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	05/01/2025

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50430 Failures at this level required more than one Deficient Practice Statement. A. Based on interview and record review the facility failed to immediately notify the physician, complete a pain assessment, complete a physical assessment, and provide pain management when severe pain with redness and swelling to the left knee began suddenly and continued for five days for one (R401) of three residents reviewed for significant change in condition in the sample list of 27. These failures resulted in R401 experiencing severe pain from 3/9/25 to 3/14/25 when R401 was hospitalized with a left femur fracture which required surgical repair. The Immediate Jeopardy began on 3/9/25 when the facility failed to immediately notify the physician, complete a pain assessment, complete a physical assessment, and provide pain management when severe pain with redness and swelling to the left knee began suddenly and continued for five days for R401. V1 Administrator, was notified of the Immediate Jeopardy on 4/24/25 at 2:40 PM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 4/28/25, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings include: The facility's Notification of Changes policy revised 2/10/25 documents the facility will promptly inform the resident, physician and residents' representative when there is a change in condition requiring notification. The facility's Pain Management policy revised 2/10/25 documents the facility will ensure that pain management is provided to residents who require such services. The facility will use a pain assessment tool, which is appropriate for the resident's cognitive status, to assist staff in consistent assessment of resident's pain. In collaboration with the physician, resident and resident's representative the facility will develop, implement, monitor and revise as necessary interventions to prevent or manage each individual resident's pain. R401's Minimum Data Set (MDS) dated [DATE] documents R401 is severely cognitively impaired. This same MDS documents R401 is dependent on staff for activities of daily living and transfers. R401's Medical Diagnosis List documents R401 has a diagnosis of Dementia without behaviors. R401's current care plan documents R401 requires a full mechanical lift with two staff members for transfers . (continued on next page)

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R401's Nurse Progress Note dated 3/9/25 at 2:41 PM, documents R401 was having pain and discomfort to the left knee. The Note documents R401 yelled out when her left knee was touched, non-pitting edema was noted to the left knee and that R401 was given Tylenol and V3 Medical Director was notified. On 4/21/25 at 2:00 PM, V4 Licensed Practical Nurse stated on 3/9/25 R401 was sitting in a high back wheelchair at the nurse's station, upright and lunging forward in the wheelchair. V4 stated she and V8 Licensed Practical Nurse repositioned R401 with the mechanical lift sling in R401's chair and R401 yelled my knee. V4 stated she assessed R401's left knee and noticed it was swollen and red. V4 stated she had the certified nursing assistants V10, V11, and V12 lay down R401 in her bed, and V4 faxed V3 Medical Director to make V3 aware of R401's left knee change. On 4/21/25 at 2:15 PM, V5 Certified Nursing Assistant stated on 3/9/25, V5 was assisting R401 with getting dressed in the morning and R401 was screaming out in pain when V5 was putting on R401's socks. V5 stated she removed R401's pants and her left knee was red and swollen. V5 stated she made the nurse aware of R401's pain and swelling in the left knee. V5 further stated that R401 had not had any falls or tried to get up on her own in a long time. V5 stated that R401 complained of pain daily the week of 3/9/25-3/14/25. R401's Physician Orders dated 3/10/25 document an order for doxycycline 100 milligrams twice a day for seven days for redness and swelling to left knee. On 4/24/25 at 12:35 PM, V20 Licensed Practical Nurse stated V20 worked on 3/10/25 dayshift from 6:00AM-6:00 PM and cared for R401. V20 stated she remembers R401 complained about pain in her left leg the week of 3/9/25-3/14/25 and would yell out when staff repositioned R401. On 4/24/25 at 12:00 PM, V19 Certified Nursing Assistant stated on 3/11/25 around 2:00 PM, V19 went into R401's room to perform perineal care. V19 stated that R401 was crying and telling V19 that her left leg was hurting. V19 stated that R401 did not want to move in bed and refused to get up for dinner and go to the dining room which R401 normally does. V19 stated that R401's left knee was swollen and red. V19 stated that she reported R401's pain to V20 Licensed Practical Nurse. On 4/24/25 