STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145031	A. Building B. Wing	05/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab & Nursing of Normal	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.

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to obtain admission orders from the hospital upon admission, failed to complete a timely admission assessment and wound assessment, failed to timely administer medications for the treatment of a leg infection, diabetes, hypertension and other comorbidities and failed to provide mobility devices. The facility also failed to implement physical and occupational therapy evaluations upon admission which resulted in R1 having to stay in bed and use a bedpan for toileting needs. These failures affected one (R1) of three residents reviewed for admissions in the sample list of nine. These failures resulted in R1 sustaining ongoing, significant emotional distress, tearfulness and fear of a delayed recovery. Findings include: R1's Minimum Data Set (MDS) dated [DATE] documents R1's Brief Interview of Mental Status (BIMS) score of 15 out of a possible 15, indicating no cognitive impaired. R1's same MDS documents R1 has a0 lower extremity impairment in range of motion on one side. On 5/16/26 at 11:00 am, R1 was seated bedside, in a wheelchair with the right leg rest elevated. The leg rest had a pillow under R1's right leg for additional support. R1's right leg was wrapped in a compression bandage from R1's right knee down to R1's toes. R1's stated (R1) was admitted a week ago Friday (5/08/26). R1 stated (R1) had an agency nurse when (R1) was admitted (later identified as V10, Agency Licensed Practical Nurse). R1 stated (R1) did not remember (V10's) name. R1 stated (V10) did not do any kind of assessment of (R1). (V10) told (R1) that (V10) did not have the discharge orders from the (local) hospital, so (V10) could not do anything for (R1) and (R1) had to stay in bed. R1 stated (V10) told R1 nothing could be done until (V10) gets the paperwork from them (the local hospital). R1 stated that (R1's) biggest concern (R1 became tearful) was going without my antibiotic. R1 stated (R1) has cellulitis in (R1's) leg. R1 stated that it was a serious infection. R1 stated that (R1) is diabetic, and infections can get much worse if (R1) misses the antibiotic. R1 stated that (R1) has neuropathy in both legs and cannot feel pain so (R1) would not be able to tell the nurses if the infection was getting worse. R1 stated (R1) knows that pain is a clear sign of an infection worsening. R1 stated (R1) did not receive (R1's) insulin either. R1 stated (R1) did not know if there was any impact from not receiving the insulin. R1 stated (V10) did not check (R1's) blood sugar that night. R1 stated (R1) was so scared (R1) could barely sleep. R1 stated (V10) said (V10) could not check (R1's) blood glucose because (V10) had no orders from the hospital. R1 stated I worried terribly (R1 paused and became more tearful) about my cellulitis infection, my blood pressure and my blood sugar. R1 stated the hospital had already told me they could not do surgery on my broken (later in hospital records identified as torn) Achilles until the infection was gone. R1 stated (R1) worried all night long. R1 stated this was a terrible experience. R1 stated (R1's) blood pressure medications were not given and (R1's) blood pressure had been elevated since (R1) was admitted . R1 stated (R1) is getting the medications now, but my blood pressure is still elevated. R1 stated (R1) saw someone yesterday that came in to talk about my diet choices. R1 stated I don't like the food here and I don't choose my own meal. R1 stated what is served is what I get. R1 stated (R1) would not eat noodles and potatoes all the time because (R1) is diabetic and manages (R1's) diet at home. R1 stated (R1) has never asked for an alternative menu. R1 stated (R1's) friend could provide more information and R1 provided R1's friend's name (V8, R1's friend) and (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

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	phone number. R1 stated the CNA (V9, Certified Nursing Assistant) came in to see how I was doing several times but (V10) did nothing except tell me I could not get out of bed, and I could not get my medication. R1 stated (V9) apologized repeatedly and said that (V10) told (V9) that (V10) couldn't do anything for (R1).R1 also stated I had already missed my meds (medications) several times when (V2, Director of Nursing/DON) came in. R1 stated V2's name and that V2 completed R1's registration. R1 stated that a floor nurse (unidentified) took over and helped. R1 stated (V2) was the one that got the paperwork from the hospital so I could get all my medications. R1 stated (R1) was supposedly going to get therapy that day. R1 