STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145965	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab of Decatur	500 West McKinley Avenue Decatur, IL 62526

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview and record review the facility failed to ensure the dignity of two residents (R1, R2) by not providing timely incontinence care out of three residents reviewed for incontinence cares in a sample list of five residents. Findings include: The facility Resident Council Minutes dated April 11, 2024 documents Residents voiced that they are being left on bed pans for a long periods of time on second shift. Residents voiced that Certified Nurse Aides (CNA) still turning off call lights without seeing what their needs are. The facility Resident Council Minutes dated 5/21/24 documents Residents voiced complaints the call lights are not getting answered throughout the day. The facility Resident Council Minutes dated 6/20/24 documents Residents voiced that call lights are not being answered in a timely manner. Residents voiced that it takes 45 minutes to an hour for call lights to be answered. 1.) R1's undated Face Sheet documents R1's medical diagnoses as Cerebral Infarction, Hemiplegia and Hemiparesis following Cerebral Infarction, Cerebral Ischemia, Chronic Obstructive Pulmonary Disorder (COPD), Encephalopathy, Severe Persistent Asthma, Spinal Stenosis, Fibromyalgia, Heart Failure, Presence of Intraocular Lens, Morbid Obesity and Neuropathy. R1's Minimum Data Set (MDS) dated [DATE] documents R1 as cognitively intact. This same MDS documents R1 as requiring assistance of two staff for transfers and maximum assistance for toileting and personal hygiene. R1's careplan intervention dated 4/17/24 documents R1 requires two staff for bed mobility, toileting and transfers using a total body mechanical lift and repositioning at least every two hours. R1's Bladder and Bowel Screener dated 4/30/24 documents R1 is totally dependent on staff for assistance with toileting. This same screener documents R1 is incontinent of bladder and bowel. (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/28/24 at 10:40 AM, V18 Certified Nurse Aide (CNA) and V10 Lead CNA provided incontinence care for R1. R1 was laying on an incontinence brief and three separate linen pads. R1's incontinence brief and first layer of linen incontinence pads were fully saturated with urine. On 6/28/24 at 10:45 AM, V18 Certified Nurse Aide (CNA) stated V18 was R1's CNA for 6/28/24 day shift from 6:00 AM-2:00 PM. V18 CNA stated V18 had not provided incontinence care for R1 prior to now. V18 CNA stated I have been in (R1's) room but I never asked her if she needed changed. I should have. I don't think (R1) likes being wet. On 6/27/24 at 2:40 PM, V3 Assistant Administrator stated R1 has voiced concerns to V3 recently. V3 Assistant Administrator stated R1 complained that staff were taking too long to answer her call light on Saturday (6/22/24) evening. V3 stated (V1) Administrator and myself (V3) went in on Monday (6/24/24) morning to speak with R1 about her concerns. R1 did tell us that she had called the police on Saturday (6/22) evening due to having to wait so long on her call light to be answered. On 6/28/24 at 11:30 AM V15 Assistant Director of Nurses (ADON) stated residents who are incontinent should be offered incontinence care at least every two hours. On 6/27/24 at 3:30 PM, R1 stated I was hanging out of my wheelchair Saturday (6/22/24) night. The staff took forever to come help me. I put my call light on around 7:00 PM because I needed to use the bathroom. No one came and no one came so I started yelling 'Help me! Help me!'. Still no one came. I called my brother and he called the facility to let them know I needed help. That was around 8:00 PM. Still no one came to help me. I finally called the police at around 9:00 PM. The fire department showed up at the same time the staff finally answered my call light. I was soaked with urine. That was at 9:45 PM. It took them (staff) two hours and forty five minutes to finally answer my call light and help me. I told the fire department that I no longer needed them because the staff finally showed up. The police came out to see me on Sunday (6/23/24) morning just to make sure I was ok. On 6/28/24 at 9:00 AM, V18 Licensed Practical Nurse (LPN) stated V18 worked Saturday (6/22/24) and Sunday (6/23/24) from 6:00 AM-6:00 PM. V18 stated I got in report on the morning of 6/23 that the fire department was here (facility) to see (R1) late Saturday (6/22/24) night. The staff didn't check on (R1) for three hours. Sunday (6/23/24) morning during breakfast the local police arrived at our facility to see (R1). They (police) were here to do a wellness check for (R1). 2.) R2's undated Face Sheet documents R2's medical diagnoses of Acute Ischemic Heart Disease, history of Urinary Tract Infections (UTI), Chronic Obstructive Pulmonary Disease (COPD), Diabetes Mellitus Type II, Neuropathy, Peripheral Vascular Disease, Left below the Knee Amputation. R2's Minimum Data Set (MDS) dated [DATE] documents R2 as cognitively intact. This same MDS documents R2 as requiring maximum assistance for toileting, dressing, bathing and transfers. R2's Care plan interventions dated 10/17/23 instructs staff to check resident every two hours and assist with toileting as needed. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/24 at 12:25 PM, R2 stated I have complained to the Administrator and nursing staff about how long it takes for my call light to be answered. Usually it is a 30-45 minute wait. The staff finally come in and then tell me they are too busy and to just pee in my depend (incontinence brief). That is embarrassing. I used to be able to walk by myself but I had my left leg amputated about a month ago and now have to rely on the staff to get me in the wheelchair and over to the bathroom to use the toilet. I don't want to wet in my incontinence brief. I never did that before. I know it's only a few feet from my bed to the bathroom but it might as well be a few miles because I can't do it on my own anymore. I don't know what takes them so long. The Administrator told me that they (staff) have been educated but I haven't seen any improvement. On 6/28/24 at 1:15 PM, V1 Administrator stated the staff should provide incontinence care every two hours and as needed. V1 stated it is not healthy for residents to sit in their urine for hours. V1 stated We (facility) know there has been an issue with long call light answering times. We (facility) are working on that. I have inserviced and talked about it several times with staff. I will do another inservice and try to get more managers on the floor. The facility policy titled 'Promoting/Maintaining Resident Dignity reviewed 12/5/2022 documents it is the facility practice to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Respond to requests for assistance in a timely manner. Groom and dress resident according to resident preference. Speak respectfully to residents. The facility policy titled 'Incontinence' reviewed 12/19/2022 documents based on the resident's comprehensive assessment all residents that are incontinent will receive appropriate treatment and services to ensure resident is maintained at highest functioning level related to continence of bowel and bladder and to assist in maintaining that level.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview and record review the facility failed to follow their Abuse Prevention Policy by not immediately suspending a staff member accused of abuse of one (R1) resident out of one resident reviewed for abuse in a sample list of five residents. Findings include: R1's Minimum Data Set (MDS) dated [DATE] documents R1 as cognitively intact. R1's Physician Order Sheet (POS) dated June 2024 documents a physician order for Duloxetine 25 milligrams (mg). Give two tablets every morning. On 6/27/24 at 4:38 PM, V5 Licensed Practical Nurse (LPN) was assisting residents in the hallway. V5 LPN actively working in facility as a nurse assisting residents and directing staff in coordination of cares. On 6/28/24 at 8:10 AM, V5 Licensed Practical Nurse (LPN) was passing medications to residents on R1's hallway. On 6/28/24 at 8:30 AM, V5 Licensed Practical Nurse (LPN) administered medication to R1 in R1's room. On 6/27/24 at 3:40 PM, R1 stated V5 Licensed Practical Nurse (LPN) would not administer R1's prescribed medication to R1 the morning of 6/27/24 during the morning medication pass. R1 stated (V5) LPN came in here (R1 room) and said 'Here are your pills'. I am supposed to take two pills for my Fibromyalgia. (V5) LPN only brought me one. I asked (V5) for the other pill and she said you are only getting one pill. You are just going to have to wait to get anything else. Now take these pills. (V5) LPN has no right to talk to me that way. (V5) had such a hateful tone. I was scared (V5) LPN was going to do something to me. (V5) LPN has been my nurse all day today. I haven't seen (V5) since this morning but I don't want her anywhere around me. On 6/28/24 at 8:40 AM, V5 Licensed Practical Nurse (LPN) stated I was going up front to do something else and (V1) Administrator asked me if (R1) had any problems in her medication pass yesterday morning. I told her no. I talked to (V1) at 5:40 PM. I did drop a pill and had to get (R1) a new pill but (R1) had no complaints. (V1) didn't ask me anything else. I wasn't suspended. (V1) didn't say anything about me being suspended or having to go home or anything like that. (V1) only asked me what happened that morning. So, I just went back to work and came in again this morning. I have been working the floor as (R1's) nurse all morning. On 6/28/24 at 9:30 AM, V1 Administrator stated the facility Abuse policy was not followed because V5 Licensed Practical Nurse (LPN) was not suspended following an allegation of abuse by R1. V1 Administrator stated I did not talk to (R1) about her allegation on 6/27/24. I spoke with (V5) LPN and did not feel like (V5) abused (R1) so I did not suspend (V5) on 6/27/24. I suspended (V5) LPN at 9:20 this morning (6/28/24) after I spoke with (R1). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled 'Abuse, Neglect and Exploitation' reviewed 12/5/2022 documents when abuse, neglect or exploitation is suspected, the Administrator/Abuse Coordinator Designee should remove the employee from resident care areas immediately, place the accused employee on paid administrative leave pending completion of the investigation, initiate an investigation immediately.

