STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145431	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehabilitation & Nursing	700 North Main Street Eureka, IL 61530

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 31283 Based on interview observation and record review, the facility failed to adequately supervise a resident (R4) exhibiting sexually aggressive behaviors, and failed to identify and protect a resident (R5) from multiple episodes of sexual abuse reviewed for abuse in the sample of five. These failures resulted in an Immediate Jeopardy. While the immediacy was removed on 04/02/24, the facility remains out of compliance at a Severity Level II as additional time is needed to evaluate the implementation and effectiveness of their removal plan and quality assurance program. Findings Include: The facility's Abuse, Neglect and Exploitation policy (revised 12/05/22) documents the following: Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. 'Abuse' means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting in physical harm, pain or mental anguish. Abuse also includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychological well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse including abuse facilitated or enabled through the use of technology. This same policy documents, Sexual Abuse is non-consensual sexual contact of any type with a resident. This policy also documents under the section titled Prevention of Abuse, Assess, monitor, and develop appropriate plans of care for residents with inappropriate sexual behavior, whether towards staff or other residents. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145431	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehabilitation & Nursing	700 North Main Street Eureka, IL 61530

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's State Report Incident Investigation (dated 03/04/24) documents the following: On March 4, at approximately 8:20 AM, it was reported by the therapist that she had walked through the dining room and saw that (R4) was attempting to touch (R5) in the area of his lap. Both were sitting in the dining room area after breakfast and no other residents were present. (R4) was leaning in towards (R5) and (R5) was not talking and sitting quietly in his wheelchair. When the therapist intervened and questioned (R4) what they were doing, (R4) stated they were doing nothing wrong and just talking. The therapist took (R4) to the activity room. (R5) was taken to the elevator to go back upstairs to his room where a nurse assessed and found no sign of injury. On March 4, at approximately 9:00 am, Social Worker interviewed both (R4) and (R5). When (R4) was interviewed, she expressed her and (R5) were, 'in love' and doing nothing wrong in the dining room. Educated (R4) regarding the necessary cognitive ability for two residents to give consent before touching each other. (R4) verbalized that she wants (R5) to touch her, and he wants her to touch him. When (R5) was interviewed, he stated, No one touches me, I have no problems. Both POAs (Power of Attorneys) and MD (physician) were notified. On March 4, at approximately 9:40 am, Social Worker interviewed six residents with BIMS (Brief Interview for Mental Status) higher than a 10 and asked if they felt safe and comfortable in the facility and they all said 'yes'. Disposition: The facility cannot find evidence of intent to harm or any negative psycho-social outcomes. The two residents do not reside on the same hall and do not sit together at meals. They will remain separated. Care Plans were updated, and Social Services will monitor residents for any negative psycho-social outcomes. R4's Minimum Data Set Assessment (dated 02/19/24) documents a Brief Interview of Mental Status score of 10, indicating moderate cognitive impairment. R4's current care plan documents the following: (R4) has a potential for behavior problem due to current personal dynamics such as: false statements of staff, rejection of cares, crying, repetitive activities, attention seeking behaviors, noncompliance of cares/facility policy, manipulative behavior towards staff, poor safety awareness, refusal to go to doctor's appointments/hospital or counseling. 02/29/24 - inappropriate behaviors attempting to touch others. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145431	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehabilitation & Nursing	700 North Main Street Eureka, IL 61530