stated (R1) was very active before falling a couple weeks ago. R1 stated (R1) did a ten-mile hike not long before the fall. R1 stated (R1) received therapy in the hospital and walked with a walker there. R1 stated (R1) was supposed to be getting up with a walker and could use a wheelchair. (R1) began to cry. R1 stated they did not have a wheelchair or walker for me to use here. R1 stated (R1) just had to lay in bed and use a bed pan and a brief (incontinent brief), until (R1) could be assessed by therapy. R1 stated (R1) received some medication that Saturday afternoon and received the antibiotic later that evening. R1 stated (R1) was worried sick and is still scared. R1 stated (R1) is waiting for the other shoe to drop. R1 stated the facility caused me so much anguish and it is hard to focus on getting healthy enough to go home.R1 also stated they had a care plan meeting on Monday (5/11/26). R1 stated (R1) went over everything and it was overwhelming to relive those first few days I was here. (V2, DON) got me a bed control for my bed because I did not have one when I came in. R1 stated (R1) was so worried about (R1's) situation and then (R1's) bed was a problem too. R1 stated (R1) had to stay in bed with no way to adjust the bed. (V10) said (V10) had to put in a work order in to get a bed control and (R1) would have to wait until Monday when the maintenance person came into work. R1 stated (R1) was restless, until a CNA (unidentified) was able to adjust something at the foot of (R1's) bed overnight. R1 stated no one should have to go through this, the feelings of despair I am still fighting off. (R1 became more tearful). R1's hospital admission to discharge paperwork dated 5/1/2026 - 5/8/2026 (7 days), documents the principal problem was Cellulitis and abscess of right legR1's Discharge Summary documents R1 has a history of Type 2 Diabetes Mellitus, Diabetic Neuropathy, Hypertension, Hyperlipidemia, and Hypothyroidism and was admitted for evaluation and management of acute kidney injury and persistent right lower extremity cellulitis and swelling refractory to outpatient oral antibiotics. Cellulitis and Abscess of Right Leg. R1 presented with ongoing swelling, erythema and pain of the right lower extremity following a fall in early April. R1 had some improvement from multiple courses of oral antibiotics (Bactrim and Cephalexin). On admission R1 had extensive cellulitis with edema and imaging revealed diffuse subcutaneous edema and a partial or full-thickness tear of the distal Achilles tendon. Doppler was negative for DVT (Deep Vein Thrombosis).R1's MRI (Magnetic Resonance Imaging) confirmed a high-grade (severe-partial) Achilles tendon tear.Initially managed with broad-spectrum antibiotics with IV (Intravenous) cefepime (Broad spectrum antibiotic) ID (infectious disease department) consulted. Cefepime transition to IV Rocephin (broad-spectrum antibiotic) followed by p.o. (by mouth) Zyvox (Linezolid, antibiotic) for cellulitis and with concern of underlying myositis (chronic inflammation of the muscle) to complete (medication) by 5/15/2026. CRP (C-reactive Protein that gets into the blood stream, as a response to inflammation) improved. ABI (ankle-brachial index - comparative blood pressure ankle and arm) normal. Complete rupture of right Achilles tendon-podiatry consulted, plan to treat nonoperatively. Splinted in maximal plantarflexion non weight bearing right foot. Evaluated by PT OT (Physical and Occupational Therapy) and patient will be discharged to rehab (the long-term care facility) and follow-up with podiatry. Acute Kidney Injury -possible prerenal and with antibiotics. Managed with IV fluids and resolved. Resume home meds on discharge for chronic comorbid conditions and follow-up with PCP (Primary Care Physician) for long-term management. Consults: Orthopedic surgery infectious disease.This same hospital Discharge Summary note documents: (R1) pleasant alert walking with therapy with a walker. Breathing comfortably on room air.Medication List: Start taking these medications:Linezolid 600 MG Tabs Commonly known as: ZYVOX, take 1 Tablet by (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	mouth every 12 hours for 15 doses. Indications: Infection of the Skin and/or Soft Tissue.Change how you take these medications:Lantus Solostar (insulin) 100 UNIT/ML (units per milliliter) Generic drug: insulin glargine Inject 26 units under the skin every evening. Hold if blood glucose is lower than 140 at night. What changed: additional instructions.Continue taking these medications:Alendronate 10 MG (Milligram)Tabs Commonly known as: FOSAMAX Take 1 Tablet by mouth every morning (before breakfast).Aspirin 81 MG Tabs, Take 1 Tab by mouth daily.Calcium carbonate-vitamin D, 600-400 MG-UNIT Tabs Commonly known as: Calcium 600 + D Take 1 Tablet by mouth 