| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145965 | A. Building<br>B. Wing | 03/07/2025 |

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

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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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35380<br><br>Based on observation, interview, and record review, the facility failed to ensure resident's rights to dignified activities of daily living. This failure affects one of nine residents (R195) reviewed for dignity on the sample list of 48.<br><br>Findings Include:<br><br>The facility's Promoting/Maintaining Resident Dignity Policy dated 2/12/25 documents it is the practice of the facility 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 and all staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights.<br><br>R195's undated Diagnoses List, documents R195 is diagnosed with Cerebral Infarction due to unspecified occlusion or stenosis of Left Posterior Cerebral Artery, Metabolic Encephalopathy, Rhabdomyolysis, and Hemiplegia, unspecified affecting left nondominant side.<br><br>R195's Care Plan dated 2/6/25 documents R195 requires substantial/maximum assist by one staff member to eat.<br><br>R195's Minimum Data Set (MDS) dated [DATE] documents R195 has an impairment on one side of both the upper and lower extremities.<br><br>On 3/2/25 at 8:57 AM R195 was sitting in his room in a reclining wheelchair with a shirt on that had stained food and drink all over the front of the shirt. R195 stated he had just eaten breakfast. R195's nails were long with dirt underneath and R195's facial hair was long and needed to be shaved.<br><br>On 3/3/25 at 1:58 PM R195 was sitting in his room in a reclining wheelchair with a shirt on that had stained coffee and food all over the front of the shirt. R195's nails were long and dirty underneath and R195's appeared to need a shave.<br><br>(continued on next page) |



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

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/3/25 at 2:04 PM V11 Certified Nursing Assistant (CNA) stated there is coffee and food on R195's shirt from lunch and she was not aware because she (V11) did not bring R195 back to his room after lunch. V11 CNA stated we don't have enough staff here and we are doing the best we can to take care of the residents.<br><br>On 3/3/25 at 2:10 PM V1 Administrator stated the expectation is for staff to follow the Policy and Procedures to meet the resident's needs and maintain their dignity and respect. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50430<br><br>Based on observation, interview, and record review the facility failed to ensure a call light was in reach for two (R58, R345) of 32 residents reviewed for call lights out of a sample list of 48.<br><br>Findings Include:<br><br>The facility's Call Light: Accessibility and Timely Response policy revised 2/6/25 documents all staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light.<br><br>1. R58's Minimum Data Set (MDS) dated [DATE] documents R58 is cognitively intact. The same MDS documents R58 needs partial/moderate assist of one staff member to transfer or ambulate.<br><br>On 03/02/25 at 10:31 AM, R58 was sitting in his wheelchair in his own room. R58's untouched breakfast tray was in front of R58 on the bedside table with eggs, toast, oatmeal, and milk. R58's call light was attached to R58's bedrail on opposite side of the bed from where R58 was sitting.<br><br>On 3/2/25 at 10:40 AM, R58 stated he hasn't eaten breakfast because his food is cold. R58 stated I'm waiting for my call light button so staff can heat up my food. R58 stated I can't walk on my own so if they don't give me my call light, I must wait for someone to come in and help me.<br><br>52228<br><br>2. On 3/02/25 at 8:53 AM R345 was sitting in a wheelchair in his room. R345's call light was lying on the floor behind him out of R345's reach. R345 stated he could not reach his call light which R345 states happens a lot.<br><br>R345's Care Plan dated 2/9/25 documents R345 requires staff assistance with all personal cares, transfers, and bed mobility due to history of the fracture of the right femur. This care plan includes an intervention to keep call light in reach at all times. |

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| F 0568<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.<br><br>52228<br><br>Based on observation, interview, and record review the facility failed to record all financial transactions for five (R60, R11, R74, R347 and R18) of seven residents reviewed for resident funds on the sample list of 48 residents.<br><br>Findings Include:<br><br>On 3/4/25 at 9:55 AM, stapled plastic pill pouches containing money were taped to the underside of the lid of the narcotic section of the medication cart. R60, R347, R74, and R18's names were written in marker on the outside of the pill pouches. R60's pouch contained $2.00, a pill pouch with a dark black marker was labeled lost and found 2.00, R347's pouch contained $5.00, R18's pouch contained $1.00, R74's pouch contained $5.00, and an nonlabeled unknown pouch contained $21.00. At that time, V13 (Licensed Practical Nurse) stated the money in the pouches is the residents money and that they have it because the business office is closed on the weekends. V13 stated they will give them their money if they need it. V13 stated there is no sign out sheet for nurses to document how much money each resident has or how much has been given to each resident.<br><br>On 3/4/25 at 10:15 AM, V3 Assistant Director of Nursing stated there should be a sign out sheet at each medication cart for the staff to keep track how much money the residents have and how much money was given. V13 stated the medication carts do not have a sign out sheet.<br><br>On 3/4/25 at 10:20 AM, the 200 hall medication cart contained two stapled plastic medication pouches taped onto the underneath of the lid of the locked narcotic drawer. There was a pouch with $20.00 labeled R11's. V3 confirmed this cart does not contain a sign out sheet for R11's money.<br><br>On 3/04/25 at 11:34 AM, V27 (Corporate Business Office Manager) stated that all money that comes into the facility for a resident should be entered into the resident fund account. V27 stated when a resident needs money then the resident would come to the business office to get it out of their account. V27 stated she was unaware that the nurses were keeping residents money in the medication carts.<br><br>R60, R11, R74, R347 and R18's resident's trust fund statements dated 8/1/24 through 3/5/25 did not document any withdrawals or deposits related to the money kept in the medication carts. At that time, V27 stated she is unsure where the money came from, but that family may have brought it in. V27 stated if this was the case then it should have been deposited into the resident account.<br><br>The Facility Resident's Fund Policy revised on 2/10/25 documents that the facility's business office will maintain a record of all financial transactions including all deposits and withdrawals. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385<br><br>Based on observation, interview, and record review the facility failed to review and accurately record physician's orders for life sustaining treatment for one (R30) of 32 residents reviewed for advance directives in the sample list of 48.<br><br>Findings Include:<br><br>The facility's Residents' Rights Regarding Treatment and Advance Directives policy dated 2/10/25 documents on admission the facility will determine if the resident has an advance directive, copies of the advance directive will be placed in the resident's chart and communicated to staff, and the facility will review advance directives with the resident or representative as part of the care planning process.<br><br>On 3/02/25 at 12:22 PM R30 stated R30 has a Do Not Resuscitate order.<br><br>R30's Minimum Data Set, dated dated dated [DATE] documents R30 as cognitively intact.<br><br>R30's Hospital Discharge Orders dated 2/15/25 document R30's code status as full code. R30's active profile and physician's orders document R30's code status as full code.<br><br>R30's Physician's Order for Life Sustaining Treatment (POLST) dated 11/22/24 documents do not attempt resuscitation (DNR). This form is signed by R30 and a physician. R30's active care plan documents R30 has a Do Not Resuscitate order.<br><br>On 3/02/25 at 1:26 PM V6 Licensed Practical Nurse stated the nurses look at the resident's profile and physician orders to determine code status. V6 stated the nurses enter the orders for code status which can be based on the resident's hospital records. V6 stated R30's hospital record documents R30's code status as full code. R30's electronic medical record profile and active physician's orders was viewed with V6. V6 confirmed full code is listed as R30's code status, which does not match R30's POLST form. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>52228<br><br>Based on observation, interview, and record review, the facility failed to provide a bed that was comfortable and in working condition for one (R346) of 32 residents reviewed for environment on a sample list of 48 residents.<br><br>Findings Include:<br><br>R346's skilled nursing assessment documents that he is alert and oriented. R346's care plan dated 3/2/25 documents R346 requires assistance with bed mobility due to fracture, infection of the right femur, and a diagnosis of low back pain.<br><br>On 3/5/25 at 8:35 AM, R346's was lying in bed on his back. The right side of the head of the bed was elevated approximately 30 degrees. The left side of the head of the bed was elevated approximately 20 degrees. R346 stated that his bed was broke and has been since 1:00 AM that morning. R346 stated he has been laying in the same position since 1:00 AM and he is uncomfortable. R346 stated that the staff called maintenance but nobody ever came in. R346 then picked up the remote to the bed and pushed multiple buttons on the remote but the bed did not move. At that time, V30 (Certified Nursing Assistant) entered the room, asked what was wrong, and then attempted to use the remote. When the bed did not move V30 checked to see if the bed was plugged in. V30 then stated there must be something wrong with the bed as it is plugged in.<br><br>On 3/5/25 at 9:30 AM V31 (Regional Maintenance Director) stated the staff on duty should have switched the bed out and not left R346 in the broken bed all night. |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52228<br><br>Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from verbal and mental/emotional abuse by staff members for two (R345, R195) of 32 residents reviewed for abuse on the sample list of 48 residents. This failure resulted in fear, emotional harm and mental anguish for both R345 and R195.<br><br>Findings Include:<br><br>1. R345's care plan dated 2/11/25 documents R345 has medical diagnoses of COPD (Chronic Obstructive Pulmonary Disease), Asthma, History of Chronic Respiratory Failure, History of Fracture to the the Right Femur, Arthritis to right hand, Depression, Diabetes Mellitus, Anemia, Pneumonia, and Hypertension. R345's minimum data assessment dated [DATE] documents that R345 is cognitively intact and has no signs and symptoms of delirium.