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	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Care	2120 West Washington Springfield, IL 62702

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40650 Based on interview and record review, the facility failed to prevent physical abuse for 1 of 4 (R2) residents, reviewed for abuse in a sample of 4. Findings include: R2's Minimum Data Set (MDS), dated [DATE] documented that R2's cognition was moderately impaired, that she uses a wheelchair to be mobile and that she requires set up help on some Activities of Daily Living (ADL's) and maximum assistance for mobility and dressing ADL's. R2's Care Plan, dated 7/8/2024, documented, Physical Assault: (R2) was in an abusive relationship in the past. She has dealt with this and declines services and intervention at this time.Resident will verbalize understanding of available services if needed. Reevaluate as needed. R2's Physicians order sheet, dated 10/2024, documented diagnoses of other postprocedural complications and disorders of digestive system, peritoneal abscess, infection following a procedure, superficial incisional surgical site, subsequent encounter, and urinary tract infection, site not specified. On 10/28/2024 at 11:00 AM, R2 stated that V3, Certified Nurse Assistant, (CNA), was in and out of her room, doing things for her, the evening before and that she was also on her cell phone talking to some girl about being her girlfriend or something while in her room. R2 stated that she left her room and was out in the hallway being loud on her phone. R2 continued to state that the next day, when (V5), Business Office Manager, came down to see her, she let her know what was going on with V3 being on her phone instead of assisting the residents. R2 continued to state that around 1:30 pm that day, (V3), CNA, came back into her room took the bowl of soup and threw it at her. She continued to state that she was not hurt. R2 continued to state that she (V3) was yelling at her telling her that she wasn't getting fired and that they were only moving her to a new hall and that she wasn't talking about a girlfriend. R2 stated that (V3), CNA, was trying to intimidate her because she told on her about being on her phone. R2 was asked if she felt safe at the facility and she stated that some people are very caring and some she is [NAME] of but she does not feel threatened and she feels safe living at the facility. She also stated that she spoke with the police and pressed charges against (V3), CNA. R2 stated that she does not fear (V3), CNA, coming back because it was taken care of as it should have been. (continued on next page)

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.

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

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Regency Care	2120 West Washington Springfield, IL 62702

