STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145600	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab & Nursing of Canton	2081 North Main Street Canton, IL 61520

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify a resident's representative of a significant change of medication regimen for one of three residents (R1) reviewed for notification of change in a sample of three. Findings include:The facility's Notification of Changes Policy dated 2/10/25, documents Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Compliance Guidelines: The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member of legal representative when there is a change requires such notification. Circumstances requires notification of change include: 3. Circumstances that require a need to alter treatment. This may include b. Discontinuation of current treatment due to i. Adverse consequences. ii. Acute Condition. Iii. Exacerbation of a chronic condition. 2. Residents incapable of making decisions: a. the Representative would make any decisions that have to be made. b. The resident should still be told what is happening to him or her.R1's admission Record dated 8/4/25, documents R1 was admitted to the facility on [DATE] with the following, but not limited to, diagnoses: Chronic Obstructive Pulmonary Disease, Alzheimer's Disease, and Chronic Atrial Fibrillation.R1's Order Audit Report dated 8/4/25, documents R1's Xarelto (blood thinner) 15mg (milligram) tablet daily was discontinued on 3/31/25.R1's entire Clinical Record does not document evidence of R1 or V5 (R1's Power of Attorney) being notified of R1's Xarelto being discontinued.On 8/4/25 at 9:28 AM V5 (R1's Power of Attorney) stated, I was never notified (R1's) Xarelto was discontinued. I am very upset about this, because I feel like (R1) needed to be on the Xarelto due to (R1) having Atrial Fibrillation.On 8/4/25 at 5:51 PM V8 (Hospice Nurse Practitioner) stated I do not recall giving (V1 Administrator) an order to discontinue (R1's) Xarelto. I would not have discontinued (R1's) Xarelto without discussing it with (V5 R1's Power of Attorney or V6 R1's spouse) and (V13 Hospice Physician). I did not notify (V5) or (V6) of (R1's) Xarelto being discontinued because I wasn't aware it was discontinued.On 8/5/25 at 7:47 AM V6 (R1's Spouse) stated he was at the facility everyday with R1 and was involved in her care. V6 stated he was never made aware that R1's Xarelto was discontinued.On 8/5/15 at 11:40 AM V2 (Director of Nursing) stated if a medication has been discontinued then the resident and the resident's representative should be notified. If the resident is on hospice and the order is from hospice, then hospice would be the ones who would notify the family.On 8/5/25 at 1:32 PM V1 (Administrator) stated, I am the one who entered the verbal order to discontinue (R1's) Xarelto on 3/31/25. I received a verbal order from (V8 Hospice Nurse Practitioner) on 3/31/25 but wrote the order from (V13 Hospice Physician). I did not notify (R1), (V5 R1's Power of Attorney) or (V6 R1's Spouse) when I wrote the verbal order to discontinue R1's Xarelto on 3/31/25. Hospice should have been the ones to notify (R1) and (V5). V1 verified at this time that R1's medical record does not include documentation of R1 or V5 being notified of R1's Xarelto being discontinued.