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R4's Medical Practitioner Progress Note (dated 03/01/24) documents: Chief Complaint: Patient reports feeling anxious all the time with occasional panic attacks. History Of Present Illness: Female with a history of MDD (Major Depressive Disorder), Anxiety and PTSD (Post Traumatic Stress Disorder). Per staff, patient requested to go to the hospital to have, 'things removed from her vagina.' Had a stylus in vagina; nursing staff report ER (emergency room) doctor documented patient could benefit from a vibrator/safe device to prevent recurrence of foreign objects getting stuck in patient's vagina. No records from hospital visit in EMR (electronic medical record) to review. Per staff, she has history of being inappropriate with other residents, i.e tried to grab another resident's penis in the past. (R4) is seen in her room, sitting in her wheelchair. She reports her mood is 'not good at all.' She shares about the incident. She states she struggles with hyper-arousal/hypersexuality and inserted stylus into her vagina. She states she had multiple inserted into her vagina prior to being sent to the ER. She becomes tearful. She states she has a lot of shame related to this and feels depressed. She requests something to help with her hyper arousal. She also reports feeling anxious all the time with occasional panic attacks. She denies suicidal or homicidal thoughts. She states she does not sleep well at night, because of leg pain and fear that she won't be able to walk again. Appetite is good. No manic or psychotic symptoms reported. Tolerating her medications without side effects reported. In agreement with ER doctor to allow patient to purchase appropriate item to prevent inserting inappropriate objects in her vagina and rectum. Patient is already taking the maximum dose of sertraline, discussed that SSRI/SNRI (Selective serotonin reuptake inhibitors/Serotonin and norepinephrine reuptake inhibitors) can lower libido, but she does not seem to be getting this effect. I think it's fair to trial a higher dose of buspirone to help decrease patient's anxiety and help some of her symptoms. If patient continues to be distressed by her symptoms or becomes inappropriate with another resident again, may need to trial divalproex in the future. No other concerns. On 03/27/24 at 12:45 PM, R4 was sitting in a wheelchair in the basement of the facility near the activity room. R4 was alert to person and place, but could not recall the date. R4 was questioned about recent events, and she stated the following: I am ok. Most of what's happened is my doing. I really don't want to talk about it. I am just a crazy old lady with a horrible sex drive. But I want to be with an adult that's my age and more alert. (R5) is confused. Anything we did was beautiful. He liked it too. When I see him, something sparks. It's nobody's business, and I think he (R5) enjoys sex as much as I do. R5's Minimum Data Set Assessment (dated 02/28/24) documents a Brief Interview of Mental Status score of 6, indicating severe cognitive impairment. R5's current care plan documents the following focus: (R5) is at potential risk for abuse related to Dementia, dependency on staff. On 03/27/24 at 12:30 PM, R5 was sitting in a wheelchair near the facility's front door. R5 was pleasantly confused and could answer simple questions. R5 confirmed that he had just eaten lunch, but could not recall what he had just eaten for lunch when asked. R5 could not recall any recent interactions with R4. R5 stated, yes, when asked if things were going ok, and stated no when asked if he had any issues or concerns. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145431	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehabilitation & Nursing	700 North Main Street Eureka, IL 61530

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/25/24 at 11:50 PM, V3 (Assistant Director of Nursing) stated, (R4) targets (R5). He (R5) is not cognizant. He cannot give a verbal response that he wants (R4) to do that (touching). (R4's) sexual behavior heightened about 3 weeks ago. She only behaves this way toward (R5), and she has been inappropriate with the two male CNAs (Certified Nursing Assistants) that currently work here. (R4) has been pulling her shirt up in the lobby in front of (R5). (R5) barley converses and does not like to be bothered. Every time (R4) comes out of her room she looks for (R5). We try to keep them separated, but (R4) can be quick. On 03/25/24 at 12:15 PM, V4 (Activity Director) verified the following written statement documented in R4 and R5's 03/04/24 Incident Investigation: On 03/03/24 at approximately 10:00 AM, I saw (R5) in (R4's) room and they were not talking, just sitting there. I walked in and started moving (R5) out of the room and (R4) said to me 'We are in love and in our own private room.' (R5) was in (R4's) room. I don't know how he got in there. My best guess is (R4) lured (R5) in there. He would not purposefully go into someone's room, but he would follow commands if someone gives him instructions. I removed (R5) from the room at that time. (R4) had been pursuing (R5) for about a month, and I feel like it really heightened about 2 to 3 weeks ago. I feel like it's been a situation where the more you tell her 'no' the more she wants to do it. We have been told to keep them separated, and if (R4) is out of her room, she will find (R5). (R5) is cognitively impaired, so he hasn't seemed bothered by any of this. But you wonder how much he really understands since he is impaired. I've had to separate them a few times this past month, mostly when (R4) has made herself close to (R5). On 03/25/24 at 12:50 PM, V2 (Director of Nursing) stated she has been employed at the facility since January 2024. V2 stated, (R4) has been sexually inappropriate towards (R5). We have been keeping them separated. (R5) is impaired and doesn't know what happening. (R4) does know. I have told her that (R5) doesn't understand being in love with you. He cannot consent. (R4) likes to sleep naked and does what she wants to do. She wants male staff to see her naked. One day she made the comment 'what are you supposed to do when your mind still thinks you're a size 6?' She has only been inappropriate with (R5). This has not occurred with any other male resident. (R5) has been indifferent about all of what's occurred with (R4). I don't even know if any of it has registered. I think if it bothered him, he would be swearing because he swears at staff often during cares. (R4) is attention seeking. She is monitored for behaviors, and it may not be documented as frequently as it occurs because staff has normalized her behaviors after observing her display them so often. R4's Behavior Monitoring and Interventions Report (dated 01/01/24 - 03/27/24) has no documentation of behaviors exhibited throughout this timeframe, with the exception of the following: an episode of grabbing others and public sex acts, both noted on 03/04/24; an episode of express frustration/anger at others and agitation noted on 03/09/24; and an episode of express frustration/anger at others and disruptive sounds noted on 03/17/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145431	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehabilitation & Nursing	700 North Main Street Eureka, IL 61530

