R2 from falling and they were in the up position at all times, failed to ensure that the TAB-S unit was in place when up in chair and that her positioning was proper in order to assist in fall prevention and failed to reassess R2 toward her needs when falls had occurred.

On 1/27/04 during initial tour of the facility, the surveyor observed R2 to be in bed with both bed rails up. R2's right bed rail was found to fall down easier with a light touch. The facility was informed of the rail failure and had the maintenance man check it. He determined that the rail was functional but had not been secured when pulled up in the high position. The facility failed to ensure that the safety rails were applied correctly in order to prevent them from falling down. Interview with staff indicate that R2 does rattle the rails on occasion in an attempt to get them to come down. Review of the care plan indicates both "side rails if requested" and "side rails x 2 up". Interview with staff indicate that R3 is to have both side rails up at all times. There is a consent form signed for the use of the side rails.

On 1/27/04 at approximately 4:25PM, R2 was observed to be sitting in her wheelchair at the nurses station. R2 had a cushion underneath her and her feet were noted to be dangling off the floor. R2 had no TAB-S unit on the wheelchair. E8, Assistant Administrator, was asked about R2's TAB-S unit not being on and she checked R2's bed for the unit. E8 was unable to find the unit. Interview with E3 on 1/27/04 indicates that R2 "likes to throw her unit into the garbage can". The facility failed to ensure that R2's TAB-S unit was an appropriate safety device for her given the fact that she could and did have a habit of removing it.

Review of the falls tracking sheet for R2 reflect many falls with 4 documented within a months time. Review of the incident report indicates on 12/31/03 at 1500, R2 was reported on the floor in front of the bathroom by a visitor. The report indicates that R2 stated she "fell on the brick out there" then stated "I fell on that rug" but there was no rug present. The Investigation portion of the incident report is blank therefore no one knows whether the TAB-S unit was sounding or not. The facility failed to adequately investigate this fall to determine if the safety prevention measures they put into place were effective or not. The facility failed to provide sufficient staff supervision as R2 fell to the floor.

An incident report dated 1/5/04 at 0145 (1:45AM) indicated that R2 was "yelling in room". When staff reached her room, R2 was on the floor and stated she had tried to get herself into her wheelchair but slipped to the floor. Again, there is no investigation present to ascertain whether or not the bed rails were up and how the rail got down to allow R2 to transfer herself without staff assistance. In addition, there is also no information regarding whether or not a TAB-S unit was on and sounding. The facility failed to assess R2's needs in light of these two falls in an effort to maintain her safety.

On 1/12/04 at 1510, R2 was found on the floor of the bathroom again. The Investigation portion of the report indicates that the TAB-S unit was "in trash can in bathroom". Again, there is no indication that the facility assessed R2's need and the appropriateness of the TAB-S unit given the fact that she can take it off and staff supervision is not sufficient enough to prevent falls.

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On 1/14/04 at 1525, R2 was found on the floor by a CNA passing by. The report indicates that R2 was sitting next to the bed on the floor with her legs extended. The report indicates R2 stated "I was trying to get out of bed + I slipped". The Investigation portion states "resident fell to floor in her room when she attempted to ambulate from her bed to her wheelchair w/o (without) assistance or use of call light". The facility failed to determine if the rail was up or not and how she would have gotten the rail down. The facility failed to determine if the safety measures they were to implement according to the care plan were used properly and failed to determine the effectiveness of those devices in an effort to maintain R2's safety. In addition, the facility failed to review and revise the care plan as R2's falls continued in an effort to prevent further falls from occurring.

In interview with E4 on 2/3/04 indicates that the facility does not do "Fall Risk" assessments as they have determined everyone is at risk. E4 also stated that no assessments for safety devices or restraints were done as the facility considers themselves "restraint free" even though they utilize TAB-S units, self-release safety devices and side rails. E4 was asked how effective R2's TAB-S unit was as a safety device when she could remove it and he stated that sometimes they are able to keep it on her, sometimes not. The facility has failed to maintain R2's safety in preventing falls from occurring.

3. Review of the clinical record identifies R3 as being an 82-year-old male admitted to the facility on 4/25/03 with diagnoses of Parkinson's Disease, Arthritis, Glaucoma and dementia. The care plan dated 11/6/03 indicates that R3 ambulated with the assist of 2, transfers from bed to recliner, has poor balance and leans out of wheelchair. R2 had a potential for injury due to decrease mobility with a short term goal being to have no falls. Staff interventions included keeping call lights within reach at all times, keep area free from obstruction, side rails up if requested, assist with ambulation and ADL's. The Evaluation indicates R3 is alert and confused, was a little resistive to care, call light not used, side rails up x 2, transfer with assist, speech slurred and inappropriate. Review of the clinical record indicates that the facility failed to assess R3 adequately and timely for falls, failed to ensure that safety precautions such as side rails were functional and used to prevent falls and failed to reassess R3's needs as his falls increased. The facility also failed to investigated falls to determine the causative factors and to ascertain whether the safety measures that were to be implemented were effective in maintaining his safety.

Review of the nurse notes and incident reports indicate that on 9/15/03 at 2235 (10:35PM), R3 was found by staff on the floor of his room. The incident report states that the resident was noted to be faced down on the right bed rail which was resting on the floor. R3 had another male resident in his bed which had the left rail still in up position. Interview with staff indicates that the resident in R3's bed often got confused at night and would crawl into another's bed when he couldn't find his own. The investigation portion of the incident report documents directly toward this and fails to include any information as to how and why the right bed rail would have fallen off the bed. R3 had no documented injuries but facility didn't initiate any additional safety measures toward preventing future falls.

