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 04/18/2022

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LOFT REHAB OF DECATUR	500 WEST MCKINLEY AVENUE DECATUR, IL 62526

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S 000	Initial Comments Complaint 2262727/IL145517	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 300.610a) 300.1035a)1)2)4)5) 300.1035b)2) 300.1035d) 300.1035e) 300.1210b) 300.1210d)3) 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 300.1035 Life-Sustaining Treatments a) Every facility shall respect the residents' right to make decisions relating to their own medical treatment, including the right to accept, reject, or	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 limit life-sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights. Included within this policy shall be: 1) implementation of Living Wills or Powers of Attorney for Health Care in accordance with the Living Will Act (Ill. Rev. Stat. 1991, ch. 110½, pars. 701 et seq.) [755 ILCS 35] and the Powers of Attorney for Health Care Law (Ill. Rev. Stat. 1991, ch. 110½, pars. 804-1 et seq.) [755 ILCS 45]; 2) the implementation of physician orders limiting resuscitation such as those commonly referred to as "do-not-resuscitate" orders. This policy may only prescribe the format, method of documentation and duration of any physician orders limiting resuscitation. Any orders under this policy shall be honored by the facility. (Section 2-104.2 of the Act); 4) procedures detailing staff's responsibility with respect to the provision of life-sustaining treatment when a resident has chosen to accept, reject or limit life-sustaining treatment, or when a resident has failed or has not yet been given the opportunity to make these choices; 5) procedures for educating both direct and indirect care staff in the application of those specific provisions of the policy for which they are responsible. b) For the purposes of this Section: 2) "Life-sustaining treatment" means any medical treatment, procedure, or intervention that, in the judgment of the attending physician, when applied to a resident, would serve only to prolong the dying process. Those procedures can	S9999		

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S9999	Continued From page 2 include, but are not limited to, cardiopulmonary resuscitation (CPR), assisted ventilation, renal dialysis, surgical procedures, blood transfusions, and the administration of drugs, antibiotics, and artificial nutrition and hydration. Those procedures do not include performing the Heimlich maneuver or clearing the airway, as indicated. d) Any decision made by a resident, an agent, or a surrogate pursuant to subsection (c) of this Section must be recorded in the resident's medical record. Any subsequent changes or modifications must also be recorded in the medical record. e) The facility shall honor all decisions made by a resident, an agent, or a surrogate pursuant to subsection (c) of this Section and may not discriminate in the provision of health care on the basis of such decision or will transfer care in accordance with the Living Will Act, the Powers of Attorney for Health Care Law, the Health Care Surrogate Act or the Right of Conscience Act (Ill. Rev. Stat. 1991, ch. 111½, pars. 5301 et seq.) [745 ILCS 70] 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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S9999	Continued From page 3 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident's code status, advanced directive, reflected their wishes when they failed to document a discussion with R5 regarding R5's wishes to have a Do Not Resuscitate (DNR) order placed in R5's medical record. The facility also failed to contact R5's physician to obtain a signed DNR order. This failure affects one (R5) of seven residents reviewed for advanced directives in a sample of ten residents. This failure resulted in R5 unnecessarily sustaining Cardiopulmonary Resuscitation on 1/10/22 at the facility and during transport to a local hospital. R5 expired at the local hospital when CPR (Cardiopulmonary Resuscitation) ceased in accord with R5's wishes. Findings Include: R5's Progress Notes dated 1/10/22 at 5:03 am by V31 RN (Registered Nurse) documents, at 4:00 am, the CNA (Certified Nursing Assistant) was in R5's room performing morning cares/bed check.	S9999		

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S9999	Continued From page 4	S9999		

R5 was alert and speaking to the CNA. The CNA reports R5 suddenly began "breathing really fast and turned red." The CNA summoned for the RN (Registered Nurse), who responded and found R5 without a pulse and not breathing. CPR was initiated immediately. 911 was called at 4:08 am and EMS (Emergency Medical Services) arrived at 4:15 am. CPR continued. At 4:21 am, V19 (R5's Daughter) was called and notified of R5's current status. V19 stated V19 "is aware that (R5) wishes to be a DNR, however, (V19) is not in possession of POLST(Practitioner Orders for Life-Sustaining Treatment)/Living Will paperwork." This writer reported to V19 that R5 would be transported to the Hospital ED (Emergency Department) via EMS squad at this time. At 4:34 am, R5 was transported out of facility via stretcher with CPR continuing via the rescue squad.

On 4/7/22 at 1:09 pm, V19 stated V19 met with facility staff; V23 Marketing and V24 Admissions prior to R5 being admitted to the facility. V19 stated R5 had voiced wishes to be a DNR so V19 alerted V23 and V24 to R5's wishes and they replied R5's hospital discharge orders would have R5's code status for the facility to implement. V19 explained that on 1/10/22, V19 received a call from the facility telling V19 that they were in the process of doing CPR on R5, V19 told them R5 "was suppose to be a DNR, that was his (R5's) wishes." V19 stated the facility reported they had "already been working on him (R5) for 20 minutes and (R5) was being sent to the hospital." V19 explained that when R5 arrived at the hospital, CPR was ceased due to the hospital having a DNR for R5 and R5 was then pronounced dead. V19 stated, "it was a horrible experience that we should not have had to go through."