at 1:00 PM, V15 Certified Nursing Assistant stated she cared for R401 the morning of 3/14/25. V15 stated that she went into R401's room to get R401 dressed for the day and R401 told V15 to be careful when rolling her because her side was hurting. V15 stated she went to roll R401 and R401 screamed it hurts really bad. V15 stated she did not get R401 out of bed that day because she was in so much pain. V15 further stated R401 had no urinary out put on V15's shift and did not eat meals. V15 stated she made V20 Licensed Practical Nurse aware of R401's condition and V20 told V15 that R401 would be having an X-ray done later in the day. V15 stated she just knew something wasn't right. R401's electronic medical record does not contain a nursing assessment or a pain assessment from 3/9/25 -3/14/25. R401's electronic medication administration record (MAR) documents on 3/12/25 at 8:54 AM R401 received Tylenol 325 Milligrams for pain. R401's MAR does not document Tylenol given on any other date for the month of March. R401's medical record does not contain a response to the Tylenol administered to R401 on 3/12/25. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R401's Nurse Progress Notes dated 3/14/25 at 4:00 PM, document on site radiology came to the facility to perform an X-Ray of R401's left lower extremity and a displaced fracture was diagnosed . The Note documents R401 was in severe pain with movement of joint/extremity and was hollering out with facial grimacing. The Note documents R401's left leg was immobilized to prevent further injury and R401 was transferred by ambulance to the local emergency room . R401's medical chart does not contain documentation of the rationale for obtaining the X-ray for R401. R401's hospital records dated 3/14/25 document R401 arrived at emergency room by ambulance after an onsite X-ray at the facility noted a left distal femur fracture with moderate angulation and displacement. This note further documents R401 will be having an Open Reduction and Internal Fixation to left leg on 3/15/25. The facility's Incident Witness statements dated 3/17/25-3/21/25 document interviews with V4 Licensed Practical Nurse (LPN), V14 LPN, V5 Certified Nursing Assistant CNA, V9 CNA, V10-V13 CNA, V15 CNA, V16 CNA which all confirmed R401 had pain with transfers, dressing and personal cares to the left leg with redness and swelling during the week ok 3/9/25-3/14/25. On 4/22/25 at 2:00 PM, V9 Nurse Practitioner stated when the resident had ongoing continuous pain, the facility should have notified V9 as V9 is in the facility Monday-Friday. V9 stated the facility reported redness on 3/10/25, but never reported ongoing complaints of severe pain. V9 further stated V9 ordered doxycycline on 3/10/25 because at the time the facility had an issue with wounds and based on the information V9 was given he felt R401 may have cellulitis. On 4/22/25 at 1:45 PM, V3 Medical Director stated he expects the facility staff to call or text V3 if a resident is screaming out in pain, so that V3 can arrange to have the resident sent to emergency room for evaluation and treatment. The Immediate Jeopardy that began on 3/9/25 was removed on 4/28/25 when the facility took the following actions to remove the immediacy. 1. The facility Nursing Staff was in serviced on 4/23/25 by V2 Director of Nursing and V17 Regional Nurse Consultant regarding pain management, evaluation and treatment, physician notifications, documentation and follow- up. In-servicing initiated on 4/23/25 all nursing staff who have not attended the in-service will be in-serviced prior to their start of next scheduled shift. Nursing staff not in-serviced will not be able to return to work until in-service has been completed. 2. All residents were assessed for pain by V6 Assistant Director of Nursing on 4/23/25. All residents have a pain scale documented on their Medication Administration Record to be completed every shift. A nonverbal pain scale was added for resident's who are not cognitively intact. 3. On 4/24/25 V2 Director of Nursing implemented daily clinical rounds with the nursing staff to ensure all acute/chronic pain is addressed, appropriate assessments are completed, and notification of the physician has been completed appropriately. Reports will be reviewed/addressed during morning clinical meeting each day. Daily morning Clinical sheets were reviewed and V2 Director of Nursing has been completing daily. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. On 4/23/25 V2 and V6 in-serviced Nursing Staff regarding physician notification of changes by phone with follow up by fax and text message. Random review of progress notes confirm physicians have been notified by phone with condition changes. 