

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145031	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Loft Rehab & Nursing of Normal		STREET ADDRESS, CITY, STATE, ZIP CODE 510 Broadway Normal, IL 61761	
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 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to assess a resident after an unwitnessed fall and failed to assist a resident off the floor following an unwitnessed fall for one (R3) of three residents reviewed for Quality of Care and Dignity on a sample list of five residents. Based on interviews with the family, this resident suffered psychosocial harm as a result of the resident being left on the floor. Findings include R3's Electronic Medical Record (EMR) documents that R3 had Alzheimer's Disease with early onset and Adult Failure to Thrive. R3's Minimum Data Set (MDS) dated [DATE], documents R3 had cognitive impairment with disorganized thinking, and inattention with altered levels of consciousness that fluctuated. This MDS also documents that R3 was not capable of making her own decisions and that R3 was dependent on staff to get from a sitting to standing position. R3's admission fall risk assessment dated [DATE] documents that R3 was at risk for falls. R3's Care Plan dated 10/23/25, documents that R3 was at risk for falling related to dementia, side effects of medication, and a terminal condition. R3's Care Plan dated 10/30/25, documents that R3 had impaired cognitive function/dementia or impaired thought process related to Alzheimer's disease with interventions to supervise resident as needed. On 11/25/25 at 12:40 PM, V18 Certified Nurse Assistant (CNA) stated V18 sat right outside of R3's room the night of R3's unwitnessed fall. V18 stated V18 went on her lunch break sometime during the middle of the night and when she returned V19 CNA told her that R3 was found on the floor in R3's room. V18 CNA stated she reported this to V7 Registered Nurse (RN) and V7 RN told V18 CNA that R3 likes to be on the floor and that the family said it's ok. V18 CNA stated V7 RN never went to R3's room and assessed R3. On 11/25/25 at 1:11 PM, V19 CNA stated that she found R3 on the floor and reported it to V7 RN and V7 RN told V19 CNA to leave R3 and the floor. V19 CNA stated V7 RN did not go to R3's room to assess R3 after being found on the floor. On 11/25/25 at 2:51 PM, V7 RN stated she was the nurse on duty at the time of R3's fall. On 11/20/25 V7 RN went on lunch break around 12:50 AM and when V7 returned V19 CNA told her that R3 was found on the floor. V7 RN stated that V8 Licensed Practical Nurse (LPN) told V7 RN in shift report that R3 would sometimes put herself on the floor and that it would not be considered a fall. V7 RN stated V7 made a mistake in not documenting the unwitnessed fall. V7 RN stated she did not assess the resident as V7 RN did not consider this a fall. On 11/25/25 at 10:23 AM, V22 Laundry Aide stated she found R3 on the floor around 6:15 AM on 11/20/25 and that there was a pillow behind R3's back and R3's head was propped against the wall. On 11/25/25 at 11:03 AM, V23 Housekeeper stated she saw R3 lying on the floor with her head leaning against the wall and dresser on the morning of 11/20/25. On 11/25/25 at 11:13 AM, V20 Activities Aide stated she recalls that on the morning of 11/20/25 her coworkers told her to go find help because R3 was found on the floor. V20 Activities Aide stated she told a nurse and CNA (unsure of their names) and they did not do anything. On 11/25/25 at 11:20 AM, V21 Activity Director stated V23 Housekeeper came to V21 Activity Director's office on the morning of 11/20/25 and stated R3 was lying on the floor and needed help. V21 Activity Director stated she went to R3's room found her lying on the floor partially on a fall mat, not covered up, with a pillow behind her back, and R3's head was leaning against the wall. On (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145031	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Loft Rehab & Nursing of Normal		STREET ADDRESS, CITY, STATE, ZIP CODE 510 Broadway Normal, IL 61761	
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 0550 Level of Harm - Actual harm Residents Affected - Few	11/25/25 at 10:35 AM, V11 Licensed Practical Nurse (LPN) stated she was the nurse coming on duty the morning R3 was found on the floor. V11 LPN stated V1 Administrator came to V11 LPN and asked V11 LPN why R3 was on the floor. V11 LPN stated V7 RN did not tell V11 LPN that R3 was found on the floor during the night. On 11/24/25 at 2:36 PM, V17 CNA stated she overheard V1 Administrator on the morning of 11/20/25 loudly addressing staff after finding R3 lying on the floor saying, what if this was your family member that was left lying on the cold floor? On 11/25/25 at 9:49 AM, V1 Administrator stated she found R3 floor in R3's room around 6:55 AM. V1 Administrator stated R3 was partially lying on a fall mat, not covered, and was not arousable. V1 stated this was unacceptable that the nurse should have assessed R3 immediately when the unwitnessed fall was reported and gotten R3 up off the floor and into her bed. On 11/25/25 at 2:43 PM, V24 (R3's) Husband tearfully stated if R3 had the ability to communicate on 11/20/25 when R3 was found on the floor, R3 would have been anxious, pissed off and questioning how she got on the floor and why she was left there. The facility's Resident Right's Policy dated 2/12/25 documents that the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. This policy documents the following: 2. Exercise of rights. The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the resident representative. 5. Respect and dignity. The resident has a right to be treated with respect and dignity, including: the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences, except when to do so would endanger the health or safety of the resident or other residents. 9. Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145031	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Loft Rehab & Nursing of Normal		STREET ADDRESS, CITY, STATE, ZIP CODE 510 Broadway Normal, IL 61761	