<br><br>On 3/2/25 at 10:23 AM, R345 was sitting in his wheelchair in his room. When asked how R345 is treated in the facility R345 put his hands together and quietly stated, I am afraid of retaliation if I tell you. R345 then stated a couple weekends ago (2/22/24 and 2/23/24) he asked for a pain pill and nobody came so he called his daughter (V25) to tell her so that she could get someone to bring him a pain pill. R345 stated a few minutes later V26 (Licensed Practical Nurse) came into his room and was mad and yelled at him that she has 30 other residents to take care of and V26 can't jump every time R345 calls. R345 stated then V26 stated she didn't appreciate being reported two days in a row. R345 began to cry and stated V26 scared R345 and he was afraid of what V26 might do.<br><br>On 3/3/25 at 10:44 AM, V25 stated R345 had called her upset that the nurse had not brought his pain pill. V25 stated she called the facility and talked to V26. V25 stated a little bit later R345 called and was crying and stated that V26 came into his room yelling at him and stated V26 doesn't like to be reported and has too many people to take care of.<br><br>On 3/06/25 at 9:23 AM, V1 (Administrator) stated that R345 is alert and orientated, makes his own decisions, and, If he said it happened, it happened. V1 stated V1 would consider V26 yelling at R345 as verbal abuse.<br><br>35380<br><br>2. R195's undated Diagnoses List, documents R195's diagnoses as: Cerebral Infarction due to unspecified occlusion or stenosis of Left Posterior Cerebral Artery, Metabolic Encephalopathy, Rhabdomyolysis, and Hemiplegia, unspecified affecting left nondominant side.<br><br>R195's Care Plan dated 2/6/25, documents R195 requires substantial/maximum assist by one staff member to eat.<br><br>R195's Minimum Data Set (MDS) dated [DATE], documents R195 has an impairment on one side of both the upper and lower extremities.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 3/2/25 at 8:57 AM, R195 stated during night shift, unknown CNA told R195 he uses his call light too much and took it away from him so he couldn't get any help. R195 stated the staff laugh at him at night and are rough with him when they transfer and roll him. R195 was visibly upset when speaking about this and stated the interaction made him very distraught as he was not able to get the help he needed without his call light. R195 stated it was hurtful when staff laughed at him and were rough.<br><br>On 3/5/25 at 10:30 AM, V2 Interim Director of Nursing (DON) confirmed R195 is at risk for abuse due to him needing assistance with Activities of Daily Living (ADL's) and because of his diagnoses. V2 confirmed staff should never take away a resident's call light or make them feel badly for using it to call for assistance. V2 confirmed staff should treat residents with respect and never be rough or laugh at them.<br><br>The facility's Abuse, Neglect and Exploitation Policy dated Revised 2/11/25, documents Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, physical abuse, and mental abuse. Mental Abuse includes humiliation, harassment, and deprivation and it is the policy of the facility to provide protection for the health, welfare and rights of each resident. |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>52228<br><br>Based on interview and record review, the facility failed to implement it's abuse policy by failing to investigate and report an allegation of verbal abuse for one (R345) of 32 residents reviewed for abuse on the sample list of 48 residents.<br><br>Findings Include:<br><br>The facility's abuse policy with a revision of 2/11/25 documents the facility will prevent and prohibit abuse. This policy documents verbal abuse as a type of abuse. This policy documents the facility will notify the state agency within 24 hours of receiving an allegation of abuse. This policy documents that allegations of abuse will be immediately investigated.<br><br>On 3/2/25 at 10:23 AM, R345 stated he was verbally abused by V26 Licensed Practical Nurse on 2/23/25.<br><br>On 3/6/25 at 9:23 AM, V1 (Administrator) stated she received a phone call from V25 (R345's family member) stating that V26 was rude to R345 which upset R345. V1 stated she did not notify the state agency or begin an investigation until 3/3/25. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>52228<br><br>Based on interview and record review, the facility failed to notify the state agency of an allegation of verbal abuse for one (R345) of 32 residents reviewed for abuse on the sample list of of 48 residents.<br><br>Findings Include:<br><br>On 3/6/25 at 9:23 AM, V1 (Administrator) stated she received a phone call from V25 (R345's family member) stating that V26 Licensed Practical Nurse was rude to R345 and made R345 upset. V1 stated she did not notify the state agency until 3/3/25.<br><br>The facility's report to the state agency dated 3/3/25 documents that the state agency was not notified regarding R345's allegation of verbal abuse by V26 until 3/3/25. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>52228<br><br>Based on interview and record review, the facility failed to immediately investigate an allegation of verbal abuse for one (R345) of 32 residents reviewed for abuse on the sample list of 48 residents<br><br>Findings Include:<br><br>On 3/6/25 at 9:23 AM, V1 (Administrator) stated she received a phone call from V25 (R345's family member) stating that V26 Licensed Practical Nurse was rude to R345 and made R345 very upset. V1 stated she did not investigate this as an allegation of abuse until 3/3/25.<br><br>The facility's report to the state agency dated 3/3/25 documents that an investigation regarding R345's allegation of verbal abuse by V26 was initiated on 3/3/25. |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32172<br><br>Based on interview and record review the facility failed to coordinate a Pre-Admission Screening and Resident Review (PASARR) level II evaluation for one of two residents (R85) reviewed for PASARR II completion on the sample list of 48.<br><br>Findings Include:<br><br>R85's Clinical Census dated March 2025 documents R85 was admitted to the facility on [DATE].<br><br>R85's Medical Diagnoses List dated March 2025 documents R85 is diagnosed with Generalized Anxiety Disorder and Post Traumatic Stress Disorder. Both diagnoses have been in place since 10/5/16.<br><br>R85's PASARR Level 1 dated 12/3/24 documents no Level II evaluation is required due to R85 not having any Significant Mental Illness (SMI) diagnosis.<br><br>On 3/5/25 at 3:00 PM V2 Regional Interim Director of Nurses (DON) confirmed if R85 had a SMI diagnosis on admission or was later diagnosed with a SMI diagnoses the facility should coordinate a PASARR level II evaluation to be completed. R85's PASARR level I evaluation upon admission should have been reviewed for accuracy. |

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| F 0659<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care by qualified persons according to each resident's written plan of care.<br><br>32172<br><br>Based on interview and record review the facility failed to follow physician orders to obtain daily weights for one of two residents (R59) reviewed for weights on the sample list of 48.<br><br>Findings Include:<br><br>R59's Medical Diagnoses List dated March 2025 documents R59 is diagnosed with Chronic Diastolic Congestive Heart Failure and Chronic Kidney Disease Stage 4.<br><br>R59's Physician Order Sheet (POS) dated March 2025 documents a physician order on 10/3/24 for daily weights, every day shift, notify the physician if there is a weight gain greater that three pounds in 24 hours or a weight gain greater than five pounds in seven days.<br><br>R59's Care Plan dated 11/22/24 documents R59 is at risk for fluid volume overload related to Chronic Kidney Disease Stage 4. Interventions include to monitor/document and report any signs or symptoms of fluid overload including sudden weight gain.<br><br>R59's Treatment Administration Record (TAR) for December 2024 documents 12 missed days for daily weights. R59's January 2025 TAR documents 11 missed days for daily weights with a 12.9 pound weight gain from 1/7/25 to 1/9/25. There is no documentation that either V18 Nurse Practitioner or V35 Medical Doctor were notified of this abnormal weight gain. R59's February 2025 TAR documents 9 missed days for daily weights. R59's March 2025 TAR documents three missed days so far for daily weights.<br><br>On 3/05/25 at 12:55 PM V20 stated if daily weights are ordered they should be completed. V20 stated R59's daily weights are related to her Congestive Heart Failure diagnoses which is monitored/treated by R59's medical provider (V35).<br><br>On 3/5/25 at 1:44 PM V18 Nurse Practitioner stated staff are to be following physician orders and should be weighing R59 daily in order to monitor for fluid overload. V18 confirmed R59's daily weights need to be completed and documented and the physician needs to be notified if there is a weight gain of three or more pounds in 24 hours or five or more pounds in seven days.<br><br>On 3/5/25 at 3:00 PM V2 Regional Interim Director of Nurses (DON) confirmed staff need to follow physician orders and R59's daily weights should be completed and documented daily. V2 confirmed if there is a designated weight gain, the physician should be notified. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35380<br><br>Based on observation, interview and record review the facility failed to provide showers as scheduled and failed to provide shaving, nail care, and grooming for four of four residents (R18, R41, R70, and R195) reviewed for showers and hygiene/grooming on the sample list of 48.<br><br>Findings Include:<br><br>The facility's Activities of Daily Living Policy dated 2/10/25, documents a resident who is unable to carry out activities of daily living will receive the necessary care to maintain grooming and personal care.<br><br>1. R18's Minimum Data Set (MDS) dated [DATE], documents R18 is dependent for personal hygiene.<br><br>R18's Care Plan dated 1/7/25, documents R18 is at risk for deterioration in Activities of Daily Living (ADL) related to generalized weakness and decline in functional status, a history of Cerebral Vascular Accident (CVA) with left sided weakness, Range of Motion (ROM) limitations to the left arm and the left ankle/foot.<br><br>On 3/2/25 at 10:00 AM, R18's hair appeared unclean, nails long, food was in R18's beard and on R18's shirt.<br><br>2. R70's MDS dated [DATE], documents upper and lower impairment on one side and R70 require substantial/maximum assist with personal hygiene.<br><br>R70's Care Plan dated 1/28/25, documents self care deficit related to Dementia, right hemiplegia, and imbalance.<br><br>On 3/2/25 at 9:27 AM, R70's nails appeared long and dirty.<br><br>3. R195's MDS dated [DATE], documents R195 has upper and lower impairment on one side, requires partial/moderate assist for eating and hygiene, and is dependent for upper and lower body dressing.<br><br>R195's Care Plan dated 2/6/25, documents R195 has a self-care performance deficit related to Hemiplegia, Stroke, and limited mobility.