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
	IL6006282	A. BUILDING: ____ B. WING ____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOFTREHAB 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 Annual Licensure Facility Reported Incident of 7/16/22/IL149362	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 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. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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

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resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These requirements were not met as evidenced by:

Based on observation, interview, and record review the facility failed to prevent falls by failing to ensure for a room environment free from accident hazards and failed to complete a thorough post fall investigation for residents. This failure affects two of three residents (R47, R63) reviewed for falls on the sample list of 59. These failures resulted in R47 sustaining a left hip fracture and R63 sustaining bruising to left forehead/scalp area and entire posterior left shoulder area.

Findings include:

1. R47's fall investigation report dated 6/29/2022 at 3:15 AM documents R47 had a fall with no injury.

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R47's fall prevention care plan includes an intervention dated 6/29/22 to ensure pathways are well lit and clutter free.

R47's nurses notes dated 7/16/22 at 7:23 AM documents R47 was sent to the emergency room due to a fall.

R47's undated fall report documents on 7/16/22, R47 tripped over a mattress laying on the floor in her room. This report documents the mattress is a safety device for the other resident in the room. This report documents R47 will be placed in a room by herself "without a fall hazard".

R47's radiology report dated 7/16/22 documents R47's complained of pain after tripping over a mattress on the floor. This report documents R47 has an impacted left femoral neck fracture (hip fracture) with a large subcutaneous hematoma lateral to the left hip.

On 8/01/22 at 12:12 PM, when asked how R47 broke her hip, R47 stated, "It was storming, and I got frightened and tripped over the corner of a mattress lying on the floor. I fell backwards and hit the floor."

On 8/3/22 at 10:02 AM, V10 Assistant Director of Nursing stated R47 fell on 6/29/22 at 3:15 AM looking for the restroom. V10 stated R47 was ambulatory. V10 stated R47 is on oxygen and will take it off to go to the restroom. V10 stated when R47 takes it off she will get confused looking for the bathroom. V10 stated R47 fell on 6/29/22 and an intervention to ensure pathways are well lit and clutter free was put into place. V10 stated after her fall on 6/29/22 and prior to her fall on 7/16/22 she was moved to a different room. V10 stated R47 was in the second bed.

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S9999	Continued From page 3 V10 stated this room had a mattress on the floor in front of the other bed in the room. V10 stated prior to moving R47 into the room an evaluation of the safety of the room should have been done. V10 stated since she would get up on her own and become confused, the mattress on the floor would be a hazard for her. V10 confirmed R47's room and bed placement. On 8/3/22 at 10:00 AM, the room in which R47 resided prior to 7/16/22 had a bed (1) up against the wall on the left side of the room. There was another bed (2), R47's former bed, up against the back wall of the room. Bed (1) and bed (2) were in an "L" shape positioning within the room. The safety floor mattress (full twin size) for a bed laid alongside bed (1) - on the floor. The space between bed (1) and bed (2) and the mattress on the floor and the middle of bed (2) was 3 feet. 2. On 8/1/22 at 9:32 AM R63 had bilateral half bed rails in the upward position towards the head of the bed, there was a pillow positioned sideways between the edge of the mattress and the bed rail. Both bed rails were shifted and unparallel to the mattress. R63 stated those bed rails are to protect me and help me move in the bed, they are not on the bed right, they move all over the place and there is a big gap. When grabbing ahold of R63's bed rails, both rails moved back and forth and shifted side to side. R63 stated, "Last week I was in the bed, and I dropped something on the floor to the left, I grabbed ahold of the rail while I was leaning over to pick it up, the rail was loose and moved, I fell face forward on my left side onto the floor". R63 pointed to her head and left shoulder area and stated I got this (R63 had dark purple, maroon discoloration to the entire left forehead/scalp area	S9999		

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and dark maroon, purple discoloration covering the entire posterior left shoulder area).

R63's medical record documents, "7/25/2022 at 7:10 AM by V9 Licensed Practical Nurse, Resident was heard calling for help from her room. Resident was observed sitting on the floor by the window. Resident informed writer that she was reaching for her personal lancet and tumbled on her left side out of the bed. Resident was assessed and assisted safely back to her bed. Resident stated that left shoulder felt tender. Bruising observed on left shoulder where shoulder made contact with the ground. Resident educated on waiting for assistance and utilizing call light."

R63's medical record documents on 08/01/22 11:05 AM, "Interdisciplinary team met to discuss fall on 7/25/22. Root cause was resident reaching out of bed to get item. Intervention is for staff to ensure that needed items are in reach."

On 8/02/22 at 1:53 PM V13 (Vice President of Clinical Operations) stated, "I was on the phone with the team yesterday (8/1/22) to complete (R63's) fall investigation. On the call was V24 Sister Facility Director of Nursing and V10 Assistant Director of Nursing. V13 stated, the information entered into R63's medical record when R63's fall occurred was what we based our information on to determine the root cause and intervention. No one interviewed R63 or V9 LPN again. The information V9 LPN had documented from R63 was from when the fall occurred. I did not re-interview R63 since the fall, nor did V9 LPN or V24."

R63's medical record did not document R63 had discoloration to the left forehead area between

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S9999	Continued From page 5 7/25/22 through 8/3/22. R63's fall investigation did not document R63's hit her head during the fall on 7/25/22. It did not document R63 had bed rails or if bed rails were functioning or in use during R63's fall on 7/25/22. R63's Brief Interview Mental Status form score dated 6/30/22 was a 15 indicating R63 was cognitively intact. On 8/02/22 at 1:15 PM V10 ADON stated, "(R63) tumbled out of bed on her left side last week, and (R63) had a lump on her head, so the bruise on R63's head is probably a result of her fall." V10 confirmed R63's medical record did not document information related to R63's discoloration to the left forehead area. On 8/2/2022 at 10:10 AM V1 Administrator stated, "we don't have (bed) rails unless the resident is assessed and needs them." V1 stated, "maintenance puts the rails on the beds. V1 grabbed ahold of R63's (bed) rail on the right side of the bed, the rail moved in a back-and-forth motion and shifted left to right. On 8/2/2022 at 10:15 AM V15 Maintenance grabbed ahold of R63's half bed rails and the rails moved in a back-and-forth motion and shifted left to right. V15 stated, "I think the cotter pins are worn out." On 8/03/22 at 9:35 AM V1 Administrator stated, "R63's bed was swapped out with a new bed with different rails." V1 confirmed R63's bed rails were not secured. V1 also confirmed R63's bed rails were not in a safe working condition. V1 confirmed there was at least a hands width gap (approximately 8 inches) between R63's bed rail and the edge of the mattress.	S9999		

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S9999	Continued From page 6 On 8/3/22 at 9:40 AM V15 Maintenance stated, "R63's bed rails were not fastened to the bed correctly." The facility's policy, dated 1/1/2020, titled "Incidents, Accidents, and Supervision" documents, "Policy: The resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistive devices to prevent accidents. This includes: 1- Identifying hazard and risk, 2- Evaluate and analyzing hazards and risks, 3- Implementing interventions to reduce hazards and risks. Policy Explanation and Compliance Guidelines: The facility shall establish and utilize a systemic approach to address resident risk and environmental hazards to minimize the likelihood of accidents." (A)	S9999		