

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145965	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/07/2024
NAME OF PROVIDER OR SUPPLIER  Loft Rehab of Decatur		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>49492</p> <p>Based on interview and record review the facility failed to ensure call lights were answered in a timely manner and was within reach for residents. This failure affects three of four residents (R2, R3, R6) reviewed for call lights on the sample list of six.</p> <p>Findings Include:</p> <p>Call lights: Accessibility and Timely Response Policy dated 8/1/2019 on line 9 states process for responding to call lights: A. Response times should be a Priority.</p> <p>1. R2's Admission Record dated 1/18/24 documents R2 is diagnosed with Abnormalities Of Gait And Mobility, Gout, and Morbid (Severe) Obesity. R2's Care Plan dated 03/11/2024 documents R2 is dependent on staff for physical needs and is at risk for falls. The Care Plan documents staff should encourage the resident to use bell to call for assistance.</p> <p>On 8/6/24 at 2:09 PM, R2 states that he uses the call light but staff don't always come very quickly, and he will have to wait a long time to be changed.</p> <p>2. R3's Admission Record dated 7/16/24 documents R3 is diagnosed with Fracture Of Head And Neck Of Left Femur, Abnormalities Of Gait And Mobility, and Weakness. R3's Care Plan dated 07/17/2024 documents R3 is High risk for falls related to Impaired Mobility, multiple diagnosis, use of antidepressant medication. The Care Plan documents prompt response to all requests for assistance.</p> <p>On 8/6/24 at 1:59 PM, R3 states that R3 can turn on the call light and no one will come for a very long time.</p> <p>3. R6's Admission Record dated 5/6/2024 documents R6 is diagnosed with Displaced Bimalleolar Fracture Of Left Lower Leg, Presence Of Right Artificial Knee Joint, Lack Of Coordination, Muscle Weakness (Generalized), Difficulty In Walking, History Of Falling, and Proliferative Diabetic Retinopathy. R6's Care Plan dated 5/7/2024 documents R6 has impaired vision, requires staff assistance to meet physical needs, and is at risk for falls. The Care Plan documents staff should respond promptly to all requests for assistance.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/7/24 at 3:20 PM R6 stated when she pushes her call light it takes forever for someone to respond. R6 states on 8/6/24 at 10:00 AM, R6 pushed the call light, wait for 1 hour and 30 min for staff. R6 stated staff never arrived, so R6 got the walker and walked herself to the restroom. R6 stated R6 waited another 45 min in the restroom before staff arrived to assist R6 back to the recliner.</p> <p>Resident council minutes document the following:</p> <p>May 21st, 2024 at 11:00 AM under section Nursing Department state: Residents voiced complaints that CNAs are late to work and call lights are not getting answered throughout the day.</p> <p>June 20th, 2024 at 11:00 AM under section Nursing Department state: Residents voiced that call lights are not being answered in a timely matter. Residents voiced that it takes 45 mins to an hour for call lights to be answered.</p> <p>July 11th, 2024 at 11:00 AM under section Old Business state: Residents also voiced that timing of call lights is still an issue.</p> <p>July 11th, 2024 at 11:00 AM under section Nursing Department state: Residents voiced when turning on call light CNA's will come into room and turn call light off and tell them they will be back and will not return.</p> <p>Grievance Logs document the following:</p> <p>6/19/24 states there is a family concern with customer service described as call light timeliness.</p> <p>6/21/24 states there is a resident concern with customer service described as call light response.</p> <p>7/6/24 states R1 concern with customer service described as call light response time.</p> <p>7/20/24 states R6 concern with customer service described as 2nd shift call light response time.</p> <p>7/26/24 states resident concern with customer service described as call light response, states call light was turned off by employee.</p> <p>On 8/7/24 at 1:40 PM, V1 (Administrator) stated call lights are an ongoing issue. V1 stated 15 to 20 minutes up to 30 minutes is an acceptable amount of time for a call light to be answered. V1 agreed that the Call lights: Accessibility and Timely Response Policy dated 8/1/2019 states process for responding to call lights: A. Response times should be a Priority. V1 agreed that on line 8 All staff members who see or hear an activated call light are responsible for responding. V1 agrees that not all staff answer call lights as stated in the Call lights: Accessibility and Timely Response Policy dated 8/1/2019.</p> <p>50430</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>49492</p> <p>Based on interview and record review, the facility failed to provide sufficient Registered Nursing (RN) hours on five of fourteen days reviewed for RN staffing. This failure has the potential to affect all 92 residents in the facility.</p> <p>Findings include:</p> <p>The facility Nursing Schedule (July 24, 2024 through August 6, 2024) document on 7/27/24, 7/29/24, 8/1/24, 8/3/24 and 8/4/24, the facility scheduled zero (0) hours of RN coverage for a 24 hour period.</p> <p>On 8/7/24 at 1:45pm, V1 Administrator confirmed the hours listed on the facility nursing schedule were correct and the facility failed to have RN coverage on 7/27/24, 7/29/24, 8/1/24, 8/3/24 and 8/4/24.</p> <p>The facility Resident Midnight Census dated 8/7/24 documents 92 residents reside in the facility.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>50430</p> <p>Based upon interview and record review the facility failed to follow their narcotic destruction policy for one (R4) of four residents reviewed for medication errors out of a sample of six residents.</p> <p>Findings include:</p> <p>The facility policy Destruction of Unused Drugs dated 6/1/24 documents The actual destruction of drugs conducted by our facility must be witnessed by two nurses.</p> <p>R4's Health Status note written by V11 Licensed Practical Nurse documents on 8/2/2024 at 4:13 PM that, Writer made aware of resident he's been transferred to hospital for hypotension and upon arrival it was observed that resident had on two fentanyl patches and received Narcan and is currently in the Intensive Care Unit (ICU).</p> <p>On 8/6/24 at 2:05 PM, V11 (Licensed Practical Nurse) stated on 8/2/24 at approximately 3:00 PM, I received a call from the Hospital stating that R4 was sent to the ER from Dialysis and the ER found 2 Fentanyl patches on R4, which were removed and Narcan was given. V11 stated she cared for R4 on 8/2/24 prior to R4 leaving facility for Dialysis. V11 stated R4 was sitting at Nurses station when alert, however, has been having increased confusion.</p> <p>On 8/6/24 at 12:15 PM, V8 (Registered Nurse/Intensive Care Unit) stated R4 was admitted to the hospital on 8/2/24 after emergency room (ER) staff found two transdermal Fentanyl patches on R4's right arm and left chest. V8 stated after R4 arrived to the ER, both patches were removed and Narcan was given.</p> <p>R4's Electronic Medication Administration Record (MAR) documents an order for a 12 microgram Fentanyl Transdermal Patch to be applied every 72 hours for pain. This MAR documents on 7/31/24 at 9:05 PM, a patch was removed and at 9:09 PM and a new patch was applied. This MAR documents the next time a patch would be applied would be on 8/3/24.</p> <p>On 8/6/24 at 1:15 PM, V4 (Registered Nurse) stated on 7/31/24 she removed a Fentanyl patch from R4's left back and placed a new patch on the left chest. V4 stated she did not look for any other patches. V4 stated she wasted the patch alone and without a witness.</p> <p>On 8/7/24 at 1:30 PM, V1 Administrator confirmed that the facility's Destruction of Unused Drugs policy states that two nurses are supposed to destroy narcotic patches together.</p>		