2 times daily.Freestyle Lite Strip Generic drug: glucose blood. Test blood Glucose Four time daily (before meals and at bedtime) Insulin dependent (Diabetic Type II).Levothyroxine 100 MCG (Micrograms) Tabs Commonly known as: SYNTHROID Take 1 Tablet by mouth daily.Lisinopril (Ace inhibitor to treat high blood pressure) 20 MG Tabs, Commonly known as: PRINIVIL, ZESTRIL Take 2 Tablets by mouth daily.Magnesium Oxide 400 MG Caps Take 1 Capsule by mouth daily.Metformin (oral medication to lower blood glucose) 1000 MG Tabs Commonly known as: GLUCOPHAGE TAKE 1 TABLET BY MOUTH TWICE DAILYSimvastatin 20 MG Tabs, commonly known as: ZOCOR, Take 1 Tablet by mouth nightly.R1's same Hospital discharge notes documents: Care Timeline: admitted to ED 05/01/26 at 5:39 pm. discharged [DATE] at 4:35 pm. discharged /Transferred to SNF (Skilled Nursing Facility).R1's local hospital After Visit Summary dated 5/8/26 documents when the medications were scheduled to be given and some, but not all of the medication orders document the last time the medication was administered at the hospital.R1's Alendronate 10 MG (Milligram) Tabs does not document when R1 was administered the last dose at the hospital. This only documents when the medication is scheduled to be given, in the morning. Aspirin 81 MG Tabs, take 1 Tab does not document when R1 was administered the last dose at the hospital. Ask your nurse or doctor and is scheduled to be given in the morning. Calcium carbonate-vitamin D, 600-400 MG-UNIT Tabs does not document when R1 was administered the last dose at the hospital. This only document when the medication is scheduled to be given in the morning and at bedtime. Test Blood Glucose Four Times Daily (BEFORE MEALS AND AT BEDTIME). This does not document when R1 received R1's last Glucose test at the hospital. Lantus Solostar 100 UNIT/ML 26 units does not document the last time R1 was given this medication at the hospital. Ask your nurse or doctor. Levothyroxine 100 MCG Tabs last time given in the hospital 5/8/26 at 6:17 am, in the hospital. Linezolid 600 MG Tabs, given last time 5/8/26 at 12:05 pm in the hospital. Lisinopril 20 MG Tabs, last time given 5/8/26 at 9:31 am in the hospital. Magnesium Oxide 400 MG Caps Take 1 Capsule by mouth daily and does not document the last time R1 was administered at the hospital. Metformin 1000 MG Tabs TAKE 1 TABLET BY MOUTH TWICE DAILY and does not document the last time R1 was administered at the hospital. Simvastatin 20 MG Tabs Take 1 Tablet by mouth nightly and does not document the last time R1 was administered at the hospital.R1's medical record does not document R1 was admitted to the facility 5/8/26. The same medical record does not document that a physician was notified and there were no admission orders from the hospital to provide care for R1.There is no documentation in R1's facility medical record to indicate any of the above medications were discussed with the hospital to determine when the last doses were given. There is no documentation in R1 medical record that documents any of the medications were administered on 5/08/26.R1's Medication Administration Record (MAR) dated 5/01/26 - 5/31/26 does not document that any of R1's medications were administered on 5/8/26, or on 5/09/26 until 4:36 pm. The same MAR dated 5/01/26 - 5/31/26 does not document blood glucose measurements were completed until 5/10/26 at 7:00 am.R1's Medication Administration audit report documents R1 medication administration was delayed until 5/9/26 at 4:36 pm. R1's same MAR documents a new physician order that was supposed to be administered beginning 5/10/26. R1's new physician order documents: Alendronate Sodium 70 MG Tablet, give 1 tablet by mouth in the morning every Sunday related to Type II Diabetes Mellitus Without Complications, sit up for 30 minutes after taking medication -Start Date- 05/10/2026 at 0500 am. R1's Alendronate Sodium 70 MG Tablet was not administered until the following Sunday 5/17/26.On (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	5/17/26 at 1:00 pm R1's Census record was reviewed with V30, Business Office Manager (BOM). R1's Census record documents R1's admission as Saturday 5/09/26. V30 confirmed R1's Census record was not accurate. R1's admission date was 5/08/26. V30 stated (V29, admission Coordinator) called me Saturday morning and ask me if (R1) was admitted (to the facility). That was about 9:00 am. (R1) was expected Friday (5/8/26). I had to tell (V29) I did not know. I went to the facility and laid eyes on (R1). (R1) had been admitted . (R1) told me about the whole situation. I could see (R1) was really upset. (R1) was very nice about it but very concerned about (R1's) leg infection and medications. I found out the DON (V2,) was coming in. I apologized for all the issues that occurred. I documented the wrong