PRINTED: 07/12/2016 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|------------------------|---|-------------|-----------------|---|-------|--------------------|
| | 145623 | | B. WING | | | С | |
| | | 145623 | b. WING | | | 07/0 | 06/2016 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| REGENO | Y CARE OF MORRIS | • | | | 095 TWILIGHT DRIVE | | |
| | | | | N | MORRIS, IL 60450 | | |
| (X4) ID PREFIX | | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID PREFI | X | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | | (X5) COMPLETION |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | TAG | | CROSS-REFERENCED TO THE APPROP DEFICIENCY) | RIATE | DATE |
| F 000 | INITIAL COMMEN | TS | F 0 | 000 | | | |
| | Complaint Investig | untion: 1672620/II #06620 | | | | | |
| E 225 | | pation: 1673630/IL#86630 | F 2 | 205 | | | |
| F 225 SS=D | () () () () | | Г | 223 | | | |
| 33=0 | ALLEGATIONS/INI | | | | | | |
| | | ot employ individuals who have | | | | | |
| | | f abusing, neglecting, or | | | | | |
| | | Its by a court of law; or have ed into the State nurse aide | | | | | |
| | registry concerning | abuse, neglect, mistreatment | | | | | |
| | | appropriation of their property; | | | | | |
| | | wledge it has of actions by a t an employee, which would | | | | | |
| | | or service as a nurse aide or | | | | | |
| | | the State nurse aide registry | | | | | |
| | or licensing authori | ties. | | | | | |
| | | nsure that all alleged violations | | | | | |
| | | nent, neglect, or abuse, f unknown source and | | | | | |
| | | f resident property are reported | | | | | |
| | | administrator of the facility and | | | | | |
| | | accordance with State law disprocedures (including to the | | | | | |
| | | ertification agency). | | | | | |
| | The facility must ha | ave evidence that all alleged | | | | | |
| | violations are thoro | ughly investigated, and must | | | | | |
| | | ential abuse while the | | | | | |
| | investigation is in p | rogress. | | | | | |
| | | vestigations must be reported | | | | | |
| | to the administrator | | | | | | |
| | | to other officials in accordance | | | | | |
| | | uding to the State survey and () within 5 working days of the | | | | | |
| | | alleged violation is verified | | | | | |
| | · | | | | | | |
| LABORATOR' | Y DIRECTOR'S OR PROVID | DER/SUPPLIER REPRESENTATIVE'S SIGN | NATURE | | 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.

Facility ID: IL6011381

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1 | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | PLE CONSTRUCTION IG | СОМ | E SURVEY IPLETED |
|--|--|--|---------------------|---|------|----------------------------|
| | | 145623 | B. WING _ | | | C 06/2016 |
| NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF MORRIS | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1095 TWILIGHT DRIVE MORRIS, IL 60450 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIEM DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 225 | Continued From pa appropriate correcti | ge 1 ive action must be taken. | F 22 | 25 | | |
| | by: Based on interview failed to thoroughly unknown origin. | NT is not met as evidenced and record review the facility investigate an injury of | | | | |
| | the following pertine status, Alzheimer's encephalopathy. R Impaired Cognitive | de: ents R1 is a 72 year old with ent diagnosis, altered mental disease, ataxia and 1 has a Care Plan for Function/dementia dated m date Set dated 6/16/2016 | | | | |
| | documents R1 with Progress Notes dat document R1 has a just monitor the bla Incident Report dat has a purple bruise a center area which indicating a center of R1 was witnessed t aggressively. This enough to break the Plavix 75 mg and A medications may fa | severe cognitive impairment. led 5/7/2016 and 5/9/2016 led 5/6/2016 documents "R1 led 5/6/2016 documents "R1 under left eye. The bruise has n is white/pink in color core area below the left eye. to be rubbing the area rubbing was aggressive led blood vessels. R1 receives spirin 81 mg daily. These licilitate increased bleeding to els causing pooling blood | | | | |

