STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145623	A. BUILDING _____ B. WING _____	C 07/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE OF MORRIS	**1095 TWILIGHT DRIVE MORRIS, IL 60450**

(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: 1673630/IL#86630	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified	F 225		

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

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F 225	Continued From page 1 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to thoroughly investigate an injury of unknown origin. This applies to 1(R1) of 3 residents reviewed for injuries. The Findings Include: Face Sheet documents R1 is a 72 year old with the following pertinent diagnosis, altered mental status, Alzheimer's disease, ataxia and encephalopathy. R1 has a Care Plan for Impaired Cognitive Function/dementia dated 10/6/2015. Minimum date Set dated 6/16/2016 documents R1 with severe cognitive impairment. Progress Notes dated 5/7/2016 and 5/9/2016 document R1 has a " black eye, mild puffiness, just monitor the black eye and no new orders. " Incident Report dated 5/6/2016 documents "R1 has a purple bruise under left eye. The bruise has a center area which is white/pink in color indicating a center core area below the left eye. R1 was witnessed to be rubbing the area aggressively. This rubbing was aggressive enough to break the blood vessels. R1 receives Plavix 75 mg and Aspirin 81 mg daily. These medications may facilitate increased bleeding to these broken vessels causing pooling blood under the left eye."	F 225		

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F 225	Continued From page 2 On 7/5/2016 at 11:54 AM E3 (Nurse) said she remembers R1 had a black eye in May of 2016. E3 said she informed E1 (Administrator) and E2 (Director of Nursing) and they both assessed R1 and saw R1 rubbing his eye aggressively. E3 said E1 and E2 determined that R1 scratched his eye and caused a black eye because R1 is on anticoagulants. On 7/5/2016 at 1:50 PM, E2(Director of Nursing) said E3(Nurse) brought R1's black eye to our attention, we (E1 and E2) assessed and saw R1 rubbing his eye. The left eye was deep purple and concluded that the Plavix and aspirin aided in the cause of the black eye. E2 said Z1(Family member) did not believe that R1 caused the black eye because he is combative and would defend himself. On 7/6/2016, E2(DON) presented minutes from a care plan meeting with Z1(Family Member). Transmittal Document dated May 22, 2016 states, "E2(DON) went over R1's chart in regards to his medications and services that R1 is getting and explained about 2 blood thinners he receives and how that could have affected his eye and that E1 and E2 witnessed R1 doing a very aggressive knuckle rub to his eye. Z1(Family Member) acknowledged what we were telling her. E2 asked Z1 if Z1 felt that if someone was to hit R1 that R1 would have not yelled out or defended himself. Z1 said she felt that one of the other residents had struck him. It was explained that if that would have been the case, R1 still would have yelled out or struck them back. Z1 agreed with the fact that R1 probably would have retaliated." On 7/6/2016 at 9:30 AM E2(DON) was asked to	F 225		

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F 225	Continued From page 3	F 225		

present the investigation for R1's black eye. On 7/6/2016 at 10:06 AM E2(DON) presented the investigation. E2 said incidents are investigated in Risk Watch and witness statements are all recorded on the incident report. There were two witnesses statements, E1(Administrator) and E2(DON). The statements documented R1 woke up with a bruise to the left eye, they (E1 and E2) saw him later rubbing the eye and believed R1 caused the bruising. E2 was asked if there were any other witness statements/investigation documented. E2 responded the witness statements are there. E2 was unable to provide direct care staff statements or other staff interviews about the black eye. During the survey no further documentation of the investigation was presented for R1 after asking.

The investigation did not include any Certified Nursing Assistants, or other resident statements. There is no thorough investigation of how R1 sustained the bruise to the left eye.

On 7/6/2016 at 2:09 PM, E12(Medical Doctor) said R1 had a black eye in May of 2016 along with a white spot in the center of the left eye. " We do not know how R1 got the black eye; we do not know what caused it. It was an injury of unknown origin. " E12 said he remembers talking to staff and nobody knew what happened.

Abuse Policy and Procedure undated states, " The facility will investigate and report incidents or occurrences in accordance with federal and state regulations."