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 - Minimal harm or potential for 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** Based on interview and record review the facility failed to ensure a resident was properly supervised to prevent a fall for one (R3) of three residents reviewed for accidents on a sample list of five. Findings include: R3's Minimum Data Set (MDS) dated [DATE] documents that R3 was not able to complete the Brief Interview for Mental Status (BIMS) due to cognitive impairment. R3's admission fall risk assessment dated [DATE] documents R3 is at risk for falls. R3's Care Plan dated 10/23/25, documents that R3 is at risk for falls related to dementia, side effects of medication and a terminal condition. R3's Care Plan dated 10/30/25, documents that R3 is an elopement risk/wanderer related to R3 is disoriented to place and has impaired safety awareness. R3's progress notes document that on 11/20/25 at approximately 6:00 AM R3 was observed on the floor in R3's room. On 11/25/25 at 12:40 PM, V18 Certified Nurse Assistant (CNA) stated V18 sat right outside of R3's room the night of her unwitnessed fall. V18 stated V18 went on her lunch break sometime during the middle of the night and when she returned V19 CNA told her that R3 was found on the floor in R3's room. V18 CNA stated that she got R3 off the floor around 4:30 AM to toilet R3 and then left R3 sitting on the edge of R3's bed. V18 CNA stated that around 6:00 AM while doing change of shift rounds R3 was found lying on the floor again next to R3's bed. On 11/25/25 1:11 PM, V19 CNA stated that she found R3 on the floor and reported it to V7 RN and V7 told V19 CNA to leave R3 and the floor. V19 CNA stated V7 RN did not go to R3's room to assess R3 after being found on the floor. On 11/25/25 at 2:51 PM, V7 Registered Nurse (RN) stated she was the nurse on duty at the time of R3's fall on 11/20/25 and that V7 RN went on lunch break around 12:50 AM and when she returned V19 CNA told V7 that R3 was found on the floor. V7 RN stated that V8 Licensed Practical Nurse (LPN) told V7 RN in shift report that R3 would sometimes put herself on the floor and that it would not be considered a fall. V7 RN stated V7 RN made a mistake in not documenting the unwitnessed fall. On 11/25/25 at 9:49 AM, V1 Administrator stated that V1's expectation of the staff was that they should have partnered with their coworkers to keep a close eye on R3 to prevent falls and keep R3 safe and comfortable. The facility's fall policy dated 2/12/25 documents that 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. Definitions: a fall is an event in which an individual unintentionally comes to rest on the ground, floor, or other level, but not as a result of an overwhelming external force. The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere. The nurse will indicate on the Fall Risk Assessment/Morse Fall Assessment the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk. This policy documents that the facility will provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status, or recent change in functional status and provide additional interventions as directed by the resident's assessment, including but not limited to: assistive devices, increased frequency of rounds, sitter, if indicated, medication regimen review, low bed, alternate call system access, scheduled ambulation or toileting assistance, family/caregiver or resident education and therapy services referral.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145031	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Loft Rehab & Nursing of Normal		STREET ADDRESS, CITY, STATE, ZIP CODE 510 Broadway Normal, IL 61761	
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review the facility failed to ensure a resident was kept free from a significant medication error for one (R3) of three residents reviewed for medication management on a sample list of five residents. Findings include: R3's Electronic Medical Record (EMR) contained a physician's order dated 10/22/25 documenting that R3 was to receive Haloperidol (HALDOL) two milligrams (mg)/ milliliter (ml) concentrate, take one ml by mouth every eight hours for agitated movements accompanied by emotional distress. R3's physician orders in R3's EMR dated 10/22/25 document an order for Haloperidol Lactate Oral Concentrate two mg/ml, give two ml by mouth every eight hours for agitation/restlessness. R3's October and November 2025 Medication Administration Record (MAR) documents that R3 received seventy-three incorrect doses of Haloperidol. R3's EMR contains a letter dated 11/20/25 documenting that V2 Assistant Director of Nursing (ADON) reported R3's Haloperidol medication error to Physicians Group. This letter documents that R3 was lethargic that day. On 11/25/25 at 12:02 PM, V2 Assistant Director of Nursing (ADON) stated V3 [NAME] President of Clinical Services did a medication audit after R3's unwitnessed fall and found that R3's physician order for Haloperidol two mg/ml, give one ml every eight hours was transcribed incorrectly as Haloperidol two mg/ml, give two ml every eight hours. V2 ADON stated validation by a second nurse is not facility policy but V2 ADON thinks it should be. On 12/01/25 at 10:00 AM, V3 [NAME] President of Clinical Services stated the nurse that incorrectly transcribed R3's physician's order for Haloperidol has been terminated and that an unwritten policy of the facility is that a second nurse should validate the physician's order that were entered into a resident's chart. V3 stated validation by a second nurse should have been done. The facility's Physician/Practitioner Orders Policy dated 2/10/25 documents that the attending physician shall authenticate orders for the care and treatment of assigned residents. This policy documents the following explanation and compliance guidelines: 2. for physician/practitioner orders received in writing or via fax, the nurse in a timely manner will: a. if not the attending, call the attending physician to verify the order and b. follow facility procedures for verbal or telephone orders including noting the order, submitting to pharmacy, and transcribing to medication or treatment administration record.		