FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING IL6006282 01/30/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2530 NORTH MONROE STREET** LOFT REHAB OF ROCK SPRINGS. THE DECATUR, IL 62526 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PRFFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S 000 Initial Comments S 000 Facility Reported Incident of 1/13/24/IL169046 S9999 Final Observations S9999 Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)1)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

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Pursuant to subsection (a), general

care needs of the resident.

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

Electronically Signed

d)

TITLE

(X6) DATE 02/21/24

PRINTED: 02/28/2024 **FORM APPROVED** Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: B WING 01/30/2024 IL6006282 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2530 NORTH MONROE STREET LOFT REHAB OF ROCK SPRINGS, THE DECATUR, IL 62526 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 S9999 Continued From page 1 nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. All treatments and procedures shall be 2) administered as ordered by the physician. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to administer prescribed pain medication to a resident in a timely manner. This failure affects one resident (R1) on the sample of eleven residents reviewed for abuse/medications. This failure resulted in R1 experiencing excruciating pain for twelve hours in the facility following a partial foot amputation requiring hospitalization for pain management and medical treatment. Findings include: R1's Nurses Notes dated 1/12/24 document R1 was admitted to the facility on 1/12/24 from (local

hospital) at 6:49 PM. R1 had his left toes removed due to a prior bone infection and poor blood circulation in his foot.

R1's Physician Order Sheet dated for 1/12/24 and 1/13/24 (printed 1/30/24) documents R1 was admitted to the facility with physician orders for pain medications including Oxycodone-Acetaminophen 10-325 milligrams (mg) every 8 hours as needed for pain, and Hydrocodone-Acetaminophen 10-325 mg every 6 hours as needed for pain.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED					
		IL6006282	B. WING			C <b>30/2024</b>				
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  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				
S9999	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)									

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6006282	B. WING		C 01/30/2024	
	PROVIDER OR SUPPLIER	RINGS THE 2530 NOF	DDRESS, CITY, S' RTH MONROE R, IL 62526	STATE, ZIP CODE E STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETE	
\$9999	On 1/30/24 at 11:2 stated, "The way of supposed to work admitted here, all the hospital get fat pharmacy fills the medications which AM or 6:00 AM the needs a certain medivers it, the nurse emergency box to the night (R1) was having some troubso I told her she night for her with their control, she needs hospital. I found the medication through AM on the 13th (1) unfortunate part, the back to the hospital R1's Medication AG January 2024 (pring Progress Notes dareceive any pain mon 1/12/24 at 6:49 R1's Nursing Progress AM, documer staff, "Something is	26 AM, V2, Director of Nursing, our pharmacy system is a is when a resident gets of the medication orders from exed to our pharmacy, then the exercise and sends us the harmoning. If a nurse nedication before the pharmacy rise can get into the CAPSA or get it. I did speak with (V10) is admitted. I guess (V10) was ble accessing the CAPSA box needed to call the pharmacy, aldn't get into the CAPSA, then nurses could access the CAPSA code. We also have some local are good about delivering ed quickly. I then told (V10) that it (R1's) pain managed and under ed to send him back to the hat (R1) didn't get any pain gh the night until around 5:52 I/13/24), so that is the then he ended up needing to go tal."  Administration Record dated for inted 1/30/24), and R1's Nurses ated 1/13/24, confirm R1 did not medication from his admission of PM until 5:52 AM on 1/13/24.  Gress Notes dated 1/13/24 at the R1 told the facility nursing isn't right with my foot. I are this much pain and look at lengths and pain and look at lengths.	r			

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PRINTED: 02/28/2024 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING IL6006282 01/30/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2530 NORTH MONROE STREET LOFT REHAB OF ROCK SPRINGS, THE DECATUR, IL 62526 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **TAG** DEFICIENCY) S9999 Continued From page 4 S9999 R1's Nursing Progress Notes dated 1/13/24 at 11:16 AM, document R1 was being admitted to (local hospital) for pain management and intravenous antibiotics. The facility's Pain Management policy dated 7/1/21 documents, "The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences." R1's Minimum Data Set dated 1/13/24 (section J) documents R1 was experiencing frequent pain which was frequently interfering with sleep and limiting daily activities. This same Minimum Data Set section documents R1 rated his pain at 10 out of a possible 10, the worst pain ever felt. This same Minimum Data Set (section C) documents R1 has no long term nor short term memory problems and is independent with decision making. On 1/30/24 at 1:07 PM, V1, Administrator, stated. "I agree with that" (R1 could have been and

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any argument for that." (A)

should have been treated for pain much earlier than 12 hours after admission) "and I don't have