Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058446	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOFT REHAB OF PEORIA, THE	1500 WEST NORTHMOOR ROAD , PEORIA, Illinois, 61614

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S0000	Initial Comments Annual Health Survey	S0000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.661 Section 300.661 Health Care Worker Background Check A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. PROFESSIONS, OCCUPATIONS, AND BUSINESS OPERATIONS (225 ILCS 46/) Health Care Worker Background Check Act. (225 ILCS 46/15) Sec. 15. Definitions. In this Act: "Initiate" means obtaining from a student, applicant, or employee his or her social security number, demographics, a disclosure statement, and an authorization for the Department of Public Health or its designee to request a fingerprint-based criminal history records check; transmitting this information electronically to the Department of Public Health; conducting Internet searches on certain web sites, including without limitation the Illinois Sex Offender Registry, the Department of Corrections' Sex Offender Search Engine, the Department of Corrections' Inmate Search Engine, the Department of Corrections Wanted	S9999		

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

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S9999	Continued from page 1 Fugitives Search Engine, the National Sex Offender Public Registry, and the List of Excluded Individuals and Entities database on the website of the Health and Human Services Office of Inspector General to determine if the applicant has been adjudicated a sex offender, has been a prison inmate, or has committed Medicare or Medicaid fraud, or conducting similar searches as defined by rule; and having the student, applicant, or employee's fingerprints collected and transmitted electronically to the Illinois State Police. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to complete the required background website checks prior to a new employee starting a work schedule for two of 10 employees (V25/Dietary Aide and V26/Certified Nursing Assistant) reviewed for health care worker background checks. This has the potential to affect all 84 residents residing in the facility. Findings include: The facility Employee Roster documents V25/Dietary Aide was hired on 2/13/2025. V25/Dietary Aide Employee File does not contain evidence of the following required background website checks as of 6/29/25: Illinois sex offender, DOC (Department of Corrections) sex offender, DOC inmate search, and DOC wanted fugitives. The facility Employee Roster documents V26/CNA (Certified Nursing Assistant) was hired on 1/16/2025. V26/CNA Employee File does not contain evidence of the following required background website checks as of 6/29/25: Illinois sex offender, DOC (Department of Corrections) sex offender, DOC inmate search, and DOC wanted fugitives. On 6/30/25 at 3:02 PM, V24/Human Resources stated she is responsible for performing the employee's healthcare worker background/required website checks. V24 verified V25/Dietary Aide and V26/CNA required background website checks had not been completed as of 6/29/25,	S9999		

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S9999	Continued from page 2 and should have been. V24 stated she completed the required background website checks for V25 and V26 on 6/29/25, after she realized she could not locate them to provide to this surveyor. V24 stated, "I am not sure why (V25) and (V26) website background checks weren't completed. They should have been done prior to their hire dates." The facility's CMS (Centers for Medicare and Medicaid Services) Long Term Care Facility Application for Medicare and Medicaid Form 671, dated 6/30/25 and signed by V1/Administrator, documents 84 residents currently reside within the facility. (C) 2 of 2 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)6) 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. 300.1210. General Requirements for Nursing and Personal Care	S9999		

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S9999	Continued from page 3 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: 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 requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure wheelchair pedals were applied to a resident's wheelchair, as care planned, while being transported by staff for one of three residents (R20) reviewed for accidents in a sample of 53. These failures resulted in R20 getting her left leg caught in her left wheelchair wheel, causing R20 to experience excruciating pain and a left femur fracture that required surgical repair. Findings include: R20's MDS (Minimum Data Set) Assessment, dated 03/07/2025, documents R20 is severely cognitively impaired and is dependent on staff for transfers. R20's current Activities of Daily Living Self-Care Performance Deficit Care Plan documents, "Interventions 3/17/2025 wheelchair locomotion: (R20) requires total assist of one staff with wheelchair locomotion to ensure (R20) reaches her destination. Ensure foot pedals in place prior to propelling wheelchair."	S9999		

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S9999	Continued from page 4 R20's current At Risk for Falling Care Plan documents, "Interventions 5/12/25 (non-skin material) to wheelchair. Staff to re-approach if (R20) is agitated. Ensure foot pedals on wheelchair with locomotion." R20's Post Fall Evaluation, dated 5/12/25 at 1:20 PM and signed by V17 (LPN/Licensed Practical Nurse), documents, "Time of Fall 1:20 PM. Fall was witnessed. Occurred in hallway. Activity at time of fall: Leg caught in wheelchair in wheels. No injury at time of fall." R20's Fall Interdisciplinary Team Note, dated 5/13/25 at 12:45 PM, documents, "Description of fall: (V16/CNA/Certified Nursing Assistant) stated, "I was pushing (R20) in her wheelchair back to her room when (R20) started to lean forward and slide off the seat of (R20's) wheelchair when another CNA (V18) came to assist and caught (R20) and lowered (R20) to the floor. (R20) did not appear to have any injuries. Root cause: (R20) was up in wheelchair being pushed by staff when (R20) became agitated, leaned forward, and started to slide off seat of wheelchair. Another CNA (V18) caught (R20) and lowered (R20) to the floor. (R20) has poor safety awareness and has impaired cognition with a BIMS (Brief Interview of Mental Status) of 99 (severely cognitively impaired). (R20) requires assist of two for transfers." R20's Progress Notes, dated 5/14/25 at 4:20 PM, documents, "(R20) screams out when touched. This behavior is new." R20's Progress Notes, dated 5/14/25 at 4:22 PM, documents order received for a STAT (Immediately) x-ray for right hip and right knee. R20's Progress Notes, dated 5/14/25 at 11:20 PM, documents, "(R20) screamed out upon a gentle touch to the upper and lower leg at 6:20 PM. 911 was called and was sent to (hospital). (R1) was admitted with a left femur fracture." R20's Emergency Department Provider Notes, dated 5/14/25, document, "(R20) is a 77-year-old with a past medical history of Dementia presenting via EMS	S9999		

