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	07/11/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 49492 Based on interview and record review the facility failed to notify a patient representative of an X-ray result for one of three residents (R1) reviewed for notification of changes in the sample list of six. Findings include: The facility's Notification of Changes policy with a Revised date of 12/13/23 documents, the purpose of this policy is to ensure the facility promptly informs the resident, consults the residents physician; and notifies, consistent with his or her authority, the residents representative when there is a change requiring notification. R1's progress note dated and timed 7/1/2024 at 11:15 AM states R1 complained of pain in the left foot and V4 LPN (Licensed Practical Nurse), notified the physician and an X-ray of R1's left foot was ordered. On 7/10/24 at 12:32 PM, V3, R1's Family, stated that the facility has not called V3 with the results of the left foot X-ray that was completed on 7/2/24. On 7/11/24 at 09:06 AM, V2 Director of Nursing confirmed that the X-ray result was received by the facility and the physician was notified on 7/3/24. V2, Director of Nursing confirmed there is no documentation the patient representative was notified. On 7/11/24 at 12:41 PM, V2 Director of Nursing stated that all parties involved should be notified of test results and the notification should be documented in the progress notes upon completion of that notification.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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** 32853 Based on interview and record review the facility failed to implement a fall prevention intervention for one of three residents (R2) reviewed for falls in the sample list of six. Findings include: The facility's Fall Prevention policy with a Revised date of 1/24/23 documents, Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. The nurse will indicate on the (Fall Risk Assessment) the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk. R2's Care Plan printed on 7/10/24 documents diagnoses including History of Falling, Urinary Tract Infection, Dementia, Wedge Compression Fracture of T11-T12 Vertebra, Wedge Compression Fracture of First Lumbar Vertebra, Abnormalities of Gait and Mobility and Muscle Weakness. R2's Care Plan with an initiated date of 5/19/24 documents R2 was at Moderate risk for falls related to multiple diagnoses and limited mobility. R2's Care Plan documents a fall intervention dated 5/19/24 of a non-slip rubber like plastic material added to the wheelchair seat. R2's Fall Risk assessment dated [DATE] documents R2 had a score of 40 which indicates a Moderate Risk for Falling. R2's Fall Investigation dated 5/29/24 at 6:10 PM documents R2 was observed lying on the floor in dining room near her wheelchair. The root cause determined for this fall was that R2 was trying to reposition herself in the wheelchair when she slipped out. There is no documentation in this fall investigation or in the Nurse's Notes that documents whether the non-slip rubber like plastic material was in the wheelchair to prevent R2 from slipping out of the wheelchair. On 7/11/24 at 9:25 AM, V2 Director of Nursing confirmed there is no documentation as to whether the non-slip rubber like plastic material that was the fall intervention was in place at the time of the fall and V2 stated she was unsure of who found R2 on the floor.