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F 0689 Level of Harm - Minimal harm or potential for 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** 41970 Based on observation, interview and record review the facility failed to maintain resident equipment in safe functioning order for one (R1) resident out of three residents reviewed for Physical Environment in a sample list of five residents. Findings include: R1's Minimum Data Set (MDS) dated [DATE] documents R1 as cognitively intact. On 6/27/24 at 3:30 PM, R1 was laying in R1's bed in her room. R1's bed cord had several areas that were wrapped in black electrical tape. On 6/27/24 at 3:40 PM, R1 stated V16 Physical Therapy Assistant (PTA) was working with R1 for therapy in R1's room on 6/21/24. R1 stated We (R1, V16) both heard this loud pop sound and saw a spark. It scared us both. (V16) jumped and said 'that shouldn't happen'. (V16) PTA left me to go get someone to look at my cords. I saw a spark and heard a loud pop sound. Then I smelled something like it was on fire. I was pretty scared until they (facility) got it fixed. On 6/27/24 at 4:30 PM, V16 Physical Therapy Assistant (PTA) stated I was working with (R1) for strengthening. (R1) was laying in her bed. I put the bed remote towards the end of (R1's) bed to move it out of the way for a minute while I got (R1) repositioned. Then there was a very loud pop sound and spark that came from the area around (R1's) head of bed or maybe over her bedside table area. I smelled something that I would describe as an electrical fire. There was no fire but I smelled that smell for a minute or so and then it went away. I couldn't be sure where the sound came from exactly but I squealed and jumped. It scared us both. I stepped out of (R1's) room momentarily to get some help. When I left (R1's) room her television was on and when I came back her television was turned off. (R1) told me she didn't touch her television remote. It just turned off on its own. I just wanted them to know there may be a problem. This all happened at around 5:00-5:30 PM on 6/21/24. I called (V17) Maintenance Director. I think (V17) came in to check out (R1's) wires. On 6/28/24 at 8:15 AM, V17 Maintenance Director stated V17 was called by the facility on 6/21/24 at 5:30 PM to check on R1's electrical cords in her room. V17 Maintenance Director stated I was out at the facility in (R1's) room by 6:00 PM. (V16) Physical Therapy Aide (PTA) told me she heard a pop and saw a spark so I came out to check things out. (R1)'s cord to her bed did have an area a few inches long that had bare wires showing. Those wires made contact with the metal frame of (R1's) bed which would have caused the pop and spark. That electricity would have flowed through the metal bed right back into the wall outlet. (R1's) room is ran by one breaker. That breaker does not control any other rooms, only (R1's). I shut off the power to (R1's) room just for a couple of minutes so that I could get those wires covered with electrical tape. Once I did that, I turned the power back on and I don't believe (R1) has had any more issues. There were several places on that same cord with electrical tape so I think that has happened before. Friday night (6/21/24) was the first time I had ever known about those exposed wires. It could really hurt someone. Since then I have done some spot checks with other resident's wires and not found any issues. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/28/24 at 1:20 PM, V1 Administrator stated R1's bed cord was unsafe. V1 Administrator stated As soon as we (facility) realized there was a safety issue with (R1's) cord, (V17) Maintenance Director came right in to the facility and got it fixed. There have been no other instances like this. We (staff) have been doing random audits of resident cords and have no other problems. We (facility) replaced (R1's) cord with a new one last night (6/27/24).