<br><br>On 3/2/25 at 8:57 AM, R195 was sitting in his room in a reclining wheelchair with a shirt on that had stained food and drink all over the front of the shirt. R195's nail were long and dirty. R195's facial hair was long and appeared to need a shave.<br><br>On 3/3/25 at 1:58 PM, R195 was sitting in his room in a reclining wheelchair with a shirt on that had stained food and drink all over the front of the shirt. R195's nails were long and dirty. R195's facial hair was long and appeared to need a shave.<br><br>40385<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 4.) On 3/3/25 at 10:03 AM, during the resident council meeting, R41 stated the facility does not have enough staff and R41 has not been getting R41's showers. R41 stated R41's showers are scheduled to be given twice weekly.<br><br>R41's Minimum Data Set, dated dated dated [DATE] documents R41 as cognitively intact and dependent on staff for bathing assistance.<br><br>R41's Shower task dated 6/12/24 documents R41's showers are scheduled for Mondays and Thursdays. R41's January and February 2025 shower documentation, provided by V2 Director of Nursing, does not document R41 was offered a shower between 1/14/25 and 1/22/25, or after 2/17/25.<br><br>On 3/4/25 at 10:07 AM V2 Director of Nursing stated showers are scheduled to be given twice weekly. At 12:30 PM V2 confirmed all of R41's shower documentation for January 2025 and February 2025 was provided. |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385<br><br>Based on observation, interview, and record review the facility failed to assess a wound, prevent cross contamination during wound care, administer wound treatments as ordered, timely notify the physician of a dehisced surgical wound, monitor bowel movements and hydration, and implement bowel interventions for three (R52, R30, R41) of 24 residents reviewed for quality nursing care in the sample list of 48. These failures resulted in R52 and R41 developing bowel obstruction and fecal impaction requiring hospitalization and treatment.<br><br>Findings Include:<br><br>1.) R52's Minimum Data Set (MDS) dated [DATE] documents R52 is dependent on staff for toileting. R52's MDS dated [DATE] documents R52 has cognitive impairment and R52 is dependent on staff for toileting. R52's Care Plan dated 11/7/22 documents R52 is at risk for constipation and includes interventions to encourage R52 to sit on the toilet and monitor/report symptoms of constipation. R52's Care Plan dated 5/23/22 documents R52 is incontinent of bowel and bladder and includes an interventions to monitor bowel habits, notify the nurse of bowel concerns, administer bowel management medications as ordered, and notify physician of concerns. R52's care plan has not been updated to include R52's history of bowel obstruction or any new bowel interventions after 10/22/22.<br><br>R52's Nursing Note dated 1/13/25 at 1:04 PM documents R52 was transferred to the hospital for seizure like activity. R52's hospital note dated 1/13/25 documents R52 arrived with abdominal distention, abdominal pain, and no bowel movements for the past day. R52's Hospital Note dated 1/14/25 documents R52's abdominal computed tomography indicated high-grade small bowel obstruction and low-grade partial colonic obstruction. A nasogastric tube was inserted and R52 was hospitalized until 1/17/25.<br><br>R52's January 2025 and March 2025 Medication Administration Records do not document any orders for bowel medications.<br><br>R52's January 2025 bowel tracking documents between 1/1/25 and 1/13/25 R52 had three small bowel movements. Bowel incontinence is recorded once on 1/2/25 and 1/6/25, but not applicable is recorded for size and consistency of bowel movements. There are no documented bowel movements between 1/1/25 and 1/7/25, 1/11/25, and 1/12/25, besides these entries. R52's February and March 2025 bowel tracking documents R52's last recorded bowel movement was a small bowel movement on 2/22/25, besides bowel incontinence on night shift on 3/11/25. This entry documents not applicable for size and consistency.<br><br>R52's medical record does not document any assessments of R52's abdomen or that R52's constipation was reported to a physician after 2/22/25.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 3/04/25 at 9:54 AM V28 Certified Nursing Assistant (CNA) stated V28 is R52's assigned CNA today and R52 had not had a bowel movement. V28 stated bowel movements are documented by the CNAs in the bowel tracking. V28 was unsure when R52's last bowel movement was and V28 would have to look at R52's bowel tracking. On 3/05/25 at 9:31 AM V39 CNA stated V39 is assigned to R52's care today and R52 had not had a bowel movement today. On 3/04/25 at 9:58 AM V13 Licensed Practical Nurse stated nothing had been passed on in shift report about R52's bowels. V13 stated the CNAs are suppose to chart bowel movements and if the resident hasn't had a bowel movement in so many days then the nurses are suppose to contact the doctor for orders. R52's bowel tracking was reviewed with V28 who confirmed R52 going three or more days without bowel movements and confirmed R52 has no active orders for bowel medications. V28 stated V28 will follow up and get orders. On 3/4/25 at 10:13 PM V40 CNA confirmed V40 documented incontinent bowel movement for R52 on night shift on 3/3/25. V40 stated the bowel movement was not enough to even consider a bowel movement, it was pate like and a minimal amount. V40 was unsure when R52 last had a bowel movement.<br><br>On 3/04/25 at 10:07 AM V2 Director of Nursing stated the CNAs should be documenting bowel movements in the resident's bowel tracking. V2 stated R52 should have bowel and hydration monitoring and stool softeners ordered since R52 has a history of bowel obstruction. V2 stated fluid intake is documented as part of meal intakes recorded by the CNAs, but is not recorded unless the resident is on strict intake and output monitoring. R52's bowel tracking was reviewed with V2 and confirmed 2/22/25 was the last recorded bowel movement. V2 confirmed no bowel medications or interventions have been implemented. V2 stated physician notification is documented in a progress note. On 3/04/25 at 1:02 PM V2 confirmed R52's December 2024 and January 2025 bowel tracking documents lack of bowel movements and R52 had no bowel medications ordered prior to R52's bowel obstruction. V2 confirmed bowel movement size and consistency should be recorded for each bowel movement. On 3/05/25 at 10:56 AM V2 stated the facility does not have a bowel protocol/policy.<br><br>On 3/06/25 at 9:36 AM V3 Assistant Director of Nursing was requested to assess R52's abdomen and bowel sounds. R52 denied stomach pain and nausea. V3 asked R52 if R52 had a bowel movement and R52 replied no. V3 asked R52 when R52 last had a bowel movement and R52 was unsure. V3 palpated R52's abdomen and used a stethoscope to assess R52's bowel sounds. V3 stated R52's abdomen is soft and not distended, and V3 heard bowel sounds in all four quadrants of R52's abdomen. V3 stated V3 will follow up with V18 Nurse Practitioner or V35 Medical Director. V3 told R52 that V3 would get an order and give something for R52 to have a bowel movement. V3 confirmed physical assessments should be noted in a progress note or in the assessment section of R52's electronic medical record.<br><br>On 3/03/25 at 1:44 PM R52's January 2025 hospitalization for bowel obstruction was discussed with V18 Nurse Practitioner. V18 stated the facility should have been tracking and monitoring R52's bowel movements and notified the physician so that a stool softener or laxative could be ordered prior to R52's hospitalization . On 3/4/25 at 10:57 AM V18 stated the facility should have informed V18 or V34 (R52's Physician) that R52 was not having routine bowel movements so that R52 could be started on a bowel medication such as Senna. V18 confirmed the staff should be monitoring R52's bowel movements closely and reporting concerns. V18 stated with R52's history of bowel obstruction V18 is prone to developing another obstruction. V18 stated signs would be complaints of abdominal pain, but R52 has Alzheimer's Disease which makes it complicated due to impaired cognition and communication. V18 stated if a bowel obstruction is left undetected and untreated for a prolonged period it could lead to death, but usually there are signs of symptoms such as abdominal distention/bloating and vomiting. V18 stated the facility should also be monitoring and ensuring adequate hydration for R52, which would also help with R52's constipation.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 2.) On 03/02/25 at 9:14 AM R30 had a wound vacuum attached to a dressing on R30's left below knee amputation surgical wound. R30 stated the nurses did not initiate a wound treatment when R30 admitted to the facility and R30 had to have additional surgery for an infection of the surgical incision.<br><br>R30's MDS dated [DATE] documents R30 as cognitively intact.<br><br>R30's nursing notes document R30 admitted to the facility on [DATE]. R30's Skin Check dated 12/31/2024 at 10:50 PM documents R30 had a new wound to the left knee amputation site that measured 3 centimeters (cm) long by 1.5 cm wide by 0.25 cm deep. This wound had 90% granulation, 100% slough, and purulent pus drainage. R30's Nursing Note dated 1/3/2025 at 10:04 AM documents an open area below R30's left knee measured 3 cm by 1.5 cm by 0.25 cm and physician (V35) was notified. R30's Nursing Noted dated 1/7/2025 at 12:51 PM documents R30's amputation site was warm to touch, and had pus, foul odor, and was larger from prior observation. Antibiotics and would culture was ordered. There is no documentation in R52's medical record that this wound was reported to V35 prior to 1/3/25 and reported to V41 (R52's Surgeon) prior to 1/9/25.<br><br>R30's Hospital Notes and Operative Report dated 1/10/25 documents dehiscence of amputation surgical site with breakdown exposing muscle and tendon that required debridement and wound vacuum placement.<br><br>R30's December 2024 and January 2025 Treatment Administration Records (TARs) do not document any wound treatments were implemented for R30's surgical wound after 12/31/24 until 1/3/25. R30's Physician Order dated 2/16/24 documents negative pressure wound therapy for left below knee amputation and change every Monday, Wednesday, Friday and as needed. There are no orders for a petroleum gauze dressing as part of R30's surgical wound care.<br><br>R30's Skin Checks dated 2/18/25, 2/19/25 and 2/26/25 do not document an assessment and/or measurements of R30's surgical wound. There are no documented wound assessments for R30's surgical wound in R30's electronic medical record after 1/31/25.<br><br>On 3/03/25 at 10:35 AM V22 Wound Nurse performed hand hygiene and applied gown and gloves prior to entering R30's room to administer R30's surgical wound treatment. V22 removed the surgical wound dressing and did not remove V22's gloves. V22 handled R30's personal cellular phone to obtain a picture of R30's wound, per R30's request and then cleaned R30's wound while wearing the same gloves. V22 changed gloves, performed hand hygiene, applied a petroleum gauze directly to R30's wound, applied foam and attached the wound vacuum.