STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146003	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab of Rock Springs, The	2530 North Monroe Street 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50430 Based on observation, interview, and record review the facility failed to implement pressure relieving interventions and re-evaluate the effectiveness of a pressure ulcer treatment when the wound did not improve for one of three residents (R2) reviewed for pressure ulcers in the sample of five. Findings include: The facility's Pressure Injury Prevention and Management policy revised 2/10/2025 documents, the facility is committed to the prevention of avoidable pressure injuries, and to provide treatment and services to heal pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. The same policy documents the facility will monitor interventions and revise as appropriate. R2's Admission Record documents R2 was admitted to the facility on [DATE] after sustaining a fall at home and developing Rhabdomyolysis. R2's Braden Scale for Predicting Pressure Sore Risk assessment dated [DATE] (Admission) documents R2 is at risk of developing a pressure ulcer due to limited mobility. R2's MDS (Minimum Data Set) assessment dated [DATE] documents R2 is cognitively impaired and had no pressure ulcers on admission (1/15/25). This same MDS documents R2 is dependent on staff for mobility. R2's Initial Wound Evaluation and Management Summary dated 2/5/25 documents a new unstageable pressure ulcer to R2's coccyx measuring 3.5 centimeters (cm) x 3 centimeters (cm) with adherent yellow and black dead tissue on the surface of the wound. The same evaluation includes a new order to apply Santyl (debridement ointment) to wound surface daily and cover with an adhesive bandage for 30 days and to offload the wound, reposition R2 per facility protocol, place R2 on a Low Air Loss Mattress, start Vitamin C 500 milligrams (mg) twice daily by mouth, Zinc Sulphate 220 mg once daily by mouth for 14 days and Multivitamin once daily by mouth, and consult dietary regarding protein supplements. R2's current Care Plan documents R2 should be on a low air loss mattress for her wounds. R2's Wound Evaluation and Management Summary dated 2/12/25 documents R2's Coccyx Pressure Ulcer as a Stage 3 measuring 5.5 cm x 3.8 cm and wound bed is soft. V4 Nurse Practitioner documents to continue the same treatment order to the pressure ulcer daily. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Wound Evaluation and Management Summary dated 2/19/25 documents R2's stage 3 coccyx pressure ulcer measurements are 5.5 cm x 4.5 cm x 2.2 cm. V4 documents the wound had moderate foul-smelling drainage and documents she manually removed a moderate amount of dead fat tissue from R2's pressure ulcer and that R2 appears to be declining. V4 documents new orders to apply Santyl once daily for 16 days to the wound bed; Sodium hypochlorite solution (Dakin's) apply to the wound bed twice daily for 30 days. Soak gauze dressing with .0125% Dakin's solution, wring out the gauze and apply to the wound bed only, twice daily for one week, until 2/26/25. If the wound is improved by 2/26/25, stop Dakin's and apply alginate silver once daily to the wound bed. R2's Wound Evaluation and Management Summary dated 2/25/25 documents R2's coccyx pressure ulcer is now a Stage 4 pressure ulcer measuring 3.7 cm x 3.2 cm x 2.5 cm. This same evaluation documents to discontinue the order for Santyl daily to the coccyx and start a new order for Sodium hypochlorite solution (Dakin's) apply to the wound bed twice daily for 30 days. Soak gauze dressing with .0125% Dakin's solution, wring out the gauze and apply to the wound bed only, twice daily. This evaluation further documents a new order for Tetracycline 500 milligrams twice a day, for 14 days for treatment of cellulitis to the coccyx wound. R2's Wound Evaluation and Management Summary dated 3/5/25 documents R2's coccyx pressure ulcer measurements were 3.4 cm x 4.2 cm x 1.5 cm with 6 cm of tunneling in the wound bed. The same evaluation further documents R2's coccyx wound is odorous, with heavy drainage and the wound tunneling has worsened with grayish/black drainage. V4 documents to continue with the same wound treatment order and oral antibiotics. This same evaluation further documents V4 manually removed black, dead tissue from the wound bed with a surgical blade. R2's Wound Evaluation and Management Summary dated 3/12/25 documents R2's coccyx pressure ulcer measurements were 2.9 cm x 3 cm x 1.5 cm with 4 cm of tunneling. V4 further documents a moderate amount of odorous drainage from wound bed. The same evaluation documents V4 manually removed dead tissue from the wound bed using a blade during assessment. V4 documents to continue the same treatment order to R2's coccyx pressure ulcer. R2's Wound Evaluation and Management Summary dated 3/19/25 documents R2's coccyx pressure ulcer measurements were 4.5 cm x 4.5 cm x 1.5 cm with 5.5 cm of tunneling. This same assessment documents R2's wound has heavy, grey, foul-smelling drainage coming from the wound with increased black, dead tissue to the wound bed which was manually removed with a blade. V4 documents to continue with the same treatment to the pressure ulcer and start Ciprofloxacin 500 milligrams by mouth, for 14 days for wound infection, and Flagyl 500 milligrams, crush and sprinkle into wound base, twice daily with dressing changes. R2's Wound Evaluation and Management Summary dated 3/26/25 documents R2's coccyx pressure ulcer measurements were 3 cm x 5 cm x 1 cm with 6.1 cm of tunneling. V4 documents R2's coccyx pressure ulcer still has moderate amounts of black dead tissue covering the wound bed, heavy drainage, and the wound tunneling is now opened at sacral area as well. V4 documents V4 manually removed dead skin tissue using a blade. This same evaluation documents to continue with the same wound treatment started on 2/19/25. On 4/2/25 at 10:00 AM, R2 is lying supine in bed on a perimeter mattress with no low air loss mattress, wearing a hospital gown. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/25 at 12:13 PM, R2 is lying in her bed supine with a hospital gown on. R2 stated she often has pain in her coccyx area and her feet. R2 stated she has a wound on her buttocks but was not sure how it started. On 4/2/25 at 1:15 PM, R2 has two separate stage four pressure ulcers on coccyx that are merging into one pressure ulcer. The original coccyx pressure ulcer is open and covered in yellow/gray tissue over the wound bed. The second pressure ulcer is on the left upper buttocks and is open with a red wound bed. Between the two wounds is a small layer of skin. The wound tunnels into R2's coccyx. V4 measured the tunneling to be 6 cm. There was a large amount of yellow and pink drainage on the adhesive bandage that was removed from R2's wound. On 4/2/25 at 1:05 PM, V4 stated R2 is supposed to be on a low air loss mattress to help with pressure distribution for wound healing. V4 stated R2 could probably benefit from having Negative Pressure Wound Therapy due to the increased amount of drainage from the wound, but V4 does not have much knowledge with using Negative Pressure Wound Therapy (wound vac). R2's Wound Evaluation and Management Summary dated 4/2/25 documents R2's coccyx pressure ulcer measurements were 4.5 cm x 8.3 cm x 2.5 cm with 6 cm of tunneling. V4 manually removed yellow colored dead skin with a blade that was covering the wound bed and documents a new order to place a Negative Pressure Wound Therapy on R2's coccyx due to increased amount of drainage to the wound site. On 4/2/25 at 1:00 PM, V3 Wound Nurse stated R2 is supposed to be on a low air loss mattress and the mattress she is on currently is not correct. V3 further stated that R2 had moved rooms over the weekend and the staff didn't move R2's low air loss mattress. On 4/2/25 at 2:00 PM, V1 Administrator and V2 Director of Nursing stated they would expect after two weeks of a wound not making progress that a new treatment would be ordered.