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	08/01/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49187 Based on interview and record review, the facility failed to maintain accurate Advanced Directive information throughout the medical record for two of twenty-two residents (R15 and R60) reviewed for Advanced Directives in the sample of 39. Findings include: 1. R15's Order Summary Report, dated [DATE], documents R15 was admitted to the facility on [DATE] with the following, but not limited to, diagnoses: Frontal Lobe and Executive Function Deficit Following Cerebral Infarction, Vascular Dementia, and Cardiac Murmur. This same report documents the following Physician order, Order date [DATE]: Full Code. R15's Illinois Department of Public Health Uniform Practitioner Order for Life Sustaining Treatment (POLST) Form, dated [DATE], documents A. No CPR (cardiopulmonary resuscitation): Do Not Attempt Resuscitation. B. Comfort-Focused Treatment: Primary goal is maximizing comfort through symptom management. Allow natural death. 2. R60's Order Summary Report, dated [DATE], documents R60 was admitted to the facility on [DATE] with the following, but not limited to, diagnoses: Malignant Neoplasm of Prostate, Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, and Malignant Neoplasm of Bladder. This same report documents the following Physician order, Order date [DATE]: Full Code. R60's Illinois Department of Public Health POLST Form, dated [DATE], documents A. No CPR. Do Not Attempt Resuscitation. B. Comfort-Focused Treatment: Primary goal is maximizing comfort through symptom management. Allow natural death. On [DATE] at 2:15 PM V1/Administrator in Training verified R15 and R60's Physician order and POLST form did not match. V1 stated, Social Services is responsible for ensuring the resident's physician order for advance directives match the resident's current POLST form. We (the facility) currently don't have a Social Service Director, so I have been trying to help with the advance directives. I have not done an audit to ensure the order and POLST form match to ensure the staff know the appropriate code status for the 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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Residents' Rights Regarding Treatment and Advance Directives, dated [DATE], documents Policy: It is the policy of this facility to support and facilitative a resident's right to request, refuse and or/discontinue medical or surgical treatment and to formulate an advance directive. Definitions: Advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health are when the individual is incapacitated. Policy Explanation and Compliance Guidelines: 1. The facility will include in the standing orders: Advance directive as indicated by the resident and/or resident representative. 5. Upon admission, should the resident/resident representative execute a new advance directive; or, if a resident or resident representative changes the advance directive c. The advance directive will be added to Physician Orders. e. The original of the POLST will be scanned into resident record after signed by the physician.

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F 0600

Level of Harm - 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 49187

Based on Observation, Interview and Record Review, the facility failed protect a resident from staff-to-resident verbal and mental abuse for one of three residents (R315) reviewed for abuse in the sample of 39. This failure resulted in R315 experiencing extreme fear and mental anguish.

Findings include:

The facility's Abuse, Neglect and Exploitation Policy, dated 12/5/2022 documents Policy: Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents must not be subject to abuse by anyone, including but not limited to facility staff, other residents, consultants, contractors, volunteers, or staff of other agencies serving the resident, family members, legal guardians, friend, or other individuals. Definitions: 2. Abuse means the willful infliction injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial wellbeing. 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. Willful means the individual acted deliberately, not that the individual must have intended to inflict injury or harm. 3. Verbal Abuse means the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to resident or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. 6. Mental abuse also includes abuse that is facilitated or caused by nursing home staff or using photographs or recording in any manner that would demean or humiliate a resident(s).

R315's Admission Record documents R315 is an [AGE] year-old female who admitted to the facility on [DATE]. This same form documents R315 has the following diagnoses: Dementia without behavioral disturbance, Major Depressive Disorder, Hypothyroidism, Type Two Diabetes Mellitus, Hypertension, and Gastro-esophageal Reflux Disease.

R315's BIMS (Brief Interview of Mental Status), dated 7/24/24, documents R315 has moderately impaired cognition.

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(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 - Actual harm Residents Affected - Few	R315's State Final Report, dated 7/28/24, documents Conducted an interview on 7/28/24 at approximately 1:35 AM with Certified Nursing Assistant (CNA) 2 (identified as V10/CNA), who witnessed CNA 1 (identified as V17/Agency CNA) shoving her phone in (R315's) face and telling her to call the jail to come get her. (V10) intervened and (V17) then walked back to the nurse's station, while (V10) tried comforting resident. Conducted an interview on 7/28/24 at approximately 1:45 AM, with CNA 3 (identified as V8/CNA) and she stated (V17) was screaming and walking up to (R315) aggressive and yelling at (R315) and just very aggressive. (V8) walked over to resident sitting in her wheelchair and offered water, as (V17) walked away. This same Final Report documents allegations against (V17) are substantiated based on two CNA witnesses (V8 and V10). (V17) worked for an outside agency. Agency is aware and that (V17) will not be allowed to return to work at this facility. On 7/30/24 at 9:45 AM R315 was lying in her bed and was dressed appropriately. A large purplish/black bruise was observed to R315's posterior right wrist. R315 looked terrified and tearfully stated, I am afraid of some of the staff here. I was screamed at and threatened multiple times the other night and I was scared. I am not sure who the person was. They told me I was going to go to jail. I don't feel safe. On 7/30/24 at 1:40 PM V10/CNA stated, On 7/28/24 around 12:30 AM (R315) started screaming help me from her room. (V8/CNA) and I went to (R315's room) to see what was going on. When we entered her room (R315's) voice was hoarse and she was saying I can't breathe. I took her vital signs, and they were within normal limits. (V8) and I went to the nurse and reported that (R315) stated she couldn't breathe. (V8), (V17/Agency CNA), and I were all by the nurse's station when we heard (R315) keep screaming from her room. (V17) then said, Oh no we aren't doing this tonight. (V17) then starting aggressively walking towards (R315's) room. (V8) and I started walking towards (R315's) room and beat (V17) to (R315). (V8) and I were trying to calm (R315) down from yelling, but she was agitated. (V8) and I decided to give (R315) some space in the lobby area and started walking down a different hallway to provide care to other residents. (V17) was near the nurse's station at that time charting. (V8) and I then could hear (R315) start screaming again. (V8) and I saw (V17) walk over to (R315) and she started screaming in (R315's) face telling her to shut up, you're nothing but a nuisance, and that she needed to sit down. When (V17) started yelling at (R315), (R315) looked scared, started screaming louder, and was crying. (R315) went over to the couch in the lobby area and sat down. As I started walking down the hallway, I heard what sounded like a slap. I immediately went back to the lobby area and asked what happened. (R315) was screaming help me I want to leave at that time. (V17) stated as she was walking towards (R315) when she tripped over the couch and the couch moved. (V17) stated the sound I heard was from the couch sliding. During this time (R315) was still screaming for help. (V17) then aggressively went over to (R315) pulled out her cellphone and dialed 911 on the screen. (V17) then shoved the cell phone in (R315's) face and said Call the cops because you are going to jail. The jail is right down the street and that is where you are going for acting like this. Come on call them. (R315) was really screaming and crying then. I then intervened and told (V17) she could not act like that to a resident and notified (V18/Agency Licensed Practical Nurse) of (V17's) behavior. (continued on next page)

