STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145647	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab of Peoria, The	1500 West Northmoor Road Peoria, IL 61614

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 30678 Based on observation, interview, and record review, the facility failed to ensure drug diversion of a narcotic did not occur for one (R1) of three residents reviewed for narcotic medications in the sample of eight. Findings include: The facility's undated Controlled Drug Policy and Procedure documents: To provide physical facilities and method of operation for the administration and control of narcotics, depressants, and stimulant drugs, which will meet the requirement of State and Federal narcotic enforcement agencies. Controlled drugs, as determined by the facility, are counted every shift by the nurse reporting on duty with the nurse reporting off-duty. The inventory of the controlled drugs must be recorded on the narcotic records and signed for accuracy of count. The controlled drug checklist must be signed by the nurse coming on duty and going off duty to verify that the count of all controlled drugs is correct, if used at facility discretion. The facility's Medication Storage policy and procedure, revised 12/20/23, documents: Narcotics and Controlled Substances: Schedule II drugs and back-up stock of Schedule III, IV and V medications are stored under double-lock and key. Schedule II controlled medications are to be stored within a separately locked permanently affixed compartment when other medications are stored in the same area, such as in a refrigerator. Any discrepancies which cannot be resolved must be reported immediately as follows: Notify the DON, charge nurse, or designee and the pharmacy; Complete an incident report detailing the discrepancy, steps taken to resolve it, and the names of all licensed staff working when the discrepancy was noted; The DON, charge nurse, or designee must also report any loss of controlled substances where theft is suspected to the appropriate authorities such as the local law enforcement, Drug Enforcement Agency, State Board of Nursing, State Board of Pharmacy, and possibly the State Licensure Board for Nursing Home Administrators. Staff may not leave the area until discrepancies are resolved or reported as unresolved discrepancies. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145647	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab of Peoria, The	1500 West Northmoor Road Peoria, IL 61614

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Pharmacy Services policy and procedure, revised 12/21/22, documents: It is the policy of this facility to ensure that pharmaceutical services, whether employed by the facility or under an agreement, are provided to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice. The facility in coordination with the licensed pharmacist, will provide for: A system of medication records that enables periodic accurate reconciliation and accounting for all controlled medications; Prompt identification of loss of or potential diversion of controlled medications; and Determination of the extent of loss or potential diversion of controlled medications. The pharmacist, in collaboration with the facility and medical director, should include within its services to: Determine (in accordance with or as permitted by state law) the contents of the emergency supply of medications and monitor the use, replacement, and disposition of the supply; and Provide feedback about performance and practices related to medication administration and medication errors. The facility's Abuse, Neglect, and Exploitation policy and procedure, revised 12/5/23, documents: Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a residents' belongings or money without the resident's consent. The Face Sheet for R1 includes the following diagnoses: Quadriplegia C1-C4 complete, Chronic Obstructive Pyelonephritis, Stage 2 Pressure Ulcer of Sacral Region, Low Back Pain, and Traumatic Left Hip Fracture. The current Physician Orders for R1 documents a physician order for Oxycodone 5 mg; give one tablet by mouth every six hours as needed for severe pain was ordered on 6/27/24. The current Care Plan for R1 documents R1 receives opiate medications related to Quadriplegia, has potential for pain related to Neuropathic pain with history of left hip fracture and stage II coccyx pressure ulcer. On 9/26/24 at 12:00 pm, R1 was sitting in a wheelchair in the dining room being assisted with meal. At 1:20 pm, R1 was being mechanically lifted from her wheelchair into bed and cares were provided. At 3:00 pm, R1 was lying in bed on her right side. R1 stated she doesn't take pain medications very often, but has them if she needs them. R1 stated she has pain off and on, and at the first of August she needed the Oxycodone for abdominal pain, but was told she didn't have any. R1 stated she asked to go to the hospital to get checked out. The MAR (Medication Administration Record) for R1, dated 7/1/24 through 7/31/24, documents R1 received three tablets of Oxycodone 5 mg during the month of July 2024; One tablet on 7/19/24, 7/25/24, and 7/26/24. The MAR for R1, dated 8/1/24 through 8/31/24, documents R1 did not receive any Oxycodone until 8/8/24. On 9/27/24 at 9:20 am, V2, DON (Director of Nursing), stated V11, Licensed Practical Nurse/LPN, informed her there was no Oxycodone for R1 in the medication cart. V2, DON, stated she called the Pharmacy and was told the medication had been delivered on the morning of 7/30/24. V2 was unable to locate the Packing Slip, Disposition Form, or the Oxycodone. V2 reported this to V1, Administrator, and an investigation was started. V2, DON, stated if the disposition sheet and the medication were missing, no one would have been able to count it, or know it was gone. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145647	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab of Peoria, The	1500 West Northmoor Road Peoria, IL 61614

