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 ______	C 02/22/2024

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 Complaint Investigations 2461126/IL169665	S 000		
S9999	Final Observations Statement of Licensure Violatiuons: 300.610a) 300.1210b) 300.1210d)6) 300.3100d)2) 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 resident to meet the total nursing and personal care needs of the resident.	S9999		

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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.

Section 300.3100 General Building Requirements

d) Doors and Windows

2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required.

These requirements were not met as evidenced by:

Based on observation, interview, and record review the facility failed to implement a facility wide system to account for residents exiting and returning to the facility and failed to provide adequate supervision for two residents (R1, R2) of three residents reviewed for elopement in a sample list of three residents. These failures resulted in (R1) eloping from the facility without knowledge of facility staff as to (R1's) whereabouts for over 20 hours. R1 was located at

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S9999	Continued From page 2 (R1's) former residence, 0.3 Miles (per Internet Map) from the facility, which required R1 to cross an undivided four-lane roadway. Finding Include: The facility's policy Elopements and Wandering Residents reviewed 12/6/22 states, "Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. Policy Explanation and compliance guidelines: 1. The facility is equipped with door locks/alarms to help avoid elopements. 2. Alarms are not a replacement for supervision. Staff are to be vigilant in responding to alarms in a timely manner. 3. The facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement and unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. 4. Monitoring and managing residents at risk for elopement and unsafe wandering: a. Residents will be assessed for unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team b. The interdisciplinary team will evaluate the unique factors contributing to the resident's risk, develop a person-centered care plan. c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. d. Adequate supervision will be provided to help	S9999		

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S9999	Continued From page 3 prevent accidents or elopements. e. Charge Nurses and Unit Managers will monitor the implementation of interventions, response to interventions, and document accordingly. f. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff. 5. Procedure for locating Missing Resident: a. Any staff member becoming aware of a missing resident will alert personnel using facility approved protocol (e.g., Internal alert code) b. The designated staff will look for the resident. c. If the resident is not located in the building or on the grounds, Administrator or designee will notify the police department and serve as the designated liaison between the facility and the police department. The administrator or designee should also notify the company's corporate office. d. DON or designee shall notify the physician and family member or legal representative. e. Police will be given a description and information about the resident; include any photos. f. All parties will be notified of the outcome once the resident is located. g. All appropriate reporting to the State Survey Agency will be conducted". 1. R1's Medical Diagnoses List printed 2/7/24 at 4:25PM includes the following diagnoses: Left Femoral Fracture with Hip Replacement, Type II Diabetes Mellitus, Chronic Kidney Disease Stage IV with Hemodialysis, and bipolar disorder. R1's Minimum Data Set (MDS) dated 1/1/24 documents R1 is moderately cognitively impaired with decreased range of motion to one lower extremity. R1's Hospital History and Physical dated 11/10/23 documents R1 was discharged home from the	S9999		

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S9999	Continued From page 4 hospital against medical advice on 11/10/23 and R1 had been hospitalized for "Uncontrolled Hypertension and Worsening Kidney Function." The History and Physical states R1 returned to the hospital 11/10/23 after experiencing a fall while walking home from the hospital resulting in a hip fracture requiring a hip replacement. R1's progress note dated 11/20/23 at 2:00PM documents R1 was admitted the facility on 11/20/23. R1's psychiatry note dated 12/29/23 documents, "Social Worker feels (R1) is not safe to go home." R1's progress note by V18, Nurse Practitioner dated 1/25/24 documents, "(R1) was seen in the facility today for routine monthly evaluation. Patient is in long-term care due to her not being able to care for herself at home due to her chronic medical conditions." TheWeatherChannel.com documents the temperature in (city) on 2/1/24 at 9:54 PM was 42 degrees Fahrenheit. The facility's Incident Documentation for (R1) dated 2/2/24 documents the security cameras were reviewed with the following timeline/information: "2/1/24 at 8:20PM (R1) was sitting in the lobby in wheelchair with a duffel bag on lap. (R1) appeared to be waiting on someone as (R1) kept looking at the door. (R1) was on her phone periodically as (R1) waited." "2/1/24 at 8:25PM (V9) Receptionist is seen taking (R1) to the elevator."	S9999		

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S9999	Continued From page 5 "2/1/24 at 8:27PM (V9) arrives on third floor with (R1). (Certified Nurse's Aides) CNAs (V10, V11, V12) were present near the Nurse's Station. However, (V9) is seen walking down the hall to look for (V8). (V9) located (V8) next to room (Room Number) and appears to be having a conversation with (V8). (R1) is seen sitting by the Nurse's station and (V11) walks over to (R1) and hands (R1) something and they exchange words. A few minutes later (V9) gets on the elevator to leave." "2/1/24 at 8:37PM No staff is in the vicinity and (R1) gets self on the elevator and goes down to the first floor." "2/1/24 at 8:38PM (V10) Certified Nurse's Aide (CNA) passes (R1) as (R1) is getting off the elevator (on first floor) and (V10) is getting on it. (R1) makes way down to the lobby where (R1) sits in wheelchair and waits." "2/1/24 from 8:38 PM until 9:28PM (R1) remains in the lobby. (R1) alternates between sitting in wheelchair and getting up to walk around the lobby and continues looking out both doors. (R1) is seen on phone a few times and looks around on the front desk." "2/1/24 at 9:29PM (R1) picks up her Duffel bag and walks out West door facing (Street Name) Street." The Incident Documentation states, "(V2) is unable to see if someone picks up (R1) or if (R1) takes off walking due to the angle/view of the camera." The facility's Incident Documentation states: "2/2/24 at 6:55PM to 7:10PM (V2) attempted to call (R1's) phone numerous times."	S9999		

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"2/2/24 at 7:15PM (V2) Director of Nursing (DON) spoke with (V7, R1's Family Member) and asked if (V7) had any updates or if (V7) had been able to get hold of (R1). (V7) said 'no it just rings. no answer' (V2) asked if (V7) had any idea where (R1) could be. (V7) stated (V7) had no idea."

