STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000244	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOFT REHAB & NURSING OF NORMAL	510 BROADWAY NORMAL, IL 61761

(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 Annual Licensure and Certification Survey Facility Reported Incident Investigation of of 02-28-2022/IL144577	S 000		
S9999	Final Observations Statement of Licensure Violation 1of 2: 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 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 Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. 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. These Regulations are not met as evidenced by: Based on observation, interview and record review, the facility failed to provide adequate staff during cares, per plan of care, to prevent a fall from bed and thoroughly investigate a fall for R36. The facility failed to document an investigation including a root cause analysis for an accident involving R245 and another resident,	S9999		

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S9999	Continued From page 2	S9999		

which resulted in minor injury. R36 and R245 are two of four residents reviewed for falls and accidents on the sample list of 37. This failure resulted in R36 rolling off the bed, during incontinence cares, and sustaining an impacted fracture of the left femoral neck.

Findings Include:

1.) The facility Fall Prevention Policy dated 9/7/21 documents 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.

On 3/14/22 at 9:58 AM, R36 was sitting up in a wheelchair and stated, "a girl was changing me (R36), and I (R36) rolled out of bed. The floor isn't too soft, let me tell you."

R36's Care Plan dated 12/17/21 documents R36 has an ADL (Activities of Daily Living) self-care performance deficit related to Hemiparesis following Cerebral Infarction affecting the left non-dominant side and has a history of falls, weakness, and a left above knee amputation. This care plan also documents R36 is at risk for falls due to having a history of falls, impaired balance/poor coordination, involuntary movements, and seizures.

R36's MDS (Minimum Data Set) dated 12/22/21 documents R36 requires extensive assistance of two staff for bed mobility and toileting and has mildly impaired cognition.

R36's Progress Notes dated 2/28/22 by V20 RN (Registered Nurse) documents a {unidentified} CNA (Certified Nurse Assistant) came to V20 to report that R36 had rolled off the bed while being

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S9999	Continued From page 3 changed and was on the floor. V20 went into R36's room to find R36 lying on R36's back, against the wall, between the windows and the bed. R36 stated that R36 rolled out of bed while being changed. R36 complained of pain, rated it a 9 on a scale of 1-10, to the left hip and pain to the back of the head. A large bump was observed to the back of the head. R36 was sent to the Emergency Room for evaluation. R36's ER (Emergency Room) Notes dated 2/28/22 by V16 Physician documents R36 is in the ER with complaints of left sided leg pain, at the distal end of femur, just above where R36's previous amputation was performed. R36 also presents with a large hematoma to the posterior aspect of the head without active bleeding or laceration and left sided chest wall tenderness. A CT scan (Computed Tomography) of the chest, abdomen and pelvis was completed and revealed an "Impacted fracture of the left femoral neck." V17 Physician who read the CT scan documented the impacted fracture "appears acute and correlates with (R36's) active symptoms. R36's Post Fall Review dated 2/28/22 contained a witness statement from V13 CNA that documents V13 transferred R36 to the bed upon R36's request due to R36 needing to be changed. Once R36 was in bed, V13 instructed R36 to roll over so V13 could provide cares. By that time, R36 was on the edge of the bed. V13 instructed R36 not to roll anymore because R36 would fall but before V13 realized it, R36 was falling out of bed. On 3/16/22 at 12:05 PM V13 CNA stated V13 was the only CNA assisting R36 on 2/28/22, when R36 rolled out of bed. V13 stated V13 was aware that R36 required two assist with bed mobility	S9999		

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however none of the other CNA's were willing to assist V13 get R36 in bed, and R36 needed changed so V13 decided to provide cares independently. V13 stated R36's bed was positioned approximately 2.5-3 feet off the floor {waist height on V13}. V13 stated after R36 was in bed, R36 wiggled onto R36's side "Before I (V13) knew it, (R36) rolled overreaching for something on the bedside table and next thing I (V13) know, (R36) rolled further and fell." V13 stated V13 tried catching R36 by grabbing R36's shirt and amputated leg but couldn't keep R36 from falling. V13 stated had V13 had assistance, the other staff would have been on the opposite side of the bed and been able to stop R36 from falling out of the bed. V13 stated V13 was coached after the incident, by V13's agency, about not providing cares independently for residents who require two assist and that V2 DON (Director of Nursing) also educated V13 that two staff were required when providing cares to R36. V13 again stated that V13 was aware that R36 required two assist but "nobody wanted to help me."

On 3/16/22 at 12:43 PM, V2 DON confirmed R36 sustained a fractured left hip from rolling out of bed.