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(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 - Actual harm Residents Affected - Few	On 7/31/24 at 9:55 AM V8/CNA stated, I witnessed (V17/Agency CNA) be verbally and mentally abusive to (R315). (R315) was walking down the hallway screaming in the middle of the night. (V17) was at the desk and said something like we are not doing this tonight. (V10) and I tried to comfort (R315) but she was agitated. We left (R315) in the lobby area to calm down and give her space. (V17) was at the nurse's station charting during this time. When I was walking down a different hallway with (V10) I heard (R315) start yelling again asking for help and screaming she wanted to leave. I then heard and saw (R315) walk over towards (R315) and started screaming at her and pointing fingers in her face. (V17) was screaming You are being a nuisance, I told you we aren't doing this tonight, you do this every night I work, and I am done. I couldn't hear everything (V17) was saying because (R315) was screaming and crying. I then witnessed (V17) pull out her cellphone, dial 911, and shove it in (R315's) face telling (R135) to call the cops because she was going to send her (R315) to jail and kept screaming in (R315's) face that the jail was right down the street and that's where she (R315) is going to live. I was scared of (V17's) behavior and scared for (R315). (R315) was very scared and crying. (V10) and I walked up to (R315) to comfort her. (V10) told (V17) to stop and (V17) walked way. I reported it to (V18/Agency Licensed Practical Nurse) with (V10) and was told by (V18/Agency Licensed Practical Nurse) to call (V1/Administrator in Training) so I did. On 7/31/24 at 2:45 PM V1/Administrator in Training stated, (V8/CNA) and (V10/CNA) called and reported to me alleged verbal and mental abuse from (V17/Agency CNA) to (R315). (V8) and (V10) both stated they witnessed the abuse. (V17) will not be allowed to come back to work here. I have not spoken with (R315) yet regarding the incident and wasn't aware that she stated she was scared. We don't have a Social Service Director, so no one has been able to provide psychosocial support for her after the alleged incident on 7/28/24. V1/Administrator in Training also verified that she had no record of Abuse Training for (V17) from the facility. V1 stated she has a binder at the nurse's desk that the agency staff reads and signs off on but verified that the abuse policy was not in the binder.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49187 Based on interview, observation, and record review the facility failed to immediately report verbal abuse and report an injury of unknown origin to the abuse coordinator for two of three residents (R47, R315) reviewed for abuse in the sample of 39. Findings include: The facility's Abuse/Neglect/ and Exploitation Policy, dated 12/5/22, documents, 6. Identification of Abuse, Neglect, and Exploitation- The facility will consider factors indicating possible abuse, neglect, and or/exploitation of residents, including, but not limited to, the following possible indicators: b. Physical marks such as bruises or patterned appearances such as a handprint, belt, or ring mark on a resident's body. c. Physical injury of a resident, of unknown source. e.Verbal abuse of a resident overheard. 14. In response to allegations of abuse, neglect, exploitation or mistreatment, the facility must: a. Ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately to the administrator of the facility. 1. R315's Admission Record documents R315 is [AGE] year-old female who admitted to the facility on [DATE]. This same form documents R315 has the following diagnoses: Dementia without behavioral disturbance, Major Depressive Disorder, Hypothyroidism, Type Two Diabetes Mellitus, Hypertension, and Gastro-esophageal Reflux Disease. R315's Skin Observation, dated 7/24/24, documents No skin concerns noted. No bruising, pressure wounds, swelling, or redness noted. On 7/30/24 at 9:45 AM R315 was lying in her bed. On R315's posterior right wrist, a large baseball size purplish/black bruise was observed. R315 stated that she wasn't sure what caused the bruise to her right wrist, but that it hurts. On 7/30/24 at 10:18 AM V7/Licensed Practical Nurse was in R315's room and observed the baseball size bruise to R315's right posterior wrist. V7 stated, I work a lot on this hall and I have not noticed the bruise on R315's right wrist. That bruise was not there a few days ago, it looks new. I am not sure what caused it. On 7/30/24 at 2:36PM V1/Administrator in Training stated, No one has reported to me a bruise of unknown origin to R315's right wrist. If there is an injury or bruise of unknown origin discovered, staff should immediately notify me as I am the abuse coordinator. 50627 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 07/30/24 at 10:15 AM, R47 was lying in bed in her room. R47 stated back in March she had an incident with (V7, Licensed Practical Nurse). R47 stated V7 told her I do not appreciate you coming to find me and approaching me about your medicine. I will come back to your room and give you your medicine. R47 stated later V7 came in her room and stated to R47 You are nothing but a pain seeker and pill popper. R47 stated when she reported this to the V23 (Former Director of Nursing) she was moved to another hallway and not given any notice. R47 stated she was told by V23 that this was the solution. R47's current electronic medical record does not document any reported abuse allegations of staff to resident verbal abuse for the past year. On 7/30/2024 at 11:52 AM, V1 (Administrator in training) stated I was aware of the verbal abuse allegation, but anything medication wise, I let to the DON (Director of Nursing) handle. I am aware it was a verbal abuse allegation. (V23) was handling it. At this time V1 confirmed she does not have any abuse documentation or any reported incidents to document any of R47's verbal abuse and intimidation allegations.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 50627 Based on interview and record review, the facility failed to investigate an allegation of staff to resident verbal abuse for one of three residents (R47) reviewed for abuse in the sample of 39 Findings include: The facility's Abuse, Neglect and Exploitation policy, reviewed/revised dated 12/5/2023, documents Investigation of Alleged Abuse, Neglect and Exploitation- When suspicion of abuse, neglect or exploitation occur, an investigation is immediately warranted. Once the resident is cared for and initial reporting has occurred, an investigation should be conducted. Components of an investigation may include. Interview the involved resident, if possible, and document all responses. If resident is cognitively impaired, interview the resident several times to compare responses. If there is no discernible response from the resident, or if the resident's response is incongruent with that of a reasonable person, interview the resident's family, responsible parties, or other individuals involved in the resident's life to gather how he/she believes the resident would react to the incident. Interview all witnesses separately. Include roommates, residents in adjoining rooms, staff members in the area, and visitors in the area. Obtain witness statements, according to appropriate polices. Document the entire investigation chronologically. On 07/30/24 at 10:15 AM, R47 was lying in bed in her room. R47 stated I used to love it here but then back in March when I was on hospice and needed morphine. I put my call light on and waited for an hour and a half. After that I got into my wheelchair and went to find my nurse, (V7, Licensed Practical Nurse). Once I found (V7), she told me I do not appreciate you coming to find me and approaching me about your medicine. I will come back to your room and give you your medicine. After getting my medication, (V7) left the room and then came back in and said, 'You are nothing but a pain seeker and pill popper.' At this time R47 was crying and said she has a lot of medical issues and is in pain all the time. R47 stated she doesn't deserve to be treated like this. R47 stated when she reported this to the V23 (Former Director of Nursing) she was moved to another hallway and not given any notice. R47 stated she was told by V23 that this was the solution. R47 stated that a few weeks ago she did have V7 as her nurse and she did not receive her medicine. R47 stated when she asked V7 for her medication V7 stated I don't know, your nurse has them. R47 stated later that day V23 approached her and stated, Never speak to (V7) again. Do not talk to her again. R47 stated she used to love it at the facility, but now all she wants to do is stay in her room and feels very lonely. R47 stated The facility only cares about the staff and does not protect the residents. R47's current electronic medical record does not document any allegations or investigation of resident to staff verbal abuse for the past year. On 7/30/2024 at 11:52 AM, V1 (Administrator in training) stated I was aware of the verbal abuse allegation, but anything medication wise, I let to the DON (Director of Nursing) handle. I am aware it was a verbal abuse allegation. (V23) was handling it. At this time V1 confirmed she does not have any abuse documentation, investigation or reported incidents to document any of R47's verbal abuse and intimidation allegations. V1 also confirmed she also does not have any documented measures to prevent R47 from being abused, feeling intimidated or feeling scared after the alleged incident.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 32061 Based on interview and record review the facility the failed to notify the facility Ombudsman monthly of resident transfers to the hospital and failed to provide the resident and resident representative with a written notice of transfer. This failure has the potential to affect all 64 residents currently residing in the facility. Findings Include: 1.) R3's medical record documents that R3 was transferred to a local hospital on 7/11/24. No evidence of a facility notification of a transfer/discharge was present on R3's chart. 2.) R18's medical record documents that R18 was transferred to a local hospital on 6/22/24. No evidence of a facility notification of a transfer/discharge was present on R18's chart. 3.) R27's medical record documents that R27 was transferred to a local hospital on 1/28/24. No evidence of a facility notification of a transfer/discharge was present on R27's chart. 50627 4.) R5's medical record documents that R5 was transferred to a local hospital on 3/8/2024. No evidence of a facility notification of a transfer/discharge was present on R5's chart. 33985 5.) R48's Progress Notes, dated 7/18/2024, documents the following: R48 was admitted to the local hospital after a functional decline. No evidence of a facility notification of a transfer/discharge was present in R48's chart. 49187 6.) R52's medical record documents that R52 was transferred to a local hospital on 4/22/24. No evidence of a facility notification of a transfer/discharge was present on R52's chart. 7.) R315's medical record documents that R315 was transferred to a local hospital on 7/24/24, 7/28/24, and 7/29/24. No evidence of a facility notification of a transfer/discharge was present on R315's chart. On 7/31/24 at 10:30 A.M., V1/Administrator in Training verified that the facility was unable to provide documentation that residents or their representative are provided with a written notice of transfer. At that time, V1/Administrator in Training also confirmed that she had not sent notification to the local Ombudsman of monthly facility transfers/discharges. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	The facility's CMS (Centers for Medicare and Medicaid Services) Long Term Care Facility Application for Medicare and Medicaid Form 671 dated 7/29/24 and signed by V1/Administrator in Training documents 64 residents currently reside within the facility.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32061 Based on interview and record review the facility failed to provide a copy of the bed hold policy for facility residents discharging to the hospital. This failure has the potential to affect all 64 residents currently residing in the facility. Findings Include: The facility policy, Bed Hold Notice Upon Transfer, dated (revised) 12/23/22 documents, At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or their representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed. 1.) R3's medical record documents that R3 was hospitalized on [DATE]. R3's medical record does not contain documentation of written notice to R3 or R3's resident representative, of the facility bed hold policy. 2.) R18's medical record documents that R18 was hospitalized on [DATE]. R18's medical record does not contain documentation of written notice to R18 or R18's resident representative, of the facility bed hold policy. 3.) R27's medical record documents that R27 was hospitalized on [DATE]. R27's medical record does not contain documentation of written notice to R27 or R27's resident representative, of the facility bed hold policy. On 7/30/24 at 1:30 P.M., V1/Administrator In Training verified that the facility did not provide R3, R18, R27 or their representative with a a Bed Hold Policy or a written Notice of Transfer. 50627 4.) R5's medical record documents that R5 was transferred to a local hospital on 3/8/2024. R5s medical record does not contain documentation of written notice to R5 or R5's resident representative, of the facility bed hold policy 33985 5) R48's Progress Notes dated 7/18/2024 at 7:15 PM documents the following: R48 was admitted to the hospital after a functional decline. R48's medical record does not have any documentation to show R48 or R48's representative received the written notice of the bed hold policy. 49187 6.) R52's medical record documents that R52 was hospitalized on [DATE]. R52's medical record does not contain documentation of written notice to R52 or R52's resident representative, of the facility bed hold policy. (continued on next page)

