STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146003	A. Building B. Wing	02/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab of Rock Springs, The	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on record review, observation and interview the facility failed to monitor a resident during wheelchair transport and failed to ensure post fall interventions were in place for one of three residents (R2) reviewed for falls in a sample list of three residents. Failing to monitor R2 during transport resulted in R2 falling out of the wheelchair and obtaining a head laceration which required sutures. Findings include: R2's undated Face Sheet documents medical diagnoses of Parkinson's Disease, Muscle Wasting and Atrophy, Abnormal Posture, Lack of Coordination, History of Falling, Difficulty in Walking, Cognitive Communication Deficit and Need for Assistance with Personal Care. R2's Minimum Data Set (MDS) dated [DATE] documents R2 as severely cognitively impaired. This same MDS documents R2 as requiring extensive assistance of one person for bed mobility, transfers, locomotion on unit, dressing, eating, toileting and personal hygiene. R2's Fall Risk assessment dated [DATE] documents R2 as a high fall risk. R2's Final Incident Report to Illinois Department of Public Health (IDPH) dated 2/3/23 documents, (R2) was observed laying on ventral side in (R2's) room near doorway. (R2) had on proper footwear, no obstacles were noted on floor and the floor was clean and dry. At the time of fall, (R2) was being pushed in wheelchair by (V9) Certified Nurse Aide (CNA), (R2's) foot slipped off the foot pedal and (R2) lunged forward. (V9) CNA was unaware that (R2's) foot slipped off. (R2) was seen in emergency room with a diagnosis of Laceration of Forehead. (R2) received three sutures and returned to facility. R2's Care Plan documents fall interventions reviewed on 12/29/22 of Do not rush (R2). Allow extra time to complete Activities of Daily Living (ADL). Anticipate and meet (R2's) needs. R2's Post Fall Observation dated 1/25/23 documents, While being pushed to room in wheelchair, (R2) put foot down upon coming into room and tumbled forward. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R2's Nurse Progress Note dated 1/25/23 at 7:25 PM documents, (V9) Certified Nurse Aide (CNA) was pushing (R2) and (R2's) feet got tangled in foot pedals and (R2) stumbled over hitting forehead on floor. (R2) received laceration to forehead. Emergency services called and transported (R2) on stretcher. R2's Hospital After Visit Summary dated 1/25/23 documents R2's reason for visit as Head Injury and Diagnosis of Laceration of Forehead. R2's Hospital Record dated 1/25/23 documents R2's Chief Complaint: Head Injury. This same record documents [AGE] year-old female brought to hospital per emergency services for evaluation after falling. (R2) has an injury to (R2's) head. This same report documents Procedures: The wound was cleaned and irrigated with Normal Saline. Wound edges were infiltrated with 1% Lidocaine. Using sterile technique wound edges were approximated with 4.0 Nylon three sutures. R2's Computerized Tomography (CT) of Head without Contrast results dated 1/25/23 document, Impression: Subcutaneous soft tissue swelling and emphysema in a bifrontal distribution, left greater than right crossing the midline. R2's Fall Interdisciplinary Team Note dated 1/26/23 at 11:00 AM documents, Root Cause: (R2) was being pushed in wheelchair by (V9) CNA, (R2's) foot slipped off foot pedal and resident lunged forward. (V9) CNA was unaware that resident foot slipped off. On 2/10/23 at 4:10 PM V3 Licensed Practical Nurse (LPN) stated, (R2) fell while (V9) Certified Nurse Aide (CNA) was pushing (R2) back to her room. (V9) CNA was not watching (R2's) feet. (R2) had foot pedals on that day but (R2) put her feet down on the ground while she was being pushed into her room by (V9). (R2's) feet got caught up under the wheels of the wheelchair and (R2) got thrown out of the wheelchair straight on her head. (R2) got stitches from that fall. (V9) felt so bad about that. (V9) was crying saying 'it was all (V9's) fault (R2) fell '. (V9) should have been paying closer attention to (R2) and that would not have happened. On 2/10/23 at 4:50 PM R2 was sitting in a wheelchair in the dining room with no foot buddy in place. On 2/10/23 at 4:55 PM V3 Licensed Practical Nurse (LPN) stated, (R2) is supposed to have foot pedals with a foot buddy in place. I do not know where they are. I looked in (R2's) room and they are not there. (R2's) CNA should have put her foot pedals and foot buddy on. That is supposed to keep (R2) from falling like that again. On 2/10/23 at 5:00 PM V5 Certified Nurse Aide (CNA) stated, I did not know (R2) was supposed to have foot pedals and the foot buddy. I guess I will have to go find those and put them on (R2's) wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/14/23 at 11:30 AM V2 Director of Nurses (DON) stated, (V9) Certified Nurse Aide (CNA) was pushing (R2) in her wheelchair down the hall heading into (R2's) room. (V9) must have been going too fast when turning into (R2's) room because that is when (R2) put her feet down. (V9) was not paying attention to (R2). (V9) should have been going at a slower pace and watching the body mechanics of (R2). That would have prevented that fall to begin with. Because (V9) was not watching (R2), (R2) got her feet caught in the front wheels, fell forward landing on her face and ended up getting stitches on her forehead. That fall was absolutely preventable. (V9) CNA felt so bad but really, she could have avoided the whole thing if she were only watching (R2). I don't know what (V9) was thinking or maybe she wasn't. V2 DON stated facility staff have been educated on R2's fall interventions. V2 DON stated, I went to the floor 2/10/23 after you (surveyor) left and saw that (R2) was not even in her right wheelchair. (R2) did not have the foot pedals or foot buddy on either. I took the staff aside right then, educated them and then had to go get all the correct things for (R2). Communication in this facility is a real problem and unfortunately as in the case of (R2) the residents suffer for it. The facility policy titled 'Fall Prevention Program' revised 1/24/23 documents the following: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Monitor for changes in resident's cognition, gait, ability to rise/sit and balance.