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/27/24 at 9:25 am, V1, Administrator, stated she was notified by V2, DON, that a card of Oxycodone for R1 had been delivered on 7/30/24, and the staff could not find it. V1 stated she immediately started an investigation and was able to determine the medication was missing. V1 stated the facility video cameras were watched, medication carts and medication rooms were checked, and the locked document shred container was drilled open and searched. V1 stated inside the shred container there were the two packing slips for R1's Oxycodone proving the order date, when it was delivered, and an empty card of Hydrocodone. V1, Administrator, stated Nurses surrounding the time frame were interviewed, pharmacy was notified, and documents received regarding when medication was given, who gave the medication, and who ordered the medication. The Pharmacy was able to tell us that the Oxycodone was ordered three times, but the facility was unable to identify who ordered the medication due to the signatures being unidentifiable and not matching any of the Nurses working at the facility. On 9/27/24 at 12:15 pm, V11, LPN, stated she worked Friday 7/26/24 and gave (R1) Oxycodone on that Friday and she still had some, like half a card left. V11, LPN, stated she did not work again until the next Thursday, 8/1/24, and R1 complained of pain, and there wasn't any Oxycodone to give her. That is crazy she didn't have any pain medication. V11, LPN, stated she reported to V2, DON, who was going to call the pharmacy. V11, LPN, stated on Friday, 8/2/24, she was called to the office and V1, Administrator, and V2, DON, began asking (V11 LPN) about R1's pain medication. V11, LPN, stated she told V1 and V2 that (R1) doesn't ask for pain meds very often and (R1) had some the last day (V11) worked and when (V11) came back (R1) didn't have any. A Medication Error Report, #285 dated 8/2/24, documents: (Don/Director of Nursing) notified of issues with pain medication, Oxycodone. Through the course of initial investigation, it was identified that there was a full card of Oxycodone that had been delivered on 7/30/24 that was not present in the narcotic drawer. Resident went to the ER (emergency room) for c/o (complaints of) pain and reported to the ER that there was no pain medication available at (the facility). Immediate Action Taken: Investigation in progress. Final Five Day to Follow to (State Agency) 8/2/24. Has a UTI (urinary tract infection) per (local hospital) ER. DON on site to verify medication discrepancy. The facility replaced the missing medication for the resident, 8/2/24. The Daily Assignment Sheet for the 400 hall, dated 7/29/24 documents V20, LPN, worked the third shift from 6:00 pm to 6:00 am on 7/30/24. V19, Former LPN, worked on the 400 hall on 7/30/24 from 6:00 am to 6:00 pm. The Narcotic Shift Count form for the 400 hall medication cart, dated 7/4/24 through 7/30/24, documents the 400 hall narcotic medications were not consistently counted, by two Nurses, at shift changes on: 7/5/24, 7/6/24, 7/9/24, and 7/10/24 through 7/30/24. The 400 hall narcotic medications were not counted at all on: 7/7/24, 7/11/24, 7/12/24, 7/16/24, 7/19/24, 7/20/24, 7/21/24, 7/25/24, 7/26/24, and 7/27/24. The facility was unable to provide a Disposition form for R1's Oxycodone. The Daily Assignment Sheets document V19, Former LPN, worked the following days on the 400 hall: 7/15/24, 7/17/24, 7/18/24, 7/23/24,7/24/24, 7/27/24, 7/29/24, 7/30/24, and 7/31/24. The pharmacy Packing Slip and Packing Slip Proof of Deliver forms, dated 7/1/24, documents 30 tablets of Oxycodone 5 mg were ordered and delivered for R1. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145647	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab of Peoria, The	1500 West Northmoor Road Peoria, IL 61614