date on (R1's) Census. It should have been recorded as 5/08/26. The first documentation is recorded below. R1's Health Status Note below is not documented as a late entry.R1's Health Status Note dated 5/9/2026 at 1:06 pm documents Note Text: Resident (R1) admitted to facility from (Local) hospital via ambulance to room (R1's room number). Resident medications had a delay in arrival due to pharmacy miscommunication (5/8/26, V10, Agency Nurse had no hospital paperwork according to interviews documented). Residents were given all AM medications this morning (not documented as administered until 4:36 pm). Residents have family at bedside. Explained all medications ordered and antibiotics are being stat delivered today. Resident alert and oriented x3 (person, place and situation, no cognitive impairment). Oriented to call light and room (R1 had been in the facility since hospital note above documents transfer 5/8/26 at 4:35 pm). Pleasant and cooperative. Here for treatment for RLE (Right Lower Extremity) Cellulitis. (R1) is non weight bearing. The right lower leg and will be evaluated by PT (Physical Therapy) today (5/9/26).R1's Health Status Note dated 5/9/2026 at 1:16 pm documents: Note Text: Spoke with (V16), Physician and notified (V16, Physician) of admission and delay in medication arrival.R1's Physical Therapy assessment dated [DATE] at 4:37 pm documents R1 is totally dependent on staff for transfer from bed to chair. (Health Status Note dated 5/9/2026 at 1:06 pm, documented above, R1 was to have been evaluated by Physical Therapy on 5/9/26).On 5/17/26 at 11:20 am V23, Director of Rehab (DOR) stated V23 was present in R1's care plan meeting. V23 said, (V23) was aware (V24, Physical Therapist (PT)) was not in the building on Saturday May 9, 2026, when (R1) was supposed to be evaluated for occupational and physical therapy. (V24) had a sick child that day. My (V23) understanding is that (R1) was evaluated on Sunday May 10, 2026. V23 also stated the transfer status R1 came from the hospital as, should have been followed, if safe. V23 stated, Therapy wants all residents out of bed as soon as possible, if safe to do so, following hospital directives. V23, also stated (R1) should have had a wheelchair and walker provided. Staff have access to the ancillary room which has the equipment available. The manager on duty, also has a key to access additional equipment in an outside building. V23 also stated (R1) should have been out of bed. Staff could have used a full mechanical lift if they were unsure of the transfer status. R1's Progress Notes *NEW* Adv- Skin Check dated 5/11/26 at 12:19 pm (three days after admission 5/8/26), signed by V11, Wound Registered Nurse/Assistant Director of Nursing, documents the following: Skin: Skin is pale in color. Skin warm / dry to touch. Normal skin turgor. Foot evaluation completed. Skin Issue: Skin issue has not been evaluated. Location: Front right lateral lower leg ([NAME]) (sic). Issue type: Other skin issue. Other skin issue description: Cellulitis Wound was present on admission. It is unknown how long the wound has been present. Undermining: No. Tunneling: No. Skin Issues Note: Generalized bruising to either arm, from hospital blood thinners and insulin shots on the abdomen; small areas of redness on the shin where the splint was present (all blanchable erythema) Skin issue education: Moisture barrier. Skin issue education: Signs and symptoms of infection. Skin issue education: Care of skin issue(s).On 5/16/26 at 1:35 pm (V11) stated I came in and assessed (R1's) Cellulitic leg on day two, Monday (5/11/26) (three days after R1's actual admission 5/8/26). (R1) had a few small areas of redness from (R1's) brace (splint) on (R1's) right lower leg. (R1) had a splint on, and had padding on those areas. (R1) had scant amount of swelling compared to (R1's) other leg. Those small spots blanched and therefore were not pressure areas. There was no heat, no open areas and (R1) stated (R1) did not feel pain because (R1) had a (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	diagnosis of Diabetic Neuropathies. (R1's) Achillies showed no indication of infection either. I did not measure the slight swelling (R1) had in (R1's) lower leg. There were no markings on (R1's) lower leg to determine the diameter of (R1's) calf or the extent of cellulitis while (R1) was in the hospital. I did not see much swelling when I assessed it. I should have measured the area so we could monitor (R1's) progress while (R1) is in the facility. I did not do that.R1's same MDS dated [DATE] documents R1's Mood assessment as follows: Total Severity Score of 11 out of a possible 27, indicated R1 had moderate depression.R1's Admitting Diagnoses list dated 5/8/26 does not document R1 as having a diagnosis of Depression or any psychiatric diagnoses/disorder.On 