Policy and Procedure Investigation of Bruises, Skin Tears, Scratches last revised 9/1/2015

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F 225	Continued From page 4 states, " The Nursing Supervisor, DON or designee will review each form for completeness and determination If the injury is unknown origin should be reported to appropriate state agencies in accordance with the facility policy on Reporting of Abuse and Injuries of Unknown Origin. If there is reasonable cause to believe or suspect that an injury has been inflicted upon a resident by a nurse or aide or another individual used by the facility according to the definition of abuse/and or neglect, the incident must be reported. If there is no reasonable cause to suspect neglect or abuse, the incident is not required to be reported. However the injury must be investigated and referred to the quality assurance process for problem identification and corrective action where necessary."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to follow their policy and report an injury of unknown origin to the state agency and follow their policy for investigating injuries of unknown origin. This applies of 1(R1) of 3 residents reviewed for injuries.	F 226		

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F 226	Continued From page 5 The Findings Include: Face Sheet documents R1 is a 72 year old with the following pertinent diagnosis, altered mental status, Alzheimer's disease, ataxia and encephalopathy. R1 has a Care Plan for Impaired Cognitive Function/dementia dated 10/6/2015. Minimum date Set dated 6/16/2016 documents R1 with severe cognitive impairment. Progress Notes dated 5/7/2016 and 5/9/2016 document R1 has a " black eye, mild puffiness, just monitor the black eye and no new orders. " Incident Report dated 5/6/2016 documents "R1 has a purple bruise under left eye. The bruise has a center area which is white/pink in color indicating a center core area below the left eye. R1 was witnessed to be rubbing the area aggressively. This rubbing was aggressive enough to break the blood vessels. R1 receives Plavix 75 mg and Aspirin 81 mg daily. These medications may facilitate increased bleeding to these broken vessels causing pooling blood under the left eye." On 7/5/2016 at 11:54 AM E3 (Nurse) said she remembers R1 had a black eye in May of 2016. E3 said she informed E1 (Administrator) and E2 (Director of Nursing) and they both assessed R1 and saw R1 rubbing his eye aggressively. E3 said E1 and E2 determined that R1 scratched his eye and caused a black eye because R1 is on anticoagulants. On 7/5/2016 at 1:50 PM, E2(Director of Nursing) said E3(Nurse) brought R1's black eye to our attention, we (E1 and E2) assessed and saw R1 rubbing his eye. The left eye was deep purple and	F 226		

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F 226	Continued From page 6	F 226		

concluded that the Plavix and aspirin aided in the cause of the black eye. E2 said Z1(Family member) did not believe that R1 caused the black eye because he is combative and would defend himself.

On 7/6/2016, E2(DON) presented minutes from a care plan meeting with Z1(Family Member). Transmittal Document dated May 22, 2016 states, "E2(DON) went over R1's chart in regards to his medications and services that R1 is getting and explained about 2 blood thinners he receives and how that could have affected his eye and that E1 and E2 witnessed R1 doing a very aggressive knuckle rub to his eye. Z1(Family Member) acknowledged what we were telling her. E2 asked Z1 if Z1 felt that if someone was to hit R1 that R1 would have not yelled out or defended himself. Z1 said she felt that one of the other residents had struck him. It was explained that if that would have been the case, R1 still would have yelled out or struck them back. Z1 agreed with the fact that R1 probably would have retaliated."

On 7/6/2016 at 9:30 AM E2(DON) was asked to present the investigation for R1's black eye. On 7/6/2016 at 10:06 AM E2(DON) presented the investigation. E2 said incidents are investigated in Risk Watch and witness statements are all recorded on the incident report. There were two witnesses statements, E1(Administrator) and E2(DON). The statements documented R1 woke up with a bruise to the left eye, they (E1 and E2) saw him later rubbing the eye and believed R1 caused the bruising. E2 was asked if there were any other witness statements/investigation documented. E2 responded the witness statements are there. E2 was unable to provide

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F 226	Continued From page 7	F 226		

direct care staff statements or other staff interviews about the black eye. During the survey no further documentation of the investigation was presented for R1 after asking.

The investigation did not include any Certified Nursing Assistants, or other resident statements. There is no thorough investigation of how R1 sustained the bruise to the left eye.

On 7/6/2016 at 2:09 PM, E12(Medical Doctor) said R1 had a black eye in May of 2016 along with a white spot in the center of the left eye. " We do not know how R1 got the black eye; we do not know what caused it. It was an injury of unknown origin. " E12 said he remembers talking to staff and nobody knew what happened.

On 7/5/2016 at 4:30PM, E1(Administrator) said " we did not submit the incident to the state agency."

Abuse Policy and Procedure undated states, " The facility will investigate and report incidents or occurrences in accordance with federal and state regulations."

Policy and Procedure Investigation of Bruises, Skin Tears, Scratches last revised 9/1/2015 states, " The Nursing Supervisor, DON or designee will review each form for completeness and determination If the injury is unknown origin should be reported to appropriate state agencies in accordance with the facility policy on Reporting of Abuse and Injuries of Unknown Origin. If there is reasonable cause to believe or suspect that an injury has been inflicted upon a resident by a nurse or aide or another individual used by the facility according to the definition of abuse/and or

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F 226	Continued From page 8 neglect, the incident must be reported. If there is no reasonable cause to suspect neglect or abuse, the incident is not required to be reported. However the injury must be investigated and referred to the quality assurance process for problem identification and corrective action where necessary."	F 226		