<br><br>On 3/3/25 at 10:58 AM V22 stated the floor nurses should be assessing the wound each time the dressing is changed and recording weekly as a skin assessment under the assessments section of R30's electronic medical record (EMR). V22 reviewed R30's EMR and skin assessments 2/19/25 and 2/26/25. V22 confirmed R52's EMR does not contain weekly assessments and/or measurements of R52's wound between 2/1/25 and 3/3/25. V22 stated V22 applied the petroleum dressing because R30 had requested it for comfort. V22 confirmed R30's wound care orders do not include the use of petroleum gauze. On 3/6/25 at 9:26 AM V22 stated gloves should be changed during wound treatments after removing the old dressing, after cleaning the wound, and when the treatment is finished. V22 confirmed V22 did not change gloves and perform hand hygiene after removing R30's wound dressing and handling R30's phone, prior to cleaning R30's wound.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 3/03/25 at 1:44 PM V18 Nurse Practitioner stated surgical wounds should be assessed regularly and treatments should be initiated when wounds are identified, if this is not implemented it could lead to sepsis. V18 stated R30 should have been evaluated by a wound provider or surgeon (V41) when R30's wound reopened.<br><br>On 3/04/25 at 1:25 PM V41 confirmed V41's office was not notified of R30's surgical wound reopening until 1/7/25. V41 stated the facility should have absolutely notified V41's office when the draining wound was first identified so that R30 could have been evaluated in V41's office sooner. V41 stated R30 could have had an internal infection brewing over the prior two weeks that finally blew open and may have required incision and drainage regardless.<br><br>The facility's Wound Treatment Management Policy dated 2/1/25 documents notify the physician to obtain treatment orders when wounds are identified, treatments are documented on the TAR, follow physician's orders when administering wound care, and monitor the progression of the wound through regular assessments.<br><br>The facility's Dressing Change Clean policy dated 8/23/24 documents remove gloves after removing the dressing, perform hand hygiene and apply clean gloves prior to cleansing the wound.<br><br>50322<br><br>3.) On 3/5/25 at 10:50 AM, R41 was lying in bed and appeared alert. R41 stated she has suffered from constipation for months since coming to the facility. R41 stated they now have her on a stool softener, and she feels she is having more regular bowel movements, but prior to her hospitalization in January of this year she couldn't even recall how long it would be between bowel movements. R41 stated it was long enough that using the bed pan was very painful but that is what is offered. R41 stated prior to hospitalization in January, she had days of horrible chest and stomach pain that wouldn't subside and finally her niece had to tell facility staff to send her to the hospital. R41 stated she had an infection at that time as well and remembers having to have multiple tests done.<br><br>R41's minimum data sheet (MDS) dated [DATE] documents R41 is cognitively intact.<br><br>R41's care plan with print date of 3/5/25 documents a plan of care for constipation related to decreased mobility and use/side effects of medication (tramadol) with an initiation date of 1/16/25.<br><br>R41's Physician Visit Notes dated 12/17/24 document constipation as an active diagnosis.<br><br>R41's bowel and bladder elimination document dated December 2024 documents R41 had no bowel movements for the following dates: 12/1, 12/2, 12/3-12/7, 12/9, 12/11, 12/13-12/17, 12/20, 12/22, 12/25-12/26, and 12/28-12/29/24 and documents no response for 12/8, 12/18 and 12/23/24.<br><br>R41's bowel and bladder elimination document dated January 2025 documents R41 had no bowel movements for the following dates: 1/1-1/3, 1/5-1/8, 1/11-1/13, 1/21-1/24, 1/26-1/27 and 1/29/25 and documents no response for the dates of 1/4, 1/10 and 1/18/25. The document documents from 1/13-1/16/25 R41 was out of the facility.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R41's bowel and bladder elimination document dated 2/3/25 through 3/5/25 documents no bowel movement for the following dates: 2/8, 2/9, 2/10, 2/12, 2/13, 2/16-2/19, 2/24-2/26, 3/1, 3/2, and 3/5 and documents no response for the dates of 2/14, 2/27, 2/28, and 3/4/25.<br><br>R41's December 2024 Medication Administration Record (MAR) documents no orders or medications administered for constipation management and that R41 received Tramadol twice daily and as needed. R41's January 2025 MAR documents R41 received Tramadol 50mg by mouth twice daily and as needed and documents no orders or medications administered for constipation management until 1/17/24 when Colace 100mg by mouth twice daily was started.<br><br>R41's progress notes dated 1/12/25 at 10:09 PM document R41 complained of chest heaviness and the medical provider ordered to send R41 to the emergency room if R41 continued to complain of chest pain. At 11:22 PM on 1/12/25 progress notes document R41 complained of chest heaviness at a rate of 5/10 but documents R41 declined to go to the hospital. On 1/13/25 at 5:37 PM progress notes document R41 complained of pain radiating down the right thigh, lower back, and chest. The Progress Notes document R41's power of attorney (POA) requested R41 be sent to the hospital. At 6:01 PM on 1/13/25, notes document R41 was sent to the local emergency department. On 1/14/25 at 5:44 am, nursing notes document R41 was admitted to the hospital for pyelonephritis and fecal impaction.<br><br>R41 hospital records dated 1/14/25 document admission diagnoses of pyelonephritis and fecal impaction. Hospital Records document an admitted [DATE] with complaints of left flank pain radiating into R41's abdomen and chest, as well as left leg pain that shoots up her side and into her arm for the last couple days, but that pain was increased and constant on this date. Computed Tomography of the abdomen documents large amounts of stool noted in the colon with distension and probable fecal impaction.<br><br>On 3/5/25 at 11:30 AM, V17, Pharmacist, stated there are no recommendations or orders for bowel protocol medications prior to 1/13/25 (hospital admission) for R41.<br><br>On 3/5/25 at 1:50 PM, V18, Nurse Practitioner stated the facility has bowel standing orders for Colace and MiraLAX for constipation to give and increase as needed. V18 stated R41 should be assisted to the toilet and not using bed pan for elimination. |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385<br><br>Based on observation, interview, and record review the facility failed to implement repositioning and incontinence cares every two hours, implement pressure relieving interventions, implement pressure ulcer treatments, identify pressure ulcers, monitor and assess pressure ulcers upon identification and weekly, and notify a physician and dietitian of newly identified and current pressure ulcers and deterioration for two (R52, R345) of six residents reviewed for pressure ulcers in the sample list of 48. These failures resulted in R52 developing left heel stage two and right heel stage three pressure ulcers and being hospitalized for an infection of the stage three pressure ulcer. R52 subsequently developed a coccyx pressure ulcer that deteriorated into a stage four pressure wound.<br><br>This failure resulted in an Immediate Jeopardy:<br><br>The Immediate Jeopardy began on 02/22/2025, when the facility failed to continue ongoing monitoring and assessments of R52's wound and skin, maintain R52's wound dressing, ensure R52's pressure reliving interventions were implemented, ensure R52's pressure ulcers were identified timely, and ensure R52's pressure ulcer was evaluated by a physician and ensure R52's nutritional status was evaluated by a dietitian, per their submitted abatement plan to the State Agency for F686J cited on 02/25/2025. V1 Administrator was notified of the Immediate Jeopardy on 3/6/25 at 10:23 AM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 3/7/25, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.<br><br>Findings include:<br><br>The facility's Wound Treatment Management policy dated 2/1/25 documents wound treatments will be administered as ordered, if there are no orders then notify the physician, check and monitor dressings daily to ensure they are intact. This policy documents the effectiveness of treatments will be monitored by the nursing staff, Director of Nursing, and wound nurse through regular assessments of the wound and to consider modifications if there is a lack of progression of healing.<br><br>(continued on next page) |

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| | 145965 | A. Building<br>B. Wing | 03/07/2025 |

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| Loft Rehab of Decatur | 500 West McKinley Avenue<br>Decatur, IL 62526 |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The facility's Pressure Injury Prevention and Management policy dated 2/10/25 documents the following: The facility shall establish a systematic approach for pressure ulcer prevention and management, including prompt assessment and treatment, reducing underlying risk factors, interventions to stabilize, monitoring the effectiveness of interventions, and modifying interventions. The facility will use a pressure injury risk assessment and consider other risk factors such as impaired mobility, co-morbid conditions, cognitive impairment, bowel and bladder incontinence, nutritional status, and previous healed pressure ulcers. The nurses will complete weekly full body skin checks and with any newly identified pressure ulcer and document these assessments in the resident's medical record. Nurses will assess pressure ulcers and document the assessment, including staging of the pressure ulcer. A care plan will be developed to include appropriate interventions for pressure ulcer prevention and management, interventions will be communicated to relevant staff, and compliance will be documented in weekly charting. Pressure ulcer preventative interventions will be implemented for all residents identified to be at risk or who have pressure ulcers. These interventions include redistributing pressure through support surfaces and offloading/repositioning, minimizing exposure to moisture, and maintaining or improving nutritional status. The Unit Manager or designee is responsible for reviewing pressure ulcer and skin documentation weekly and documenting findings in the medical record. The physician will be notified when new pressure ulcers are identified, wound progression, and complications.<br><br>1. On 3/03/25 at 9:32 AM R52 was sitting in a wheelchair in R52's room. R52 stated R52 thinks R52 has a sore on R52's bottom, but was unable to give any additional information about R52's wound and wound care. On 3/3/25 intermittent observations were conducted from 9:32 AM until 3:12 PM of R52 sitting in a wheelchair in R52's room. There was a foam cushion on R52's wheelchair seat.