STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011597	A. BUILDING: ____ B. WING ____	C 09/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOFT REHAB & NURSING OF CANTON	2081 NORTH MAIN STREET CANTON, IL 61520

(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 9/4/22/IL151506	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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 interview and record review, the facility failed to identify safety risks for a new admit for one resident (R1) out of three residents reviewed for falls in a sample of three. This failure resulted in R1 falling and sustaining an acute mildly displaced and comminuted fracture involving the surgical neck of the left humerus. Findings include: The facility's "Incidents, Accidents and Supervision" policy dated 1/1/2020 documents "The resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and	S9999		

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S9999	Continued From page 2 assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s)." R1's medical record documents R1 was admitted to the facility on 8/29/22 for skilled therapy services due to a postoperative open reduction and internal fixation of the left intertrochanteric femur fracture. Fracture of left femur due to fall at home. R1's medical record documents and admitting diagnosis of "Fracture of neck of Left femur, vascular dementia, psychotic disturbances, mood disturbance and anxiety. " R1's minimum data set (MDS) dated 9/6/22 documents R1's cognitive skills for daily decision making as "Severely impaired." R1's admission MDS scores R1's brief interview of mental status (BIMS) as a 99. R1's neurological admission screen dated 8/29/22 documents "Resident is very confused and can verbalizes some things however cannot verbalizes her needs." R1's medical record dated 8/29/22 documents "Resident arrived via family transport from hospital. Two person total assist to assist resident out of car. Staff instructed via this nurse to use full mechanical lift until therapy evaluates and states otherwise. Left hip fracture with post surgical wound. Resident is alert with confusion. Regular diet and physically can feed herself however family states she will not feed herself and will want staff to feed her. CNA's (Certified	S9999		

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S9999	Continued From page 3	S9999		

Nursing Assistant) instructed to have resident out to dining room for meals."

R1's medical record dated 8/29/22 documents, "Resident is very confused respirations easy non labored, lung sounds clear, active bowel sounds in all four quadrants. Post surgical to left hip with edema noted to left lower extremity 3 plus pitting, pedal pulses present. Groin red, open wound to sacrum."

R1's medical record dated 9/4/22, documents "Found resident on floor face down, with left arm underneath her next to her bed, incontinent of bowel, pulled out indwelling catheter, soiled (incontinence brief) in chair next to bed."

R1's medical record dated 9/5/22, documents "Called primary care physician regarding X-ray results of left humerus. Findings was proximal humeral fracture presumable acute. New orders to call orthopedic office to set up an appointment for outpatient orthopedics. No therapy today. Sling to left arm for comfort only. continue with pain management as ordered. If pain medication is not helping call doctor for further orders. Family was here and spoke with doctor as well on the phone."

R1's hospital record dated 9/8/22, documents "Acute mildly displaced and comminuted fracture involving the surgical neck of the left humerus."

On 9/23/22 at 9:58 AM, V3, Registered Nurse (RN) stated, "(R1) was here for physical therapy because she had a fall at home and had hip surgery. I don't think she understood how to use the call light. She was very confused. We don't have an alternate call light method that I know of, just the push button call light and the tap call light.

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S9999	Continued From page 4	S9999		

She wasn't on any type of increased monitoring. She was very restless, but we gave her medication for it."

On 9/23/22 at 1:45 PM, V4, Licensed Practical Nurse (LPN) verified she was the nurse that found R1 on the floor on 9/4/22 and stated, "(R1) had taken of her soiled (Incontinence brief) and threw it in the chair next to her bed. She had an indwelling catheter that she also ripped, probably when she took off the depends. I think (R1) was trying to get up herself cleaned up when she fell. (R1) always thought she had to go to the bathroom. Her confusion got worse toward evening time because I think she was sundowning. (R1) had the tap call light, but she didn't understand how to use it. She was too confused. She had poor safety awareness. She thought she could get up and walk on her own, but her hip surgery prevented her from walking. She was on the standard two hour checks and there was no adjustment to her environment."

On 9/23/22 at 2:08 PM, V2, Director of Nursing (DON) stated "Ok, so about that. I'll be completely honest with you, there was no baseline care plan done for (R1). It was discovered during (R1)'s fall investigation. I've educated the staff to make sure one is completed for all new admits, but unfortunately there wasn't one completed for (R1) to address her safety concerns. R1 did have the push pad call light, but no, I don't think that's an appropriate intervention for someone who is too confused to understand how to use it."

(B)