

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2026
NAME OF PROVIDER OR SUPPLIER Loft Rehabilitation & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - 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 record review, interview and observation the facility failed ensure a resident (R2) was free from physical abuse by another resident (R1) for two of seven residents reviewed for abuse. The facility's abuse , Neglect, Exploitation Policy dated 1/23/26 documents the following: 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.R1 is a [AGE] year-old resident admitted on [DATE] with diagnoses including: Cognitive Social or Emotional Deficit Following Cerebro-vascular Disease; Schizoaffective Disorder, Bipolar Type; Major Depressive disorder, and Anxiety. R1's current Care Plan documents: (R1) has potential to be verbally/physically/aggressive related to Mental/Emotional illness, Poor impulse control.The facility's Incidents By Incident Type report, under Physical Aggression Initiated Incidents dated 4/28/26 at 11:30am documents an incident of resident-to-resident altercation initiated by R1 against R2.The facility's State Report dated 4/28/26 documents the following: (R1)'s right hand made contact with (R2)'s left upper arm. (V5) CNA/Certified Nursing Assistant stated, I saw (R2) trying to get past (R1) and they started arguing as he (R2) was trying to get by. I saw (R1) make contact with the back of her right hand to (R2)'s left upper arm.On 6/16/6 at 4:00pm V2 ADON/Assistance Director of Nursing verified R1 did strike R2 on 4/28/26 and the incident investigation found resident-to-resident physical abuse did occur.		

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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