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	145431	A. Building B. Wing	08/01/2024

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

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	7.) R315's medical record documents that R315 was hospitalized on [DATE], 7/28/24, and 7/29/24. R315's medical record does not contain documentation of written notice to R315 or R315's resident representative, of the facility bed hold policy. On 7/30/24 at 1:30 P.M., V1/Administrator in Training verified that the facility was unable to provide documentation that residents or their representatives have been provided a bed hold policy when residents are sent out to the hospital. V1/Administrator in Training stated, We (the facility) do not have a Social Service Director and only have an Interim-Director of Nursing, so I am not sure the nursing staff are even aware to give residents a bed hold policy when they discharge to the hospital. The facility's CMS (Centers for Medicare and Medicaid Services) Long Term Care Facility Application for Medicare and Medicaid Form 671 dated 7/29/24 and signed by V1/Administrator in Training documents 64 residents currently reside within the facility.

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 08/01/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 33985 Based on record review and interview the facility failed to ensure the care plan was updated for one of 24 residents (R17) in a sample of 39 reviewed for care plans. Findings Include: The facility policy, named Care Plan Revision Upon Status Change, revised 1/25/2024, documents the following, The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. Policy Explanation and Compliance Guidelines: 1.) A comprehensive care plan will be reviewed, and revised as necessary, when the resident experiences a status change.) The care plan will be updated with the new or modified interventions. R17's Face Sheet, dated 7/7/2024, documents: Special Instructions: UNDER NO CIRCUMSTANCES IS V21- R17's Friend, ALLOWED TO TAKE R17 OFF THE PROPERTY. V21 is allowed to visit; V21 is allowed to go outside with resident as long as they DO NOT leave the property. V21 is NOT allowed to bring in outside food and beverages. The facility Resident/Family Complaint, dated 7/8/2024, documents the following: R17 left the building with V21/R17's Friend and did not return to the building until around 3:00 PM that day. When V4/Activity Director brought R17's absence up to the attention of V12/LPN (Licensed Practical Nurse) she did not seem to have a concern about R17 or that V22/R17's Family Member, was very worried about R17. (R17) left the facility with V21/Friend at 8:00 AM and R17 had not returned in four hours. On 7/29/2024 at 2:33PM V2/Interim DON (Director of Nurses) stated, R17's care plan is not updated to show the special instructions that R17 is not to leave the facility with R17's significant other (V21).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 38396 Based on observation, interview and record review, the facility failed to provide a resident with scheduled Physician ordered showers for one of one resident (R12) reviewed for hygiene in the sample of 39. Findings include: The facility's Activities of Daily Living (ADLs) policy, dated 12/5/23, documents Care and services will be provided for the following activities of daily living: Bathing, dressing, grooming and oral care. Assisting with coordinating other care and physician services. This same policy documents A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. R12's current Care Plan, dated 6/1/24, documents (R12) has an ADL self-care performance deficit related to dementia, spinal stenosis, depression, altered mental status. Interventions/Tasks: Bathing/Showering; Requires staff supervision with showering. Prefers a bath at least one time weekly. This same care plan documents R12 is cognitively intact has diagnoses of Sciatica, Pain in Joints, Difficulty in Walking and Lack of Coordination. On 7/29/24 at 12:18 PM, V20 (R12's Family Member) stated She (R12) isn't getting showers. She's went weeks without a shower. R12's current Physician Orders, dated 7/30/24, documents R12 has a physician order to Start antibacterial soap daily to bathe/shower 7 days prior to surgery (start July 29, 2024) every day and night shift prior to surgery until 8/5/2024. On 7/30/24 at 9:25 AM R12 was sitting in her room in a recliner chair. R12 stated I am not happy about much here anymore. Residents suffer cause we can't get the help we need due to staff always being busy. I need a bath everyday this week. I am not getting them for some reason. I was supposed to have one yesterday and did not get it. On 7/31/24 at 10:00 AM V1 (Administrator in Training) stated the staff should document in the computer when they give residents baths or showers. R12's electronic shower/bath task dated, July 2024, documents R12's last shower or bath was given on 7/23/24. On 8/1/24 at 9:33 AM, V29 (Certified Nursing Assistant) stated staff usually do a shower sheet for baths and showers and they are documented in the computer. On 8/1/24 at 1:30 PM V11 (Vice President of Clinical Operations) provided R12's paper shower sheet documentation for July and confirmed the two most recent showers that R12 received took place on 7/23/24 and 7/31/24 (missing two scheduled showers on 7/29 and 7/30/24.)