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | A. BUILD | | (X3) DATE SURVEY COMPLETED | | | |
|---|---|--|--------------------|----------------------------|---|--------------|----------------------------|
| | | 145623 | B. WING | | | | C 06/2016 |
| NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF MORRIS | | | | 10 | REET ADDRESS, CITY, STATE, ZIP CODE 95 TWILIGHT DRIVE ORRIS, IL 60450 | <u> 077</u> | 00/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 225 | remembers R1 had E3 said she informed (Director of Nursing and saw R1 rubbing E1 and E2 determinand caused a black anticoagulants. On 7/5/2016 at 1:50 said E3(Nurse) brought attention, we (E1 arrubbing his eye. The concluded that the locause of the black of member) did not be eye because he is of himself. On 7/6/2016, E2(DO) was tates, "E2(DON) was tates, "E2(DON) was to his medications a and explained about and how that could E1 and E2 witnessed knuckle rub to his eacknowledged what Z1 if Z1 felt that if swould have not yelles aid she felt that on struck him. It was each are the case or struck them back R1 probably would | a black eye in May of 2016. ed E1 (Administrator) and E2 d) and they both assessed R1 g his eye aggressively. E3 said ned that R1 scratched his eye eye because R1 is on O PM, E2(Director of Nursing) ught R1's black eye to our nd E2) assessed and saw R1 e left eye was deep purple and Plavix and aspirin aided in the eye. E2 said Z1(Family elieve that R1 caused the black combative and would defend ON) presented minutes from a with Z1(Family Member). ent dated May 22, 2016 rent over R1's chart in regards and services that R1 is getting at 2 blood thinners he receives have affected his eye and that ed R1 doing a very aggressive eye. Z1(Family Member) t we were telling her. E2 asked omeone was to hit R1 that R1 ed out or defended himself. Z1 e of the other residents had explained that if that would ex R1 still would have yelled out ex. Z1 agreed with the fact that | | 225 | | | |

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION ING | | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|--------------------|---|-----------|----------------------------|--|--|
| | | 145623 | B. WING | | | C 07/06/2016 | | |
| NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF MORRIS | | | | STREET ADDRESS, CITY, STATE, ZIP O 1095 TWILIGHT DRIVE MORRIS, IL 60450 | | 07700/2010 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | SHOULD BE | (X5) COMPLETION DATE | | |
| F 225 | present the investig 7/6/2016 at 10:06 Å investigation. E2 sa Risk Watch and wit recorded on the incomplete witnesses statement E2(DON). The state up with a bruise to saw him later rubbic caused the bruising any other witness statements are the direct care staff statements are the direct care staff statements about the no further document presented for R1 at The investigation d Nursing Assistants, There is no thoroug sustained the bruis On 7/6/2016 at 2:09 said R1 had a black with a white spot in We do not know that a what cause unknown origin. " talking to staff and Abuse Policy and F The facility will inveoccurrences in accoregulations." | gation for R1's black eye. On MM E2(DON) presented the aid incidents are investigated in mess statements are all sident report. There were two mts, E1(Administrator) and ements documented R1 woke the left eye, they (E1 and E2) mg the eye and believed R1 g. E2 was asked if there were statements/investigation sponded the witness re. E2 was unable to provide tements or other staff e black eye. During the survey station of the investigation was fter asking. | F 2 | 225 | | | | |

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|---------------------|--|-------------------------------|----------------------------|--|
| | | 145623 | B. WING _ | | | C / 06/2016 | |
| NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF MORRIS | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1095 TWILIGHT DRIVE MORRIS, IL 60450 | , , | 30/2010 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE | |
| F 226 SS=D | designee will review and determination should be reported in accordance with of Abuse and Injuris reasonable caus injury has been influred or aide or an facility according to neglect, the incider no reasonable caus the incident is not reasonable caus the incident is not referred to the qual problem identification necessary." 483.13(c) DEVELO ABUSE/NEGLECT The facility must depolicies and proced mistreatment, negleand misappropriation. This REQUIREMED by: Based on interview failed to follow their unknown origin to their policy for invesorigin. | ng Supervisor, DON or weach form for completeness of the injury is unknown origin to appropriate state agencies the facility policy on Reporting es of Unknown Origin. If there is to believe or suspect that an icted upon a resident by a other individual used by the the definition of abuse/and or it must be reported. If there is see to suspect neglect or abuse, equired to be reported. must be investigated and ity assurance process for on and corrective action where it is expected. | F 22 | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|----------------------|-----|---|-------|----------------------------|
| 145623 | | B. WING | | | C 07/06/2016 | | |
| NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF MORRIS | | | | 10 | TREET ADDRESS, CITY, STATE, ZIP CODE 095 TWILIGHT DRIVE IORRIS, IL 60450 | 1 07/ | 00/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 226 | The Findings Included Face Sheet documents following pertinatus, Alzheimer's encephalopathy. Impaired Cognitive 10/6/2015. Minimud documents R1 with Progress Notes day document R1 has a just monitor the blass a purple bruise a center area which indicating a center R1 was witnessed aggressively. This enough to break the Plavix 75 mg and Amedications may fathese broken vesse under the left eye." On 7/5/2016 at 11:50 and saw R1 rubbin E1 and E2 determinand caused a black anticoagulants. On 7/5/2016 at 1:50 said E3(Nurse) broattention, we (E1 ameticognitive status). | ents R1 is a 72 year old with ent diagnosis, altered mental disease, ataxia and R1 has a Care Plan for Function/dementia dated and date Set dated 6/16/2016 a severe cognitive impairment. Ited 5/7/2016 and 5/9/2016 a "black eye, mild puffiness, ck eye and no new orders." Ited 5/6/2016 documents "R1 a under left eye. The bruise has n is white/pink in color core area below the left eye. Ite be rubbing the area rubbing was aggressive e blood vessels. R1 receives aspirin 81 mg daily. These acilitate increased bleeding to els causing pooling blood | F 2 | 226 | | | |

| , | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|--------------------|---|-------|------|-------------------------------|--|
| | | 145623 | B. WING | | | | C 06/ 2016 | |
| NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF MORRIS | | | | STREET ADDRESS, CITY, STATE, ZIP COL 1095 TWILIGHT DRIVE MORRIS, IL 60450 |)E | 01/1 | 55/2010 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | HOULD | BE | (X5) COMPLETION DATE | |
| F 226 | cause of the black of member) did not be eye because he is of himself. On 7/6/2016, E2(DO care plan meeting of Transmittal Docume states, "E2(DON) who his medications and explained about and how that could E1 and E2 witnessed knuckle rub to his eacknowledged what Z1 if Z1 felt that if should have not yellow said she felt that on struck him. It was enave been the case | Plavix and aspirin aided in the eye. E2 said Z1(Family elieve that R1 caused the black combative and would defend DN) presented minutes from a with Z1(Family Member). Ent dated May 22, 2016 rent over R1's chart in regards and services that R1 is getting at 2 blood thinners he receives have affected his eye and that ed R1 doing a very aggressive eye. Z1(Family Member) to we were telling her. E2 asked omeone was to hit R1 that R1 ed out or defended himself. Z1 are of the other residents had explained that if that would ex R1 still would have yelled out of L2 agreed with the fact that | F 2 | 226 | | | | |
| | present the investig 7/6/2016 at 10:06 A investigation. E2 sa Risk Watch and wit recorded on the inc witnesses statemer E2(DON). The state up with a bruise to the saw him later rubbic caused the bruising any other witness statemented. E2 re | O AM E2(DON) was asked to ation for R1's black eye. On AM E2(DON) presented the id incidents are investigated in ness statements are all ident report. There were two ats, E1(Administrator) and ements documented R1 woke the left eye, they (E1 and E2) and the eye and believed R1 at E2 was asked if there were tatements/investigation sponded the witness re. E2 was unable to provide | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145623 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | COMPLETED | | |
|--|--|--|-------------------|-----|---|------------------------|----------------------------|--|
| | | 145623 | B. WING | | | C 07/06/2016 | | |
| NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF MORRIS | | | | 109 | REET ADDRESS, CITY, STATE, ZIP CODE 05 TWILIGHT DRIVE DRRIS, IL 60450 | 1 017 | 00/2010 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE | |
| F 226 | direct care staff stainterviews about the no further documer presented for R1 at The investigation d Nursing Assistants, There is no thoroug sustained the bruis On 7/6/2016 at 2:05 said R1 had a black with a white spot in We do not know honot know what caus unknown origin. "talking to staff and On 7/5/2016 at 4:30 we did not submit that agency." Abuse Policy and Forcedus and Procedus and Procedus and Procedus Skin Tears, Scratch states, "The Nursindesignee will review | tements or other staff e black eye. During the survey ntation of the investigation was fter asking. id not include any Certified or other resident statements. gh investigation of how R1 e to the left eye. PM, E12(Medical Doctor) k eye in May of 2016 along the center of the left eye. " w R1 got the black eye; we do sed it. It was an injury of E12 said he remembers nobody knew what happened. PM, E1(Administrator) said " he incident to the state Procedure undated states, " estigate and report incidents or ordance with federal and state are Investigation of Bruises, nes last revised 9/1/2015 ng Supervisor, DON or w each form for completeness | | 226 | | | | |
| | should be reported in accordance with of Abuse and Injurio is reasonable cause injury has been inflinurse or aide or an | If the injury is unknown origin to appropriate state agencies the facility policy on Reporting es of Unknown Origin. If there e to believe or suspect that an icted upon a resident by a other individual used by the the definition of abuse/and or | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | TIPLE CONSTRUCTION ING | (X3) DA | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|------------------------|--|-------------------------------|----------------------------|--|
| | 145623 B. WING | | | C 07/06/2016 | | | |
| NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF MORRIS | | | | STREET ADDRESS, CITY, STATE, ZIP CO 1095 TWILIGHT DRIVE MORRIS, IL 60450 | | /00/2010 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | SHOULD BE | (X5) COMPLETION DATE | |
| F 226 | neglect, the inciden no reasonable caus the incident is not re However the injury referred to the qual | ge 8 It must be reported. If there is see to suspect neglect or abuse, equired to be reported. It must be investigated and ity assurance process for on and corrective action where | F 2 | 26 | | | |