Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005722	A. BUILDING: ______ B. WING ______	C 09/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOFT REHABILITATION & NURSING	700 NORTH MAIN STREET EUREKA, IL 61530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Original Complaint Investigation: 2126772/IL138195	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.3210t) 300.3240c) 300.3240d) 300.3240e) 300.3240g) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. Section 300.3240 Abuse and Neglect	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act) d) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) e) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) g) A facility shall comply with all requirements for reporting abuse and neglect pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act. These requirements are not met as evidenced by: Based on interview and record review the facility failed to recognize and investigate an allegation of seclusion as possible abuse for one (R1) of six residents reviewed for abuse in a sample of six. This failure resulted in the facility not readily	S9999		

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S9999	Continued From page 2	S9999		

initiating an investigation which further led to the alleged perpetrator continuing to work in the facility and care for R1 and further subjecting all other residents (R5 and R7- R14) who came in contact with the alleged perpetrator to potential abuse.

Findings include:

The facility's Abuse Policy dated 11/1/2020 documents, "V. Investigation of Alleged Abuse, Neglect and Exploitation. A) An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B) Written procedures for investigation include: 1) Identifying staff responsible for the investigation; 3) Investigating different types of alleged violations; 4) Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses's and others who might have knowledge of the allegations; 5) Focusing the investigation on determining if abuse, neglect, exploitation and/or mistreatment has occurred, the extent and cause; and 6) Providing complete and thorough documentation of the investigation."

R1's Current Face Sheet documents R1 has a diagnosis of Alzheimer's and Dementia with Behavioral Disturbances.

R1's Current Care Plan documents R1 is a high risk for Elopement: 7/7/21; one to one supervision with reevaluation for incremental monitoring as appropriate.

The facility's Daily Assignment Sheet dated 9/12/21 documents V5/CNA worked one on one with R1 from 6:00 PM to 10:00 PM and worked on the COVID unit (700 Hall) from 10:00 PM until

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6:00 AM.

The facility's Resident Roster dated 9/12/21 documents R1's room as 508-B and R7's room as 703-A. V5/CNA had access to R1 and R7 during V5's 9/12/21 shift.

The facility's Daily Assignment Sheet dated 9/15/21 documents V5/CNA worked in the facility on 600 Hall and COVID Unit (700 Hall) from 2:00 PM through 10:00 PM.

The facility's Resident Roster dated 9/15/21 documents R5 and R7 through R14 resided on the 600 and 700 halls. V5/CNA had access to R5 and R7 through R14 during V5's 9/15/21 shift.

On 9/16/21 at 11:10 AM V1/Administrator stated, "The sheets show who worked and where at. If someone called in or didn't show up there would be a line through their name and the reason why not worked."

On 9/16/21 at 9:30 AM V1/Administrator stated, "Yes, a Certified Nurse's Assistant/CNA came up to me and (V4/Former Director of Nurses/DON), who walked out Monday (9/13/21), and said a CNA was locking (R1) in her room and blocking her doorway and cussing at her. I asked the CNA for dates and times and she couldn't give me any. She quit and no longer works here anyway." When asked if she did an investigation V1 stated, "I didn't (do an investigation), the CNAs were complaining a lot that day. It is what it is. I will have to check if V4 did one." At this time V1 could not provide a copy of an abuse allegation involving R1.

On 9/16/21 at 5:30 PM V4/Former DON stated, "I do not work there anymore. (V1/Administrator)

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S9999	Continued From page 4 has only been there since 9/7/21 and is the Abuse Coordinator. Before (V1) coming (V18/Acting Administrator/Marketing Director) did the (State reportable incidents). I was being the DON and working the floor all the time, there was no way I could have done the Abuse Coordinator and DON. The Sunday before I quit, I had to work first and second shift as a floor nurse. There is no way I would have taken on the responsibility of Abuse Coordinator also. So, if they are saying I was the Abuse Coordinator, it is to cover their butts." On 9/17/21 at 12:40 PM V1/Administrator stated, "So I guess the CNA (V15) that told me she heard a CNA was locking (R1) in her room and cussing at (R1) did not quit. I remembered that after I asked (V4/Former DON) if she did a report and she said she had already taken care of it." On 9/17/21 at 1:00 PM V15/Certified Nursing Assistant (CNA) stated, "I had told (V4/Former Director of Nursing/DON) back on 8/1/21 that I heard (V5/CNA) was mistreating (R1). (V1) wasn't here at the time and I believe (V18/Acting Administrator/Marketing Director) was filling in as the Administrator. I don't know whose responsibility it was, but I told (V1), (V4) and (V14/Clinical Reimbursement) on 9/12/21 that I heard (R1) was being locked in her room and talked to inappropriately by (V5/CNA)." (B)	S9999		