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/28/2024 at 1:45 PM, V5, Business Office Manager (BOM), stated that she went in to see R2 when she 1st got to work on 10/15/24. She stated that (R2) was her daughter's grandmother. She continued to state that (R2) told her that (V3) was on her phone being loud in her room and in the hallway, the day or night before. V5 stated that once (R2) told her this she went to the (V2), Director of Nurses, immediately with this information. She then stated that around 11:30 am she took (R2) some soup and then she went and covered the front desk for another girl. V5 continued to state that at 1:39 pm she received a text message from (R2) telling her to get down to her room and see what the CNA had done to her. She stated that she immediately asked if she was hurt and if she was ok, V5 stated that was the soup that she brought into her at 11:30 am so it wasn't hot any longer. V5 continued to state that she ran and got (V1), Administrator and (V2), Director of Nurses to come and check out (R2). V5 also stated that around 1:00 pm, they had the girl (V3), CNA in (V1's) office and the voices were getting really loud. On 10/29/2024 at 10:00 AM, V2, Director of Nurses, stated that she was told by (V5), BOM, about (V3), CNA being on the phone while taking care of residents and that she also had a complaint by another staff member about her being on her phone and that she went and looked for her. V2 stated that she found her in the sun room, talking on her phone. V2 stated that her and (V3) had a talk about not being on her phone while taking care of residents and that she could use her phone on her break time and away from care areas. V2 stated that (V3) apologized and went back to work. Later that morning, therapy staff came to her and stated that a resident had complained that (V3) was on her phone while she was doing incontinent care. V2 stated that she went down to that residents room to talk to him and (V3) walked by and saw her sitting there talking to the resident and that was when she went to (V1's) office and was upset. V2 continued to state that (V3) did raise her voice trying to talk over her but (V3) acted more upset and was defending herself and did not seem to be agitated. V2 then stated that she did not see (V3) leave the facility, but was told that soup was thrown on (R2) by (V3), so her, (V1), Administrator,(V5), BOM, and another nurse went immediately to go check on (R2) and assess her. V2 stated that when (V3) left the building at 1:05 pm and then returned around 1:39 pm to throw soup on (R2), no one would of even wondered why she was coming possible through the employee entrance because she was working that day. On 10/29/2024 at 8:45 AM, V1, Administrator, stated when asked about when (V3), CNA, was pulled into the office and spoken with about her being on her phone how was her demeanor. V1 stated that they didn't pull (V3) into her office, and that she came in there upset and not agitated as she could tell, stating that she could not lose her job because she was homeless and that she was on her phone because someone was calling her about a place to live. V1 continued to state that she was concerned that this person needed assistance because she was homeless. V1 continued to state that (V3) left the building at or around 1:05 pm, but then at 1:15pm or so, (V5), BOM, got a text message from (R2) to come down to her room immediately to see what (V3) had done to her. V1 continued to state that no one saw (V3) come back into the building through the front door and that every door code was the same so she may have come in through the employee entrance. V1 continued to state that she had maintenance change all the door codes the same day. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/2024, an Interview was done by V1, Administrator. V7, CNA was interviewed regarding the event that took place on 10/15/2024. It documented, Tuesday October 15, 2024. Delivered lunch tray to (R2). Did anything occur when you delivered her lunch tray (V7, CNA): The girl that had that group was standing in the room. I assumed she was doing something with (R2). Did you hear or see anything occur when you delivered the tray? (V7, CNA)- No. Did you speak to the CNA that was in the room? (V7) when she came out of the room, yeah. What was said during that conversation? (V7) She was asking me who she needed to talk to because she was fed up with having that group. I told her go talk to (Staffing). What time was that? (V7) Around lunch time maybe 12:30. Did you see this aid after that? (V7) No. Do you know the aides name? (V7, CNA) I believe it was (V3, CNA). It continued to document, Did you see or hear that CNA, (V3) speak inappropriately to any resident while you were working? (V7, CNA) No. Did you see (V3) enter (R2's) room around 1:30 PM? (V7) No. Did you see (V3) throw soup at (R2), (V7)- No. It continues, Did (V3,CNA) have any interaction with you around 1:30 PM? (V7) No. Report to State Agency, dated 10/18/2024, documented, (R2) reported to the Business Office Manager (V5) that an Agency CNA, (V3) entered her room at approximately 1:35 pm and stated I didn't say I had some girlfriend. They are not going to fire me; they are going to just move me. (R2) then stated, That girl with the pink bonnet picked up my bowl of soup and threw it at me and said that's what you get. (R2) had soup on her gown, her bed, the wall and the soup bowl was upside down on the right side of (R2's) bed. Head to toe assessment completed, no injuries. (R2) state, The soup was not hot. It continues, (V3, CNA) left the facility prior to her scheduled shift ending after being upset about being told she was not to be on her phone by the DON (V2). (V1) Administrator attempted to call (V3, CNA) per phone number on file (XXX-XXX-XXXX), a female aswered and said, wrong number. It continues, (V3) was immediately put on the do not return list with (Staffing Agency), (V6, Staffing Agency Supervisor) was notified via phone that (V3, CNA) is to not return to our facility or facility property related to occurrence and provided allegation information. The facility's policy, Resident care policy and procedure regarding abuse and neglect, involuntary seclusion, exploitation, Misappropriation of Resident Property, Injuries of Unknown Origin, and social Media, dated 03/15/2018, documented, 1. All residents have the right to be free from verbal, sexual, physical, mental abuse, corporal punishment, involuntary seclusion, neglect, misappropriation of property, exploitation