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 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. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the resident's representative was involved with the interdisciplinary team quarterly to review and revise a resident's care plan for one of three residents (R1) reviewed for care plans in a sample of three. Findings include: R1's Care Plan Sign in Sheet, dated 5/13/25, only documents V4's (Social Service Director) signature as attending R1's care plan meeting held on 5/13/25. R1's IDT (Interdisciplinary) Care Plan Care Conference, dated 5/13/25, documents V4 (Social Service Director), R1, V6 (R1's Spouse), and V7 (R1's Family Member) attended the care conference. This same Care Conference documents (R1) had her care plan today, (V6 R1's Spouse) and her son (identified as V7 R1's Family Member) attended. Due to no other department managers being available for the care plan the family would like it rescheduled for about a month with all department managers. On 8/4/25 at 9:28 AM V5 (R1's Power of Attorney) stated (R1) admitted to the facility on [DATE]. We (the family) had a big meeting with the interdisciplinary staff on 2/18/25. During that meeting it was told to us that they schedule meetings every three months with the family to go over (R1's) progress or (R1's) care in general. The facility scheduled a meeting sometime in May and the only person from the facility that attended (R1's) care plan meeting was (V4 Social Service Director), not the whole team as promised. (V6 R1's Spouse) and (V7 R1's Family Member) were there for the meeting and ready to discuss where (R1's) care was at and how she was doing. On 8/5/25 at 7:47 AM V6 (R1's Spouse) stated I showed up to the care plan meeting on 5/13/25 with (V7 R1's Family member) to discuss (R1's) care. I had many concerns I wanted to go over with (R1's) care that I wanted different departments to answer to. When (V7) and I arrived at this meeting, the only person that was in attendance was (V4 Social Service Director). (V7) and I both voiced concerns regarding (V4) being the only one at the care plan meeting, when there were other issues in other departments that needed address to have a better plan in place for (R1's) care. (V4) told us the other departments she invited to the care plan meeting told her they were unable to attend that morning, so that is why it was just (V4). (V4) told us we would have to reschedule a care plan meeting for (R1) if we wanted more than just her in the meeting. I don't feel like that is right when we were promised to have meeting to discuss (R1's) care at least every three months with a team of people. On 8/4/25 at 11:15 AM V4 (Social Service Director) stated she is the one in charge of scheduling care plan meetings and conducting the care plan meetings with the residents, family members, and members of the interdisciplinary team including, Activities, Nursing, Dietary, and Therapy (if resident is on therapy). V4 stated when a resident arrives to the facility she will schedule an initial care plan meeting with the interdisciplinary team, the resident, and family and then schedule them quarterly after that to keep everyone on the same page. V4 stated, I set up (R1's) quarterly care plan meeting for 5/13/25 with (R1), (V6 R1's Spouse), and (V7 R1's Family Member.) (V5 R1's Power of Attorney) could not make the meeting because he lives out of state. When (V6) and (V7) arrived at the facility for (R1's) care plan meeting, I was the only available person to attend (R1's) care plan meeting from the facility. No other department was able to attend. (V6) stated he wanted everyone to be at the care plan meeting because he wanted to discuss (R1's) overall care, so I told (V6) we would have to reschedule the care plan meeting. I email all departments that are supposed to attend the care plan meetings every Monday for the scheduled resident's care plan meetings of the week. If someone out of the department cannot attend, they should make me aware as soon as possible so I can let the family and resident know ahead of time or we (the facility) can figure out someone else out of that department to attend. Whoever attends would sign the sign in sheet and the sign in sheets are accurate. V4 stated the care plan meeting was rescheduled for 6/17/25 but was never conducted because R1 passed away on 6/13/25. On 8/4/25 at 2:12 PM V3 (Vice President of Clinical Services) stated a care conference should be scheduled with the resident and (if available) the resident's representative at least every three months. The care conferences should consist of the Dietary Manager, MDS (Minimum Data Set) Coordinator, a facility Nurse, Social Services, Activities, the resident, and (if available) the resident's representative to discuss a resident's plan of care as a group and to ensure the resident's needs are being met. On 8/5/25 9:50 AM V15 (Dietary Manager) stated I get notified weekly by email of the resident care plan meetings schedule for that week. I sometimes must work in the kitchen if we have a call in or I may be ill so I can't always make the care plan meetings. I would sign the residents care plan conference sign in sheet if I attended the meeting. On 8/5/25 at 9:54 AM V10 (MDS Coordinator) stated I am the nurse they want going to the residents scheduled care plan meetings. I get notified via emails on