2.) R245's Progress Note dated 3/1/2022 at 1:53PM documents " Housekeeping staff reported to this nurse that resident told her another resident ran over her foot with their wheelchair. This nurse went to assess resident who was in the hallway in her wheelchair, with her back to the wall, and her feet in the middle of the hallway. Resident asked about what happened, and she showed this nurse her right foot. She said it was her toes. This nurse

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S9999	Continued From page 5 assessed, noting resident has discoloration of the Right Lower Extremity which appears to be from long term edema and blood flow issues, as it is cooler to touch and a purple tint to the skin. Resident able to move all toes, and pulse palpable. Skin remains intact. Resident encouraged to turn her chair parallel to the wall, so her feet would not be exposed as much to passersby. Resident agreed and this was done .Resident informed that she could also utilize the lounges in the facility as well. Fax sent to provider office, and phone call made to resident representative. Will continue to monitor for injury/pain." On 3/15/22 at 11:00AM when complete investigation documentation was requested from V2, Director of Nursing V2 stated "We monitored (R245) after it was reported to us. It wasn't a fall, so I didn't get any statements from staff or identify a root cause." The facility's policy "Accidents and Supervision" dated 12/1/20 states "The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring for effectiveness and modifying interventions when necessary. Definitions: 'Accident' refers to any unexpected or unintentional incident, which results in injury or illness to a resident. " (A) Statement of Licensure Violation 2of 2:	S9999		

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S9999	Continued From page 6 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210c) 300.1210d)2) 300.3220f) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and	S9999		

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S9999	Continued From page 7 the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.3220 Medical Care f) All medical treatment and procedures shall	S9999		

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be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act

These Regulations are not met as evidenced by:

Failures at this level required more than one deficient practice statement.

A.) Based on observation, record review and interview, the facility failed to obtain and initiate orders for a Bipap (bilevel positive airway pressure) machine for one of six residents (R67) reviewed for respiratory care on the sample list of 37. This failure resulted in worsening respiratory function, which required increased oxygen use for R67.

B.) Based on observation, record review and interview, the facility failed to secure a portable oxygen cylinder tank, prevent contamination of oxygen tubing, and failed to change out visibly soiled oxygen tubing, mask, and suction canister for two of six residents (R13, R34) reviewed for oxygen on the sample list of 37.

Findings Include:

a.) On 3/14/22 at 10:28 AM, R67 was lying in bed with oxygen running at 6 Liters/NC (Nasal Cannula). R67's skin was ashen in color. R67's oxygen tubing was lying on the floor. R67 had a Bipap Machine sitting on top of a small refrigerator, next to R67's bed. The mask and tubing for the Bipap Machine were uncovered. R67 gasped for breath when trying to talk, waiting several seconds and taking multiple breaths

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between words. R67 stated it was hard to talk due to not being able to breath. R67 also stated R67 got the Bipap machine a couple of weeks ago but that R67 has never used it due to nobody teaching R67 how to.

R67's Medical Record Documents R67 was admitted to the facility on 1/28/21 and then hospitalized from 2/6/22 - 2/11/22.

R67's Hospital Consult Note dated 2/10/22 by V31 Pulmonologist documents R67 is in the hospital due to Hypoxemic Hypercarbic Respiratory Failure. This note documents R67 has a known history of Lung Disease, severe malnutrition and deconditioning, along with being bedridden for 8 months, and now displaying profound Cachexia. This note also documents R67 has been hospitalized multiple times, approximately once a month for the last three months. V31 discussed "trying a Bipap at night to improve (R67's) Hypercarbia" and R67 agreed to try it. V31's Recommendations due to R67's Hypercarbic Respiratory Failure is "limit oxygen to maintain saturations greater than 89 in less than 95%", and "nocturnal Bipap to help ventilation and help bring down CO2 {Carbon Dioxide)."

R67's March 2022 Physician Orders document a diagnosis of Acute and Chronic Respiratory Failure with Hypoxia and Hypercapnia with an order for oxygen at 2-6 Liters to keep saturation levels between 88-90%. As of 3/14/22, these orders do not contain an order for the Bipap Machine.

R67's Progress Notes document continued breathing difficulties after R67's return from the hospital: 2/25/22 - Nurse Spoke with V32 Physician regarding R67's request to increase

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S9999	Continued From page 10 oxygen to 6 Liters. R67 is sating at 84% on 5 Liters of oxygen via NC (Nasal Cannula) but when oxygen is bumped down to 4 Liters, R67 is sating at 90%. V32 stated to continue at 4 Liters for now and that V32 would come to see R67 the following day. R67 educated to take some deep breaths in through the nose and out through the mouth. Will continue to monitor resident at this time. 2/25/22 - V32 Physician called back and gave orders to put R67's oxygen on at 6 Liters via NC at this time. High flow concentrator and high flow NC brought to R67's room and set up for resident at this time. R67 stated "I (R67) am feeling better already". R67 reminded to take slow deep breaths in through the nose and out through the mouth. Progress noted dated 3/1/22 by V34 ADON (Assistant Director of Nursing) - R67 noted to have ongoing complaints of wanting R67's oxygen turned up to 7 Liters and is asking staff to do so for R67. R67 given extensive education at this time regarding chronic pulmonary dysfunction, and the use of oxygen. Discussed the depression of the drive to breathe with higher levels of oxygen Liters Per Minute, causing lower oxygen saturations, and perpetuating the shortness of breath felt. R67 is having denial of this and needing multiple explanations with different wording. R67 educated on sitting up for lung expansion, deep breathing/pursed lip breathing techniques, and need for carbon dioxide to be expelled from the lungs. R67 taught to sling accessory muscles with a pillow for any discomfort caused by deep breathing exercises. An incentive spirometer was given, and instructions given written and verbal. R67 refused to try it at this time but stated R67 would later. R67 also laid self-back flat in the bed, despite education to sit up when feeling short of breath. Will continue to encourage and educate as	S9999		

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needed.