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** 33985 Based on record review and interview the facility failed to ensure that a mentally ill resident did not leave the building unsupervised for one (R17) of three residents reviewed for Safety in a sample of 39. Findings Include: The facility policy, Accidents and Supervision, dated 1/5/2023, documents, The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and the facility will provide the adequate supervision. R17's Diagnosis Information documents the following diagnosis: Cerebral Infarction Frontal Lobe with Executive Function deficit, Alcohol Induced Dementia, Alcohol Dependence, Schizoaffective Disorder, Bipolar Type, Schizophrenia, Major Depressive Disorder, moderate, Anxiety Disorder, and Cognitive Social Deficit. On 7/29/2024 at 10:36 AM V1/Administrator in Training, stated, R17 left the faciity on [DATE] with V21 (R17's Friend) to go out for lunch. V22 (R17's Family Member), informed staff later that day, that R17 should never leave the facility with V21. They both are alcoholics, and this is why I do not want her going out with V21. When they are together, they drink a lot and they both get out of control. The previous facility should have sent you the paperwork and informed you of this. I am R17's HCPOA (Health Care Power of Attorney), and I do not want R17 leaving the facility with V21. On 7/30/2024 at 8:45 AM V4/Activity Director stated, I called V22 (R17's Family Member), because I was concerned. V21 (R17's Friend) had taken R17 out in the morning and R17 had been gone more than four hours. I was getting worried. We were not informed that R17 was not to go out of this facility with V21. On 7/29/2024 at 3:35 PM V12/LPN (Licensed Practical Nurses), stated, I allowed R17 to leave the facility with V21 (V17's Friend). I had no idea that R17 was not to leave the facility with V21. No one had told me this or I must have missed this in report, and it was not flagged anywhere in the chart. R17 signed herself out. R17 was alert and oriented when R17 left. R17 was gone at least six hours and came back in good spirits, did not smell like alcohol, and did not act like she was drinking. The local police were called by V22 (R17's Family Member). V22 told the police that R17 was missing, R17 was not missing. At the time that R17 left I did not realize that R17 was a recovering alcoholic. I guess I did not pay attention to what was in her chart. The local police were called, and they wanted me to call them when R17 came back to the facility. I called the police when R17 came back to the facility. The police did an assessment on R17 to ensure that R17 was not under the influence of alcohol and R17 was not. R17 told me that she drank a glass of wine with dinner.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 49187 Based observation, interview and record review, the facility failed to ensure an indwelling urinary catheter tubing was off the floor and an indwelling catheter urinary drainage bag was covered for one of two residents (R15) reviewed for indwelling catheters in the sample of 39. Findings include: The facility's Catheter Care Policy, dated 1/24/23, documents Policy: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. Policy Explanation: 2. Privacy bags will be available and catheter drainage bags will be covered at all times while in use. R15's Order Summary, dated 7/30/24, documents the following physician order: Maintain indwelling catheter with 16 french 20 cubic centimeter balloon. R15's current Care Plan, dated 5/1/24, documents I have an Indwelling (Urinary) Catheter related to obstructive uropathy and urinary strictures. On 7/29/24 at 9:51 AM R15 was sitting in her wheelchair in the middle of the memory care unit hallway. R15's indwelling urinary catheter drainage bag was attached underneath her wheelchair uncovered with the indwelling urinary catheter tubing lying on the floor. On 7/30/24 at 1:24 PM R15 was sitting in her wheelchair in her room watching television. R15's indwelling urinary catheter drainage bag was attached underneath her wheelchair uncovered and visible from the hallway. R15's indwelling urinary catheter tubing was lying on the floor underneath her wheelchair. V9/Licensed Practical Nurse verified R15's indwelling urinary catheter drainage bag was uncovered, and her indwelling urinary catheter tubing was lying underneath R15's wheelchair on the floor. V9 stated, (R15's) urinary catheter bag should be covered with a dignity bag and the tubing should not be dragging on the floor. I am not sure why it is. On 7/30/24 at 2:51 PM V2/Regional Nurse Consultant stated, Staff should always ensure resident's urinary catheter drainage bags are placed in a privacy bag and the catheter tubing should never be dragging on the floor. The staff know that.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 35509 Based on Interview and record review, the facility failed to provide eight hours of Registered Nurse Coverage seven days a week. This has the potential to affect all 64 residents living in the facility. Findings: The Facility's Nursing Schedule for the month of July states there is no Registered Nurse coverage for the following days: 7/06/24; 7/07/24; 7/13/24; 7/20/24; 7/21/24; 7/26/24; 7/27/24; 7/28/24. The document, (Facility) Daily Posting of Nurse and Certified Nurse Assistant, was also checked for Registered Nurse (RN) coverage. Several days (which are the same dates of no RN coverage) were not posted: 7/06/24; 7/07/24; 7/13/24; 7/20/24; 7/21/24; 7/26/24; 7/27/24; 7/28/24. This was confirmed by V1, Administrator in Training, on 7/31/24 at 2:15 PM. On 8/01/24 at 10:25 AM, V1, Administrator in Training, stated, We have given you what you requested, including the Agency Nurses that worked. It has been difficult to have Registered Nurse coverage on weekends. The facility's Long-Term Care Facility Application for Medicare and Medicaid Form CMS (Centers for Medicare and Medicaid Services) 671 dated 7/29/24, signed by V1, Administrator in Training, documents 64 residents currently reside within the facility.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 35509 Based on observation, interview and record review, the facility failed to have the Daily Posting of Nurse and Certified Nurse Assistant posted each day. This has the potential to affect all 64 residents living in the facility. Findings: The document, (Facility) Daily Posting of Nurse and Certified Nurse Assistant, could not be provided for the following days: 7/02/24; 7/04/24; 7/06/24; 7/07/24; 7/13/24; 7/14/24; 7/20/24; 7/21/24; 7/25/24; 7/26/24; 7/27/24; 7/28/24; 7/29/24. On 7/29,24 at 9:15 AM, the Daily Posting of Nurse and Certified Nurse Assistant posting which was located on the Receptionist's desk in the Faciity's Lobby, was dated, 7/25/24. On 7/31/24 at 2:15 PM, V1, Administrator in Training, confirmed these postings were not available, stating, No, the Daily Posting of Nurse and Certified Nurse Assistant were not always posted. The facility's Long-Term Care Facility Application for Medicare and Medicaid Form CMS (Centers for Medicare and Medicaid Services) 671 dated 7/29/24, signed by V1, Administrator in Training, documents 64 residents currently reside within the facility.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 50627 Based on observation and record review, the facility failed to ensure the medication error rate was less than five percent with two medication errors in a medication pass sample of 29, making the medication error rate 6.9% for one of five residents (R5) reviewed for medication administration in the sample of 39. Findings include: R5's current Medication Administration Record (MAR), dated 7/1/24-7/31/24, documents R5 has an order for blood glucose monitoring followed by a sliding scale Insulin Aspart Injection Solution 100 units/milliliter. Inject as per sliding scale: if 110 - 140 = 5; 141 - 169 = 6; 170 - 199 = 7; 200 - 229 = 8; 230 - 259 = 9; 260 - 289 = 10; 290 - 319 = 11; 320 - 349 = 12; 350 - 399 = 13 call provider for above 400, subcutaneously before meals related to Type Two Diabetes Mellitus This (MAR) documents administration times are 7:30 AM, 11:30 AM and 5:30 PM, before meals. R5's current Medication Administration Record (MAR), dated 7/1/24-7/31/24, documents, R5 has an order for Metformin Oral Tablet (medication to lower blood sugar) 500 milligrams. Give 500 mg by mouth one time a day related to Type two Diabetes Mellitus. Scheduled time is 8:00 AM. On 7/29/24, at 10:30 AM, V14 (Registered Nurse/RN) checked R5's blood glucose level and then administered R5's Metformin by mouth in a spoon with a sip of water. On 7/29/24, at 10:40 AM, V14 verified that R5's blood sugar monitoring with sliding scale insulin should have been given before R5 ate breakfast and that R5's Metformin should have been given at 8:00 AM. V14 stated I am new here and this is my first day, I am just learning the floor. The Facility Medication Administration Policy Dated 1/4/2023 documents Medications administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. This policy also documents for medication administration Administer within 60 minutes prior or after scheduled time unless otherwise ordered by physician. The facility must ensure that it is free of medication error rates of five percent or greater as well as significant medication error events. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility Medication Error Policy, dated 9/28/2023, documents It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents care and services safely in an environment free of significant medication errors. Medication Error means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order; manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication or biological; or accepted professional standards and principals which apply to professionals providing services. This policy also documents The facility must ensure that it is free of medication error rates of five percent or greater as well as significant medication error events. The facility will consider factors indicating errors in medication administration, including, but not limited to, the following: a. Medication administered not in accordance with the prescriber's order. Examples include but not limited to incorrect dose, route of administration, dosage form, time of administration, medication omission, and incorrect medication.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50627 Based on Observation, Interview and Record Review, the facility failed to monitor blood sugar glucose levels and administer physician ordered sliding scale insulin timely, hold subsequent doses of insulin after a medication error, ensure a physician prescribed medication for Parkinson's (Sinemet) was dose adjusted and reordered to prevent withdrawal of therapeutic medication levels and complete medication error reports after errors were identified for two of five residents (R5, R52) reviewed for medications in the sample of 39. This failure resulted in R5 eating breakfast without scheduled insulin, suffering fatigue, drowsiness, confusion, and an elevated blood sugar level of 487 and resulted in R52 not receiving Sinemet for 25 days, resulting in increased tiredness, unsteady gait, increased tremors and decreasing the therapeutic blood level of R52's Sinemet from the prescribed dosage increase plan. Finding include: The Facility Medication Administration Policy, dated [DATE], documents Medications administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. This policy also documents for medication administration Administer within 60 minutes prior or after scheduled time unless otherwise ordered by physician. The Facility Medication Error Policy, dated [DATE], documents It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents care and services safely in an environment free of significant medication errors. Medication Error means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order; manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication or biological; or accepted professional standards and principals which apply to professionals providing services. Significant medication error means one which causes the resident discomfort or jeopardizes his/her health and safety. This policy also documents The facility must ensure that it is free of medication error rates of five percent or greater as well as significant medication error events. The facility will consider factors indicating errors in medication administration, including, but not limited to, the following: a. Medication administered not in accordance with the prescriber's order. Examples include but not limited to incorrect dose, route of administration, dosage form, time of administration, medication omission, and incorrect medication. This policy also documents If a medication error occurs, the following procedure will be initiated. The nurse assesses and examines the resident's condition and notifies the physician or health care practitioner as soon as possible. Monitor and document the resident's condition, including response to medical treatment or nursing interventions. Document actions taken in the medical record. Once the resident is stable, the nurse reports the incident to the appropriate supervisor and completes the incident or occurrence report. The Facility Timely Administration of Insulin Policy Dated [DATE] documents It is the policy of this facility to provide timely administration of insulin in order to meet the needs of each resident and to prevent adverse effects on a resident's condition. This same policy documents All insulin will be administered in accordance with physician's orders. Insulin administration will be coordinated with mealtimes and bedtime snacks unless otherwise specified in the physician order. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The facility's Medication Reordering Policy, dated [DATE], documents, Policy: It is the policy of this facility to accurately and safely provide or obtain pharmaceutical services including the provision of routine and emergency medications and biologicals in a timely manner to meet the needs of each resident. Definitions: Acquiring medication is the process by which the facility requests and obtains a medication. Policy Explanation and Compliance Guidelines: 1. Acquisition of medications should be completed in a timely manner to ensure medications are administered in a timely manner. 3. Each time a nurse is administering medications and observes (6) or less doses left of one kind, that nurse will reorder the medication, time permitting. 1. R5's current Medication Administration Record (MAR), dated [DATE]-[DATE], documents R5 has an order for blood glucose monitoring followed by a sliding scale Insulin Aspart Injection Solution 100 units/milliliter. Inject as per sliding scale: if 110 - 140 = 5; 141 - 169 = 6; 170 - 199 = 7; 200 - 229 = 8; 230 - 259 = 9; 260 - 289 = 10; 290 - 319 = 11; 320 - 349 = 12; 350 - 399 = 13 call provider for above 400, subcutaneously before meals related to Type Two Diabetes Mellitus. This (MAR) documents administration times are 7:30 AM, 11:30 AM and 5:30 PM, before meals. R5's current Care Plan, dated ,d+[DATE], documents (R5) has Type 2 Diabetes Mellitus. Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Fasting Serum Blood Sugar as ordered by doctor. Monitor/document/report as needed any signs or symptoms of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul (abnormal rapid breathing) breathing, acetone breath (smells fruity), stupor, coma. On [DATE] at 10:30 AM, R5 was sitting in his room in a wheelchair. R5 appeared to be tired and had difficulty keeping his eyes open when spoken to. R5 did not give verbal response when questioned and required assistance with taking morning medications. At this time V14 (Registered Nurse) confirmed that R5 did not have a 7:30 AM blood glucose check or insulin and that R5 has already eaten breakfast. V14 stated she is new and just hadn't got to R5 yet during her morning medication pass. At 10:40 AM, V14 checked R5's blood sugar and the result was 487. V14 then left R5 in his room and went to the nurse's station. On [DATE] at 11:28 AM, V13 (R5's Nurse Practitioner) called V14 (Registered Nurse) and gave a verbal telephone order for R5 to be given 14 units of Insulin Aspart subcutaneously and recheck blood sugar in 15 minutes. On [DATE] at 11:42 AM, V14 administered 14 units of Insulin Aspart to R5. R5's MAR dated [DATE]-[DATE] documents on [DATE] at 12:24 PM R5's blood sugar was 356 and V14 administered another 13 units of scheduled Insulin Aspart. This same MAR documents on [DATE] at 5:30 PM, R5's blood glucose level was 91 and no sliding scale Insulin Aspart was indicated to be administered. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 1:49 PM, V13 (R5's Nurse Practitioner) confirmed she gave a one-time order for R5's insulin on [DATE] when his blood sugar was elevated. V13 stated she was not made aware that R5 missed his 7:30 AM blood glucose monitoring and sliding scale insulin that morning. V13 stated I was not aware that (R5) had eaten without insulin. Knowing that may have changed my treatment. I would not expect the high dose of insulin to be given and then administer another large amount of insulin less than an hour later. The additional 13 units of sliding scale insulin should have been held. (R5's) blood sugar should have just been monitored at that point since the one-time dose was given so close to the next scheduled sliding scale dose. (R5) is not typically sleepy or lethargic when I see him in the facility. That was likely from eating and missing the morning insulin which resulted in his blood sugar elevating. Nurses should be letting me know all the facts. I depend on them to alert me of changes since they see the residents every day and can recognize what is and isn't normal. R5's current electronic medical record does not document a medication error report was completed for R5's insulin medication error on [DATE]. On [DATE] at 10:30 AM, V1 (Administrator in Training) stated she does not have a medication error report for R5. 