5/17/26 at 8:48 am V8, R1's Friend stated I was with (R1) the afternoon (R1) was admitted . We left the hospital at 4:30 pm. The hospital handed (R1's) discharge paperwork to the ambulance staff. I know they (Emergency Medical Technician) provided those too that nurse. The whole admission process was a horrible experience for (R1). I have never seen (R1) so distraught. My heart was broken to see (R1) crying over this. I told them how (R1) was overwhelmed and afraid (R1) was not going to get (R1's) antibiotic, or insulin medications. Then (R1) had to stay in bed for two days and had no therapy. (R1) has always been very active. Just lying around in bed played a big part on (R1's) psyche. Using a bed pan and (incontinent brief) was awful for (R1). (R1) couldn't get up and they had no walker for (R1). (R1) just wanted to heal and come home. The nurse (V10, Agency LPN) told (R1) that (R1) had to stay in bed. We are not rule breakers. (R1) followed the rules. The hospital had (R1) using a walker and had (R1) pivot transfer. V8 stated (R1) told them in the care plan meeting (R1) felt like (R1) was going down a black tunnel and had been fearful since (R1) got to the facility. V8 stated, I stayed with (R1) until well after 10:00 pm. The head nurse (V2, Director of Nursing) came in the next day around 11:30 am. I was told (V2) would be here at 9:00 am. By 11:30 am (R1), had missed more of (R1's) medications. (V2) was very apologetic about the whole ordeal. V8 stated the facility had stock medication they could give R1, but not (R1's) antibiotics. It was not given because it had to come from the pharmacy. That did not happen until later that evening. This added to (R1's) despair. It seemed to go on and on. (R1's) blood pressure has been elevated since (R1) got to the facility. V8 also stated (V8) had concerns with the timing of R1's leg treatment not being done until 5/11/26 when it was supposed to be changed every two days. V8 also stated (R1's) therapy evaluation was not completed in a timely manner.On 5/16/26 at 11:45 am during review of R1's medical record, V2, Director of Nursing (DON) stated I am very aware of all the failures that occurred on (R1's) admission. This was an agency nurse (V10). (V10) did not meet my expectations for Quality of Care in our facility. I DNR-ed (Do Not Return to work) (V10), immediately. V2 then said I came in Saturday late morning (5/9/26). This was the day after (R1) was admitted (5/08/26). I came in as soon as I heard what had happened. (R1) had not even had an initial assessment. (R1's) orders were here from the hospital when I came in. I'm not sure how the orders were missed that night. All the hospital information was here. This should have been reviewed prior to (R1's) admission, or at least once (R1) arrived. (R1) came in after 6:00 pm, I believe. There is no excuse for failing to complete (R1's) full admission assessment. Without review of (R1's) hospital medical records and no assessment, we can't provide continuity of care. Thankfully, there was no major impact on the residents (R1). The failures could have resulted in major problems. (R1) was extremely upset, not agitated, but very emotional. (R1) was holding back tears, as anyone would be. I apologized repeatedly for everything. We have meds in the stat (immediately available) safe (medication storage) and most meds were on hand. (V10) should have called the hospital, if (V10) didn't think the orders were here. I reviewed the orders immediately and started a full assessment. The floor nurse (unidentified) finished the assessment, while I started picking up the pieces from all the failures. Numerous errors were made. I got (R1's) medications ordered. The meds were ordered Stat (to be delivered as soon as possible), from (private company) Pharmacy. The ones (medications) we had here in the facility were given immediately. Morning meds were given early afternoon. (R1) did miss (R1's) antibiotic on admission. (R1) may have missed one or two doses all together. (R1) also missed one dose of (R1's) insulin the night of (R1's) admission. We actually had insulin on hand. (R1) (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	is alert and oriented. (R1) asked for, and should have gotten (blood glucose checks) that should have been done at the resident's request, (R1's) a Diabetic. The antibiotic was not a common antibiotic that we have in our stat safe. It had to be ordered from the pharmacy. The pharmacy knew this was needed right away. It came later in the afternoon and was given. (V16, Physician,) was on call. (V16) confirmed (R1's) meds and said all the hospital orders should have been followed. (V16) was aware that (R1's) admission assessment was not completed until I came in that next day. I notified (V17) Regional Nurse Manager, of everything that