STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145647	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2025

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 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. 50627 Based on interview and record review, the facility failed to report alleged physical abuse to the State Agency for one of six residents (R1) reviewed for abuse in the sample of six. Findings include: The Facility's Abuse, Neglect and Exploitation Policy, dated 12/5/2023, documents, When abuse, neglect or exploitation is suspected, the Administrator/Abuse Coordinator Designee should contact the State Agency to report the alleged abuse. The facility must annually notify covered individuals' obligation to comply with the following reporting requirements each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of or is receiving care from the facility. Each covered, individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. On 1/21/2025 at 2:25 P.M, V7 (Activities Aide) stated on 1/6/2025, R1 was in the dining room area and reported to V7, My aide hit me. V7 stated V7 reported what R1 had said to V1 (Administrator). On 1/22/2025 at 2:15 P.M, V1 (Administrator) confirmed V7 reported to V1 that R1 alleged a Certified Nursing Assistant/CNA had hit her. V1 verified an investigation into the allegation was started. V1 stated, I did not report this (alleged abuse) to the (local state agency). As of 1/22/25, the past six months of reports to the State Agency did not contain R1's abuse allegation made on 1/6/25.

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