<br><br>On 3/03/25 at 2:19 PM V11 Certified Nursing Assistant (CNA) stated V11 last offered to lay R52 down and provide toileting assistance at 10:00 AM and R52 refused at that time. V11 stated R52 is suppose to be laid down/repositioned and toileted at least every two hours and refusals of care are suppose to be reported to the nurses, but V11 had not reported R52's refusal of care today. V11 stated there are usually four or five CNAs working on R52's unit and North Wing, but today there were only three CNAs. V11 entered R52's room. There was a strong urine odor in the room, confirmed with V11. V11 stated V11 was just getting ready to lay R52 down, and the staffing today has affected V11's ability to provide R52's cares. At 2:41 PM R52 was in R52's room scooted down in the wheelchair. V10 and V11 CNAs entered R52's room and attempted to transfer R52 from the wheelchair. R52 was tearful, moaning and shaking. R52's fists were clenched and R52 complained of buttock pain when V11 and V10 CNAs attempted to transfer R52. V10 and V11 stated R52 acts like this when R52 is in pain from sitting in the wheelchair too long, they will need to allow R52 time to calm down and reapproach later. At 3:12 PM V11 and V19 CNA transferred R52 into bed and provided incontinence care. R52 was tearful, anxious, shaking, moaning, and complaining of R52's bottom hurting. R52's brief was saturated with urine and R52 had a golf ball sized pressure ulcer to the coccyx. Slough covered approximately 10% of the wound bed. The wound was not covered with a dressing at the time of the transfer. V11 stated R52 had a dressing on early this morning, V11 didn't pay attention to when it became dislodged, and did not report this to the nurse.<br><br>R52's Minimum Data Set (MDS) dated [DATE] documents R52 required dependence on staff for toileting and supervision/touching assistance for bed mobility and transfers; and R52 had one facility acquired stage two pressure ulcer. R52's MDS dated [DATE] documents R52 has cognitive impairment, R52 is dependent on staff for toileting and transfers, and needs partial/moderate assistance with bed mobility.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | R52's Braden assessment dated [DATE] documents R52 is at risk for developing pressure ulcers and R52's Braden assessment dated [DATE] documents R52 is at high risk of developing pressure ulcers. These forms do not document implementation of pressure relieving interventions as indicated on the forms.<br><br>R52's (active) Care Plan documents R52 has Parkinson's Disease and Alzheimer's Disease, R52 is incontinent of bowel and bladder and has Moisture Associated Skin Damage of the sacrum. This care plan includes interventions to report signs of skin breakdown, provide prompt incontinence care, administer treatments as ordered, follow dietitian recommendations, refer to the wound provider, and complete weekly wound assessments. This care plan does not include pressure relieving interventions for heels, besides repositioning and an air mattress.<br><br>There are no documented weekly skin assessments in R52's medical record after 12/5/24 until 12/26/24. R52's Skin Check dated 12/26/24 documents R52 had a new facility acquired intact blister on the right heel. There is no documentation that this wound was reported to a physician or that treatment orders and preventative measures were implemented for R52's heel wound. R52's Nursing Note dated 12/28/24 at 12:16 AM documents R52 was drowsy, difficult to arouse, and had refused medications. R52 had a large open, draining, blister on the right heel/ankle and another small open, draining wound on the left ankle. R52 was transferred to the emergency room .<br><br>R52's Hospital Notes dated 12/28/24 document R52 was admitted to the hospital with a stage two pressure ulcer of the left heel and cellulitis of a stage three pressure ulcer of the right heel. R52 was given intravenous antibiotics and hospitalized until 1/1/25.<br><br>R52's Skin Check dated 1/10/25 documents R52 had right and left heel blisters and a new facility acquired sacral wound that measured 1.8 centimeters (cm) long by 0.5 cm wide. This wound is described as Moisture Associated Skin Damage (MASD). R52's Hospital Note dated 1/14/25 documents R52's sacral wound as a stage two pressure ulcer. R52's Wound assessment dated [DATE] is the last recorded assessment of this wound in R52's medical record. This assessment documents R52's sacral wound as MASD that measured 1. 5 cm by 0.8 cm by 0.1 cm deep. R52's Skin Monitoring Forms (shower sheets) dated 2/17/25, 2/20/25 and 2/24/25 indicate impaired skin on R52's sacrum but there are no descriptions of this area. R52's skin assessments dated 2/20/25 and 2/27/25 do not include R52's sacral wound.<br><br>R52's March 2025 Treatment Administration Record (TAR) documents to cleanse sacral wound and apply honey hydrocolloid dressing every three days on night shift as of 2/9/25.<br><br>R52's Initial Wound Evaluation & Management Summary dated 1/8/25 and recorded by V21 Wound Nurse Practitioner, documents R52's right heel stage two pressure ulcer measured 2.5 cm by 4.5 cm and to use skin protectant daily, float heels in bed, offload wound, and use a pressure relieving boot. There is no documentation in R52's medical record that R52 was evaluated by V21 after 1/8/25 until 3/5/25. There is no documentation in R52's medical record of when R52's sacral pressure ulcer deteriorated and that a physician was notified to obtain new treatment orders, or that R52's nutritional status was evaluated by a dietitian between 12/1/24 and 3/3/25.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | R52's Wound Evaluation and Management Summary dated 3/5/25, recorded by V21, documents R52's right heel ulcer is resolved and R52's coccyx wound as a stage four pressure ulcer that measured 2.3 cm by 1.3 cm by 2.1 cm deep. This wound contained 30% necrotic (dead) tissue and 40% slough (dead tissue). The wound is described as being odorous with gray colored drainage, periwound is erythematous and painful to palpation. This wound required debridement to remove the dead tissue. V21 ordered Doxycycline (antibiotic) 100 milligrams twice daily by mouth for 14 days and a new treatment for 0.125% Dakins (bleach) solution soaked gauze packed into the wound and covered with a dressing twice daily. V21 recommended offloading the wound, repositioning per facility protocol, using an air inflated wheelchair cushion, and limiting time in the wheelchair to two hours at a time. There is no documentation that R52's order for Doxycycline was implemented as of 3/6/25 at 10:15 AM.<br><br>The facility's Wound Log dated 2/25/25 does not include R52's sacral pressure ulcer.<br><br>On 3/3/25 at 2:36 PM V10 CNA stated there were three CNAs for the evening shift last night on the North Wing and R52's unit, which was not enough staff, causing toileting and incontinence cares to fall behind. V10 stated R52's wound was present three weeks ago when V10 started working for the facility, the wound has gotten worse and R52 complains of pain. V10 stated the nurses were aware of this.<br><br>On 3/03/25 at 3:37 PM V22 Wound Nurse stated V22 has not done any treatments for R52 and was unsure if R52 had any wounds. V22 assessed R52's wound and stated the wound was unstageable due to slough. V22 stated V22 would notify the physician and get a treatment order.<br><br>On 3/04/25 at 10:31 V24 Licensed Practical Nurse (LPN) stated R52 had an intact blister on the right heel and V24 was unsure if the physician was notified or any treatments/interventions were implemented for this wound. V24 stated since it (blister) is intact, we don't really apply a treatment.<br><br>On 3/04/25 at 10:39 AM V3 Assistant Director of Nursing (ADON) stated V3 assessed R52's buttocks on 2/20/25 and described R52's sacral area as the skin being whitish/pink in color and superficially open between the epidermis and dermis layers of skin. V3 reported this to the former DON and did not notify the physician or get new treatment orders. V3 stated the CNAs are suppose to notify the nurse when dressings are dislodged so that a new dressing can be applied.<br><br>On 3/4/25 at 11:41 AM V23 LPN stated V23 transferred R52 to the hospital in December 2024 due to a right heel blister that was open and draining. V23 stated within the last two weeks V23 has changed R52's sacral dressing at least once or twice and it looked as though the wound was getting worse. V23 thought V23 notified V34 (R52's Physician) and documented this in a note, but sometimes V34 is difficult to get a hold of so V23 may have passed it onto the day shift to follow up on. V23 was unsure if the facility's Medical Director (V35) should be contacted in the event that a resident's physician is unable to be reached. At 3:25 PM V23 stated V23 could not recall if any heel pressure relieving interventions were implemented for R52. V23 stated R52 had a dressing on the left heel that V23 did not remove and R52 did not have any active treatment orders for R52's heel wounds the day V23 sent R52 to the hospital in December. V23 stated to refer to R52's TAR to determine when V23 last administered R52's sacral wound treatment. V23 stated at that time the wound was deeper, had slough, and was draining. R52's February 2025 TAR documents V23 administered R52's sacral wound treatment on 2/24/25 and 2/27/25.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 3/4/25 at 10:07 AM V2 Director of Nursing (DON) stated V2 saw R52's wound today and R52 had sacral MASD that opened within the last two weeks. V2 stated if there is a wound then it should have a wound assessment completed weekly in the assessments section of the electronic medical record, and the physician should be notified of wounds which would be documented in the nursing notes. V2 stated skin checks should also be completed weekly in the assessments section and should include wound identification. V2 stated the standard of care is for residents to be repositioned and provided incontinence care every two hours. V2 stated R52 should have physician orders for pressure relieving boots or floating heels and this should also be documented in R52's care plan. At 2:25 PM V2 stated R52's nursing note dated 1/13/25 was the only documentation V2 could find that R52's wounds were reported to a physician. V2 confirmed there were no orders or care plan for heel pressure relieving interventions. On 3/06/25 at 11:08 AM V2 stated if the nurses are unable to reach V34 (R52's Physician) then they should contact either V35 Medical Director or V18 Nurse Practitioner, who both are available to take calls 24 hours per day.<br><br>On 3/4/25 at 10:57 AM V18 Nurse Practitioner stated residents at risk for developing pressure ulcers and those with pressure ulcers should be provided incontinence care and repositioning/offloading at least every two hours. V18 confirmed if wounds are not monitored/assessed, wound dressings aren't maintained, pressure relieving interventions, incontinence care and repositioning aren't implemented, and newly identified wounds and deterioration aren't being reported to a physician, these things can contribute to the development of pressure ulcers and wounds deteriorating. V18 stated pressure ulcers should be reported to the facility's wound provider and evaluated. V18 stated V18 was notified yesterday of R52's sacral wound. V18 stated the facility should have reported R52's heel wounds, implemented pressure relief for R52's heels such as floating heels or heel protectors, and implemented a protective dressing treatment for R52's intact blister. V18 confirmed wounds should be covered with dressings maintained as ordered. V18 stated if these things aren't implemented then the resident is at risk for the wound becoming infected, developing sepsis, and the wound deteriorating.