happened. V2 also stated Of course, I did get (R1) a bed remote that morning. There was no reason for (R1) not to have had that the night before. (R1) remained pretty upset. I just kept repeating how sorry I was. We had a full, care plan meeting Monday. We discussed every need (R1) had. There was no reason for (V10) to drop the ball. (R1) now has a walker and wheelchair. (R1) could have had them both when (R1) was admitted . There was no reason for (R1) to lie in bed all that time. Hospital paperwork was clear. (R1) was to be up with a walker and staff assistance. V2 also stated (V10) should have completed an assessment of R1's leg. (V10) did not assess that either. (V11, Wound Licensed Practical Nurse/ADON) our Wound nurse assessed (R1's) leg on Monday. (V11) determined there was no open areas and no sign of infection. (R1) had been taking antibiotics in the hospital. Therefore, there was no negative outcome to the wound itself. A delay in wound assessment was just one more of the issues. I did everything I could to fix all this stuff, once I was aware.The facility policy Physician/Practitioner Orders dated reviewed /revised 2/10/2026, documents the following: Policy: The attending physician shall authenticate orders for the care and treatment of assigned residents. Policy Explanation and Compliance Guidelines:1. A physician/practitioner may include, but is not limited to, a resident's: a. Attending physician.The facility policy Pharmacy Services dated reviewed /revised 2/10/2026, documents the following: Policy: It is the policy of this facility to ensure that pharmaceutical services, whether employed by the facility or under an agreement, are provided to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice.The facility policy Safe Resident Handling/Transfers dated reviewed /revised 2/10/2026, documents the following: Policy: It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the residents while keeping the employees safe in accordance with current standards and guidelines. Compliance Guidelines: 1. The interdisciplinary team or designee will evaluate and assess each resident's individual mobility needs, taking into account other factors as well, such as weight and cognitive status. 2. The resident's mobility needs will be addressed on admission and reviewed quarterly, after a significant change in condition or based on direct care staff observations or recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145031	A. Building B. Wing	05/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab & Nursing of Normal	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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility repeatedly failed to maintain complete and accurate medical records for one of three residents (R1) reviewed for admission/medical records on the sample list of nine.Findings include:R1's Census record documents R1 was admitted to the facility on [DATE] (per hospital note below, R1 was admitted to this long-term care facility on 5/8/26).R1's ED (Emergency Department) to Hosp-admission (Hospital-Admission) dated 5/1/2026 - 5/8/2026 (7 days), Status: discharged (Local Hospital) Medical Center.R1's same Discharge note documents Treatment team, Principal problem: Cellulitis and abscess of right leg post fall in April.The same Discharge note documents R1 was admitted to the local hospital 05/01/26 at 5:39 pm. discharged to this long-term care facility for Physical and Occupational Therapy on 5/08/26 at 4:35 pm.R1's Minimum Data Set (MDS) dated [DATE] documents R1's Brief Interview of Mental Status (BIMS) score of 15 out of a possible 15, indicating no cognitive impaired. R1's same MDS documents R1's was admitted to the facility on [DATE]. R1's same MDS documents R1 has had no falls prior to admission. R1 was admitted from the hospital, as noted above for a leg injury from a fall at home.R1's Adv - Psychotropic Evaluation dated 5/16/26 at 12:34 pm documents R1's Brief Interview of Mental Status score as 11 out of 15, indicating moderate cognitive impairment. On 5/17/26 at 12:35 pm V5, Registered Nurse/Minimum Data Set/ Care Plan Coordinator (RN/MDS/CPC) reviewed R1's electronic medical record. V5 confirmed R1's Minimum Data Set was documented inaccurately when V5 entered the wrong admission date of 5/9/26, off the census that was also incorrect. R1 was admitted [DATE]. V5 continued the review of R1's electronic medical records. V5 said V5 found a note that documents R1 had a fall at home prior to (R1's) admission to the hospital therefore V5 had coded the MDS wrong. V5 confirmed R1's Brief Interview of Mental Status score (BIMS) is correctly recorded as 15 out of 15, indicating no cognitive impairment on V15, Social Service Director assessment. V5 recognized V5 had documented R1's BIMS as 11 out of 15, indicating R1 was moderately