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	V5's (Certified Nursing Assistant) witness statement noted in the facility's 03/04/24 Incident Investigation documents, (R4) wheeled herself up to (R5) at the table in the lobby. (R4) was crouched over to her side, leaning in towards (R5). I said, '(R4), keep it PG' (parental guidance, some material may not be suitable for children), and she said 'OK.' I continued with my vitals but I kept circling around and watching her and she was inching herself closer to (R5) and then I turned and looked and her shirt was up and he was grabbing her breast. I told (R4) 'that is inappropriate' so I unlocked her wheelchair and moved her closer to the TV. (R4) was upset and shouting that she can have relationships and it is her right. On 03/25/24 at 01:40 PM, V5 verified the above statement and stated this incident occurred on 03/04/24 at approximately 10:00 AM. V5 then stated, I have been on light duty and was sitting at the receptionist desk when this occurred. (R4) has been approaching (R5). She inches up to him and has been sexually inappropriate previously. (R4) will gravitate toward (R5) if she sees him. This has been happening since some time in February. (R5) doesn't get angry or really react at all. He definitely does not have the mental capacity to consent. Once you move (R4) away from him, she will find a way to return. She has said 'it's not a crime to love somebody.' I have told her that her actions out in the open are inappropriate. She has been lifting her shirt up in the front lobby when (R5) is present, and I have had to intervene a few times. I went and mentioned this to (V1, Administrator) in the beginning when it first had started. I wrote a statement about it. (R4) was always lifting up her shirt and (R5) being next to her with his hand there. She would begin touching and rubbing his hand and it would escalate to her shirt lifted up and his hand ends up on her breast. I never witnessed her shirt going up but would catch it once it was up. I would see her display the initial behavior and knew it was going to progress to her shirt up with his hand on her, so I knew to watch closely and be more aware. I never intervened when they were handsy but knew to step in when her shirt was up. She has also tried reaching in (R5's) pants. R4's Custom Alert (dated 03/04/24 and written by V5) documents the following: (R4) was addressed by multiple aides out in the hall to keep it PG and hands to herself. (R4) sneaks in the second eyes are off of her. Her breast was out with another resident's hand up her shirt while (R4) was reaching to (R5's) pants. V6's (Certified Nursing Assistant) witness statement noted in the facility's 03/04/24 incident investigation documents the following: (R4) was trying to hold (R5's) hand and I moved them apart, but she seemed to find him again and we kept an eye on her. On 03/25/24 at 02:25 PM, V6 verified the above statement and stated, She had found her way back to him and I had to separate them again. This was on 03/04/24 around 10:30 AM. (R4) is always the one approaching (R5). She has the awareness and knows she shouldn't be doing what she's doing. If she can see him, you've got to watch her. She's 100% with it and knows right from wrong. V7's (Certified Nursing Assistant) witness statement noted in the facility's 03/04/24 incident investigation documents, I was told she (R4) was trying to get her hands down his (R5) pants and asking him to do the same. On 03/25/24, V7 verified the above witness statement and then stated the following: We tried to keep them separate, but she will go back to him if you don't completely separate them, meaning not just moving her away from him in the same vicinity. She has to be moved to where she cannot see him, like she needs to be taken downstairs for activities. (R4's) behaviors started about two months ago. Initially she made comments. It went from her making these inappropriate comments to talking about doing things to herself. It continued to escalate as she began approaching (R5). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145431	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehabilitation & Nursing	700 North Main Street Eureka, IL 61530

