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	02/17/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow transfer and fall prevention policies and did not provide adequate supervision for 2 of 2 (R2, R6) residents in the sample of 14. This failure resulted in R2 being forcefully lifted from the floor by V5, Certified Nursing Assistant, CNA, without the use of a gait belt or mechanical lift, and R6 sustaining a fall that resulted in a fracture.Findings include:R2's face sheet documents an admission date of 12/4/2025. Diagnosis includes Sepsis, Cerebral Infarction, Type 2 Diabetes, Dementia, Cellulitis of Buttock.R2's Minimum Data Set, MDS, documents R2 is severely cognitively impaired. R2 is dependent for mobility and transfers. Has upper and lower one-sided impairment.R2's care plan updated 12/17/2025 documents R2 is at risk for falls related to history of stroke, traumatic brain injury, history of falls, dementia, incontinence, medication use. Interventions include: 02/1/26 bed/chair alarm. On 1/5/26 cushion in reclining chair, keep within vision of staff when up in wheelchair. 12/7/25 low bed, fall mat. Always keep non-skid footwear on while up. Reclining chair for mobility. Make sure call light is always within reach. No risk of abuse documented on care plan.R2's fall assessment dated [DATE] documents R2 is at high risk for falls.On 2/6/2026 at 10:30am Surveyor observed video of incident involving R2 and V5, Certified Nursing Assistant, CNA. Video time stamped 2/1/2026 at 8:14PM, shows V5 walking into video frame and R2's arm reaching for V5. V5 picks up R2 by R2's shoulders and forcefully puts R2 on the bed. V5 then pulls on R2's right leg and shirt and straightens R2 in bed. V5 then raised R2's bed and puts pillow behind R2. During encounter R2 can be heard calling out Ouch and moaning. No gait belt, no staff assistance, no assessment, no mechanical lift, in room during transfer.R2's progress notes dated 2/1/2026 at 9:15PM documents Situation, Background, Assessment, Recommendation, SBAR, it was reported to writer that R2 rolled out of bed on to the floor. He was observed lying on fall mat next to bed. Background: R2 is on hospice. Can be restless at times and fidgets with his blankets. Alert to self only, confused per normal. Assessment (Registered Nurse)/Appearance (Licensed Practical Nurse): Range of Motion, ROM within normal limits. Neurological within normal limits. No visible injuries.R2's fall investigation dated 2/6/2026 documents R2 was observed on the floor next to his bed lying on the fall mat. Bed was in low position. R2 unable to give description. R2 assisted back to bed. Post fall assessment shows range of motion within normal limits. No signs of pain/discomfort. Head to toe assessment completed with no visible injury noted. R2 did not go to hospital.R2's abuse investigation documents on 2/2/2026 phone interview with V4, Licensed Practical Nurse, LPN, revealed that V4 was not aware that R2 had fallen. This was not reported by V5, CNA. On 2/4/2026 via phone interview with V6, CNA, documented V6 was not aware R2 had a fall and was not asked by V5 to help transfer R2. On 2/5/2025 V7, CNA, documented V7, was not aware R2 had a fall and was not asked by V5 to help transfer R2. Resident interviews documented on R2's abuse investigation documents R7, R8, R9, R10, R11, R12, R13, and R14 all deny ever being improperly transferred in facility.On 2/6/2026 (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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F 0689 Level of Harm - Actual harm Residents Affected - Few	at 10:30AM V8, R2's family member, stated R2 has dementia and gets out of bed. Bed is in low position. We have a video recorder in R2's room and saw on video V5 very forcefully manhandle R2 from floor to bed and forcefully reposition in bed. Stated facility terminated V5. I sent the video in with complaint. Stated R2 can be heard yelling Ouch Ouch. We also sent video to Administrator and police were notified.On 2/6/2026 V1, Administrator, stated I found out about the video on 2/2/2026 the day after it was taken. I found out about the incident from the family. V5 did not report the incident, did not report R2 fell out of bed and was on the floor, did not tell the nurse, did not follow policy and did not transfer appropriately. We started an abuse investigation and fall investigation on 2/2/2026. The Director of Nursing, DON, assessed R2. V5 was terminated on 2/3/2026 when he came in to work. V5 did not work after the video. R2 is very confused, we can't even get a Brief Interview for Mental Status, BIMS on him. Surveyor asked V1 if she thought R2 was intimated by the transfer involving V5. V1 stated I don't feel R2 has the cognition to have been intimidated. The incident was against policy and inappropriate, but I don't think V5 was trying to hurt R2. V5 had been here 3 years and never disciplined. I was shocked. The staff and residents loved him.On 2/13/2026 at 3:00PM V4, LPN, stated I was working the evening that R2 was on the floor in his room and V5, CNA, transferred R2 back to his bed without telling anyone R2 had fallen. I did not find out until a couple of days later that the incident even happened. I had never known V5 to do anything like that. I worked with V5 as a CNA before becoming a nurse and he was not one to roughly handle the residents. If a resident is on the floor the resident is not to be moved until they are assessed, vitals taken, and neuro checks started. V5 did not tell anyone R2 was on the floor.On 2/13/2026 at 11:00AM V11, Assistant Director of Nursing, ADON, denied seeing video of V5 picking R2 up off the floor. Stated I had not known V5 to ever do that. I understand R2 was assessed the next day after the video was shared, and he was not injured. I would expect any resident that is on the floor to be assessed before being transferred and for a gait belt or mechanical lift to be used.On 2/13/2026 at 1:10PM V14, Nurse Practitioner, NP, stated I am not familiar with R2 or the circumstance. If a resident was on the floor, I would expect