<br><br>On 3/4/25 at 3:16 PM V20 Registered Dietitian (RD) stated V20 has been the facility's dietitian since September/October 2024 and V20 rounds in the facility weekly. V20 stated V20 was not made aware that R52 had wounds, so V20 did not evaluate R52 until today. V20 confirmed R52's nutrition had not been evaluated between 12/1/24 and 3/3/25. V20 stated V20 recommended adding fortified foods with R52's meals and will probably recommend adding Vitamin C and Zinc. V20 stated V20 would have recommended these things sooner if V20 was notified of R52's wounds.<br><br>On 3/5/25 at 3:48 PM V21 Wound Nurse Practitioner stated V21 just evaluated R52's wound which presented as an unstageable pressure ulcer with slough and necrosis that required debridement. After debridement it is a stage four pressure ulcer that measured 2.3 cm by 1.3 cm by 2.1 cm deep. V21 stated V21 had to stop the debridement due to the amount of pain R52 experienced. V21 confirmed R52 should have been evaluated by V20 RD and V21, should have been repositioned and provided incontinence care every two hours, have dressing maintained, and wound assessments and monitoring completed. V21 stated these are certainly big factors in wound healing and can contribute to R52's wound deterioration. V21 stated V21 had last evaluated R52 for a heel ulcer, which is now healed, but that was prior to R52 going to the hospital. V21 stated no one notified V21 that R52 had returned from the hospital and that R52 had wounds. V21 stated V21 is ordering Doxycycline and additional blood work due to R52's pain and concern for infection. V21 stated the facility has had a lot of wound nurse turnover.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 3/6/25 at 10:15 AM V22 Wound Nurse confirmed V22 rounded with V21 on 3/5/25 and V21 mentioned ordering Doxycycline. V22 stated either V22 or V2 are responsible for entering V21's orders and R52's Doxycycline order had not yet been transcribed/implemented.<br><br>The facility presented an abatement plan to remove the immediacy on 3/6/25 at 12:08 PM and presented revision of the abatement plan on 3/6/25 at 12:28 PM, 12:42 PM and 2:42 PM, and on 3/7/25 at 9:37 AM. 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 on 3/6/25 at 12:20 PM, 12:32 PM, and 2:12 PM, and on 3/7/25 at 9:24 AM. The facility presented a revised abatement plan on 3/7/25 at 9:46 AM and the survey team accepted the abatement plan on 3/7/25 at 9:47 AM.<br><br>The Immediate Jeopardy that began on 2/14/25 was removed on 3/7/25 when the facility took the following actions to remove the immediacy:<br><br>1.) R52 was assessed and treated by the Wound Care Physician on 3/5/25.<br><br>2.) V22 Wound Nurse was hired on 2/26/25 as the facility's full time wound nurse, confirmed with V22 on 3/7/25.<br><br>3.) V2 Director of Nursing and V22 Wound Nurse conducted facility wide skin checks on 3/6/25 and 3/7/25 of all residents.<br><br>4.) V22 Wound Nurse initiated audits on 3/7/25 that included a review of the resident skin checks, provisions of incontinence care, turning and repositioning, notifications to the physician and Registered Dietician, and monitoring of wound treatments.<br><br>5.) On 3/6/25 and 3/7/25 V2 Director of Nursing conducted an inservice training for nurses and Certified Nursing Assistants on the topics of skin assessments, wound assessments, identifying and reporting new and deteriorating wounds, implementing and maintaining wound treatments, notification of physician and dietitian, incontinence care, and turning and repositioning. This was confirmed through documented in-service sign in sheets and staff interviews confirmed on 3/7/25. Any remaining staff will receive this training prior to their next scheduled shift, confirmed with V2 and V22 on 3/7/25.<br><br>6.) On 3/6/25 V22 was in-serviced by V2 on the facility's skin and wound management programs and notification of registered dietitian and physician. This was confirmed on 3/7/25 through documented in-service and interviews with V2 and V22. V2 and V22 confirmed V22 will be responsible for monitoring/tracking/processing of physician orders and dietitian recommendations.<br><br>7.) On 3/7/25 at 2:37 PM V2 stated V22 will bring the audits to the Quality Assurance meetings to be reviewed by the interdisciplinary team weekly, monthly, and quarterly. This was also confirmed with V1 and V22.<br><br>52228<br><br>2. R345's care plan dated 2/11/25 documents R345 has history of Pressure Ulcers and that R345 is cognitively intact and has no signs and symptoms of delirium.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 3/5/25 at 1:45 PM, V6 (Licensed Practical Nurse) and V19 (Certified Nursing Aide) laid R345 down in R345's bed. There was a pencil eraser sized partial thickness wound to R345's right buttock. R345's wound did not have a treatment on it. V6 stated V6 was unaware of the open area and stated that she will have the wound doctor look at it. V6 stated there is no treatment for this area. R345 stated this area has been present and was seen by the nurse a couple nights ago.<br><br>R345's nurse's note dated 2/19/25 at 6:39 PM documents R345 has a new skin issue to the buttocks.<br><br>R345's physician order sheet does not contain a treatment order for the right buttock.<br><br>R345's Initial Wound Evaluation note dated 3/5/25 documents R345 has a 0.1 centimeter (cm) by 0.2 cm stage two pressure ulcer to the right buttock. This note documents the duration of this wound as greater than two days. This evaluation contains an order for medical honey to be applied once daily and covered with a gauze dressing. |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32172<br><br>Based on interview and record review the facility failed to identify significant weight loss, notify a physician or registered dietician regarding significant weight loss or implement interventions to prevent further weight loss for one of five residents (R45) reviewed for Nutrition on the sample list of 48. This failure resulted in continued weight loss even after a severe weight loss was identified.<br><br>Findings Include:<br><br>The facility's Weight Monitoring policy dated 2/10/25 documents Based on the resident's comprehensive assessment; the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight. Interventions will be identified, implemented, monitored and modified (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status. Newly recorded resident weights should be compared to the previous recorded weight. A significant change in weight is defined as 5% change in weight in one month, 7.5% change in weight in three months, 10% change in weight in six months. The physician should be informed of a significant change in weight and may order nutritional interventions. The Registered Dietitian or Dietary Manager should be consulted to assist with interventions and any actions should be recorded in the nutrition progress notes. Specific interventions should be noted on the care plan and any new orders should be administered as directed.<br><br>R45's Medical Diagnoses List dated March 2025 documents R45 is diagnosed with Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure, Anemia, Protein Calorie Malnutrition, Vitamin D Deficiency, History of other Endocrine, Nutritional and Metabolic Disease, and Hypokalemia.<br><br>R45's Physician Order Sheet (POS) dated March 2025 documents an order for a regular diet and monthly weights.<br><br>R45's Care Plan dated 10/14/24 documents R45 has had a significant weight loss and staff should monitor R45's weight for any further loss and notify the medical doctor and registered dietician. The registered dietician needs to evaluate and make recommendations as needed. The same care plan dated 5/22/24 documents R45 requires assistance with eating including supervision by staff, finger foods when having difficulty with utensils, and milkshakes or liquid food supplements when the resident refuses or has difficulty with solid food; or provide nutritious foods that can be taken from a cup or a mug where appropriate.<br><br>R45's Weight Log documents R45 weighed 158.4 pounds on 7/5/24 and six months later, on 1/7/25 R45 weighed 137.4 pounds. This is a -13.26% weight loss in six months' time. R45 continued to lose weight and in February 2025 her weight was 135.8 pounds.<br><br>R45's Nutrition/Dietary Note dated 1/14/25 documents R45's current weight as 137 pounds. This is noted to be a significant weight loss. The note documents R45's physician (V35) would be notified and staff would request extra calories with meals. (This notification was not documented/completed and no new interventions were implemented).<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R45's Mini Nutrition assessment dated [DATE] documents R45's weight loss is greater 6.6 pounds in the last 3 months. R45's Mini Nutrition Score is 8 which puts her in the at risk of malnutrition category.<br><br>On 3/6/25 at 1:00 PM V36 Certified Nurses Assistant reported R45's March weight was 134.2 pounds.<br><br>On 3/05/25 at 1:00 PM V20 Registered Dietician confirmed R45 had significant weight loss from July to January 2025 and V20 was not notified and did not have the opportunity to implement any interventions to prevent further weight loss. V20 confirmed she could have added more calories or implemented other interventions had she been notified but she was not and has not assessed R45 since October of 2024. V20 confirmed R45 could be at risk nutritionally due to her diagnoses and staff should be monitoring monthly weights closely and making proper notifications.<br><br>On 3/5/25 at 1:45 PM V18 Nurse Practitioner stated he was never notified of R45's weight loss and did not have the opportunity to put any interventions in place to prevent further weight loss. V18 stated staff should be monitoring resident's weights on a regular basis. V18 confirmed if new interventions would have been implemented it could have prevented further weight loss.<br><br>On 3/5/25 at 3:00 PM V2 Interim Regional Director of Nurses confirmed staff need to be monitoring resident's weights and if there is a consistent unplanned weight loss or significant weight loss the physician should be notified and the registered dietician should be consulted. V2 confirmed there is no documentation in R45's record that V35 physician or V20 dietician were notified of R45's consistent unplanned or significant weight loss and no new interventions were put into place. R45 continued to lose weight over the next two months. |

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| Loft Rehab of Decatur | 500 West McKinley Avenue<br>Decatur, IL 62526 |