49187 2. R52's Neurology After Summary Visit, dated [DATE] and signed by V15 (R52's Neurology Nurse Practitioner), documents Read the attached information 1. Carbidopa; Levodopa Tablets 2. Parkinson's Disease. Start Sinemet 25-l00 mg (milligram) tablets. Week l: 0.5 tablet in AM, Week 2: 0.5 tablet twice a day. Week 3 and 4: 0.5mg TID (three times a day). (The Facility) staff is to update this office weekly while titration. Will send refills if tolerating. This same Summary Visit had attached information as follows: Carbidopa; Levodopa Tablets- treats the symptoms of Parkinson disease. It works by increasing the amount of dopamine in your brain, a substance which helps manage body movements and coordination. This reduces the symptoms of Parkinson, such as body stiffness and tremors. Do not stop taking except on your care team's advice. You may develop a severe reaction. Parkinson's Disease- causes problems with movements. It makes it harder for you to walk or control your body. It is a long-term condition that gets worse over time. Symptoms of this condition can vary. The main symptoms can be seen in your movement. These include shaking or tremors that you cannot control. This happens while you are resting. Stiffness in your neck, arms, and legs. Trouble making small movements that are needed to button your clothing or brush your teeth. Losing facial expressions. Walking in a way that is not normal. You may walk with short, shuffling steps. Loss of balance when standing. You may sway, fall backward, or have trouble making turns. R52's MAR (Medication Administration Record), dated [DATE], documents no administration of Sinemet from [DATE] to [DATE] or a new physician order to give Sinemet for a total of 19 missed days. R52's Fax Sheet, dated [DATE] and signed by V15/R5's Neurology Nurse Practitioner, documents Resume Sinemet ,d+[DATE] titration as attached on this prescription. Nursing to contact once beginning of Week 4 with an update of medication (or sooner if needed). Will determine new dose adjustment after update is received. Do not allow medication to expire. R52's MAR, dated [DATE], documents no administration of Sentiment from [DATE] to [DATE] or a new physician order to give Sinemet for a total of five missed days. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 9:54 AM, R52 had a (electronic wandering monitor bracelet) located on her left wrist. Resident was sitting on the couch sleeping in the activity room on the memory care unit. On [DATE] at 10:11AM, R52 was sitting hunched over on the couch sleeping in the activity room on the memory care unit. R52 was non-responsive to verbal stimuli. V9 (Licensed Practical Nurse) stated, (R52) has been sleeping all day recently. That is not like (R52). When (R52) does wake up she has been shaky and has an unsteady gait. I am not sure what is going on with her. V9 confirmed that (R52's) Sinemet order had expired on [DATE]th and no new order was received from V15's (R52's Neurology Nurse Practitioner) office before it expired. On [DATE] at 1:41 PM, V16/Neurology Office Nurse stated she was unaware that R52's Sinemet order had expired and that this is not the first time (the facility) has allowed this to happen. V16 stated, (R52) came to our office in [DATE] due to the family having concerns with (R52's) gait, balance, increased tremors, and sleepiness. (V15/R52's Neurology Nurse Practitioner) wrote a new order to start Sinemet for Parkinson's Disease. (V15) wrote the order to titrate the dose over four weeks. Before the four weeks were up the facility was supposed to update us with how (R52) was tolerating the new medication and to not allow the medication prescription to expire. We (Neurology) did not receive an update and did not know the facility allowed the Sinemet order to expire. (The facility) did not call our office until [DATE] letting us know they had allowed the Sinemet order to expire and forgot to call and give us an update. (The facility) reported (R52) had not received the Sinemet since [DATE]. (The facility) reported at that time they noticed a difference when (R52) was on the Sinemet and that she was more awake, and alert and her balance was much better. (V16) wrote a new order on [DATE] to start the Sinemet titration over again and for the facility to call our office to update how (R52) is tolerating the mediation. It was instructed to call us before week four was up and to not allow the medication order to expire. (The facility) has not called us to give us an update and I was unaware (R52) has not received her Sinemet since [DATE]. (R52) could experience increased fatigue, unsteady gait, and tremors for stopping the medication once again. On [DATE] at 2:30 PM, V2 (Regional Nurse Consultant/Interim Director of Nursing) stated she was unaware that R52 has not been receiving her Sinemet or that the facility did not call to give Neurology an update and allowed the medication order to expire and that this is the second time it has happened. V2 stated, I am unsure what the nurses are supposed to do when a medication has been missed or a medication error has been made. They should have caught it before hand and called the ordering physician. I would have to look at the Medication Policy to see what the nurses should have done. No medication error report was filled out for the missed doses of Sinemet in June or [DATE]. On [DATE] at 10:30 AM, V28/R52's Primary Physician stated the facility did not notify him of needing an updated order for R52's Sinemet in June or [DATE] or that R52 had missed doses of her Sinemet. V28 stated, (R52) could experience increased tremors and excessive tiredness when stopping Sinemet. It's not good (R52) missed her doses. It doesn't cause a long-term effect, but It can cause a short-term effect for (R52).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35509 Based on Observation, Interview and Record Review, the facility failed to: properly cool down and document potentially hazardous foods; maintain a clean kitchen; label food items; discard outdated food items; replace rusted shelving. This has the potential to affect all 64 residents living in the facility. Findings: The document Cooling Cooked Potentially Hazardous Foods/Time Temperature Controlled for Safety, dated 1/16/24, states, Hot foods are cooled in the refrigerator from 135 degrees Fahrenheit (F) to 70 degrees F within two hours. Within four more hours the food is cooled to 41 degrees F. Cooling time from 135 degrees F to 41 degrees F does not exceed a total of six hours. The time and temperature are recorded at the beginning of the cooling process. The timing of the cooling process begins when the temperature of the food is at 135 degrees F. Two hours later the temperature is taken and recorded. The food needs to be 70 degrees F or lower. If the food is not 70 degrees F or lower, the food is discarded. The temperature is taken and recorded again four hours later. The food needs to be 41 degrees F or lower. If the food is not 41 degrees F or lower, it is discarded. The United States Department of Agriculture, (USDA) Hazard Analysis Critical Control Points (HACCP) Cool Down Temperature Log, states, The total cooling process may not exceed six hours. Potentially hazardous foods must be cooled from 135 degrees Fahrenheit (F) to 70 degrees F within two hours. These food items must be chilled from 70 degree F to 41 degrees F or below within four hours. Record temperatures every hour during the cooling cycle. Record corrective actions, if applicable. The food service manager will verify that food service employees are cooling food properly by visually monitoring foodservice employees during the shift and reviewed, initialing, and dating this log each working day. Maintain this log for a minimum of one year. The documents, Cooling Down Foods - Tracking Chart, (for potentially hazardous foods) provided by the facility are inconsistently filled in and difficult to decipher. The year was not written on the charts. There are no Cool Down Temperature charts for the months of 8/2023; 9/2023; 12/2023; 3/2024; 4/2024; 5/2024; only one temperature is recorded for 2/2024 and 6/2024. A total of 13 Cool Down Temperatures were provided for the past 12 months. The temperature at six hours is not recorded for several foods and many of the temperatures at two hours are also blank without documentation. The food temperatures taken by staff were not initialed or verified/initialed by the Dietary Manager. On 7/29/24 at 10:45 AM. V5, Dietary Manager, stated, Yes, we are supposed to fill in the Cool Down Temperature Logs but the log for July isn't filled in. I've only been here for six weeks, and I don't know why the charts were not completely filled in or why not all the months had logs of the cool down temperatures. They should have been. I do know that the meals we served today were cooked this morning. (continued on next page)

