

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 02/18/2026
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>Based on interview and record review the facility failed to replace misappropriated goods in a reasonable time frame for one (R6) of three residents reviewed for abuse/misappropriation. R6 had to replace (iPhone) with R6's own personal money and the facility failed to report this to the state agency. Findings Include: On 1/5/2026 at 2:40PM, R6 reported that R6 was looking for R6's cellular device and couldn't find it. After looking through R6's room and in the dining room for the phone. V9 Registered Nurse stated at approximately 3:00PM on 1/5/2026, V9 notified R6's Power of Attorney and the facility Management of the missing phone. On 1/5/2026 at 7:34PM, V11 Normal Police Officer documented V11 took a report over the phone for a theft that occurred at this facility. V11 called and spoke with V10 (R6's) Power of Attorney. V10 stated V10 told V11 that R6 was staying at this facility and received a call from the facility that R6's cellular device with a black case, was missing. V10 gave V11 the Life 360 location for the phone, and it showed the phone was in the road 200 block of a local road. It showed this location at approximately 2:13PM on 1/5/2026. V11 documented the location and had not been updated for approximately five hours. V11 went out to this location and searched for the phone but could not locate it. On 2/10/2026 at 1:35PM, V10 (R6's) Power of Attorney stated V10 received a phone call from the facility reporting that R6 was missing R6's cellular device. V10 stated she contacted the police department and talked with V1 Administrator and stated the facility stated they have no responsibility related to the missing phone. V10 stated V10 contacted the Normal Police Department on 1/5/2025 around 7:30PM. V10 stated V10 bought and took R6 a new phone. On 2/10/2026 at 2:15PM, V1 stated V1 never reported the missing phone to the state agency and the facility. V1 also stated that the facility is not liable for misappropriation of goods when residents are in the facility, especially if the residents are cognitively intact. V1 stated the facility did not replace R6's cellular phone. The Facilities Abuse Prevention Policy Dated 1/24 documents that the facility affirms the right of the resident to be free from misappropriation of property, deprivation of goods and services by staff or mistreatment. This policy also documents that the facility would keep the resident informed of the conclusions of the investigations.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 145031	If continuation sheet Page 1 of 6

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on Interview and record review the facility failed to report to state agency an allegation of misappropriated goods in a reasonable time frame for one (R6) of three residents reviewed for abuse/misappropriation of goods in a sample of three residents. Findings Include: On 1/5/2026 at 2:40PM, R6 reported to V9 Registered Nurse that R6 was looking for R6's cellular device and was unable to locate it after searching through R6's room and in the dining room/common area for the phone. V9 stated at approximately 3:00PM on 1/5/2026, R6's Power of Attorney and the facility Management was informed of R6's missing phone. On 1/5/2026 at 7:34PM, V11 local Police Officer documented V11 took a report over the phone for a theft that occurred at this facility. V11 called and spoke with V10 (R6's) Power of Attorney. V10 stated V10 told V11 that R6 was staying at the facility and received a call from the facility that R6's cellular device with a black case, was missing. V10 gave V11 the Life 360 location for the phone, and it showed the phone was in the road of the 200 block of a local road. It showed this location at approximately 2:13PM on 1/5/2026. V11 documented the location had not been updated for approximately five hours. V11 went out to this location and searched for the phone but could not locate it. On 2/10/2026 at 1:35PM, V10 (R6's) Power of Attorney stated V10 received a phone call from the facility regarding R6's missing iPhone. V10 stated V10 contacted the police department and talked with V1 Administrator and V1 stated the facility has no responsibility related to the missing phone. V10 stated V10 contacted the local Police Department on 1/5/2025 around 7:30PM. V10 stated V10 bought and took R6 a new phone with personal funds and was not reimbursed by the facility. On 2/10/2026 at 2:15PM, V1 Administrator stated V1 never reported R6's missing phone to the state agency. V1 also stated the facility is not liable for misappropriation of goods when residents are in the facility especially if the residents are cognitively intact. V1 stated the facility did not replace R6's phone. The Facilities Abuse Prevention Policy Dated 1/24 documents that the facility affirms the right of the resident to be free from misappropriation of property, deprivation of goods and services by staff or mistreatment. This policy also documents that the facility would investigate, report to the state agency and keep the residents informed of the conclusions of the investigations.