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| F 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385<br><br>Based on observation, interview and record review the facility failed to effectively manage pain by failing to accurately assess for pain, notify the physician of pain and implement orders for pain medications for two (R52, R84) of two residents reviewed for pain in the sample list of 48. This failure resulted in R52 experiencing uncontrolled pain as evidenced by moaning, grimacing, tearfulness, clenched fists and complaints of pain.<br><br>Findings Include:<br><br>The facility's Pain Management policy dated 2/10/25 documents the facility will recognize when a resident is experiencing pain, observe for nonverbal signs of pain, identify circumstances when pain can be anticipated, conduct ongoing pain assessments using a tool that is appropriate for the resident's cognitive status, and collaborate with the resident's physician to manage or prevent pain in accordance with the resident's care plan, assessment, and current standard of practice.<br><br>1.) On 3/03/25 at 9:32 AM R52 was sitting in a wheelchair in R52's room. R52 stated R52 thinks R52 has a sore on R52's bottom, but was unable to give any additional information about R52's wound and wound care. On 3/3/25 intermittent observations were conducted from 9:32 AM until 3:12 PM of R52 sitting in a wheelchair in R52's room. There was a foam cushion on R52's wheelchair seat.<br><br>On 3/03/25 at 2:19 PM V11 Certified Nursing Assistant (CNA) stated V11 last offered to lay R52 down and provide toileting assistance at 10:00 AM and R52 refused at that time. At 2:41 PM R52 was in R52's room scooted down in the wheelchair. V10 and V11 CNAs entered R52's room and attempted to transfer R52 from the wheelchair. R52 was tearful, moaning and shaking. R52's fists were clenched and R52 complained of buttock pain when V11 and V10 CNAs attempted to transfer R52. V10 and V11 stated R52 acts like this when R52 is in pain from sitting in the wheelchair too long, they will need to allow R52 time to calm down and reapproach later. At 3:12 PM V11 and V19 CNA transferred R52 into bed and provided incontinence care. R52 was tearful, anxious, shaking, moaning, and complaining of R52's bottom hurting. R52's brief was saturated with urine and R52 had a golf ball sized sacral pressure ulcer.<br><br>R52's Minimum Data Set (MDS) dated [DATE] documents R52 has cognitive impairment, R52 does not receive scheduled or as needed (PRN) pain medications, R52 is dependent on staff for toileting and transfers, and R52 needs partial/moderate assistance with bed mobility.<br><br>R52's (active) Care Plan documents R52 has Parkinson's Disease and Alzheimer's Disease, R52 is at risk for pain and has sacral moisture associated skin damage (MASD). This care plan includes interventions to administer pain medications as ordered, assist to reposition frequently for comfort, notify the physician of changes in pain, report nonverbal expressions of pain, and treat pain prior to treatments and turning to ensure resident comfort.<br><br>R52's Wound assessment dated [DATE] documents R52's sacral wound measured 1.5 cm by 0.8 cm by 0.1 cm deep. R52's March 2025 Treatment Administration Record (TAR) documents to cleanse sacral wound and apply honey hydrocolloid dressing every three days on night shift as of 2/9/25. R52's February and March TARs document R52's pain is assessed every shift and rates R52's pain as 0 on a 1-10 scale.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | There are no active physician orders for pain medication in R52's medical record as of 3/3/25 or that R52's pain was reported to a physician prior to 3/4/25 when Tylenol 650 milligrams every eight hours was ordered.<br><br>R52's Wound Evaluation and Management Summary dated 3/5/25, recorded by V21 Wound Nurse Practitioner, documents R52's sacral wound as a stage four pressure ulcer that measured 2.3 cm by 1.3 cm by 2.1 cm deep. This wound contained 30% necrotic (dead) tissue and 40% slough (dead tissue). The wound is described as being odorous with gray colored drainage, periwound is erythematous and painful to palpation. This wound required debridement to remove the dead tissue. V21 ordered Doxycycline (antibiotic) 100 milligrams twice daily by mouth for 14 days and a new treatment for 0.125% Dakins (bleach) solution soaked gauze packed into the wound and covered with a dressing twice daily. V21 recommended offloading the wound, repositioning per facility protocol, using an air inflated wheelchair cushion, and limiting time in the wheelchair to two hours at a time.<br><br>On 3/3/25 at 2:36 PM V10 CNA stated R52's wound was present three weeks ago when V10 started working for the facility, the wound has gotten worse and R52 complains of pain. V10 stated the nurses were aware of this.<br><br>On 3/4/25 at 3:25 PM V23 Licensed Practical Nurse (LPN) stated the last time V23 administered R52's sacral wound treatment the wound was deeper, had slough, and was draining. R52's February 2025 TAR documents V23 administered R52's sacral wound treatment on 2/24/25 and 2/27/25, the last times that V23 administered R52's wound treatment.<br><br>On 3/4/25 at 10:07 AM V2 Director of Nursing (DON) confirmed R52 would have potential for pain related to R52's wound, R52 has no pain medication ordered, and R52's pain assessments document no pain. V2 stated physician notification would be documented in a nursing note.<br><br>On 3/4/25 at 10:57 AM V18 Nurse Practitioner stated the nurses should have reported R52's pain so that we could implement pain medication orders for R52. V18 stated (R52) should not be in pain.<br><br>On 3/5/25 at 3:48 PM V21 Wound Nurse Practitioner stated V21 just evaluated R52's wound which presented as an unstageable pressure ulcer with slough and necrosis that required debridement. After debridement (mechanical removal of dead tissue) it is a stage four pressure ulcer that measured 2.3 cm by 1. 3 cm by 2.1 cm deep. V21 stated V21 had to stop the debridement due to the amount of pain R52 experienced. V21 stated V21 is ordering Doxycycline and additional blood work due to R52's pain and concern for infection.<br><br>2.) On 3/02/25 at 9:46 AM R84 stated R84 has frequent pain to lower back and knees, which the nurses are aware of, and R84 had recent back surgery. R84 stated R84's pain medications help take the edge off. On 03/02/25 at 9:57 AM R84 was lying in bed with legs elevated on a pillow. R84 yelled out and moaned when V7 CNA lifted R84's legs off of the pillow and with turning when V7 provided R84's incontinence cares. R84 yelled out, R84's breathing was heavy, R84 whimpered, and R84 had tears in R84's eyes during R84's cares. There was a dressing on R84's lower back. V7 told R84 I'm sorry. R84 stated R84's knees hurt and the pain travels up R84's back. R84 told V7 that R84 needed a pain pill from the nurse and R84 rated R84's pain as a 10. On 3/02/25 at 1:55 PM and on 3/3/25 at 9:23 AM R84 was lying in bed asleep.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R84's MDS dated [DATE] documents R84 as cognitively intact, R84 does not receive scheduled pain medication, and R84 has moderate pain frequently. R84's active Care Plan documents R84 has pain related to radiculopathy, spinal stenosis and osteoarthritis. This care plan includes interventions to administer pain medication as ordered, assess pain, discuss precipitating factors, and notify the physician of any changes in pain.<br><br>R84's February and March 2025 Medication Administration Records document R84's pain is assessed every shift and R84's pain rating was between 4 and 8 on nine occasions between 2/1/25 and 3/2/25. Norco 5-325 milligrams (mg) was given 16 times and Tramadol 50 mg was given nine times between 2/1/25 and 3/2/25. R84's March MAR does not doucment pain medication was administered until 2:03 PM on 3/2/25.<br><br>On 3/02/25 at 1:28 PM V6 LPN stated R84 mostly complains of pain during R84's cares and during therapy. V6 stated V6 offered R84 a pain pill at 7:30 AM and again at 12:47 PM, but R84 declined the pain medication. V6 stated R84 has orders for Tramadol and Norco PRN and no scheduled pain medications ordered. V6 stated R84 will deny being in pain and then 15-20 minutes later will complain of pain during therapy. V6 stated that no one had reported that R84 requested a pain pill today and R84 had not received any pain medication during V6's shift today.<br><br>On 3/03/25 at 1:14 PM V37 Certified Occupational Therapy Assistant stated R84 has back pain and pretty severe pain in R84's legs causing R84 to be sensitive to touch. V37 stated R84's pain affects R84's ability to participate in therapy and it is difficult for R84 to stand in the lift device. V38 Physical Therapy Assistant stated R84 has constant pain to both knees and back pain that comes and goes. V38 stated R84's knees are bone on bone and R84 was suppose to have knee replacement surgery prior to R84's back surgery. V37 and V38 stated they both have discussed R84's pain with the nurses, but R84 only has PRN pain medication which R84 often doesn't request until R84 is in therapy already and in pain. |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>50430<br><br>Based on interview and record review, the facility failed to ensure there were sufficient nursing staff in the facility to provide adequate care and assistance for residents, resulting in long call light response times and wound treatments and assessments not being completed timely for eight (R41, R7, R58, R66, R84, R79, R40, R52) of 32 residents reviewed for staffing out of a sample list of 48.<br><br>Findings Include:<br><br>The undated Facility Assessment documents the facility will follow Federal minimum staffing standards. Facilities with higher acuities and needs may need to adjust their staffing numbers higher than the minimum standard.<br><br>The undated Facility Assessment documents the facilities daily Certified Nursing Assistant (CNA's) needs are 24 CNAs for a resident census of 97.<br><br>The facilities Daily Staffing sheets documents on 2/28/25, 3/1/25, and 3/2/25 there was 19 CNA's who worked, on 3/3/25 and 3/4/25 there were 20 CNA's who worked.<br><br>The Resident Council Minutes dated 1/27/25 documents under new business that call lights are taking over thirty minutes to be answered. Resident Council Minutes dated 2/14/25 documents that call lights continue to be an issue and is taking 30-45 minutes to be answered.<br><br>A resident council meeting was conducted on 3/03/25 at 10:03 AM. R79 stated the food doesn't taste good and it's served cold both in the dining room and when eating in her room. R79 stated there is no way for them to keep the food hot since it is on open racks. They don't have the staff to pass the trays timely. R41 stated call lights are a big problem, that is ongoing and R41 has waited 45 minutes for R41's call light to be answered, which is bad if you're waiting to use the bathroom. R66, R40, R41, R7 and R79 also stated call light response times are an ongoing problem, the facility doesn't have enough staff, a lot of staff have quit, and they aren't getting their showers twice weekly as scheduled.<br><br>On 03/05/25 01:05 PM, V6 Licensed Practical nurse stated she has 32 residents today that she is responsible for. V6 stated due to staffing she has a hard time completing her assessments, treatments and processing laboratory results and physician orders. V6 stated she normally must pass stuff off to the next nurse and that's how things sometimes get missed or forgotten. V6 further stated she has 45 hours of overtime as of yesterday from 2/26/25-3/5/25. V6 stated If a CNA doesn't show up for their shift and coverage is not found the nurses assign those residents to other CNAs.V6 stated we have a hard time keeping staff at this facility.