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S9999	Continued From page 5 R5's January 2022 Physician Order's do not document a code status. R5's Admission Assessment dated 1/7/22 by V31 RN (Registered Nurse) documents R5's code status as DNR (Do Not Resuscitate). R5's MDS (Minimum Data Set) dated 1/10/22 documents R5's BIMS (Brief Interview for Mental Status) was not performed however per staff, R5's long and short term memory were "OK". On 4/7/22 at 2:17 pm, V23 Admissions stated R5 was admitted on a Friday {1/7/22} and that V23 did not discuss R5's advanced directive wishes with R5 at that time because R5 came to the facility with a POLST from dated 5/2/2018 which documents R5 wishes to have CPR attempted. V23 also stated that R5's hospital discharge orders dated 1/7/22 document R5 as a DNR, as of 1/2/22, which is a discrepancy that the nurse should have clarified. On 4/7/22 at 2:38 pm, V2 Interim DON (Director of Nursing) confirmed if there are discrepancies in a resident's orders, the nurse should be getting the orders clarified. V2 explained that R5 was admitted with a POLST from the hospital that documents to attempt CPR however R5's discharge orders documented R5 as a DNR. V2 further explained that if R5 has a DNR at the hospital but this facility doesn't have a signed DNR form, then R5's status would be a full code at the facility until the facility received the signed DNR order, especially with also having a POLST saying to attempt CPR. On 4/11/22 at 1:38 pm, V31 RN confirmed V31 completed R5's admission assessment and that R5, who was alert and oriented, made it known	S9999		

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S9999	Continued From page 6	S9999		

that R5 wished to be a DNR. It was passed on in report to me that V17 Physician had all of the DNR paperwork at V17's office and that V19 (R5's daughter) was suppose to be bringing it into the facility. V31 stated R5 ended up coding a few days later and due to the facility not having the signed DNR paperwork, CPR was initiated.

On 4/12/22 at 4:00 pm, V17 Physician stated in January 2022, R5 was brought into the hospital and was very frail and declining in health. The last known code status for R5 was a full code from back in 2018. V17 explained that due to R5's condition V17 and R5 had a conversation if R5 wanted to remain a full code and it was at that time, in January 2022, that R5 chose to become a DNR. V17 stated R5 was cognitively intact and able to make that decision independently. V17 stated that after R5 passed away, V19 contacted V17 and was upset that R5 had to be put through CPR when R5's wishes were to be a DNR. V17 explained that the DNR was the most recent order and that's what the facility should have followed but the if the facility had questions, they should have called V17 to clarify R5's code status. "The facility definitely made a mistake with this case and these quality of care issues need to be taken care of."

The facility Cardiopulmonary Resuscitation Policy dated 1/1/2020 documents, It is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement guidelines regarding CPR. "If a resident experiences a cardiac arrest, facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services and in accordance with the resident's advance directives."

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S9999	Continued From page 7 The facility Residents' Rights Regarding Treatment and Advanced Directives Policy dated 1/1/2020 documents, it is the policy of this facility to support and facilitate a residents' right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive. The facility will include in the standing orders: "Advance directive as indicated by the resident and/or resident representative." On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communication to the staff. Upon admission, should the resident/resident representative execute a new advance directive; or, if a resident or resident representative changes the advanced directive: "Social Service Designee or designee will notify the resident's nurse and the IDT (Interdisciplinary Team) of the advance directive/change to advance directive, the resident's nurse will notify the attending physician of advance directive/change to advance directive. The nurse will document in the progress notes that the physician is notified of the advance directive and that the original POLST form is awaiting physician signature. The advance directive will be added to the Physician Orders, The copy of the POLST will be scanned into resident record pending physician signature, the original of the POLST will be scanned into resident record after signed by the physician." (A)	S9999		

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S9999	Continued From page 8 Statement of Licensure Findings 2 of 2 300.698e) Section 300.698 COVID-19 Vaccination of Facility Staff EMERGENCY e.) Each facility shall post conspicuous signage throughout the facility notifying staff that the facility makes available opportunities for staff to be up to date on COVID-19 vaccinations. The signs shall be on 8.5 by 11-inch white paper, with text in Calibri (body) font and 26-point type in black letters. This regulation is not met as evidenced by: Based on observation and interview, the facility did not post signage on white paper with text in Calibri, throughout the facility indicating the facility makes opportunities available for staff to be up to date on the COVID-19 vaccinations. This failure has the potential to affect all 61 residents who reside at the facility. Findings Include: On 4/7/22 from 9:45 am - 2:45 pm, 4/8/22 from 6:00 pm - 9:00 pm, and 4/11/22 from 9:45 am - 3:00 pm, there were no signs posted indicating the facility makes opportunities for staff to become up to date on their COVID-19 vaccinations. On 4/11/22 at 2:03 pm, V26 LPN (Licensed Practical Nurse)/Infection Preventionist stated V26 was not aware of the new state mandate of having signs posted regarding staff vaccinations. On 4/11/22 at 2:24 pm, V1 Administrator stated	S9999		

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S9999	Continued From page 9 V1 was not aware of the new mandated signage for opportunities made by the facility for staff to become fully vaccinated against COVID-19 explaining, "things change so quickly, it's hard to keep up." The facility Daily Census dated 4/7/22 documents 61 residents reside at the facility. (C)	S9999		