the use of a gait belt at least and probably a mechanical lift, not pulling them up and putting them back in bed. 2.R6's face sheet documents an admission date of 10/31/2025. Diagnosis includes Senile Degeneration of Brain, Hypertensive Heart Disease with Heart Failure, Congestive Heart Failure, Atrial Fib, Metabolic Encephalopathy. R6's Minimum Data Set, MDS, dated [DATE] documents Brief Interview for Mental status, BIMS, 4. R6 requires partial/moderate assistance with mobility, transfers, and walking.R6's care plan updated 12/22/2025: I had an actual fall related to dementia, poor safety awareness. Interventions include cushion, nonskid footwear, and a clear pathway.R6's fall assessment dated [DATE] documents R6 is a high risk for falls.R6's progress note dated 11/23/2025 at 9:40AM documents Certified Nursing assistant, CNA, alerted nurse that R6 was on floor in another resident's bathroom. R6 located on the floor of the shower in room. R6's head and back against shower wall with feet pointed toward the door, right leg flexed, left leg extended. R6 was holding left shoulder with right hand. R6 was tearful and complained of pain in head, left shoulder, buttocks and right lower extremity. R6 verbalized inability to move. R6 assessed, notifications made, transfer to Emergency Department, ED. R6's progress notes dated 11/24/2025 at 10:00AM documents Situation: Interdisciplinary Team, IDT, met and reviewed. According to nurse documentation: CNA alerted nurse that R6 was on floor in another resident's bathroom. R6 located on the floor of the shower, head and back against shower wall with feet pointed toward the door, right leg flexed, left leg extended. R6 was holding left shoulder with right hand. R6 was tearful and complaining of pain in head, left shoulder, buttocks and right lower extremity. Background: R6 has history of degeneration of the brain-senile, Atrial (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Fib, dementia, asthma, right clavicle fracture, and prior falls. Assessment according to nurse documentation: Assessed for neurological deficits, safety ensured, CNA delegated to stay with R6, family notification, Emergency Medical Services, EMS, contacted transport, V2, Director of Nursing, DON, notified. Recommendations: 11/24/25: Will review upon return.R6's initial fall investigation dated 11/24/2025 documents (R6), with a BIMS of 4, was observed on the floor in the bathroom. (R6) was taken to the bathroom and assisted to bed approximately 20 minutes prior. R6 complained of pain to left shoulder, right lower extremity, and buttocks. R6 would not allow staff to assist her off of floor due to complaints of pain. Vital Signs, VS, 136/72, 86, 97.3, 18. Neurological checks within normal limits, WNL. Power of Attorney, POA notified and requested R6 be sent to Emergency Room, ER, due to pain. Physician notified. R6 was transferred to ER via ambulance for evaluation. Computerized Axial Tomography, CT, scan results show a nondisplaced avulsion fracture of the right ilium and a re-demonstration minimally displaced right distal clavicle fracture. R6 was admitted to the hospital for treatment of urinary tract infection, UTI and pneumonia. Fractures will not be treated operatively. Investigation initiated, final report to follow. Investigation is complete. R6 with a BIMS of 4, was observed on the floor in the bathroom. Approximately 20 minutes prior, resident was assisted to the bathroom and then bed. Call light was placed within reach. Upon assessment after fall, resident was complaining of pain to her left shoulder, lower right extremity, and buttocks. VS 136/72, 86, 97.3, 18. Resident was unable to report what she was doing at the time of the fall. POA was notified of fall and pain and requested R6 be sent to the ER for evaluation. Physician notified. R6 was transferred to ER via ambulance for evaluation. CT scan results showed a non-displaced avulsion fracture to the right ilium, and a re-demonstration minimally displaced right distal clavicle fracture. Fractures were not treated operatively. Resident was admitted overnight for treatment of pneumonia and UTI. She returned to the facility where she continues with hospice care. Care plan was reviewed and updated with new interventions. R6's computerized axial tomography, CAT, scan results dated 11/23/2025 at 10:53AM documents Bones and soft tissues. There are new calcifications that is seen anteriorly within the right iliacus (8/394). There is a peripherally enhancing fluid collection seen within this region as well measuring 1.6 cm (4/406). This extends inferiorly 4.3 cm. Findings are suspicious for avulsion fracture with associated muscle injury. No destructive osseous lesion.On 2/10/2026 at 9:30AM V1 stated she sent in a reportable on R6. R6 was very confused and a wanderer.On 2/13/2026 at 1:49PM V11 ADON, stated R6 was very much a wanderer. She would get up on her own. It didn't help to remind her to stay sitting or wait for assistance because she would not remember. We had a bucket seat and a cushion, but she was able to get up anyway.On 2/13/2026 at 9:30AM V10, CNA, stated R6 had a cushion. She would just get up and wander all the time. Everyone, even the kitchen staff, knew her and would remind her to sit down.Facility transfer policy with a revision date of 3/18/2018 states Should a resident fall to the floor, the resident will be first be assessed by a nurse. If the resident is deemed medically appropriate to transfer from the floor, a full size mechanical (Hoyer TM type) lift will be used. If the resident is not medically appropriate to transfer from the floor, emergency medical technicians will be notified and said technicians will transfer the resident.Facility fall policy with a revision date of 4/2024 states It is the policy of this facility to assess each resident's fall risk on admission, quarterly, and with each fall. This will help facilitate an interdisciplinary approach for care planning to appropriately monitor, assess and ultimately reduce injury risk. Factors related to the risk will be addressed and care planned.