STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006282	A. BUILDING: _____ B. WING _____	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOFT REHAB OF ROCK SPRINGS, THE	2530 NORTH MONROE STREET DECATUR, IL 62526

(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 Facility Reported Incident of October1, 2021/IL138867	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3240a) 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 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care needs of the resident. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on interview and record review, the facility failed to protect residents from mental abuse for one of six residents (R1) reviewed for abuse on the sample list of 10. The facility posted a video of R1 displaying behaviors on social media. This failure resulted in humiliation and psychological harm to R1. Findings Include: The facility Abuse, Neglect and Exploitation Policy dated 6/8/2020, documents each resident has the right to be free from abuse. Residents must not be subject to abuse by anyone, including, but not limited to; facility staff, consultants, contractors, volunteers, or staff of other agencies serving the resident, family members, legal guardians, friends or other individuals. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Mental Abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation.	S9999		

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S9999	Continued From page 2 Mental abuse also includes abuse that is facilitated or caused by nursing home staff taking or using photographs or recording in any manner that would demean or humiliate a resident(s). R1's State Report dated 10/1/21, by V1 Administrator documents "this writer was notified that an agency CNA (Certified Nursing Assistant) took a video of a dementia resident (R1) and posted to social media." On 10/5/21 at 11:43 am, V1 stated that on 9/30/21, V18 Agency CNA was placed on DNR status (Do Not Return) by the facility due to a derogatory social media post V18 made about the condition of the facility on 9/29/21, under the name of V26 (V18's Social Media Users Name). V1 stated then on 10/1/21, V20 Agency CNA and V21 CNA made V1 aware of another social media post that V18 made on 10/1/21, under the name of V26, which showed R1 displaying behaviors. V1 explained that the 10/1/21 social media post was a video of R1 sitting in a wheelchair shouting "bang, bang, bang, bang, bang" repeatedly. V1 stated that after watching the video, V1, V2 Interim DON (Director of Nursing), V3 ADON (Assistant Director of Nursing), V5 Infection Preventionist, and V27 Corporate Nurse all interpreted that the video was made and posted "to make fun of (R1's) behaviors." V1 stated the video showed R1's face, so the viewer could see who the resident was. V1 explained V1, V2, V3, V5, and V27 all "agreed that it was considered resident mental abuse." V1 stated the facility notified V18's agency about the second social media post and wrote a summary statement for the agency detailing the video. V1 stated that after sending the written description of the video, the agency sent V18's rebuttal, in which V18 denied posting the video.	S9999		

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S9999	Continued From page 3	S9999		

V1's letter to V28 Agency's Management dated 10/1/21, documents "this morning I was notified that a CNA from your agency had taken, and posted to (social media), a video of one of my resident's on our dementia unit. I personally viewed the video which included footage of behaviors. I'm sure you realize the gravity of this situation. The CNA from our agency is (V18) under the (social media) name of (V26). (V18) had previously been DNR'd (Do Not Return) for derogatory verbal postings regarding this building. The evidence of the video was only revealed this morning. Per our previous discussion, (V18) is not allowed to work at any of the company's facilities from this day forward. This incident has been reported to the Decatur Police Department and will be sent to IDPH (Illinois Department of Public Health)."

R1's MDS (Minimum Data Set) dated 7/5/21, documents R1 has severe cognitive impairments.

On 10/5/21 at 10:12 am, R1 was sitting in a wheelchair on the dementia unit. R1 was talking to R1's self. When asked a question regarding the abuse allegation and staff taking videos of R1, R1 would keep repeating what was asked but would not answer the questions.

On 10/5/21 at 1:07 pm, V20 Agency CNA stated V20 had seen a social media post that V18 made under the user name of V26 regarding "how nasty the building was." V20 explained V20 is friends with V18 on social media so V20 knew it was V18 even though the video was posted under the user name of V26. V20 then stated, a couple days later, V21 CNA asked V20 if V20 had seen V18's second social media post. V20 had not seen it but went onto social media at that time and watched

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S9999	Continued From page 4 V18's posted video, which showed R1 having behaviors. V20 stated V20 immediately reported it to administration. On 10/5/21 at 1:22 pm, V2 confirmed V20 came to V2 with a social media video of R1 displaying behaviors that had been posted by V18 under the name of V26, and that V2 viewed the video. On 10/5/21 at 1:29 pm, V19 Scheduler stated V19 knows V18 outside of the facility and knows that V18 has multiple social media accounts under different names, including that of V26. On 10/6/21 at 10:25 am, V23 (R1's Family) stated the facility called V23 on 10/1/21 to report that an unidentified CNA had taken a video of R1 and posted it on social media. V23 stated V23 has witnessed R1's behaviors of repeatedly saying bang, bang, bang in the past. V23 stated, if R1 was not cognitively impaired, R1 "would be appalled, just devastated" if R1 knew a video had been taken of R1 and posted to the Internet. R1 "always had a compassionate heart for people with memory issues. (R1) would just be beside (R1's self)." (B)	S9999		