DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146139	A. BUILDING ______ B. WING ______	C 01/04/2011

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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigation # 1045130 / IL51250	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review the facility failed to assure that residents are transferred properly to prevent accidents for one (R3) of three residents. The finding include: The facility's incident log was reviewed and R3 was identified as having two incidents where he received skin tears while receiving care. On 11/15/10 he received a skin tear on the back of his upper left arm, while being transferred by staff . On 12/23/10 he received a skin tear on the back of his right arm while staff prepared him for his shower. On 1/3/11 at 12:05 PM, R3 was asked if I could look at his arms. He agreed. He still had an open area on his back upper left arm and a healing tear on his upper right arm. He was asked what had happened to upper left arm. He said that a man had done it with his thumb while putting him	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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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) COMPLETION DATE
F 323	Continued From page 1 to bed. He said that he didn't know the man's name but he thought he could identify him. He indicated that he didn't feel it was done on purpose but that they were in too big of a hurry. He did not recall the injury to his upper right arm. The facility's incident report dated 11/15/10 stated that R3 was transferred manually and that a mechanical lift should have been used. There were two Certified Nursing assistants involved , one was a male. E1, Administrator and E2, Director of Nursing, confirmed on 1/4/11 that R3 should have been transferred by the mechanical lift on 11/15/10 and not manually transferred.	F 323		