

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146003	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER Loft Rehab of Rock Springs, The		STREET ADDRESS, CITY, STATE, ZIP CODE 2530 North Monroe Street Decatur, IL 62526	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>42702</p> <p>Based on interview and record review, the facility failed to provide showers to three (R7, R9 and R10) of four residents reviewed for resident rights and self-determination, on the sample list of ten.</p> <p>Findings Include:</p> <p>The facility Bath/Shower/Tub policy dated 11/1/19, documents the facility will accommodate resident bathing preferences including frequency, time, and method as much as is practicable and will document the date and time the shower/tub bath was performed.</p> <p>On 10/5/21 at 2:00PM, R7 stated, I (R7) got a shower Friday, and I got a bed bath today. I (R7) would rather always have a shower, but I (R7) agreed to a bed bath today, but I (R7) prefer showers. I (R7) would like two a week.</p> <p>On 10/5/21 at 12:07 PM, R9 stated, We aren't getting showers because the shower on {unit}2 is broken and has been for over a month. I (R9) am supposed to get two a week. They do give us bed baths, but I (R9) want a shower. They used to take us to the 4th floor for showers and that was fine, but with COVID, we are kept on this floor.</p> <p>On 10/5/21 at 12:12 PM, R10 stated, I (R10) haven't had a shower in a month! We do get bed baths, but I (R10) want a shower at least one to two times a week.</p> <p>On 10/6/21 at 10:15PM, V2 Interim Director of Nursing stated, I (V2) would expect residents to be showered per the shower schedule. They are being showered now. When they were on droplet isolation, they were getting bed baths. They came off droplet isolation on 9/19/21. The showers should be documented on the Medication Administration Record.</p> <p>R7, R9 and R10's September and October Medication Administration Records do not document showers.</p> <p>On 10/6/21 at 1:05PM, V12 Certified Nursing Assistant (C.N.A.) stated, When we come in (at the beginning of the shift) the nurses tell us who are our showers. If they require a (mechanical lift), they get a bed bath. Yeah, they've only been getting bed baths but if they want a shower, we are supposed to start giving them to them now. That is what another C.N.A. told me this morning.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>34201</p> <p>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.</p> <p>Findings Include:</p> <p>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. 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).</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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</p> <p>(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).</p> <p>R1's MDS (Minimum Data Set) dated 7/5/21, documents R1 has severe cognitive impairments.</p> <p>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.</p> <p>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 V18's posted video, which showed R1 having behaviors. V20 stated V20 immediately reported it to administration.</p> <p>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.</p> <p>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.</p> <p>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).</p>		