STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005938	A. BUILDING: _____ B. WING _____	C 03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOFT REHAB OF DECATUR	500 WEST MCKINLEY AVENUE DECATUR, IL 62526

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S 000	Initial Comments Facility Reported Incident of 3/12/23/IL157816	S 000		
S9999	Final Observations Statement of Licensue 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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care and personal care shall be provided to each 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 utilize safe handling device (gait belt) during an unsteady pivot transfer for one (R1) of five residents on the total sample list of nine. This failure resulted in R1 being lowered to the floor by staff while R1 continued to hold onto a wheeled walker injuring R1's shoulder, R1 sustained a clavicular fracture. Findings include: R1's medical record documents on 3/12/2023 at 11:30 AM, "Fall Progress Note: called to resident room because physical therapy had to lower resident to the floor. Physical therapy stated while walking resident resident hit her leg on the bottom piece of wheelchair, and resident got weak and	S9999		

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S9999	Continued From page 2	S9999		

had to be lowered to the floor. While lowering resident to the floor resident would not let go of walker. Upon assessment resident complained of pain on right shoulder. Change in condition: Signs & Symptoms: Resident was lowered to the floor and has laceration on lower right leg and pain in left shoulder.

R1's Physical Therapy Treatment Encounter notes document on 3/12/23 by V3 Physical Therapist, Patient tolerated most therapy exercises/balance/gait activities with contact guard assist and stand by assist. At around 11:45 AM as patient was performing a stand pivot transfer with contact guard assist, patients right leg was slightly caught in leg rest/wheel joint area and patient was controlled lowered onto PT thigh, R1 was then controlled lowered into long sitting position in a controlled fashion, R1 had a hold of the front wheeled walker during this process and complained of left shoulder pain after she was resting in long sitting.

R1's medical record documents on 3/12/2023 at 4:00 PM, returned from hospital and has stitches in lower right leg that need removed in 7 days and sling on left arm. Resident has fracture to left collar bone.

R1's Emergency Room records dated 3/12/23 documents, Chief complaint: complaints of left shoulder and right ankle pain after falling while working the physical therapy, states she lost her footing with her walker, wound on right leg. Radiology findings: Left Shoulder: mildly displaced midclavicular fracture is present. A 6 centimeter laceration on right lower leg, Skin closure: 13 sutures.

On 3/22/23 at 2:30 PM R1 was laying in bed with

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S9999	Continued From page 3	S9999		

sling to R1's left arm. R1 stated, "I was in this room doing leg routines (exercises) with the therapist, he had me stand up, he did not have one of those belts on me, I took a few steps, I could tell my feet were not very sturdy, he said something about going back to bed, I turned slowly to sit back down and my legs gave out, I kept telling him "I falling, im falling" he said no you are not, I could tell he didn't have a hold of me very well and I knew he didn't have one of those belts on me and I am a bigger lady, he got me down on the floor, my shoulder was killing me and I saw the blood all over the floor then, I didn't know what I had done to my leg, it must have got caught on something. It all happened so quickly." R1 had steri strips and a bordered dressing to the right shin area.

On 3/23/23 at 10:45 AM V3 Physical Therapist stated, "I had worked with (R1) about 4 weeks prior, (R1) was looking to discharge to an assisted living, I went to (R1's) room, (R1) was a stand by assist, contact guard assist, (R1) was dressed and up in her wheelchair, we started with seated exercises, (R1) completed all of those, then we did standing exercises, (R1) was a stand by assist for a pivot transfer, she did fine, I did not put a gait belt on (R1). We started to ambulate with wheelchair close to follow, we were all done I asked (R1) if (R1) wanted to lay down or sit in the wheelchair and (R1) said sit in the wheelchair, . during the pivot transfer (R1's) leg grazed the front right wheel on the wheelchair, (R1) said "ouch my leg is caught" and lunged forward towards cross bar on walker, I grabbed on to (R1) and kept telling (R1) I was going to lower (R1) to the floor, (R1) was panicking and kept yelling, I had (R1) in a half squat position seated on my thigh and (R1) looked at her leg gash and kept saying "let me down, let me down." I told (R1) I

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S9999	Continued From page 4 would let (R1) slide down my leg onto the floor, so we did a slow slide into a seated position, (R1) kept ahold of the walker and didn't let go, when (R1) got sat down on the floor (R1) complained of shoulder pain, I removed (R1's) hands off the walker." The Facility's investigation report documents, "On 3/12/23 (R1) hit her right lower leg on the wheelchair pedal while walking with therapy and was lowered to the floor after she got weak. (R1) noted to have laceration on right lower leg and complaints of left shoulder pain. Obtained order and sent to Emergency Room. Summary of investigation: (R1) was working with therapy in her room, During a pivot transfer (R1) caught her distal right lower leg on the foot pedal connected on the wheelchair. Resident loudly stated, "my leg, my leg", (R1) then leaned forward and looked down and saw blood panicked and started to go to a sitting position while still holding on to the walker. (R1) was positioned lateral to the wheelchair, therapist was positioned behind her with his hands at her hips and he used his leg for support as resident continued to repeat "I want down, therapist assured resident that he was able to support her while she was lowered to his thigh. (R1) continued to stated "let me down" therapist then lowered resident to a long sitting position, during this time (R1) was still holding on to the walker and her arms were still in a hyper flexed position. Therapist removed residents hand from walker and called for help. (R1) transferred to Emergency Room. Disposition: Interventions-therapy staff to be in-serviced on gait belt use. Returned form Emergency Room with appointment with orthopedic physician, a sling to her left arm and 13 sutures on right lower leg. Type of injuries: Fracture of the left collar bone, Right lower leg laceration."	S9999		

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S9999	Continued From page 5 On 3/23/23 at 2:20 PM V2 Director of Nursing stated, "(R1) was in her room with the therapist (V3). They were doing a pivot transfer, (R1) caught her leg on something on the wheelchair, (R1) started screaming "my leg, my leg", saw blood and panicked, and (V3) lowered onto his thigh and (R1) continued to yell out and hold onto the walker, and (V3) lowered (R1) down his shin onto the floor, during the entire lowering (R1) kept ahold of the walker and did not let go, (V3) had to remove (R1's) hands from the walker, (V3) had kept ahold of (R1) on her side/hip area. During my investigation I determined there is an area on the wheelchair where the foot pedals sit on top of that R1 may have hit her leg, so the intervention is to keep the foot pedals on the wheelchair at all times, during transfers they can be swung out. (V3) was not using a gait belt, I think (V3) would have had better control of (R1) if a gait belt would have been used, (R1) is a larger lady. V2 confirmed, (R1) panicked and would not let go of the walker, and a gait belt would have made (R1) feel more secure." The facility's policy, with a revision date of 12/15/22, titled "Safe Resident Handling/Transfers" documents, "It it the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize the risks for injury and provide and promote safe, secure and comfortable experiences for the resident while keeping the employees safe in accordance with current standards and guidelines. 5- handling aides may include gait belts, transfer boards, inflatable camel lift assists, transfer bars or any additional mounted equipment like grab bars. 13- staff members are expected to maintain compliance with safe handling/transfer practices. Failure to maintain	S9999		

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S9999	Continued From page 6 compliance may lead to disciplinary action." (B)	S9999		