On 12/13/03 at 0030 (12:30AM), according to the incident report and nurse notes, "CNA found resident at bed check lying on floor next to bed. Found lying on L (left) side with legs extended...Lg (large) hematoma to L side forehead c (with) sm (small) cut ...." The interventions identify the

hematoma at being 4cm x 5cm in

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size and a skin assessment noted that his left outer aspect of the elbow was red and also the outer aspect of the left knee and calf. The investigation states "resident found on floor w (with) hematoma of an unknown origin". The nurses notes contain the same information as the incident report. Neither provide any evidence that the facility investigated R3's fall out of bed to determine how or why the bed rail fell off the bed and if it was in the up position when staff left him as indicated in the care plan. There is also no evidence that the facility reassessed R3's needs and implemented additional measures toward preventing R3 from falling again.

On 1/1/04 at 1030, R3 was again found lying on the floor at bedside on a mat. The Investigation identifies R3 as having scratches on his nose and forehead with a little bleeding of unknown origin but again offers no evidence that the facility attempted to determine if the bed rail was up or down when staff last left him and if the rail was functioning properly. In addition, the facility has no assessment of R3's falls and no revisions or new interventions initiated in an effort to decrease his falls. The care plan fails to identify the use of the bedside mat.

On 1/3/04, R3 fell again at 2230 with the report stating "Pt (patient) on floor again on his lt side facing his bed. Pt's side rail down on rt and up on lt. Pt unable to tell writer how he got on floor,..." The investigation states "resident found on floor of an unknown origin". There is no other information present in the nurses notes. Again, there is no evidence that the facility attempted to determine why one rail was down. The facility failed to reassess R3's falls and implement additional measures to ensure R3 was kept free of falls.

R3 was evaluated and placed on Hospice and on 1/29/04 expired. The discharge note states "transferred c assist - fell 9/15 no serious injuries - balance very poor - did not ambulate - incontinent of b + b (bowel and bladder)...". The facility failed to initially assess R3 toward fall prevention, failed to reassess R3's needs as he had repeated falls, failed to review and revise the care plan including implementation of additional measures in an effort to prevent further falls.

4. Review of the clinical record identifies R4 as being a 98-year-old male admitted to the facility on 10/04/01 with diagnoses of Mild senility, Restless leg syndrome and irritable bowel among others. The care plan dated 1/23/04 indicates that R4 is alert, confused, doesn't use the call light, side rails up x 2, TAB-S unit in place, wander guard on, up in wheelchair per staff but frequently gets out of bed, wanders about facility, soft safety belt in place, removes at times, total care for ADL's, poor memory and "no falls". Review of the Resident Fall Tracking Log indicates that R4 had falls on 1/21/03, 5/14/03, 6/2/03 and 7/27/03.

On 1/21/03 R4 removed his TAB-S unit and fell to floor. There is no assessment as to why the facility would deem the TAB-S unit to be an effective safety measure if R4 was able to remove it without assistance.

On 5/14/03 at 2215, the incident report states "entered room for bed check + noted resident to be sitting on floor leaning against side of bed...". The TAB-S unit was applied and the side rails were up when staff last saw R4 but were off and down when found on the floor. Again, the facility failed to reassess R4 toward his needs given that he can undo the TAB-S unit and let down the rail.

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On 6/2/03 at 2320, the nurses notes state Awhen making rounds found (R4) lying on the floor. When I approached him, he said >I was fiddling in my bed and landed on the floor on my Abuttocks=@. The investigation simply states R4 fell out of bed onto the floor and contains no information as to whether the TAB=S unit was in place along with the side rails or not. In addition, there is no evidence that the facility reassessed R4's needs and attempted to implement new measures in an effort to prevent further falls.

On 7/27/03 at 0600, an incident report states "res found on floor next to bed. res let side rail down and tried to get up (without) assistance. Res hit head. Moderate amt (amount) of blood noted. Left hand also bleeding middle finger + index finger". R4 was sent to the emergency room for evaluation. The nurses notes contain the same information and indicate at 1125 the hospital was called regarding R4's condition. The notes state "pt has dislocation of 2nd and 3rd digit, laceration to the forehead et bridge of nose" requiring sutures. Again, there is no evidence that the facility reassessed the appropriateness of the TAB=S unit and side rails since R4 could remove them. The facility also failed to investigate how R4 could "let the side rails down". There is no information as to whether either of these measures were implemented at the time of the fall. The care plan was reviewed and found to contain no revisions toward maintaining safety for R4.

The facility failed to initially assess R4's need toward maintaining safety, failed to reassess as falls occurred, failed to ensure that measures identified in the care plan were implemented and were effective and failed to prevent R4 from repeatedly falling and sustaining injuries.

5. During tour of the facility on 1/27/04 at approximately 1PM, R2, R5, R6, R7 and R8 were observed in bed with side rails up. Surveyors rubbed hand across the top of the bed rails and bed rail came down. No pressure or force was used to get the side rail down. Surveyors immediately informed E2 (Administrator) who summoned the maintenance man for repair. Surveyors stayed with the residents until staff were available to ensure resident safety. During the tour of the facility Z2 and Z3 (Resident family members) stated that they had problems in the past, with bed rails malfunctioning and falling down. Z2 and Z3 stated that the facility had put new springs and additional springs on the bed rails to keep them up. E9 (CNA) was in the room when R8's bed rail came down. It was confirmed that there was a problem with the bed rails and that they come down easily.

Record review shows that all the above residents are at risk for injury and are to have both side rails up while in bed.

(A)