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Loft Rehabilitation & Nursing	700 North Main Street Eureka, IL 61530

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The document, Cleaning Schedule Policy, dated 1/16/24, states, The healthcare community stores, prepares, distributes and serves food in a sanitary manner to prevent foodborne illness. A daily cleaning schedule will be posted in the kitchen with specific cleaning assignments to include both routine cleaning/sanitizing tasks along with deep cleaning tasks. Director of Food and Nutrition Services will review the cleaning a schedule each day to assure the tasks have been completed in a satisfactory manner. The documents, Cleaning Matrix, the form is undated, state, These are daily requirements. If you see something needs to be cleaned at any time, you are expected to do so. AM Cook. Every morning check labeling and dating. Deep Clean Preparation Area. PM Cook. Clean preparation shelf. Empty/Clean/Re-Organize utensil containers /drawers; Degrease and clean oven. AM Dietary Aide. Wipe down all doors in kitchen; clean refrigerator by sink; clean refrigerator in (food) preparation area. PM Dietary Aide. Clean refrigerator in (food) preparation area; Clean refrigerator by sink. Not all kitchen areas/items are included on the cleaning charts. The document, Ice Dispensing, dated 1/16/24, states, The ice machine is cleaned at a frequency specified by the manufacturer or absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold. On 7/29/24 at 10:05 AM, on the plate that is the threshold for the ice well in the interior of the ice machine had visible wet/slimy in appearance pink and brown spots of a substance, on its lip. The ice machine was full, and the ice was within touching distance of the substance. V5, Dietary Manager (DM), confirmed the substance, stating, I didn't notice that it needed cleaning. Food splashes of unknown origin were on the walls of the kitchen. The bottom area along the walls and around standing appliances had an accumulation of old black grime, grease and dirt. The floors had a sticky dried substance that was not fresh. Drawers containing cooking utensils had crumbs in the bottoms of the drawers. The ceiling of the microwave oven had old unknown brown dried food particles. The doors on the bottom of the storage unit by the range had a sticky grease residue covering. The ovens and range grease trays needed contained dried grease. The reach in cooler doors needed to be wiped down on the inside and outside. The air vent unit on the wall in the kitchen had rust and accumulated dust on the grill. The racks on the shelving units holding pots and pans and various vessels were rusted. V5 confirmed these deficiencies that needed cleaning, stating, 'I've been trying to get everyone to help get the kitchen cleaned up. I didn't know rust was an issue in the kitchen. The document, Storage of Dry Goods/Foods, dated 1/16/24, states, Food stored in bins (e.g., flour or sugar) is removed from original packaging. Bins are labeled and dated. Opened products are labeled, dated with the use by date and tightly covered to protect against contamination from insects and rodents. Opened products that have not been properly sealed and dated are discarded. The document, Storage of Refrigerated Foods Policy, dated 1/16/24, states, Refrigerated food is stored in a manner that ensures food safety and preservation of nutritive value and quality. Food in the refrigerator is covered, labeled and dated with a use by date. Open products that have not been properly sealed and dated are discarded. (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/29/24 at 10:15 AM, the cooler contained a one-gallon jar of mustard, 20 percent full, with a brown crusty substance along the lid area. A 21 fluid ounce container of an electrolyte replacement beverage was opened, 30 percent full, no open date or label. An eight fluid ounce container of a Thickened Dairy Beverage had an expiration date of 7/25/24. Two opened two-pound containers of vanilla yogurt, each 50 percent full, did not have a label or open date. Both had received by dates of 6/26/24. A half of a case of thawed eight-ounce health shakes were in the cooler. These did not have a thaw date. V5, Dietary Manager, confirmed these deficiencies in the cooler, and stated, I didn't know that the thaw date was needed. I'll need to get in touch with the company. Enclosed inside a large metal container sitting under the food preparation area were a 50-pound sack of sugar, 25 percent full and a 50-pound sack of rice, 80 percent full, both in their original paper packing. When the bag of sugar was lifted, a 50-pound paper sack, empty and scrunched remained in the container. The container did not have a label describing its contents and the lid was not tight fitting failing to seal the container when closed. V5 stated, I've been trying to get some new storage containers but haven't got around to it. The upstairs dining room's refrigerator held three take out containers that appeared to have been in the refrigerator for some time. These contained lasagna; beef stew with potatoes on top of rice; unknown dried food item, possibly hamburger. There were no labels or dates on the containers. The refrigerator also held two custard pies, loosely covered with parchment paper, dated 7/22/24 to be used 7/24/24; an eight fluid ounce container of a Thickened Dairy Beverage had an expiration date of 4/26/24; an opened 10 ounce jar of medium chunky salsa, 25 percent full, had a crusty substance surrounding the lid, without an open date or label; a half full plastic cup containing an unknown substance did not have a label or date; a five pound 50 percent full container of Parmesan cheese did not have a label or open date. V5 acknowledged these deficiencies. The facility's Long-Term Care Facility Application for Medicare and Medicaid Form CMS (Centers for Medicare and Medicaid Services) 671 dated 7/29/24, signed by V1, Administrator in Training, documents 64 residents currently reside within the facility.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 38396 Based on interview, observation and record review, the facility failed to provide oversight and leadership to Administrator in Training and nursing staff to ensure implementation of its policy and procedures regarding advanced directives, abuse prevention, abuse reporting, abuse investigation, hospital transfers, medication administration, medication errors, resident supervision, quality assurance meetings and infection Preventionist requirements. Cross reference F578, F600, F607, F609, F610, F623, F625, F689, F727, F759, F760, F868 and F882. These failures have the potential to affect all 64 residents residing at the facility. Findings include: The facility's Administrator job description, dated June 2021, documents Major duties and responsibilities: Plans, develops, organizes, implements, evaluates and directs the overall operation of the facility as well as its programs and activities, in accordance with current state and federal laws and regulations. Identifies, in conjunction with the Director of Nursing and selected department heads, the facility's key performance indicators. Establishes an ongoing system to monitor these key indicators such as the Quality Assurance and Performance Improvement process throughout the facility. Evaluates key performance indicator outcomes with department heads to determine the need for action from leadership and/or management such as re-education or revision related to the facility's outcomes, regulatory compliance and/or customer satisfaction. Ensures implantation of any and all new policies, procedures, guidance and regulations as directed by the (facility) corporate team. Ensures delivery of excellent customer service and compassionate quality care and services across an interdisciplinary team approach as evidenced by adequate, and competent facility staff, employee turnover, general cleanliness, physical plant condition, and optimal resident functioning-physically and psychosocially. Ensures resident incidents and concerns that rise to a reportable event such as alleged abuse, neglect, mistreatment, misappropriation, etcetera, are reported to the correct entity within the stated regulatory requirement. Promotes safe work practices, safety rules, and accident prevention procedures to prevent employee injury and illness. The facility's Social Services Designee job description, dated June 2021, documents The Social Services Designee will assist the Administrator in the planning, developing, organizing, implementing, evaluating, and directing of social services programs of this facility. The social service designee will meet with administration, medical and nursing staff, and other related departments in planning social services, as directed. The social services designee will assist the administrator in ensuring that staff members are knowledgeable about resident's rights and encourage staff to maintain and enhance each resident's dignity in recognition of each resident's individuality. The social services designee will engage in advance care planning for assigned residents upon admission, and make sure that any advanced directives are reviewed with the resident/resident representative on a regular basis. The social worker will ensure that staff members are made aware of the resident's code status and end of life wishes and will assist with informing and educating residents and their representatives about health care options and ramifications. The social services designee will advocate for residents and assist them in assertion of their rights within the facility. The social services designees will assist with investigations of abuse allegations. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Facility Assessment, dated 7/24/24, document the facility's provided services and care is based off of residents needs and includes the following roles; Administration, Social Services, Director of Nursing and Infection Control and Prevention Specialist. R315's State Final Report, dated 7/28/24, documents witnessed verbal abuse and intimidation from V17 (Certified Nursing Assistant) to R315 on 7/28/24, was substantiated. On 7/31/24 at 2:45 PM, V1 (Administrator in Training) stated (V17) will not be allowed to come back to work here. I have not spoken with (R315) yet regarding the incident and wasn't aware that she stated she was scared. We don't have a Social Service Director, so no one has been able to provide psychosocial support for her after the alleged incident on 7/28/24. V1 also verified that she had no record of Abuse Training for (V17) from the facility. V1 stated she has a binder at the nurse's desk that the agency staff reads and signs off on but verified that the abuse policy was not in the binder. On 7/30/24 at 10:15 AM, R47 stated she had an incident with a nurse (V7, Licensed Practical Nurse) where V7 made her feel afraid to speak to her. R47 stated she ended up being moved to a different room and the former Director of Nursing (V23) acted like it was her fault. R47 stated that V7 still works in the facility and has spoken to her since the incident but they do not get along. On 7/30/24 at 11:52 AM, V1 (Administrator in training) stated I was aware of the verbal abuse allegation (for R47), but anything medication wise, I let the DON (Director of Nursing) handle. I am aware it was a verbal abuse allegation but (V23) was handling it. At this time V1 confirmed she does not have any abuse documentation, investigation or reported incidents to document any of R47's verbal abuse and intimidation allegations. V1 confirmed she also does not have any documented measures to prevent R47 from being abused, feeling intimidated or feeling scared after the alleged incident. On 7/29/24 at 12:18 PM, V20 (R12's Family Member) stated she has concerns with the facility not doing what is best for the residents. V20 stated R12 has lived in the facility for several years and lately they have had more problems. V20 stated In the Spring 2024, other family alerted us that (R12) wasn't acting herself. (R12) said she wasn't getting her medications and when I asked about this, the Administrator (in Training, V1) said I don't know what the nurses do. That was all the resolution we received. On 7/29/24, at 10:40 AM V14 (Registered Nurse) completed a significant medication error after not administering R5's scheduled accucheck and insulin prior to the breakfast meal. V14 went to the nurses station after R5's blood glucose monitoring result was elevated and outside of insulin parameters. V14 stated she needed to notify R5's provider (V13, R5's Nurse Practitioner). V14 looked around the nurses station and was unable to locate a phone number for V13 for 10 minutes. V14 then picked up the phone to call V1 (Administrator in Training) and stated Today is my first day, I don't know the flow or where things are. I am not sure how to dial out on the telephone. I don't even know what the Administrator (in training) looks like. I don't think (the facility) has a DON. At 10:50 AM, V1 came to the nurses station and also searched for several minutes before locating V13's telephone number for V14 to call. R52's Medication Administration Record, dated July 2024, documents no administration of R52's Sinemet from 7/25/24 to 7/30/24 or a new physician order to give Sinemet for a total of 5 missed days. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/30/24 at 2:30 PM V2 (Interim Director of Nursing) stated she was unaware that (R52) has not been receiving her Sinemet or that the facility did not call to give Neurology an update and allowed the medication order to expire. V2 confirmed this is the second time it has happened. V2 stated, I am unsure what the nurses are supposed to do when a medication has been missed or a medication error has been made. They should have caught it before hand and called the ordering physician. I would have to look at the Medication Policy to see what the nurses should have done. No medication error report was filled out for the missed doses of Sinemet in June or July 2024. On 7/30/24 at 1:30 P.M., V1(Administrator in Training) verified that the facility was unable to provide documentation that residents or their representatives have been provided a bed hold policy when residents are sent out to the hospital. V1 stated, We (the facility) currently do not have a Social Service Director and only have an Interim-Director of Nursing, so I am not sure the nursing staff are even aware to give a bed hold policy to resident's when they discharge to the hospital. On 7/30/24 at 2:15 PM V1 (Administrator in Training) verified R15 and R60's Physician order and POLST (Physician Order for Life Sustaining Treatment) form do not match. V1 stated, Social Services is responsible for ensuring the resident's physician order for advance directives match the resident's current POLST form. We (the facility) currently don't have a Social Service Director, so I have been trying to help with the advance directives. I have not done an audit to ensure the order and POLST form match to ensure the staff know the appropriate code status for the residents. On 7/31/2024 at 11:35 PM V1 (Administrator in Training) confirmed that V2 is the Interim Director of Nursing and is filling duties for the facility's Infection Control Preventionist. V1 stated, I was not able to locate the Infection Preventionist certificate. On 7/31/24, at 11:00 AM, V1 (Administrator in Training) stated she has her temporary Nursing Home Administrator license and started working as the facility's administrator on 8/13/2023. On 8/1/24 at 11:35 AM, V1 confirmed the facility has several agency nurse and nursing assistants. V1 stated The nurses on the floor are responsible for reconciling physician orders and making sure they are implementing those. (V2, Interim Director of Nursing) has been helping out as well. When Nurses or CNA's (Certified Nursing Assistants) are agency they are orientated when they come in for their first shift. I orientate now, or the CNA or Nurse that they are working with will. So when a new agency nurse comes here there is a binder they are to look at and the nurse working with them should train them. Monday (7/29/24) we had two agency nurses (V14 Registered Nurse and V24 Licensed Practical Nurse) and so (V12 Licensed Practical Nurse) was our nurse who should be making sure (V14) was orientated since it was her first day. (V12) was also training (V35, Licensed Practical Nurse) and they were downstairs working on the 600 hall. (V14) was working upstairs. V1 confirmed she was made aware of more abuse concerns this week. V1 stated We have had the two prior abuse citations recently. One was in April and another in June. Both were sexual abuse and the same perpetrator. We talk about Abuse in QAA (Quality Assessment and Assurance) monthly and we started talking about it more in April with the first Abuse citation we received. We don't have a designated Infection Control Preventionist (ICP), those duties have been completed by the DON. I know they are supposed to be separate roles. We didn't have either the ICP or the DON at our July meeting. In March I think I just wasn't able to be there (QAA meeting) that day and in November we didn't have the Medical Director present (at the QAA meeting). (continued on next page)