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/25/24 at 03:05 PM, V1 (Administrator) stated facility staff started realizing that R4 had been getting close to R5, Last month. Mid-February. She was getting real close to (R5). She was whispering and began making sexual comments. She would say things like it's her right to have a boyfriend and 'We are adults. Leave us alone. We're in love.' We explained to (R4) that cognitively, (R5) doesn't understand and he cannot make this type of decision himself. I think she understands what It means for someone to be able to make decisions for themselves. (R4) tends to live in her own little world and was thinking she and (R5) were boyfriend and girlfriend. She also displays attention seeking behavior. She likes attention. She has been sneaky about this she'll look up to see if you're watching her. We had placed her on 15 minute checks after the 03/04/24 incident for 48 hours. We've never implemented one-on-one supervision, but definitely made sure she was in areas of high visibility. I think she has prompted (R5). I can totally see her manipulating the situation, especially with his impaired cognition. He does not grab at anyone else, so for his hands to be in contact with her, she's physically or verbally manipulated the situation somehow. V8's (Certified Nursing Assistant) witness statement noted in the facility's 03/04/24 incident investigation documents, (R4) sits in the lobby with her shirt up and no bra on and just sits there, and there are times family comes in to visit. I ask her to put her shirt down and she acts like she is doing nothing bad. On 03/26/24 at 09:50 AM, V8 verified her witness statement and stated the above occurred on 03/03/24, (R4's) shirt was up and I told her to stop and she said, 'Why? We're in love.' I told the nurse and she told me to separate them. I took (R5) in his room and transferred him into his recliner. All of this started in February. First (R4) was lifting up her shirt. She was sexually inappropriate and it seemed to progress to her constantly attempting to pursue (R5). You could move her to the other end of the lobby and she'd begin making her way back to him. This happened multiple times. Several staff would move (R4) away from (R5) and she would always seem to find her way back to him. I witnessed her with her shirt up twice on 03/03/24, and then again in the dining room about a week later. If (R5) physically had his hands on (R4) it is because she prompted him. (R5) will follow instruction, so I could see (R4) telling him to do things. (R5) does not grab at anyone. If that was the case, he'd be touching others as well. On 03/26/24 at 11:15 AM, V9 (Physical Therapy Assistant) stated she is the individual who witnessed the 03/04/24 incident between R4 and R5. V9 stated, I walked into the dining room and (R4) was talking to (R5). I knew they weren't supposed to be together and they were supposed to be separated. (R4) had been observed being sexually inappropriate with (R5) for a week or two prior to this day. I asked her what she was doing and she said 'nothing.' I told her to keep moving along and she did, but I continued observing. I overheard (R4) ask (R5) to put his hand in her pants, and I immediately intervened. I told her that was inappropriate and pushed her wheelchair to activities. I told (V3, Assistant Director of Nursing) about what had occurred and (V10, Social Service Director) called and spoke with me about the incident later that day, or the following day. On 03/27/24 at 10:30 AM, V11 (Certified Nursing Assistant) verified her witness statement noted on the facility's 03/04/24 incident investigation and stated, I usually work in the dementia unit. I was walking to the dining room for something and out of the corner of my eye I saw (R4) taking her shirt off. I went over and put her shirt back on and explained that she cannot be doing that in the lobby. I saw her doing it again when I was heading back the my unit, so I removed her from the area and pushed her wheelchair over by the CNA (Certified Nursing Assistant) that was working. I can't remember who was working that day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145431	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehabilitation & Nursing	700 North Main Street Eureka, IL 61530

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/26/24 at 12:10 PM, (V10, Social Service Director) stated, I believe it was mid-February when (R4) started to approach (R5). She was getting in his personal space, and staff was instructed to separate them. She had been hypersexual and began pursuing him. (R5) is cognitively impaired and cannot consent. (R4) knows what she's doing. V10 verified that R4's care plan was updated on 02/29/24 after R4 was observed hypersexual and approaching R5 and, getting in his personal space. On 03/27/24 at 09:55 AM, V1 (Administrator) stated the 03/04/24 abuse allegation investigation regarding R4 and R5 was unsubstantiated, I did not feel like either one had the intent to be malicious. We initiated 15 minute checks on (R4) for 48 hours and placed her in areas of high visibility. I don't like doing one-on-one supervision as it can be upsetting and disruptive to the resident. We attempted to engage (R4) in more activities to redirect her focus. I would do one-on-one supervision if there were concerns about resident safety. This incident wasn't a safety concern. She (R4) wasn't going after all of the residents. (R4) and (R5) rooms are located on different hallways so we could keep them separated. The Immediate Jeopardy was identified on 04/01/24 at 07:45 AM to have begun on 02/29/24 when R4's care plan was updated for R4 displaying inappropriate behaviors of attempting to touch others. V1 (Administrator) and V2 (Director of Nursing) were notified of the Immediate Jeopardy on 04/01/24 at 08:20 AM. The surveyor confirmed through interview, observation and record review that the facility took the following actions to remove the Immediate Jeopardy: On 04/03/24, V1 (Administrator) provided copies of the following In-Service/Meeting Attendance Forms completed on 04/01/24 and 04/02/24 with indication that this training was administered by V1 and V2 (Director of Nursing): Abuse/Neglect Policy/Procedure and Education; Abuse/Neglect In-Service; Abuse: Who to Report Abuse to/What is Abuse; Appropriate Seating for a Resident that Displays Inappropriate Touching and Redirection Tools to Divert Attention to Positive Outcome; and Monitoring Resident Behaviors for Signs and Symptoms of Abuse or Potential for Abuse. These attendance forms confirm all staff working on 04/01/24 and 04/02/24 received the required education. An In-Service Attendance Sheet for staff members not present at the in-services on 04/01/24 or 04/02/24 was also provided and these staff members were called and the education was administered via telephone conversation. On 04/03/24, the following staff members were interviewed and could speak in detail of the recent abuse training that they had received, including the facility's abuse prevention and reporting policy, including definitions of abuse and immediate actions needed, identification of sexual abuse and protection of residents, and increasing supervision for a sexually aggressive resident: V2 (Director of Nursing); V3 (Assistant Director of Nursing); V6, V8, V15, V18, V20 and V21 (Certified Nursing Assistants); V19 (Registered Nurse); V22 (Dietary Manager); V23 (Housekeeping/Laundry); V4 (Activity Director); and V24 (Maintenance). CNAs (Certified Nursing Assistants) and Licensed Nurses elaborated on the education administered regarding documenting resident behaviors and new behavior interventions. All staff interviewed were able to elaborate on behavioral interventions to utilize with a sexually aggressive resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145431	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehabilitation & Nursing	700 North Main Street Eureka, IL 61530