On 2/8/23 at 9:00AM V2 reviewed the above dates and times and verified that the timeline documented in the facility's incident documentation dated 2/2/24 is correct per time stamped recordings. V2 stated, "(R1) came to us from the hospital for rehabilitation after (R1) broke a hip."

On 2/8/24 at 2:46PM V11, Certified Nurse's Aide (CNA) stated, "I was working the night (R1) left the facility. I saw (R1) after (V9) brought (R1) back to third floor. (R1) was in the dining area watching TV. I then went to do my rounds and get everyone to bed. (V10) and (V12) (Also CNAs) were working the floor with me and they were down the hall. V8 the nurse was also down the hall, and I guess that is when (R1) just slipped out. I wondered why (R1) had her dialysis bag. (R1) was confused and had dialysis. (R1) used a wheelchair when (R1) got tired. I don't think (R1) was safe to cross (Street Name) Street in the dark. I really don't know how (R1) made it that far without getting hurt."

On 2/8/24 at 3:00PM V8, Licensed Practical Nurse (LPN) stated, "I was working 6:00PM to 6:00AM the night (R1) left the facility. (V9) Receptionist brought (R1) back up to the floor when (V9) locked the lobby doors. (V9) told me (R1's) family had not picked (R1) up. When I noticed (R1) was not on third floor later in the shift, I just assumed (R1's) family had picked (R1)

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S9999	Continued From page 7 up. I did not call family or the physician. I reported to the shift the next morning (R1) was with (R1's) daughter. (R1) was confused and used a wheelchair for distance but could walk short distances. I do not feel (R1) was safe to leave the facility alone, at night." On 2/8/24 at 3:15PM (V14), Certified Nurse's Aide (CNA) stated, "I was told when I came to work 2/2/24 (R1) was out with (V7). I called (V7) and found out (R1) was not with family and (V7) did not know where (R1) was and could not reach (R1) by phone. I reported this to the nurse, and we became aware (R1) was missing. The nurse reported this to Administration, and they started to look for (R1). In no way do I think (R1) was safe to leave here alone at night. (R1) is weak after dialysis and she is recovering from a broken hip and can't walk that well. (R1) is pretty confused." On 2/8/24 at 12:11PM V22, Social Services Director stated, "When psychiatry saw (R1) I told them (R1) was not safe to go home alone because (R1) was moderately cognitively impaired and did not show good judgement because of her mental illness." When asked if R1 had changed significantly between 12/29/23 and discharge V22 stated "No." On 2/8/24 at 9:00AM V1, Administrator stated, "The security cameras are only able to be monitored in real time from my office. When I'm not here my office is locked, and the floor staff do not have access to the camera images." On 2/8/2024 at 11:58AM, V21 (Licensed Practical Nurse) reported the first-floor entrance door alarms are not audible on the third floor. V21 reported residents who live on the third floor are free to access the third-floor elevator	S9999		

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independently and go to the first floor whenever they want. V21 denied reception staff, who are in the lobby on the first floor adjacent to the facility entry doors, notify third floor staff when residents leave or return to the facility.

On 2/8/2024 at 1:25PM, V16 (Receptionist) reported first floor reception staff do not notify staff on the third or fourth floors when a resident leaves or returns to the facility.

On 2/9/2024 at 11:50AM, V16 (Receptionist) reported residents who reside on the third and fourth floors can access the lobby area near the facility exit doors independently.

On 2/9/2024 at 11:50AM, V16 (Receptionist) reported the main facility exit doorways are only alarmed audibly in the immediate vicinity and do not have any visual alarm anywhere in the facility.

On 2/9/2024 at 11:50AM, V16 (Receptionist) stated, "As far as I know (staff are unable to hear the activated facility exit door alarms after 8:00PM because staff are no longer present on the first floor near the lobby after 8:00PM)."

On 2/9/2024 at 11:50AM, V16 (Receptionist) reported the facility has residents that know the exit doorway alarm disarm code because they see staff enter the code when residents are taken outside to smoke and hear staff "shout out" the code to vendors exiting the facility.

On 2/7/24 at 7:20AM V7 stated, "(R1) was gone (from facility) all night Thursday (2/1/24) and no one knew where (R1) was until the next day 2/2/24. (R1) lost her phone somewhere when (R1) was walking to the apartment complex where we finally found (R1). We were frantic. I

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S9999	Continued From page 9 told (V2) to call the police but they didn't, they went to where (R1) was staying and found (R1). Then I went over, and (R1) had a lot of swelling in (R1's) legs and feet but was OK. (R1) had dialysis the day (R1) left and that left (R1) weak. (R1) did not have any medications, not even insulin. Nobody let us know (R1) left alone and didn't return. (V9) helped (R1) call me (2/1/24). I made it clear that there was no family emergency, and we wouldn't be coming to pick (R1) up." On 2/7/24 at 1:27PM V18, Nurse Practitioner stated, "(R1) was definitely not safe or mobile enough given her chronic medical conditions to be allowed to leave the facility unattended on 2/1/24 at night without the benefit of a wheelchair or a walker. I do not believe (R1) had the safety awareness or judgement to make the decision to leave the facility." (A)	S9999		