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident's anticoagulant therapy was maintained related to a diagnosis of Atrial Fibrillation, obtain a valid physician order prior to discontinuing the medication, and document clinical justification to discontinue a residents anticoagulant therapy for one of three residents (R1) reviewed for quality of care in a sample of three. These failures resulted in (R1) who was at high risk for thromboembolic (blood clots that form in one location and travel to another location, potentially blocking blood flow) events, experienced complications from a suspected complication of Acute Cerebrovascular Accident due to Cerebrovascular Disease and passed away after Xarelto was discontinued for 75 days without physician authorization or documented clinical justification.Findings include: R1's admission Record, dated [DATE], documents R1 was admitted to the facility on [DATE] with the following, but not limited to, diagnoses: Chronic Obstructive Pulmonary Disease, Alzheimer's Disease, and Chronic Atrial Fibrillation. R1's Order Summary Report, dated [DATE], documents an order for Xarelto (blood thinning medication) 15mg (milligrams) on [DATE] to be taken once daily. R1's Order Summary Report, dated [DATE], documents V1 (Administrator) received a verbal order on [DATE] from V13 (Hospice Physician) to discontinue R1's Xarelto. R1's Clinical Census documents R1 started receiving Hospice Services on [DATE]. R1's Plan of Care with a review date of [DATE] documents, (R1) is on anticoagulant therapy related to Chronic Atrial Fibrillation. Administer anticoagulant medications as ordered by physician. Monitor for side effects and effectiveness every shift. This same plan of care documents (R1) has a personal history of cerebral infarction. Give Medications as ordered by physician. Monitor/document side effects and effectiveness. R1's Progress Note, dated [DATE] and signed by V12 (Licensed Practical Nurse) documents R1 passed away on [DATE] at 8:01 PM. R1's Certificate of Death, dated [DATE], documents date of death : [DATE]. Cause of Death: Complications from Suspected Acute Cerebrovascular Accident due to Cerebrovascular Disease. Xarelto's Warning Label, dated 3/2020, documents Warning: (A) Premature discontinuation of Xarelto increases the risk of thrombotic events. To reduce this risk, consider coverage with another anticoagulant if Xarelto is discontinued for a reason other than pathological bleeding or completion of a course of therapy. Indications and Usage: XARELTO is indicated to reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation. R1's entire Clinical Medical Record (including Hospice Medical Record) does not include evidence of a documented clinical justification of why R1's Xarelto was discontinued. There is also no evidence in R1's Clinical Medical Record of a Physician giving the order to discontinue R1's Xarelto medication or signing an order to discontinue R1's Xarelto medication. On [DATE] at 9:28 AM V5 (R1's Power of Attorney) stated at some point (R1) was taken off her blood thinner (Xarelto). I was not aware of this until I requested (R1's) medical records (after R1 expired) and did not see Xarelto on her medication list. I could not see where a physician discontinued her Xarelto but noticed (R1) had quit receiving at some point during her stay. I am very upset (R1) wasn't receiving her Xarelto throughout (R1's) entire stay because (R1) had Atrial Fibrillation and was at high risk for strokes. I would not have wanted (R1's) Xarelto to be discontinued and the facility and hospice were aware of that. On [DATE] at 10:48 AM V14 (Registered Nurse/Owner of Hospice) stated, We (hospice) send all current orders to the facility for each resident on our hospice. (V5 R1's Power of Attorney) called me after (R1) had passed away asking why (R1's) Xarelto had been discontinued. Our orders for (R1) did not show (R1's) Xarelto had been discontinued, nor do I have any signed order by a hospice physician or hospice nurse practitioner discontinuing (R1's) Xarelto. V14 verified there is no clinical justification to discontinue R1's Xarelto in R1's hospice medical records because they (hospice) still had the order as active. On [DATE] at 2:35 PM V9 (R1's Primary Physician) stated she did not authorize for R1's Xarelto to be discontinued. On [DATE] at 5:51 PM V8 (Hospice Nurse Practitioner) I do not recall giving (V1 Administrator) an order to discontinue (R1's) Xarelto. I would not have discontinued (R1's) Xarelto without discussing it with (V5 R1's Power of Attorney or V6 R1's spouse) and (V13 Hospice Physician). On [DATE] at 11:40 AM V2 (Director of Nursing) stated she responsible for medication oversight and hospice coordination. V2 stated, if a high-risk medication is being discontinued it would be my expectation for the nurse receiving the order or discontinuing the order to document the clinical justification to discontinue the medication. V2 verified