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	02/25/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure adequate supervision and prevent an intermittently confused resident from exiting the facility, unannounced to staff, through alarmed exit doors after a visitor silenced the door alarm without staff knowledge. Staff failed to monitor the alarm system and failed to recognize the resident's elopement. The resident exited the building unsupervised, during freezing temperatures, wearing only a tee shirt and sweatpants. Approximately 13 minutes later, the resident was discovered by a patrolling police officer in the facility parking lot, adjacent to an access road used by residents of a nearby apartment complex, creating a high risk for traffic- related injury. The resident was found lying on the ground next to an overturned wheelchair and had sustained multiple contusions and lacerations requiring an emergency room evaluation for one of four residents (R1), reviewed for accidents and supervision, in a sample of seven. The facility's failure to prevent unauthorized silencing of exit alarms; monitor alarm status; provide adequate supervision of an intermittent cognitively impaired resident and identify and respond promptly to an elopement placed the resident in immediate danger of serious injury or death, including hypothermia, trauma from falls or being struck by a vehicle. Findings include:These failures resulted in an Immediate Jeopardy. The Immediate Jeopardy started on 12/10/25 when R1 exited the facility, unannounced to staff, through alarmed exit doors after a visitor silenced the door alarm without staff knowledge.V1 (Administrator) and V2 (Director of Nurses) were notified of the Immediate Jeopardy on 02/23/2026 at 1:40 P.M.While the immediacy was removed on 02/23/2026, 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 monitoring.The facility policy, Elopements and Wandering Residents, dated (revised) 2/2/26 directs staff, This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Elopement occurs when a resident leaves the premises or a safe area without authorization and/or necessary supervision to do so. The facility is equipped with door locks/alarms to help avoid elopements. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. The facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement or unsafe wandering. Including identification and assessments of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks and monitoring for effectiveness and modifying interventions when necessary. Any staff member becoming aware of a missing resident will alert personnel using facility approved protocol. The designated staff will look for the resident. If the resident is not located in the building or on the grounds, Administrator or designee will notify the police department and serve as designated liaison between the (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	prior to his leaving the facility unattended and V1 states that in hindsight, he should have had an alarm on.On 2/23/26 at 9:25 A.M., V14/Maintenance Director stated all facility exit doors are alarmed and a code must be entered to enter or exit the facility. States the facility front door has two doors to enter/exit. States the first door is for the (wandering alert bracelet) system, which will not allow a resident with a (wandering alert bracelet) to exit, as it locks the door if a resident with a bracelet gets too close. States the second door is locked at all times and a code must be entered. States he conducts routine weekly checks of all facility doors. States if the door alarm is sounding and someone entering the facility enters the code, the door is unlocked, and the alarm is silenced. States as far as he is aware, most family members have been given the code to the doors so they can enter and exit as desired. On 2/23/26 at 9:32 A.M., V1/Administrator stated staff are trained during orientation by the Social Services Director (V16) on the facility Code Yellow protocol. States the facility does Code Yellow drills but is unable to state how frequently. States when a door alarm is sounding, the facility protocol is for someone to respond to the alarm and do a preliminary search of the area, if no resident is seen, Code Yellow is announced, and the nurses are responsible for completing a facility wide head check. If a missing resident is noted, then a wider facility perimeter check is completed and if the resident is unable to be located at that time, the police are called. On 2/23/26 at 9:38 A.M., V16/Social Services Director stated most (facility) family members have the code to the front door so they can enter and exit anytime.On 2/23/26 at 9:47 A.M., V4/Licensed Practical Nurse stated he was working the evening of 12/10/26 and R1 was assigned to him. States he had been assigned to R1 in the past and knew R1 was confused at times. States he had witnessed R1's spouse enter the code to the front door in front of R1 many times during the evening. States R1 even knew the code to the front door as V4 had overheard R1 repeat it. States when he came to work on 12/10/25 at 6 PM, he was told in report that R1 was very agitated and anxious. States when he talked with R1, that R1 was very fixated and adamant that he had to be somewhere. States R1 was wandering around, going to the front door repeatedly. States he made the decision to administer Lorazepam 0.5 MG (milligrams) by mouth to R1 in an effort to get R1 to calm down. States after he administered the Lorazepam at 6:54 PM, R1 remained in the lobby, in his wheelchair while V4/LPN headed down the hall to pass evening medications to other residents. States he did not place R1 on 1:1 supervision. States he did not inform R1's assigned CNA to increase supervision of R1. States he did not hear the door alarm when he was down the hall taking care of other residents and did not know that R1 had exited the facility. States he only became aware of the situation when V5/Certified Nursing Assistant ran back into the facility to alert him that R1 was injured in the parking lot. States it is common practice in the facility for resident family members to be given the code to the door alarm, so they can come and go as they want. On 2/23/26 at 10:10 A.M., V7's spouse entered the facility front doors by entering a code into the two doors. At that time, stated his spouse has been a resident since last fall and facility staff provided him with the code to the doors upon her admission.On 2/23/26 at 11:29 A.M., V8 and V9's daughter entered the facility front doors by entering a code into the doors. At that time, she stated how else am I supposed to get in and out. They gave me the code a long time ago.Abatement Plan received on 2/23/26 at 5:48 P.M., from facility Administrator. After review, revision requested.Abatement Plan received on 2/24/26 at 11:23 A.M., from Facility Administrator. After review, revision requested.Abatement Plan received on 2/24/26 at 1:10 P.M., from facility Administrator. After review, Abatement Plan was accepted on 2/24/26 at 4:19 P.M.On 02/24/2026 the surveyor confirmed through interview and record review that the facility took the following actions to remove the Immediate Jeopardy:Immediate action(s) taken:Resident in question was discharged to home on (continued on next page)

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