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on Interview and record review the facility failed to complete a thorough investigation of misappropriated goods in a reasonable time frame and failed to replace the misappropriated goods for one (R6) resident of three residents reviewed for abuse/misappropriation of goods in a sample of three residents. Findings Include: On 1/5/2026 at 2:40PM, R6 reported to V9 Registered Nurse that R6 was looking for R6's cellular device and couldn't find it after looking through R6's room and in the dining room. V9 Registered Nurse stated at approximately 3:00PM on 1/5/2026, R6's Power of Attorney and the facility management was informed of the missing phone. On 1/5/2026 at 7:34PM, V11 Local Police Officer documented V11 took a report over the phone for a theft that occurred at this facility. V11 called and spoke with V10 (R6's) Power of Attorney. V10 stated V10 told V11 that R6 was staying at the facility and V10 received a call from the facility that R6's cellular device with a black case, was missing. V10 gave V11 the Life 360 location for the phone, and it showed the phone in the road of the 200 block of a local road. It showed this location at approximately 2:13PM on 1/5/2026. V11 documented the location had not been updated for approximately five hours. V11 went out to this location and searched for the phone but could not locate R6's phone. On 2/10/2026 at 1:35PM, V10 (R6's) Power of Attorney stated V10 received a phone call from the facility regarding R6's missing cellular device. V10 stated V10 contacted the police department and talked with V1 Administrator. V1 stated the facility has no responsibility related to the missing phone. V10 stated V10 contacted the local Police Department on 1/5/2025 around 7:30PM. V10 stated V10 bought a new cellular device using personal funds and was never reimbursed by the facility. On 2/10/2026 at 2:15PM, V1 stated V1 never reported the missing cellular phone to the state agency. V1 also stated the facility is not liable for misappropriation of goods when residents are in the facility especially if the residents are cognitively intact. V1 stated the facility did not replace the phone nor did they identify who took the cellular device. The cellular device could have possibly been taken by staff, agency staff or visitors. V1 stated V1 didn't believe V1's staff would take the phone because V1 knows her staff. The Facilities Abuse Prevention Policy Dated 1/24 documents that the facility affirms the right of the resident to be free from misappropriation of property, deprivation of goods and services by staff or mistreatment. This policy also documents that the facility would investigate, report to the state agency, and keep the resident informed of the conclusions of the investigations.</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, Interview, and Record Review the facility failed to prevent esophageal obstruction during medication administration by administering multiple medications at a time for one (R2) resident of three residents reviewed for medication administration on the sample list of three residents. This failure resulted in R2's esophagus becoming obstructed, with an inability to breathe, the Heimlich maneuver was performed, and R2 was transferred to the local emergency room for further evaluation. Findings Include:Nursing Progress note dated 1/17/2026 at 8:00 PM documents at approximately 7:45 PM V13 Registered Nurse (RN) was called to room by a Certified Nursing Assistant (CNA) who reported the resident (R2) was not able to breathe. Writer entered room and observed the resident's lips being cyanotic; (R2's) Oxygen level was observed at 64% and the writer asked the resident (R2) if she could breathe and the resident (R2) shook her head side to side indicating no. Writer assessed airway and could not see anything obstructing the airway, the resident (R2) put hands to her throat indicating she was choking. Writer sent CNA to go get another nurse and the crash cart. Writer began performing the Heimlich maneuver on resident (R2), resident then went unresponsive. Writer continued the Heimlich maneuver an additional three times and observed resident (R2) throw up what appeared to be applesauce and undigested food. Resident (R2) was unconscious less than one minute and was able to start answering questions approximately two minutes after regaining consciousness. 