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S9999	Continued from page 5 (Emergency Medical Services) from a nursing home after ground-level fall two days ago with resulting left leg pain. Has been increasing over the last couple of days. Staff sent (R20) in. The reason for the fall is unclear. (R20) does apparently fall frequently. (R20) is clearly in a lot of pain. (R20) is unable to provide any further history due to Dementia. Left leg is held externally rotated and shortened compared to right, tender to palpation from the proximal knee to the left hip. X-Ray Femur Impression: Acute periprosthetic distal left femur fracture." R20's Surgical Note, dated 5/16/25 and signed by V23 (Surgeon), documents R20 received an open reduction internal fixation to repair the fracture to R20's distal femur. R20's State Report, dated 5/15/25 and signed by V1 (Administrator), documents, "After a thorough investigation was completed, the root cause was determined to be (R20's) foot slipped while being propelled, (R20) began to lean forward, at which time staff had to lower (R20) to the floor for safety. Upon readmission therapy reassessed for safe wheelchair positioning." On 06/30/25 at 1:33 PM, V17 (Licensed Practical Nurse/LPN) stated, "On 5/12/25 (R20's) legs were crossed and (V16/CNA/Certified Nursing Assistant) was pushing (R20) down the hallway. (R20) was having behaviors and did not have wheelchair pedals on her wheelchair. (R20) went to slide down in her wheelchair and (R20's) left leg got caught in the wheel of the wheelchair. When (R20) went to slide down, (V18/CNA) was able to cradle (R20) and lower (R20) to the floor, but (R20's) left foot was bent under and caught in the wheelchair wheel." On 6/30/25 at 1:45 PM, V18 (CNA) stated, "On 5/12/25, I lowered (R20) to the floor gently. (R20) kept putting her feet down having behaviors and resisting to be pushed in the chair or be touched. (R20) was being combative by putting her feet down and did not want to go. (R20) then raised her legs not wanting to go and started leaning forward and went to fall so me and (V16/CNA) lowered (R20) to the floor. (R20) did not have wheelchair pedals on her wheelchair during the fall or while being pushed in the wheelchair. I know (R20) does have wheelchair pedals, and I do not know why the pedals were not on (R20's) wheelchair."	S9999		

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S9999	Continued from page 6 On 6/30/25 at 1:52 PM, V16 (CNA) stated, "On 5/12/25, I was pushing (R20) down the hallway to her room. (R20) was sliding down in her wheelchair. (V18) was following. (R20) was screaming at us. I kept telling (R20) I was going to push her, and she needed to put her feet up so I could push her. (R20) was yelling at us. (V18) came behind me, got underneath (R20) and cradled (R20) gently to the ground. (R20) did not have wheelchair pedals on her chair. Sometimes (R20) has wheelchair pedals and sometimes (R20) does not have wheelchair pedals. I do not know why." On 6/30/25 at 1:15 PM, V20 (Occupational Therapist) stated if a resident is having behaviors and putting their feet on the floor while staff are pushing the wheelchair, then the staff should stop pushing the resident because a fall could occur. They should place foot pedals on the wheelchair and monitor the resident's behavior. On 07/01/2025 at 10:00 AM, V1 (Administrator) stated, "I did not know the nurse (V17/LPN) saw (R20's) foot get caught in the wheelchair." V1 verified when R20 was having behaviors and V16 was pushing R20 in the wheelchair on 5/12/25, V16 should have stopped pushing R20 while she was having behaviors, and should have made sure R20 had wheelchair pedals on R20's wheelchair to prevent R20 from putting her feet down and getting R20's foot caught in the wheelchair wheel. On 7/1/25 at 10:30 AM, R20 was sitting in her wheelchair in the dining room watching television. R20's wheelchair had a wheelchair pedal on the left side of the wheelchair. R20's left leg had a leg brace and was not on the foot pedal. R20 did not have a wheelchair pedal to the right side of her wheelchair and R20's right foot was on the floor. On 7/1/25 at 10:31 AM, V22/R20's Primary Physician stated if R20's care plan stated R20 was supposed to have foot pedals on while be pushed in her wheelchair, then staff should have had them on. If R20's wheelchair pedals were on it could have potentially helped with preventing her fall or getting her leg caught in the wheel. On 7/1/25 at 10:45 AM, V27 (CNA) stated staff usually	S9999		

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S9999	Continued from page 7 push R20's wheelchair with the left foot pedal on and without the right foot pedal on. The Accidents and Supervision policy, dated 2/10/25, documents, "The resident's 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 an injury or illness to a resident. "Fall" refers to unintentional coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g. (example), resident pushes another resident). An episode where a resident lost his/her balance and would have fallen if not for another person or if he/she had caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. "Risk" refers to any external factor, facility characteristic (e.g., staffing, or physical environment) or characteristic of an individual resident that influences the likelihood of an accident. Policy Explanation and compliance Guidelines: 3. Implementation of Interventions- using specific interventions to try to reduce a resident's risk from hazards in the environment. The process includes a. Communicating the interventions to all relevant staff. b. Assigning responsibility c. Providing training as needed d. Documenting interventions (e.g., plans of action developed through the QAA (Quality Assurance) Committee of care plans for the individual resident) e. Ensuring that the interventions are put into action h. Facility-based interventions may include but are not limited to: i. Educating staff ii. Repairing the device/equipment iii. Developing or revising policies and procedures. Resident-directed approaches may include i. Implementing specific interventions as part of the plan of care ii. Supervising staff and residents, etc. (etcetera) iii facility records document the implementation of these interventions." (A)	S9999		