<br><br>On 03/05/25 at 1:16 PM, V16 CNA/Scheduler stated V42 Human Recourses Director and herself review staffing daily. V16 stated corporate sends a daily staffing sheet based on census to let them know how many staff are needed on the floor. V16 stated we do our best to staff the facility, but often staff call in or don't show up for work.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 03/05/25 at 1:16 PM, V1 Administrator stated the Facility Assessment was completed when she first came to the facility and the staffing numbers listed reflect the facilities census and staffing at that time. V1 confirms there is not enough staff in the facility to provide proper resident care, and last week the facility stopped taking admissions because there is not enough staff in the facility to care for the residents they have.<br><br>On 03/02/25 at 10:31 AM, R58 stated I must often wait with my call light on to receive any help. R58 stated they don't have enough staff here to take care of everyone.<br><br>On 03/02/25 between 09:40 AM and 9:50 AM R84 stated food doesn't taste good and it's cold. R84 stated they are always short of help. R84 stated she hasn't been cleaned up yet today. It has taken up to 2 hours for call light to be answered while needing incontinence cares.<br><br>On 3/03/25 at 2:19 PM V11 Certified Nursing Assistant stated we usually work with 4-5 CNAs, but today only had 3 for the North side and half of 300 hall. V11 stated she was just getting ready to lay R52 down, and stated staffing today has affected her ability to provide cares for R52, she is supposed to be toileted and laid down to reposition every 2 hours. V11 stated R52 requires a sit to stand lift and two staff for transfers. V11 Stated there are a lot of residents on North side that need two staff members for assistance. V11 stated she was only able to get one assigned shower done today, so not all the showers were completed as scheduled today.<br><br>The facility's Long-Term Care Facility Application for Medicare and Medicaid dated 3/2/25, documents there are 97 residents residing in the facility. |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>32172<br><br>Based on observation, interview, and record review the facility failed to post daily, up-to-date, nurse staffing information. This failure has the potential to affect all 97 residents residing in the facility.<br><br>Findings Include:<br><br>On 3/3/25 at 10:28 AM posted staffing in case near front entrance dated 2/28/25.<br><br>On 3/5/25 at 9:15 AM and 4:00 PM posted staffing in case near front entrance remains dated 2/28/25.<br><br>On 3/4/25 at 3:51 PM V2 Interim Regional Director of Nurses (DON) confirmed Posted Daily Staffing should be updated daily.<br><br>Throughout the survey concerns were identified related to staffing, showers, cold food, turning and repositioning, toileting, incontinence care, infection control, and call light wait times.<br><br>The Resident Council Meeting Minutes dated 1/27/25 and 2/14/25 both document resident concerns with call light wait times.<br><br>The Long Term Care Facility Application for Medicare and Medicaid dated 3/2/25 documents 97 residents reside in the facility. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>40385<br><br>Based on interview and record review the facility failed to monitor risk of bleeding related to medication use for one (R15) of seven residents reviewed for unnecessary medications in the sample list of 48 residents.<br><br>Findings Include:<br><br>The facility's Anticoagulants High Risk Medications policy dated 2/10/25 documents risks associated with antiplatelet and anticoagulant use includes bleeding and hemorrhage, drop in hematocrit and blood pressure, and thromboembolism. This policy documents that resident's care plan should include interventions to minimize risk of adverse consequences.<br><br>R15's Physician Order dated 2/19/25 documents administer Eliquis (anticoagulant) 2.5 milligrams (mg) by mouth twice daily. R15's Physician Order dated 2/20/25 documents administer Clopidogrel Bisulfate (antiplatelet) 75 mg by mouth daily. R15's medical record does not include physician orders to monitor for risk and signs of bleeding related to anticoagulant and antiplatelet use.<br><br>R15's Care Plan dated 11/1/23 documents is at risk for bleeding and bruising related to Aspirin and Clopidogrel use, and includes interventions to administer medications as ordered and monitor/report any signs of adverse reactions and complications. This care plan does not include Eliquis.<br><br>On 3/03/25 at 1:44 PM V18 Nurse Practitioner stated V18 is aware that R15 receives both Eliquis and Clopidogrel, which has been discussed with V35 Medical Director as well. V18 stated one of the medications is ordered for Atrial Fibrillation and the other is for Cerebral Vascular Accident. V18 stated R15 needs to be closely monitored for risk of bleeding associated with these medications.<br><br>On 3/03/25 at 2:06 PM V6 Licensed Practical Nurse stated there should be an order for monitoring for anticoagulant use and bleeding complications and this is recorded on the Treatment Administration Record. V6 confirmed R15 did not have an order to monitor anticoagulant risk for bleeding complications. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>50430<br><br>Based on observation, interview, and record review, the facility failed to ensure food was palatable and food temperatures were satisfactory, and failed to ensure meals were served timely, for five (R79, R58, R47, R30, R84) of five residents reviewed for food satisfaction on the sample list of 48.<br><br>Findings Include:<br><br>The facility's Food Temperatures policy revised 2/12/25 documents to ensure food safety, hot food will be held and served at a temperature no lower than 135 degrees Fahrenheit (F).<br><br>A resident council meeting was conducted on 3/03/25 at 10:03 AM. R79 stated the food doesn't taste good and it's served cold both in the dining room and when eating in her room. R79 stated there is no way for them to keep the food hot since it is on open racks. They don't have the staff to pass the trays timely.<br><br>On 03/02/25 at 10:31 AM, R58 was sitting in his wheelchair asleep with an untouched breakfast tray in front of R58 with scrambled eggs, toast, oatmeal, and milk. R58 stated he hasn't eaten breakfast because food is cold.<br><br>On 3/2/25 at 9:18 AM, R47 stated the food is always cold when his room tray is delivered and tastes terrible. R47 stated his family often brings him food from home because R47's food is too cold to eat.<br><br>On 03/02/25 09:23 AM R30 stated the food doesn't taste very good, and not served hot. Scrambled eggs cold. They don't have enough staff to pass trays timely.<br><br>On 03/02/25 between 09:40 AM and 9:50 AM, R84 stated food doesn't taste good and it's cold.<br><br>On 3/2/25 at 11:50 AM, three food holding carts were sitting in the kitchen with resident room trays for each hall dished up and covered with a plate cover. V4 confirms these are resident room trays ready to be delivered to the halls for staff to deliver to the residents eating in their rooms.<br><br>On 3/2/25 at 12:00 PM, all three food holding carts were still sitting in the kitchen.<br><br>On 3/2/25 at 12:05 PM, V4 Dietary Manager delivered the food cart for the residents on the 100 hall.<br><br>On 3/2/25 at 12:20 PM, V8 Licensed Practical Nurse started to serve room trays. V4 used a calibrated thermometer to obtain the food temperature from the first tray, the fried chicken temperature was 113 degrees F, and mashed potatoes were 139 degrees F. V4 stated the food was not warm enough.<br><br>On 3/2/25 at 12:40 PM, the food holding cart still had nine room trays to be passed. V4 obtained another temperature on a food tray still on the holding cart and the fried chicken was 100.7 degrees F. V4 stated it's taking too long to pass the lunch trays, so the food is too cold now.<br><br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 03/03/25 at 11:22 AM, V4 stated meals are to be served to residents at a temperature no less than 135 degrees. |

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|---|---|
| F 0850<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Hire a qualified full-time social worker in a facility with more than 120 beds.<br><br>50430<br><br>Based upon interview and record review the facility failed to employ a qualified Social Worker on a full-time basis in a facility of 150 beds. This failure has the potential to affect all 97 residents who reside in the facility.<br><br>Findings Include:<br><br>The facility's undated Facility Assessment documents there are 150 licensed beds in the facility. This assessment also documents the facility requires one full time social worker on staff.<br><br>The facility's Long-Term Care Facility Application for Medicare and Medicaid dated 3/2/25, documents there are 97 residents residing in the facility.<br><br>On 3/6/25 at 1:30 PM, V1 Administrator stated V32 Social Service Director, is covering Activities and Social Services. V1 confirms V32 does not meet the qualifications to be a Social Worker in the facility. V1 stated V32 does not have a degree in Social Work or Human Services. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145965 | A. Building<br>B. Wing | 03/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Loft Rehab of Decatur | 500 West McKinley Avenue<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>35380<br><br>Based on interview and record review, the facility failed to implement their water management plan that included the required risk assessment, control measures, and testing protocols to reduce the risk of growth of Legionella and other pathogens in the facility's water system. This failure has the potential to affect all 97 residents in the facility.<br><br>Findings Include:<br><br>The facility's Water Management Plan dated 2023, fails to fully document the required facility water system risk assessment where Legionella and other pathogens could grow and spread in the facility water system. The facility failed to implement any specific testing protocols, acceptable ranges for control measures, or any corrective actions when control limits are not maintained to reduce the risk of waterborne pathogens in the facility water system.<br><br>On 3/7/25 at 9:30 AM, V1 Administrator stated V1 does not have access/documentation to what has been completed, if it has been completed.<br><br>The facility's Water Management Program dated Revised 5/1/24, documents a risk assessment will be conducted by the water management team annually to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water system. Data to be used for completing the risk assessment include: water system schematic/description, Legionella environmental assessment, resident infection control surveillance data, environmental culture results, rounding observation data, water temperature logs, water quality reports from drinking water provider, and community infection control surveillance date. Control measures will be applied to address potential hazards at each control point with a variety of measures being used such as: physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens. |