911 was activated upon second RN entering the room. Resident (R2) gagged and appeared to swallow and forcibly coughed with a gurgle sound, writer leaned resident onto right side and resident threw up a second time. Writer applied high flow nasal cannula and observed residents' oxygen saturation increase to 96%. Resident (R2) was able to answer questions via her communication board. Resident wrote on her board that I (R2) laid my bed down too fast after having a snack. Resident immediately educated to keep head of bed elevated at minimum 45 degrees and to tuck her chin when she is experiencing difficulty swallowing. Resident (R2) shook her head up and down indicating understanding. Resident wrote she feels better but still feels like Something is in her lungs. EMS/emergency medical service arrived and was given report, copy of face sheet, SBAR (Situation-Background-Assessment-Recommendation), bed hold policy and POLST (Practitioner Order Form Life-Sustaining Treatment) form. Voicemail left for contact on residents (R2's) profile via the other nurse. Writer called and spoke with ER charge at the local hospital and gave an additional verbal report. Writer also called the on-call provider for the facility and notified her of this occurrence. Resident agreeable to going to the hospital for further evaluation. Resident left with EMS on room air at 95% and shaking her head and using her tablet to answer questions for EMS. Resident transferred out at approximately 8:10 PM. Physician answering service notified resident was sent out with voicemail to call the facility back with any further questions.R2's Emergency Department Notes dated 1/17/2026 at 9:31 PM document R2 was seen for choking episode/aspiration.R2's Minimum Data Set assessment dated [DATE] documents R1 is cognitively intact. The GG assessment reports R2 is dependent with transferring, turning, and repositioning. R2 is also set up/supervision with eating. Physician Orders Dated 12/21/2025 documents Speech therapy Clarification: Swallowing evaluation completed on R2. Patient with mild lingual weakness but able to score a seven on the Functional Oral Intake Scale indicating regular texture with thin liquids, however, four minutes status post swallow patient noted to cough stating it was due to texture with thin liquids, however, four minutes status post swallow R2 was noted to cough when R2 consumed anything by mouth, stating it was due to dryness but maybe reflux response based on latency of cough. Speech therapy recommended two times a week for four weeks to address safe swallowing strategies and muscle strengthening.Speech Evaluation Therapy</p> <p>(continued on next page)</p>		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	<p>Notes dated 1/15/26 documents that R2 was seen for a swallowing evaluation due to concerns R2 could not swallow multiple pills over the weekend when presented by the agency nurse. R2's able to safely swallow one pill at a time with applesauce. This document also states R2 is concerned about swallowing pills on the weekend when agency staff is present. On 2/10/26 at 8:07AM, R2 wrote on R2's white communication board that V13 Registered Nurse was giving R2 multiple medications, and R2 takes one medication pill at a time with applesauce. R2 stated R2 tried to raise R2's hand at V13 instructing one pill at a time. R2 stated R2 was scared and frightened as V13 left the room due to R2 still swallowing the medication. V14 Certified Nursing Assistant came in to change R2 due to R2 is incontinent of urine. R2 continued that R2 was still trying to swallow the pills (medications) administered by V13 when V14 laid the head of the bed down from an elevated position to a flat position to change R2 and R2 then began choking. R2 stated V13 came back into R2's room where V13 completed the Heimlich maneuver and R2 stated R2 went to the Emergency Room. On 2/10/26 at 2:45PM, V6 Director of Rehab stated R2 prefers one medication pill at a time due to swallowing complications. R2 has been on Speech Therapy since 7/2025 due to R2's swallowing difficulties. V6 stated speech therapy recommendations were recommended to the physician. On 2/11/26 at 3:15PM, V14 Certified Nursing Assistant stated V14 was completing rounds and V13 Registered Nurse had just come out of R2's room. V14 went into R2's room to change R2 due to urine incontinence and noticed R2 started to cough and drool. V14 stated V14 went to lay R2 down to change R2 and R2 started gasping, coughing, and drooling. V14 stated V13 was still outside the room