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 08/01/2024

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Long-Term Care Facility Application for Medicare and Medicaid Form CMS (Centers for Medicare and Medicaid Services) 671 dated 7/29/24 documents 64 residents currently reside within the facility.

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 08/01/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 38396 Based on Interview and Record Review, the facility failed to ensure the required members attended the facility's scheduled Quality Assurance meetings. This failure has the potential to affect all 64 residents residing in the facility. Findings include: The facility's Facility Assessment, dated 7/24/24, documents the assessment was reviewed on 7/24/24 with the QAA/QAPI (Quality Assessment and Assurance/Quality Assurance and Performance Improvement) committee. The facility's QAPI plan, dated 7/3/24, documents The QAA committee will review data from areas the organization believes it needs to monitor on a monthly basis to assure systems are being monitored and maintained to achieve the highest level of quality for our organization. Members of the QAA committee may be added according to the perceived needs of the community, however will have as key members the following positions: Medical Director, Administrator, Director of Nursing, Regional Nurse Consultant, Regional Operations Consultant, Infection Preventionist. The facility's (undated) Quality Assurance Committee list, provided by V1 (Administrator in Training), does not include an Infection Control Preventionist (ICP). The facility's QA (Quality Assurance) sign in sheet, dated 7/25/24, documents the Interim Director of Nursing (DON, V2) was not in attendance to the July 2024 meeting. The facility's QA sign in sheet, dated 3/13/24, documents the only members in attendance to the March 2024 QA meeting were V23 (Former Director of Nursing), V28 (Medical Director) and V34 (former Dietary Manager). The facility's QA sign in sheet, dated 11/16/23, documents the facility's Medical Director (V28) was not in attendance. On 8/1/24 at 11:35 AM, V1 (Administrator in Training) confirmed that all required members have attended the quarterly QAA meetings. V1 stated We don't have designated ICP, those duties have been completed by the DON. I know they are supposed to be separate roles. We didn't have either the ICP or the DON at our July meeting. In March I think I just wasn't able to be there that day and in November we didn't have the Medical Director present. The facility's Long-Term Care Facility Application for Medicare and Medicaid Form CMS (Centers for Medicare and Medicaid Services) 671 dated 7/29/24 documents 64 residents currently reside within the facility.

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 08/01/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 33985 Based on record review and interview the facility failed to ensure that they had a qualified Infection Preventionist and failed to obtain the certificate to show the completion of the training. This failure has the potential to affect all 64 resident residing in the facility. Findings Include: The Facility Assessment, dated July 24, 2024, documents the following: Training requirements. A facility must develop, implement, and maintain an effective training program for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment. On 7/30/2024 at 2:23 PM V2/Interim DON (Director of Nurses) stated, I will try to find the certificate to show that I have completed the appropriate infection control training. I didn't see it after I was done with the training. Yes, I just completed most of the training late in the evening yesterday, 7/29/2024 at 6:10 PM. I stayed up last night to try and get it all done. All the training to become an Infection Preventionist was not done prior to your entrance on 7/29/24. On 7/31/2024 at 11:35 PM V1/Administrator in Training stated, I was not able to locate the Infection Preventionist certificate. The facility's Long-Term Care Facility Application for Medicare and Medicaid Form CMS (Centers for Medicare and Medicaid Services) 671 dated 7/29/24 and signed by V1/Administrator in Training, documents 64 residents currently reside within the facility.