

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 01/02/2026
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to answer call lights in a timely fashion for three of three residents (R2, R7, R10) reviewed for call lights in the sample list of eleven. Findings Include: Grievance logs dated October 2025, November 2025 and December 2025 all document residents having to wait extended times for help with various activities. Resident Council Minutes dated 12/3/25 document 13 residents attended the meeting and documented staff need to answer call lights quicker. R2's Medical Record reviewed 12/30/25 documents R2 admitted to the facility on [DATE] from a local hospital with Diagnoses of Weakness, Right Sided Hemiparesis, Cognitive Decline, B12 Deficiency, Back Pain, Right Lower Extremity Pain, Microscopic Hematuria, Diabetes Mellitus, Hypertension, Hyperlipidemia, Cerebral Vascular Accident, and Multiple Sclerosis. R2's medical record does not contain an admission assessment or admission note from a licensed nurse from time of arrival until discharge. On 12/30/25 at 10:20am V4, R2's Family, stated that R2 did not have a call light but rather a call bell that was rang several times and went without any staff members answering the sound of the bell. On 12/30/2025 R7's Care Plan dated 11/26/25 documents R7's admission to the facility on [DATE] with the following diagnoses: Aphasia Following Cerebral Infarction, Dysarthria Following Cerebral Infarction, Apraxia Following Cerebral Infarction, Pulmonary Hypertension, Atrial Fibrillation, and Benign Prostatic Hyperplasia. The Minimum Data Set, dated [DATE] documents R7 is cognitively impaired. On 12/30/25 at 11:20am R7 stated the call light system works, though once activated it has taken anywhere from 30min to two hours to get a response from staff. On 12/30/2025 R10's Care Plan dated 11/27/25 documents R10's admission to the facility on [DATE] with the following diagnoses: Abnormal Levels of Other Serum Enzymes, Lichen Simplex Chronicus, Malaise, Hyperlipidemia, Muscle Wasting and Atrophy, Specified Disorders of Muscle and Lack of Coordination. R10's Minimum Data Set documents R10 is cognitively intact. On 12/30/25 at 1:00pm R10 stated call light response time can vary but have been as long as two hours. On 1/2/26 at 12:45pm V16, Corporate Nurse, stated staff should answer the call light in under 10 minutes. On 1/2/26 at 1:05pm V19, DON, stated staff should answer the call light in under 10-15 minutes to meet resident needs. The Call Lights: Accessibility and Timely Response policy dated 2/06/25 documents: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. Policy Explanation and Compliance Guidelines: 9. Process for responding to call lights: a. Response times should be a priority.</p>

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
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse by another resident for two of three residents (R8 and R9) reviewed for abuse in the sample list of eleven. Findings Include: On 12/30/25 the facility provided an investigation file dated 12/2/25 documenting a physical incident occurred between two roommates/residents (R8, R9). The file documents staff responded immediately, intervening to stop the interaction and separate the residents. R8's Current Care Plan reviewed on 12/30/2025 documents R8's admission to the facility on 5/1/2025 with the following diagnoses: Metabolic Encephalopathy, Protein-Calorie Malnutrition, Anemia in Chronic Kidney Disease, and Dementia in other Diseases, Moderate, with Agitation. R8's Minimum Data Set, dated [DATE], documents R8 with a brief interview for mental status score of 14 indicating R8 is cognitively intact. R8's Care Plan dated 06/27/2025 addresses wandering without purpose and wandering into other resident's spaces. R9's Current Care Plan reviewed 12/30/2025 (DOB 6/21/63) documents R9's admission to the facility on 1/30/2025 with the following diagnoses: Retention of Urine, Primary Generalized Osteoarthritis, Mild Intermittent Asthma, Recurrent Left-Shoulder Dislocation, and Disorders of Bone Density/Structure. R9's Minimum Data Set, dated [DATE] documents R9 with a brief interview for mental status score of 3 indicating cognitive impairment. R9's care plan dated 10/06/2025 documents Behavioral Symptoms are present. V14's (Activity Aide) statement dated 12/8/2025 documents R9 and R8 exchanged words then V14 removed R8 and R8 put himself back in and the two began engaging hits to one another. V9's (Certified Nursing Aide) statement dated 12/8/2025 documents V9 heard yelling from the room, as V9 was making her way there to separate the residents the activity aide (V14) stated R8 and R9 had been kicking each other. V15's (Licensed Practical Nurse) statement dated 12/8/25 documents R8 engaged in an altercation with R9 in their room. On 12/30/2025 at 11:02 AM R8 was unavailable for interview due to being transferred from the dialysis clinic to the acute care hospital for further care. On 12/30/2025 at 11:37 AM R9 stated he had a physical altercation with his old roommate, R8. R9 stated R8 hit him so R9 hit him back.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide showers for three (R1, R3 and R6) of five dependent residents reviewed for activities of daily living out of a sample list of eleven. Findings Include: R1's current Medical Record documents R1's admission to the facility on [DATE] with the following diagnoses: Acute Osteomyelitis Right Ankle and Foot, Weakness, Chronic Atrial Fibrillation, and Chronic Kidney Disease Stage Four. R1's Care Plan includes a focus regarding ADL deficits initiated 04/11/2025. R1's Minimum Data Set (MDS) dated [DATE] documents R1 is cognitively intact. On 12/30/2025 at 9:42 AM R1 stated he received a bed bath last night with water staff retrieved from another area of the facility. R1 stated he had not received a shower or bed bath for approximately two weeks prior to last night's bed bath. R1 described his bed bath water as lukewarm. R1 stated the hot water has not been working for a couple of months and that the lack of hot water is the entire uptown hall. R1 stated