at this time that she did not see clinical justification in R1's medical record after the discontinuation of R1's Xarelto on [DATE]. On [DATE] at 1:09 PM V13 (Hospice Physician) stated, I know Xarelto was on (R1's) medication list when admitting to hospice. I was not notified (R1's)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure coordination of care and communication between the facility and hospice provider for one of one resident reviewed for hospice services in a sample of three. Findings include:The facility's Agreement with Hospice Care, dated and signed [DATE], documents Coordination of Services: Hospice Provider and Facility have agreed to participate in a system of communication as described in Hospice Provider's policies and procedures to: 1. Ensure the Hospice Provider's IDG (Interdisciplinary Group) maintains responsibility for directing, coordinating, and supervising the care and services provided. 1. Ensure that the care and services are provided in accordance with Hospice Provider Plan of Care. 1. Ensure that the care and services provided are based on assessment of the Hospice Patient and family needs. 1. Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement. 1. Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions. 7. Coordination of Services for Hospice Residents. For Hospice Residents, Hospice Provider shall further coordinate services by: 1. Designating specific member of the hospice Provider IDG that will be responsible for a Hospice Resident. The designated Hospice Provider IDG member is responsible for: 1. Overall coordination of Hospice Care of the Hospice Resident with the Facility representatives. 1. Overall coordination of Hospice Care for the Resident with the Facility Representative. 1.Communicating with Facility representatives and other health care providers participating I the provision of care for the Terminal Illness and related conditions to ensure quality of care. 1. Hospice Provider must ensure that the Hospice Provider IDG communicates with the Medical Director of the Facility, the Attending Physician, and other physicians participating in the provision of care to the Hospice Resident as needed to coordinate the Hospice Care with medical care provided by other physicians.The facility's Coordination of Hospice Services, dated [DATE], documents Policy: When a resident chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practical physical, mental, and psychosocial well-being. Policy Explanation and Compliance Guidelines. 2. The facility and hospice provider will coordinate a plan of care and will implement interventions in accordance with the resident's needs, goals, and recognized standards of practice in consultation with the resident's attending physician/practitioner and resident' representative, to the extent possible.R1's Clinical Census documents R1 started receiving Hospice Services on [DATE]. This same Census documents R1 expired on [DATE] in house.On [DATE] at 2:35 PM V9 (R1's Primary Physician) stated she did not authorize for R1's Xarelto to be discontinued and was not aware of R1's Xarelto being discontinued. I noticed while reviewed (R1's) medical records on [DATE], (R1) had medication changes including the Xarelto medication being discontinued. Hospice has not collaborated with me at all. My expectation is to be involved in my patient's medication changes while on hospice including (R1's) medication changes, that just didn't happen. On [DATE] at 5:51 PM V8 (Hospice Nurse Practitioner) stated I do not recall giving (V1 Administrator) an order to discontinue (R1's) Xarelto. I would not have discontinued (R1's) Xarelto without discussing it with (V5 R1's Power of Attorney or V6 R1's spouse) and (V13 Hospice Physician). I did not notify (V5) or (V6) of (R1's) Xarelto being discontinued because I wasn't aware it was discontinued. When I would arrive to the facility for a visit, I would get in our hospice binder that the facility should be using for communication, and the orders would be missing or not put in there or the care plan would be gone. I would take notes to put in the binder myself and then the next time I arrived at the facility they would be gone. I tried to get a printout of our medication list and match it with the facility's and let them know if there was a discrepancy, but next time I would come in, it still wouldn't be fixed.On [DATE] at 7:47 AM V6 (R1's Spouse) stated he was at the facility everyday with R1 and was involved in her care. V6 stated he was never made aware that R1's Xarelto was discontinued. V6 stated, I just felt like the facility and Hospice were never on the same page. I am not sure where the gap is, but I just want to save someone else from having to go through what we went through with (R1) with communication between the facility and hospice. Neither one could tell us who was supposed to notify us of changes or why the Xarelto was discontinued.On [DATE] at 1:09 PM Interview with V13 (Hospice Physician) stated, I never met (R1) personally. I know Xarelto was on (R1's) medication list when admitting to hospice. When we (Hospice) go through resident's medications during admission, we try to minimize what