and V14 went and got V13. V13 instructed V14 to go get the crash cart and another nurse. Facility Resident Rights Policy revised on 2/2/26 documents the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside of the facility. The Policy also documents the resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights. This policy also documents that the resident has the right to be informed of, and participate in, his or her treatment, including: the right to participate in the development and implementation of his or her person-centered plan of care. Facility Medication Administration Policy Revised on 2/2/2026 documents The qualified employee who is giving medication must Position resident to accommodate administration of medication and observe resident consumption of medication.</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interview and Record Review the facility failed to answer a call light in a timely manner that resulted in a fall with injury for one (R1) resident of three residents reviewed for falls in a sample list of three residents. This failure resulted in R1 rolling from the bed, complaining of pain, requiring transfer to the local emergency room and diagnosed with multiple left and right rib fractures. Findings Include:R1's Progress Note written by V7 Licensed Practical Nurse dated 1/6/26 at 6:15 PM, documents R1 was observed lying face down between R1's bed and the wall. R1's roommate was yelling for help when the Certified Nurse Assistant entered the room and observed resident on the floor. It appeared R1 was reaching for something and rolled out of the bed. The bed was regular height. R1 was turned over carefully and R1's head was placed on a pillow. R1 didn't answer when asked what she was doing. 911 was called as R1 did say she was in pain all over. R1 was transported to a local emergency room Department at 6:40PM on 1/6/26.R1's Emergency Department Notes dated 1/6/26 at 10:58PM document R1 has a nondisplaced right lateral fifth through ninth rib fracture and nondisplaced acute fractures of the anterior left sixth, seventh, eighth and tenth ribs.R1's Minimum Data Set assessment dated [DATE] documents R1 is cognitively intact.R1's Care Plan documents a fall intervention to ensure bedside table is next to R1's bed, where R1 can reach R1's items dated 12/8/25 and to keep call light within reach at all times dated 5/12/2025.On 2/09/26 at 10:38AM, R1 and V12 (R1's Family) stated R1 was transferred to another facility due to this incident. V12 stated R1 put on R1's call light to get someone to help R1 get popcorn off the floor that R1 wanted to eat. R1 stated R1's call light was on for approximately 40 minutes. R1 went to reach for the popcorn and rolled out of bed onto the floor. R1 stated R1's roommate started yelling for help. On 2/09/26 at 11:45 AM, V6 Director of Rehab stated at times the call lights go off for over 30 minutes as there are only two Certified Nursing Assistants on second and third shift at times.On 2/09/26 at 12:15PM, V7 Licensed Practical Nurse, stated there were two Certified Nursing Assistants on the floor and a trainee. V7 stated that R1 was reaching for something on the floor when R1 rolled out of bed. V7 stated, the facility staff try to answer call lights in a reasonable time, but at times facility staff are with other residents or in the dining room. V7 stated that R1 had a pressure relieving mattress for R1's wound and when R1 went to reach for something, R1 most likely slid off the bed.On 2/09/26 at 1:30PM, V4 Registered Nurse stated that at times the staff can't get to the resident soon enough after the call light is activated. V4 stated R1 was also a mechanical lift and had a pressure relieving mattress.On 2/10/26 at 9:30AM, V8 Certified Nursing Assistant stated that there were two certified nursing assistants for 27 residents due to a Certified Nursing Assistant was going with another resident to a doctor's appointment. V8 stated especially at nighttime and during dinner time and bedtime, the call lights can go off for over 20 to 40 minutes. On 2/10/26 at 10:00AM, V2 Director of Nursing stated the facility staff should be answering call lights in a reasonable time frame which would be less than 10 minutes. Facility Call light Policy revised on 1/26/2026 documents the facility will be equipped with a call light at each resident's 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. This policy also documents response times should be a priority.The Facility Incident and Accidents policy revised on 2/2/2026 documents that assuring that appropriate and immediate interventions are implemented, and corrective actions are taken to prevent recurrences and improve the management of resident care.</p>		