the other half of the facility called Downtown has hot water for use. R3's current Medical Record review documents R3's admission to the facility on [DATE] with the following diagnoses: Chronic Obstructive Pulmonary Disease with Acute Exacerbation, Acute and Chronic Respiratory Failure with Hypoxia, and Type Two Diabetes Mellitus with Diabetic Neuropathy. R3's Care Plan includes a Care Plan focus regarding R3 having an ADL self-care performance deficit related to Fatigue, Impaired balance and Limited Mobility that was initiated 02/21/2024. R3's MDS dated [DATE] documents R3 is moderately cognitively impaired. On 12/30/2025 at 9:52 AM R3 stated she does not get two showers a week every week. R3 stated she gets showers that are warm to touch. R6's Current Medical Record review documents R6's admission to the facility on [DATE] with the following diagnoses: Fracture of Upper and Lower End of Left Fibula, Repeated Falls, and Disorders of Muscle. R6's Care Plan dated 12/18/25 documents a Care Plan focus regarding ADL self-care performance deficit related to upper and lower left fibula fracture initiated 12/18/2025. On 12/30/2025 at 10:13 AM R6, with the use of a dry erase board and marker, wrote the facility has been experiencing lack of hot water, on her hall, for over a month. R6 communicated she is taken to another part of the facility to shower where there is hot water available for use. R6 communicated she doesn't feel that she gets enough showers at this facility. On 1/2/2026 at 1:30 PM V16, Corporate Nurse, stated residents are to be receiving two showers weekly and not all residents are getting the showers as required. V16 stated V16 was unable to provide correct documentation of dates the residents' received showers. The Activities of Daily Living (ADLs) policy dated 2/10/2025 documents: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care. 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal hygiene and oral hygiene.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medical records were complete and accurate for four of four residents (R1, R2, R6, R9) reviewed for documentation in the sample list of eleven. Findings Include: On 12/30/25 R2's Medical Record review of Hospital Notes documents R2 admitted to the facility on [DATE] (unknown time) from a local hospital with Diagnoses of Weakness, right sided hemiparesis, Cognitive Decline, B12 Deficiency, Back Pain, Right Lower Extremity Pain, Microscopic Hematuria, Diabetes Mellitus, Hypertension, Hyperlipidemia, Cerebral Vascular Accident, and Multiple Sclerosis. The facility medical record does not contain an admission assessment or admission note with a time of arrival from a licensed nurse from time of arrival until discharge later on 11/24/25. On 12/30/25 at 10:20am V4, R2's Family, stated that R2 was not seen or assessed by a nurse while being in the facility for five hours and wanted to leave. V4 stated V4 arranged for a transport to another local nursing facility and informed staff that a transport was on the way to pick up R2. V4 stated a transport company arrived at 09:22pm and a nurse still had not assessed R2. R2 left with the transport company to another facility after being in the facility for five hours. On 1/2/26 at 12:45pm V16, Corporate Nurse consultant, stated nurses should have assessed R2 for needs as soon as reasonably possible. V16 confirmed there is no nursing note or assessment in R2's medical record. On 1/2/26 at 1:05pm V19, Director of Nursing, confirmed a nurse should have assessed R2 upon arrival to the facility and V19 also confirmed the medical record does not contain an assessment or admission note indicating R2 was not seen by a licensed nurse during the five-hour period that R2 was in the building. 2. The Activities of Daily Living (ADLs) Policy Dated 12/05/22 documents: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care. 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. R1's Current Medical Record review documents R1's admission to the facility on [DATE] with the following diagnoses: Acute Osteomyelitis Right Ankle and Foot, Weakness, Chronic Atrial Fibrillation, and Chronic Kidney Disease, Stage Four. R1's Current Care Plan documents a Care Plan focus regarding activities of daily living deficits initiated 04/11/2025. On 12/30/2025 at 9:42 AM R1 stated he had not received a shower or bed bath for approximately two weeks prior to last night's bed bath. R6's Current Medical Record review documents R6's admission to the facility on [DATE] with the following diagnoses: Fracture of Upper and Lower End of Left Fibula, Repeated Falls, and Disorders of Muscle. R6's current Care Plan documents a care plan focus regarding activities of daily living self-care performance deficit related to upper and lower left fibula fracture initiated 12/18/2025. On 12/30/2025 at 10:13 AM R6, with the use of a dry erase board and marker, communicated she doesn't feel that she gets enough showers at this facility. On 12/30/2025 R9's (DOB 6/21/63) Care Plan dated 10/20/25 documents R9's admission to the facility on 1/30/2025 with the following diagnoses: Retention of Urine, Primary Generalized Osteoarthritis, Mild Intermittent Asthma, Recurrent Left-Shoulder Dislocation, Disorders of Bone Density/Structure. On 12/30/2025 at 11:37 AM R9 stated R9 gets very few showers. On 12/31/25 V21, Regional Nurse, provided shower sheets for R1, R6 and R9. On 12/31/25 surveyors reviewed the provided shower sheets and determined them to be inaccurate/altered. Dates and signatures on the shower sheets did not match the same dated floor staff assignment sheets provided. On 1/2/25 at 1:30pm V16, Corporate Nurse, confirmed the shower sheets were marked with white correction tape. V16 confirmed the signatures on the shower sheets provided were inconsistent with the same dated assignment sheets. V16, confirmed the shower sheets provided were inaccurate. 1. The Documentation in Medical Record policy dated 09/01/25 documents: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Policy Explanation and Compliance Guidelines: 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred.</p>		