impaired in the Psychotropic Evaluation dated 5/16/26 at 12:35 pm. V5 confirmed V5 documented this in error.On 5/17/26 at 1:15 pm V15, Social Service Director stated R1's BIMS score is 15 not 11. R1 is alert and oriented. That had to be inaccurately documented.There is no documentation in R1's medical record that R1 was admitted to the facility on [DATE]. R1's Hospital Discharge summary above was found by V2, Director of Nursing, on 5/09/26 according to V2's interview, below.There is no documentation that hospital paperwork was not provided to the facility 5/8/26.There is no documentation that a physician was notified 5/8/26, that there was no admission orders received from the hospital, to provide R1's care, medications and treatments.There is no documentation in R1 medical record that any of the medication and treatments ordered on the hospital discharge paperwork were entered into the electronic medical record and transmitted to the pharmacy on 5/8/26.There is no documentation R1 was assessed on admission on [DATE].R1's Medication Administration Record dated 5/1/26-5/31/26 documents a new physician order that was supposed to be administered beginning 5/10/26. R1's new physician order documents: Alendronate Sodium 70 MG Tablet, give 1 tablet by mouth in the morning every Sunday related to Type II Diabetes Mellitus Without Complications, sit up for 30 minutes after taking medication -Start Date- 05/10/2026 at 0500 am. R1's Alendronate Sodium 70 MG Tablet was not documented as being administered on 5/10/26.On 5/17/26 at 1:00 pm V30, Business Office Manager (BOM) confirmed R1's Census record documents R1's admission as Saturday 5/09/26. V30 confirmed R1's Census record was not accurate. V30 stated V30 had documented the wrong date on R1's Census record. V30 confirmed R1's admission date should have been recorded as 5/08/26.There is no documentation in R1 medical record that any of the medication and treatments ordered on the hospital discharge paperwork were entered into the electronic medical record and transmitted to the pharmacy on 5/8/26.There is no documentation that a physician was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145031	A. Building B. Wing	05/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab & Nursing of Normal	510 Broadway Normal, IL 61761

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	notified there were no admission orders to provide care for R1.R1's Health Status Note below is not documented as a late entry. R1 was admitted [DATE] not 5/9/26 as documented below.R1's Health Status Note dated 5/9/2026 at 1:06 pm documents Note Text: Resident (R1) admitted to facility from (Local) hospital via ambulance to room (R1's room number). Resident medications had a delay in arrival due to pharmacy miscommunication (5/8/26, V10, Agency Nurse had no hospital paperwork according to interviews documented). Residents were given all AM medications this morning (not documented as administered until 4:36 pm). Residents have family at bedside. Explained all medications ordered and antibiotics are being stat delivered today. Resident alert and oriented x3 (person, place and situation, no cognitive impairment). Oriented to call light and room (R1 had been in the facility since hospital note above documents transfer 5/8/26 at 4:35 pm). Pleasant and corporative. Here for treatment for RLE (Right Lower Extremity) Cellulitis. (R1) is non weight bearing. The right lower leg and will be evaluated by PT (Physical Therapy) today (5/9/26).On 5/16/26 at 11:00 am R1 said R1 was admitted a week ago Friday (5/08/26) by V10. (V10) said nothing could be done until (V10) gets the paperwork from them (local hospital). R1 said V10 did not complete an admission assessment. R1 said R1's admission assessment was not completed until 5/9/25 by V2, Director of Nursing who obtained the hospital paperwork.On 5/16/26 at 11:45 am V2, Director of Nursing (DON) confirmed R1's hospital paperwork was not obtained until 5/9/26, and V10, LPN had not completed an admission assessment or documented a note on R1's admission 5/8/26.The facility policy Documentation in Medical Record dated as revised 02/02/26 documents the following: Policy: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.3. Principles of documentation include, but are not limited to:a. Documentation shall be factual, objective, and resident centered.i. False information shall not be documented.ii. Record descriptive and objective information based on first-hand knowledge of the assessment, observation, or service provided.iii. Subjective information shall be recorded only as relevant, such as the resident's verbalizations, in quotation marks.b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the residents' care and/or responses to care.c. Documentation shall be timely and in chronological order.