5. On 4/28/25 at 10:00 AM, each nurses station contained a list of hot rack charting for nurses to review daily. V2 is updating hot rack sheets daily with changes. Facility Nurses will use hot rack charting with their report sheet for shift to shift nursing report to assist with communication and follow up. The report sheets will be reviewed by V2 and discussed in morning QA (Quality Assurance) meetings. 6. On 4/28/25, V2 Director of Nursing provided a print out of the daily dashboard electronic clinical record. V2 Director of Nursing is reviewing the Point Click Care Dashboard, 24- hour report, pain management, and physician notification of change, daily for four weeks, to ensure effective measures are implemented for quality resident care. 7. V2 Director of Nursing provided a pain management weekly audit sheet dated 4/23/25 and 4/27/25. This audit documents five residents are being reviewed weekly for pain management. 8. The facility Pain, Change in condition, and notification of changes in-service dated 4/23/25 documents V2 Director of Nursing reviewed policies and procedures with all nursing staff. V2 Director of Nursing will discuss pain management policy and procedure and notification of changes at monthly nursing meeting. 9. On 4/23/25 and 4/25/25 V2 Director of Nursing and V1 Administrator held an interdisciplinary meeting to discuss changes in conditions of residents. V1 provided quality assurance meeting notes dated 4/23/25 and 4/25/25. The facility presented an abatement plan to remove the immediacy on 4/24/25. The survey team reviewed the abatement plan and was unable to accept the plan to remove the immediacy. The abatement plan was returned to the facility for revisions. The facility presented a revised abatement plan on 4/24/25 and the survey team accepted the abatement plan on 4/25/25. 37813 Based on interview and record review the facility failed to assess a resident following a fall and failed to recognize a change in condition following a fall for one resident (R408) of five residents reviewed for falls in a sample list of 27 residents. This failure resulted in R408 being hospitalized with a subdural hematoma resulting in left midline shift of the brain tissue, increasing pressure on the brain, hemiparesis and pain from left hip displacement requiring neurosurgery and orthopedic repair. Findings Include: R408's current diagnoses list includes the following diagnoses: Fractured Left femur with Left Hip Replacement, Type II Diabetes, Heart failure with Cardiomyopathy, and Alzheimer's Disease. R408's Minimum Data Set (MDS) dated [DATE] documents R408 is cognitively intact, and able to rise from sitting to standing with partial/moderate assistance upon admission 4/16/25. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R408's Fall risk assessment dated [DATE] documents R408 is at high risk for falls. R408's Medication Administration Record for April 2025 does not document R408 was administered Hydrocodone-Acetaminophen Oral Tablet 10-325 MG (milligrams) 1 tablet by mouth every 6 hours as needed for Pain between 4/16/25 (admission) until 4/19/25 following an unwitnessed fall. On 4/19/25 at 02:06AM R408's Progress Note documents (R408) was yelling out for help, (V24 agency LPN) and staff arrived (to) room and observed (R408) laying on the floor on her back under the bed wrapped in her blanket, resident examined for injuries including head and body no complaint of pain or discomfort. Full Range of Motion for all extremities. No neurological checks or post fall assessments are documented from 4/19/25 at 5:20AM until 4/19/25 at 9:57 PM. No neurological checks or post fall assessments are documented at any time on 4/21/25 or 4/22/25. R408's Medication Administration Record for April 2025 documents R408 was administered Hydrocodone-Acetaminophen Oral Tablet 10-325 MG 1 tablet by mouth 4/19/25 at 3:57AM, 4/20/25 at 12:25AM and 7:09AM, 4/22/25 at 9:10AM and 6:12PM, and 4/23/25 at 8:27AM. On 4/29/25 at 10:30 AM, V20 Licensed Practical Nurse stated she cared for R408 on 4/22/25 from 6:00 AM-6:00PM. V20 stated R408 asked for a pain pill in the morning for leg pain. V20 stated R408 asked for another Norco two hours later. V20 stated it was too soon for R408's Norco so V20 offered R408 a Tramadol. V20 stated R408 told her that Tramadol doesn't work for her, and she has told the staff that. V20 stated she also offered R408 a Tylenol to have instead of Tramadol and R408 stated if Tramadol doesn't help then neither will Tylenol. V20 stated she gave R408 another Norco by the end of her shift and left a note on the report sheet requesting R408's Norco frequency be increased because she does not feel the Tramadol was helping. V20 stated she did not complete neurological assessments for R408 on her shift or an assessment on R408 because V20 was not informed R408 had a fall on 4/19/25. On 