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided a Phone Reorder Form, dated 7/18/24 at 5:01 pm, documenting V19, Former LPN, attempted to reorder Oxycodone 5 mg for R1, which was not sent by the Pharmacy due to being too early and was previously delivered on 7/1/24. The facility provided two Medication Re-order Forms documenting that Oxycodone 5 mg was again re-ordered for R1 two times on 7/29/24 via fax (facsimile) machine, with unidentifiable signatures consisting of one straight line and one scribbled marking. The Daily Assignment Sheet, dated 7/29/24, documents V19, Former LPN, worked from 6:00 am to 6:00 pm. The pharmacy Packing Slip, dated 7/29/24, documents Oxycodone was ordered for R1 and the Packing Slip Proof of Delivery, dated 7/30/24, documents a card containing 30 Oxycodone 5 mg were delivered and signed for by V20, LPN, the third shift Nurse at 5:23 am. The facility's initial report to the State Agency, dated 8/2/24, documents the facility verified misappropriation of R1's narcotic Oxycodone on 8/2/24. DON notified of issues with pain medication, Oxycodone. The facility replaced the missing medication for the resident on 8/1/24. Through the course of the initial investigation, it was identified that there was a full card of Oxycodone that had been delivered on 7/30/24 that was not present in the narcotic drawer. The local Police were notified, and case (number) filed. Final to follow. The Facility investigation documents interviews were obtained on 8/2/24 from the Residents from the 400 hall and with V11, LPN/Licensed Practical Nurse, V19, Former LPN, V20, LPN, and V21, LPN. V11, LPN's, interview documents V11, LPN, dispensed one Oxycodone to R1 on 7/26/24 and recalls there being approximately a half of card (15) of Oxycodone remaining, and when she returned to work on 8/1/24 there was no Oxycodone available for R1. V19, Former LPN's, interview documents numerous attempts were made to contact V19 without success, and when V19 arrived at the facility for her 6:00 pm shift (V19) was immediately escorted to the conference room and advised she was being suspended for not following facility policy for narcotic count; reasonable suspicion of missing narcotics-Oxycodone. V19, Former LPN, denied knowing of anyone taking R1's medications from the facility. V19, Former LPN, stated, You all want to do a drug test, do it: when they low I re-order; resident (R1) asked for a pain med, look at the sheet; I be on my meds as (V2, DON) be on me to reorder; may have been a few on the card prompted me to reorder; don't remember calling in a refill; sometimes I count cards sometimes I don't; maybe I did fax. V20, LPN's, interview documents V21 stated she put away the narcotics when they came from pharmacy the morning of 7/30/24, did not leave anything unattended on the medication cart. V20, LPN, stated when she handed off the keys on 7/30/24 to V19, Former LPN, there were two cards of Norco (Hydrocodone) in the medication cart and no Oxycodone. V20, LPN, stated right after shift change, V19, Former LPN, left the facility to go get gas and left report on the medication cart. V21, LPN, denied seeing narcotics being taken out of the facility. This Report documents video surveillance verified: V20, LPN, placed narcotic medications into the 400 hall narcotic medication lock box on 7/30/24 prior to shift change; V19, Former LPN, with bizarre behaviors of shuffling through papers in a bin at the Nurses Station; V19 putting something under her jacket, between her lab coat and jacket; V19 going into the medication room at 5:18 am and coming out of medication room at 5:18 am, then going back into the medication room at 5:19 am and coming back out at 5:21 am, without taking anything in or out of the room; and V19, Former LPN, leaving the facility . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145647	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab of Peoria, The	1500 West Northmoor Road Peoria, IL 61614

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's investigation summary documents: The facility notified the provider of the issue and orders received to replace the missing medication/Oxycodone for (R1) on 8/1/24. (The facility) pharmacy notified and the facility assumed the charges for the missing medication so (R1) not responsible for the cost of replacement. (Local City) Police notified of incident report #24-16252. Nursing staff assigned to the cart interviewed. Schedule and delivery times verified, and nurse assigned during the time frame in question immediately suspended. Reeducation of narcotic policy /process started with licensed nursing staff. VP (Vice President) of Clinical Services assisted with the investigation. Recycle bins emptied; cart thoroughly checked and reconciled. R1 interviewed and denied current pain and stated she has received her pain meds when requested. Thirty resident interview and all state their medication needs have been met; they are receiving their pain meds to address pain, and all feel safe at the facility. The facility's Disposition documents: Through the course of the investigation the facility has substantiated missing medication/Oxycodone. The facility replaced the medication at no charge to the resident. The (City) Police Department notified and formal report made #24-16252; The officer stated there was not enough evidence to charge the suspended nurse member criminally. The suspended nurse was not reinstated; terminated for not following process and reasonable suspicion based on observations through the course of the investigation. The facility used this incident as an opportunity to improve its processes and provide additional reeducation on medication management/inventory control. The employee file for V19, Former LPN, includes a Disciplinary Action Form that was completed for V19, Former LPN, on 8/9/24. This form documents V19, Former LPN, was terminated on 8/9/24 for reasonable suspicion and not following facility policy and procedure for missing medications, medication administration, and narcotic counts.