STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E848	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Decatur Rehab & Health Care CT	136 South Dipper Lane Decatur, IL 62522

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 37813 Based on interview and record review the facility failed to treat one resident (R1) with respect of three residents reviewed for dignity in a sample list of three. Findings Include: R1's Progress Note documents R1 was admitted to the facility 8/7/24 at 4:00PM. On 8/19/24 at 10:19AM R1 stated I fell at home and broke my knee cap and my arm. Then I went to (the local hospital) and was sent to (the facility) The CNA's (Certified Nurses Assistant) here didn't know how much help I needed. There was once when a CNA on night shift (does not remember name) pulled my right arm. I told her I had broken that arm and the CNA stated 'no you didn't you just broke your left knee'. They were just generally uncaring and rude. R1's progress note dated 8/7/24 at 5:00PM documents (V9) Registered Nurse (RN) went back in (R1's room) and told (R1) once again how (R1) was going to transfer to the bed pan and that (V9) is in charge and we both (V9 and R1) have to go by the doctor's orders not what we want to do. (V9) told (R1) (V9) understood (R1) didn't want to be there. (R1) was asking the CNA's to go to a hotel. When (V9) left the room (R1) was on the phone saying 'they are lying'. On 8/20/24 at 11:00AM after reviewing the above quoted progress note V1 (Administrator) stated I do not think that note is respectful at all. We definitely should treat residents with more respect than that.

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 0584 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37813 Based on observation, interview, and record review the facility failed to maintain a resident room in a clean sanitary manner for two residents (R1, R2) of three residents reviewed for housekeeping in a sample list of three. Findings include: On 8/19/24 at 10:19AM R1 stated (R2) was my roommate when I was at (the facility). (R2) urinated all over the bed, and it smelled bad. The facility did not clean the floor in our room and it was covered in urine. The shower also smelled like urine. I just couldn't live with that. R1's Progress Note documents R1 was admitted to the facility 8/7/24 at 4:00PM and left against medical advice on 8/13/24 at 3:00PM. R2's Minimum Data Set (MDS) dated [DATE] documents R2 is cognitively intact and frequently incontinent of urine. On 8/19/24 at 11:30AM R2's room was very cluttered with belongings and there was a strong ammonia like odor. The floor was so sticky the surveyor's shoes stuck to the floor when walking. The floor was stained with a yellow brown substance. At this time, R2 was sitting in the dining room waiting for lunch socializing with other residents. R2 had the same ammonia like odor observed in R2's room. On 8/20/24 at 9:00AM V1 (Administrator) stated Sometimes (R2) wants to change herself when wet. (R2) is very modest. We realize the floor in (R2's) room gets dirty and we were discussing doing floor cleaning in the whole facility doing that room first. V1 verified there was an odor in (R2's) room.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 37813 Based on interview and record review the facility failed to initiate a base line care plan and initiate resident centered interventions for one resident (R1) reviewed for Care Plans in a sample list of three. Findings Include: The facility's policy Baseline Care Planning revised 11/1/17 states It is the policy of (the facility) to promptly asses the plan (of) care for each resident admitted to the facility. Pending completion of the Comprehensive Resident Assessment and Care Plan, the interdisciplinary team shall asses each resident for potential needs. A Plan of Care (Baseline Care Plan) shall be developed to include instructions needed to provide effective person centered care to each resident, based on his/her initial assessment and professional standards of quality care, to serve as a functional guide in the delivery of care until such time as a comprehensive plan is developed. R1's Physician's Order Sheet (POS) for 8/7/24 to 8/31/24 includes the following diagnoses: Chronic Anemia, Chronic Depression, Frequent Falls, Closed Fracture of the Distal End of the Right Humerus, Open Reduction Internal Fixation of Left Patella, T12 Compression Fracture, Orthostatic Hypotenson, Alcohol Abuse, and Anxiety. R1's Progress Note documents R1 was admitted to the facility 8/7/24 at 4:00PM and left against medical advice on 8/13/24 at 3:00PM. There is no documentation of a baseline Care Plan or resident specific interventions for care for R1. On 8/19/24 at 10:19AM R1 stated I fell at home and broke my knee cap and my arm. Then I went to (the local hospital) and was sent to (the facility) The CNA's (Certified Nurses Assistant) here didn't know how much help I needed. There was once when a CNA on night shift (does not remember name) pulled my right arm. I told her I had broken that arm and the CNA stated 'no you didn't you just broke your left knee'. I just didn't get the help I needed, On 8/20/24 at 10:00AM V1 (Administrator) stated I can see that no Baseline care plan was documented for (R1). V1 verified without a Care Plan staff would not have been aware of what level of assistance (R1) required.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37813 Based on observation and interview the facility failed to complete an admission Fall Risk Assessment for a resident with history of falls with injury. Ths failure affects one (R1) of three residents reviewed for falls in a sample list of three residents. Findings Include: The facility's policy Fall Prevention revised 11/10/18 states Policy: To provide for resident safety and to minimize injuries related to falls; decrease falls and still honor resident's wishes/desires for maximum independence and mobility. Procedure: Conduct fall assessments on day of admission, quarterly, and with a change in condition. Identify, on admission, the resident's risk for falls. Assessment of fall risk will be completed by the admission nurse at the time of admission. Appropriate interventions will be implemented for residents determined to be at high risk at the time of admission for up to 72 hours. The admitting nurse will assign a temporary category. R1's Physician's Order Sheet (POS) for 8/7/24 to 8/31/24 includes the following diagnoses: Chronic Anemia, Chronic Depression, Frequent Falls, Closed Fracture of the Distal End of the Right Humerus, Open Reduction Internal Fixation of Left Patella, T12 Compression Fracture, Orthostatic Hypotenson, Alcohol Abuse, and Anxiety. R1's Progress Note documents R1 was admitted to the facility 8/7/24 at 4:00PM and left against medical advice on 8/13/24 at 3:00PM. There is no documentation of a complete admission nursing assessment, an admission fall risk assessment, or other baseline assessment. On 8/19/24 at 10:19AM R1 stated I fell at home and broke my knee cap and my arm. Then I went to (the local hospital) and was sent to (another hospital) to have surgery on my knee. I was then sent back to the local hospital where I started therapy. I thought I was coming to this facility to get more therapy, but that never happened. The CNA's (Certified Nurses Assistant) here didn't know how much help I needed. On 8/19/24 at 2:00PM V5 (Licensed Social Worker/Hospital Case Manager) stated When we discharged (R1) from the hospital we did not feel (R1) was safe to go home. We had issued a Notice of Medicare Noncoverage to (R1) which (R1) did not choose to appeal. We placed (R1) at (the facility) with a plan for (R1) to continue with intermittent therapy until (R1) was safe to return home. On 8/20/24 at 10:00AM V1 (Administrator) stated I can see that no admission fall risk assessment or complete admission assessment were documented. (R1) was here to get stronger and have some therapy. The problem with the therapy was since we are an intermediate care facility there would be a co-pay for therapy and (R1) was not wanting to apply for Medicaid to have that.