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/04/24 at 01:27 PM, R4 was lying in bed covered with a sheet. V5 (Certified Nursing Assistant) was sitting in a chair near the doorway to R4's room providing one-to-one supervision. On 04/03/24 at 10:05 AM, R4 was in her room lying in her bed, and V21 (Certified Nursing Assistant) was providing one-to-one supervision. V21 stated, She hasn't wanted to come out of her room much since she's been on one-to-ones. If she decides to go to the dining room for lunch today, she will be seated at a table with other female residents, but I am guessing she will want to eat in her room. R4 was observed eating lunch in her room on 04/03/24 at 12:16 PM. On 04/03/24, V1 (Administrator) provided a copy of the 1:1 Staffing Sheet for R4, which documents one-to-one supervision has been provided to R4 on 04/01/24 - 04/03/24. R4's Progress Note (dated 04/02/24) documents V10 (Social Service Director) contacted psychiatric services for notification of R4's recent behaviors, and an appointment was scheduled for R4 to be evaluated on 04/09/24. R5's Progress Note (dated 04/01/24) documents the following: (V10, Social Service Director) spent some time with (R5) today. No psycho-social distress noted. (R5) was relaxing in his recliner. On 04/03/24 at 11:19 AM, V10 verified the above progress note and stated she will continue monitoring R5 for psycho-social changes. R4 and R5's current care plans were revised on 04/02/24 to reflect the recent abuse concerns, and new behavioral interventions had also been implemented at that time. On 04/03/24, V1 (Administrator) provided copies of Focused Audit Tools, which document V10 (Social Service Director) interviewed five facility staff members and five residents regarding any concerns, or reports of resident abuse, with emphasis on inappropriate touching. V1 also provided a copy of a resident roster containing all residents in the facility with a Brief Interview for Mental Status score of 8 or above, and documents V10 conducted interviews with these residents for any abuse concerns. On 04/03/24, V1 provided a copy of an In-Service Education Attendance sheet with documentation that V26 (Director of Operations) met with the facility's department managers and education regarding their roles and responsibilities related to abuse/neglect prevention, reporting, investigation and follow-up was administered. On 04/03/24, V1 stated the facility has not had any allegations of abuse reported since the allegation involving R4 and R5 on 03/04/24. V1 spoke in detail regarding the following process: In the event of any future resident-to-resident allegation of sexual abuse, the alleged perpetrator resident will immediately be placed on one-to-one supervision until primary care, nursing, and psychiatric evaluations can be completed. The outcomes of these evaluations will be used to determine next steps and treatment which could include continue one-to-one supervision for the initiation of discharge planning to a facility with focus on behavior management. The Interdisciplinary Team will review the circumstances of the allegation to assess whether a root cause can be identified, such as a physiological change. The care plans of residents involved will be updated to reflect the next steps for treatment and staff will receive education on new interventions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145431	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehabilitation & Nursing	700 North Main Street Eureka, IL 61530

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/03/24, V1 stated the facility has integrated the focus on abuse/neglect into the facility's QAPI (Quality Assurance and Performance Improvement) process and abuse and neglect will be discussed in detail at the facility's upcoming Quality Assurance meeting, scheduled for 04/18/24. V1 also confirmed V12 (R1's Primary Physician/Medical Director) was notified of all abuse concerns on 04/02/24, and V1 stated that V12 will attend the 04/18/24 meeting, and will continue to participate in the Quality Assurance process.