4/29/25 at 10:45 AM, V23 Certified Nursing Assistant stated V23 cared for R408 on 4/22/25 from 6:00 AM-2:00PM. V23 stated R408 was complaining of pain her entire shift. V23 stated R408 was complaining of pain on her left side and her left arm was drawn up with bruises. V23 further stated R408 had redness on her left side. V23 stated she got R408 up with a sit to stand mechanical lift. V23 stated R408 went to therapy after V23 got R408 ready for the day. V23 stated when R408 came back from therapy R408 wanted to use the toilet. V23 stated when R408 was finished using the toilet V23 was unable to get R408 off the toilet. V23 stated it took three staff members to get R408 off the toilet with a sit to stand mechanical lift and a gait belt. V23 stated R408 was not bearing any weight during the transfer. V23 stated she made V20 Licensed Practical Nurse aware of R408's pain and change in condition several times during her shift. V23 further stated she also cared for R408 the morning of 4/23/25. V23 stated she went to V1 Administrator to make her aware of V23's concerns about R408 and V1 went with V23 to get R408 ready for the day. V23 stated R408 was unable to move when they were changing R408 in bed. V23 stated V1 stated she was going to change R408's transfer status to full mechanical lift transfers. V23 stated later that day R408 was sent to the hospital. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A witness statement signed by V1, Administrator dated 4/23/25 documents (V27), Admission Coordinator reported to (V1) (R408) had discoloration to top of left hand 4/23/25 at approximately 8:15AM. (V1) went to investigate discoloration to left hand. This statement also documents (V1) assisted (V23) CNA (Certified Nurse's Aide) with morning cares and during cares (V1) noted flaccid left upper and lower extremities. (R408) voiced no complaint of pain. (V1) immediately spoke with husband and facility Director of Nursing regarding her clinical observations and concerns while cares. After discussing, it was determined further medical evaluation was necessary. (R408) was then transported via facility van to the emergency room . On 4/28/25 at 10:00AM V1, Administrator verified the above statement was correct. R408's head CT (Computerized Tomography) dated 4/23/25 at 11:24AM documents Acute Extra axial hemorrhage overlying the right cerebral hemisphere extending along the tentorium most likely subdural. This document also states Proximally 7MM (millimeter) of midline shift is present. R408's physician's progress note dated 4/24/25 at 6:25AM from higher level trauma hospital documents Patient is a 70 yrs. (years) old female with a subdural hematoma and a dislocated left Hemiarthroplasty. This document also states Neurosurgery team plans to take patient to Operating Room today for subdural evacuation. Orthopedic team will be there to attempt closed reduction under sedation prior to initiation of subdural evacuation. On 4/29/25 at 1:40PM V9 Advanced Practice Nurse for the facility stated according to current standards of practice if a resident is taking increasing pain medication particularly following a fall the physician should be notified to determine the cause of the increased pain. If a resident has had a fall the resident should be assessed at least every shift for the possible effects of the fall including neurological signs. I saw (R408) for the first time 4/22/25. I saw she had the diagnosis Alzheimer's Disease. I did not know her baseline cognition. (R408) was confused when I saw her, and I assumed it was her baseline. On 4/30/25 at 1:56 PM V29, the physician who completed R408's history and physical in ICU (Intensive Care Unit) verified The ICU team agree the fall was the cause of the left hip dislocation and the subdural hematoma. A subdural hematoma is a traumatic brain bleed. If R408 had been seen sooner the 7MM midline shift in the brain might have been avoided. The midline shift is critical because it causes compression of the brain. A stroke or brain bleed is a brain attack, and delays cause loss of function. The Vicodin might have masked part of the pain from the hip dislocation. The other factor in the pain is once the bleed started R408 might have had decreased sensation to the left side of her body. The delay in care was detrimental to R408's outcome. The left sided neglect I saw in R408 was one of the worst I have seen in my residency. In fact, I raised R408's hand and asked her if it was her hand and she said it was one of my colleague's hand because her brain was unable to recognize it as hers. The facility's Notification of Changes policy revised 2/10/25 documents the facility will promptly inform the resident, physician and residents' representative when there is a change in condition requiring notification.