

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 07/16/2026
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)		
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify a resident's physician of a change in condition for one (R4) of six residents reviewed for change in condition in a sample list of 12. Findings Include: R4's Care Plan dated 6/14/2026 documents diagnoses of Sepsis, Intestinal Obstruction, Acute Kidney Failure, Metabolic Encephalopathy, Repeated Falls, Weakness, Peripheral Vascular Disease, Obstructive Sleep Apnea, Dementia, Psychotic Disturbance, Mood Disturbance, Anxiety, Reduced Mobility, Difficulty in Walking, and Traumatic Ischemia of Muscle. R4's Minimum Data Set, dated [DATE] documents R4 is moderately cognitively impaired. On 7/14/2026 at 10:25 a.m., V37 Hospital Nurse stated R4 entered the emergency room with stroke-like symptoms, including left-sided facial droop, left arm weakness, and slurred speech (on 7/5/26). V37 stated EMS (Emergency Medical Services) informed hospital staff R4 had been experiencing these symptoms for more than 24 hours, making R4 ineligible for stroke-alert interventions. V37 stated R4 was short of breath, and oxygen saturation was low upon arrival. On 7/14/2026 at 10:45 a.m., V11 Register Nurse (RN) stated on 7/5/2026, R4 exhibited facial drooping, shortness of breath, and difficulty swallowing. V11 reported to EMS that R4 was last seen at baseline approximately 24 hours earlier. On 7/14/2026 at 11:45 a.m., V17 Certified Nurse Assistant (CNA) stated on 7/4/2026, R4 did not seem like R4's self. V17 stated when assisting R4 that morning, V17 observed slurred speech, slouching to one side in the wheelchair, and difficulty eating breakfast. V17 stated V17 notified V13 Licensed Practical Nurse (LPN). V17 stated on 7/5/2026, V17 again found R4 with slurred speech and leaning, with symptoms significantly worse than the prior day. V17 stated V17 notified V11, and R4 was transferred to the hospital. V17 told EMS that R4 had been experiencing slurred speech and leaning for 24 hours. On 7/14/2026 at 11:55 a.m., V13 Licensed Practical Nurse stated V13 did not recall being notified by the CNA on 7/4/2026 regarding R4's stroke-like symptoms. On 7/14/2026 at 12:45 p.m. V2 Director of Nursing (DON) stated that for nonemergency changes the nurses will fax or call physicians regarding a change in condition. V2 stated for an emergency staff should call 911 if patient needs sent to the emergency room and then notify the doctor. V2 stated V2 expects nurses to call doctors for stroke-like symptoms and not wait 24 hours to update the physician or send a resident out. On 7/14/2026 at 12:50 p.m. V31 Medical Director/Physician stated V31 does not recall receiving any notification regarding R4's change in condition on either 7/4/2026 or 7/5/2026. On 7/14/2026 at 1:09 p.m. V2 DON stated an electronic assessment form was completed on 7/5/2026 when R4 was sent the emergency room, the doctor was notified at 3:00p.m. and the POA (Power of Attorney) was notified at 9:29 a.m. V2 stated there was no documentation regarding R4's symptoms reported by V17 CNA on 7/4/2026. On 7/14/2026 at 3:00 p.m. V2 DON confirmed the electronic assessment form dated 7/5/2026 contains vital signs dated 7/4/2026 at 2:15 a.m. and R4 was sent to the emergency room 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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 145031	If continuation sheet Page 1 of 3

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/5/2026 at 9:29 a.m. The Vital Signs Evaluation section states the most recent vital signs for change in condition are blood pressure 148/64 lying, pulse 73, respirations 16, and temperature 98.1 (degrees Fahrenheit) forehead with Oxygen saturation of 89 percent all dated 7/4/2026 at 2:15 a.m. V2 said the vital signs must have auto populated in the form from an earlier set of vital signs entered in the computer. V2 confirmed there are no vital signs entered for R4 during the time of the change of condition. V2 also confirmed the electronic assessment form documents a start date of symptoms as 6/30/2026. V2 confirmed the date of 6/30/26 is incorrect. On 7/15/2026 at 10:39 a.m. V2 DON also shared that a set of vitals were taken from the EMS staff when they arrived, but no vital signs were measured by the in-house nursing staff. On 7/14/2026 at 12:20 p.m., V33 Family Member reported that the emergency room physician informed him that R4 had experienced a stroke on the left side and was unable to squeeze with the hand or lift the left foot, which was positioned off to the side. The Facility's Notification of Change Policy revised on 2/2/2026 documents the facility promptly informs the resident, consults the resident's physician and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Definitions: life-threatening Conditions for example Heart Attack or Stroke. Under Compliance Guidelines: Circumstances requiring notification include #2 significant change in the resident's physical, mental or psychosocial conditions such as deterioration in health, mental or psychosocial status.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed protect the resident's right to be free from physical abuse by another resident for two (R2, R3) of three residents reviewed for abuse in a sample list of 12. Findings include: R2's Electronic Health Record (EHR) documents R2 admitted to the facility on [DATE] with diagnoses including Major Depressive Disorder, Primary Insomnia, Diabetes Mellitus With Diabetic Neuropathy, Lymphedema, Type 2 Diabetes Mellitus With Stable Proliferative Diabetic Retinopathy, Bilateral, Venous Insufficiency, and Dementia, Mild, With Agitation. R2's Minimum Data Set, dated [DATE] documents R2 has mild cognitive impairment. R3's EHR documents R3 admitted to the facility on [DATE] with diagnoses including Convulsions, Cerebral Infarction, Intellectual Disabilities, Major Depressive Disorder, Cognitive Communication Deficit, and Alzheimer's Disease. R3's EHR documents on June 30, 2026 R3 has moderate cognitive impairment. The facility's Final Incident Report Form, undated, labeled 5 day follow up, documents After investigation which included interviews, (R2) stated (R2) did not think (R2) was moving fast enough in his wheelchair while leaving the dining room which caused (R3) to become aggravated. According to a CNA's (V3) statement, R3 then lightly hit R2. R2 then grabbed R3's shirt and told R3 to not put R3's hands on R2 again. On 7/13/26 at 10:45AM, R2 stated R3 was in a rush to get out of the dining room and R2 was moving slowly and R3 hit him. R2 stated R3 hit me but it was no big deal, I wasn't injured, and then (R3) went on by me like it was no big deal. On 7/13/26 at 10:48AM, R3 stated R3 did not recall any incident's with other residents. On 7/13/26 at 12:55PM, V6, R2's spouse, stated V6 was notified that R2 and R3 had a disagreement and R2 was hit by R3 when the residents were coming out of the dining room. V6 stated V6 was told there was no injury to R2. On 7/13/26 at 2:39PM, V3 Certified Nursing Assistant confirmed V3's written statement. V3 stated V3 was assisting residents in the dining room, and witnessed R3 make contact with R2 while R2 was leaving the dining room. V3 stated V3 separated the residents. On 7/13/26 at 2:45PM, V4 Licensed Practical Nurse stated V4 was informed of the incident between R2 and R3 in which R3 was observed hitting R2. On 7/14/26 at 1:45PM V2, Director of Nursing, confirmed the abuse policy documents residents have a right to be free from abuse. V2 stated the policy was not followed if the incident took place. The facility's abuse policy dated 2/11/2025 documents It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies' and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Section VI Protection of Resident documents The facility will make efforts to ensure all residents are protected from physical and psychosocial harm.		