On 3/16/22 at 9:27 AM, V11 Corporate Nurse stated it appears that R67 returned to the facility from the hospital with the Bipap but didn't have an order for it. "Staff should have followed up and gotten an order for it. I believe (V2 DON (Director of Nursing)) called and got an order for it last night." This is definitely a problem! V11 confirmed that not using the Bipap at night as recommended by V31 Pulmonologist could be why R67 is feeling shorter of breath and having the feeling of needing more oxygen.

On 3/16/22 at 10:05 AM, V2 DON with V11 Corporate Nurse present clarified that the Bipap for R67 did not return from he hospital with R67 but instead got delivered to the facility for R67 after R67 returned to the facility. V2 stated staff should have followed up with V 31 Pulmonologist and/or V32 Physician at that time to obtain and implement the orders for the Bipap. At this time, V2 stated V2 called V32 (R67's Physician) yesterday to tell of the Bipap error and get an order. V2 also called V31 Pulmonologist, to get clarification as to if R67 needs to have oxygen running concurrently with the Bipap at night but is still waiting for V31 to return the call.

b.1.) R13's MDS (Minimum Data Set) dated 12/8/21 documents R13 requires supervision with set up for ADL's (activities of daily living).

R13's Care Plan dated 12/10/21 documents R13 using oxygen PRN (as needed) due to COPD (Chronic Obstructive Pulmonary Disease).

On 3/14/22 at 10:18 AM, R13 was sleeping in R13's wheelchair. R13's oxygen concentrator was on and running however the tubing and NC

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S9999	Continued From page 12 (Nasal Cannula) were lying on the floor. There was a portable oxygen cylinder tank standing in the corner of the room, next to the closet, that was not in a cart nor secured in any way. On 3/14/22 at 11:43 AM, V2 DON (Director of Nursing) stated V2 stated the oxygen cylinder should be secured for safety. On 3/14/22 at 12:44 PM, R13 was sitting up in R13's wheelchair with R13's oxygen tubing draped across the bed and lying on the floor. R13 stated R13 removes and applies R13's own oxygen but that facility staff "have never told me (R13) to put it in a bag when I'm not wearing it." On 3/14/22 at 3:40 PM, R13 was sitting up in the wheelchair with oxygen running at 4 Liters/NC. R13 stated nobody had changed the set up and that it is the same tubing and NC that was attached to the machine earlier. The facility Oxygen Safety Policy dated 4/27/21 documents, staff, residents, and families will be educated on oxygen safety precautions in accordance with their roles and responsibilities related to the use and storage of oxygen. Cylinders will be properly chained or supported in racks or other fastenings (i.e. sturdy portable carts, approved stands) to secure all cylinders from falling, whether connected, unconnected, full or empty. The facility Oxygen Administration Policy dated 5/10/21 documents oxygen is administered to resident who need it, consistent with professional standards, comprehensive person-centered care plans, and the resident's goals and preferences. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000244	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOFT REHAB & NURSING OF NORMAL	510 BROADWAY NORMAL, IL 61761

(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	Continued From page 13 contaminated. b.2.) R34's Order summary dated 3/16/22 includes the following diagnosis: Neoplasm of the Larynx and Tracheostomy. On 03/14/22 at 12:52 PM R34 was lying in her bed with oxygen tubing and tracheostomy (trach) collar in place. The collar was attached to a portable ventilator (receiving only bipap level of support) supplying 30% oxygen and respiratory support as ordered. There was a portable suction machine in place at bedside. The tubing was not dated as to last time changed. The suction canister was full of green thick liquid. The tubing and collar were covered in patches of yellow green secretions. It was difficult for R34 to speak, but she was able to state "they don't change the tubing and suction container for weeks at a time. I don't like that." R34's Minimum Data Set dated 1/14/22 documents R34 is moderately cognitively impaired and able to make needs known. On 3/16/22 at 11:30AM V2 Director of Nursing stated, "The trach collar and tubing and the suction tubing and container should be changed weekly or if they are dirty." The facility's policy Tracheostomy Care dated 12/1/20 states "The facility will ensure that residents who need respiratory care, including tracheostomy care and tracheal suctioning, is provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences. The facility's policy Oxygen administration dated	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000244	A. BUILDING: _____ B. WING _____	03/16/2022

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LOFT REHAB & NURSING OF NORMAL	510 BROADWAY NORMAL, IL 61761

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S9999	Continued From page 14 5/10/21 states "Staff shall perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include: a. Follow manufacturer recommendations for the frequency of cleaning equipment filters. b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. c. Change humidifier bottle when empty, every 72 hours or per facility policy, or as recommended by the manufacturer. Use only sterile water for humidification. d. If applicable, change nebulizer tubing and delivery devices every 72 hours or per facility policy and as needed if they become soiled or contaminated. e. Keep delivery devices covered in plastic bag when not in use." (A)	S9999		