

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 03/25/2026
NAME OF PROVIDER OR SUPPLIER Loft Rehab of Peoria, The		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to complete a thorough investigation and remove the perpetrator from resident cares while the investigation was underway for one of three residents reviewed for abuse in the sample of six. Findings include: The facility's Abuse, Neglect, Exploitation Policy, dated 1/23/26 documents, Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Definitions: Verbal Abuse- means the use of oral, written or gestured communication or sounds that willfully include disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Investigation of Alleged Abuse, Neglect and Exploitation- A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or report of abuse, neglect or exploitation occurs. B. Written procedures for investigation include: 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations: 6. Providing complete and thorough documentation of the investigation. V1. Protection of the Resident- The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation; D. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator. R2's admission Record documents R2 is a [AGE] year-old female who admitted to the facility on [DATE] with the following, but not limited to, diagnoses: Chronic Obstructive Pulmonary Disease, Anxiety Disorder, Bipolar Disorder, Age- Related Osteoporosis, and Generalized Muscle Weakness. R2's MDS (Minimum Data Set) Assessment, dated 2/25/26, documents R2 is moderately cognitively impaired. On 3/20/26 at 10:24 AM, V2/DON (Director of Nursing), stated V3/Assistant DON reported an allegation to her on 2/11/26. According to the report, a resident (R2) claimed two CNAs/Certified Nursing Assistant (V6 and V7) called her a c**t. V2 then instructed V3 to notify corporate staff V4/Vice President of Operations and V12/Regional Director of Operations, as they were covering for the Administrator (V1) that week. On 3/20/26 at 11:19 AM, V3/ADON stated, On 2/11/26 (R2) caught me in the dining room and reported to me that two CNA's (V6 and V7) had used foul language towards (R2) and called (R2) a c**t. I told (R2) I would investigate the situation. I immediately went and reported the allegation to (V2/DON) who told me I had to report it to the corporate staff (V4 and V12). I then immediately reported the alleged allegation to (V4 and V12). After (V4 and V12) spoke to (R2), they instructed (V6 and V7) to be removed from (R2's) hallway and place them on a different hallway at the other side of the building. (V6 and V7) were at the facility working during that time and were never suspended to my knowledge. On 3/20/26 at 12:55 PM, the Regional Director (V12) and the President of Operations (V4) mentioned they were covering for the Administrator (V1) during the week of 2/11/26. V12 said on 2/11/26, the DON (V2) told her that apparently, R2 claimed to the ADON (V3) two CNAs (V6 and V7) called her a c**t and were being mean to her. Once they heard this, they pulled R2 into an office to talk. R2 then changed her story, (continued on next page)</p>

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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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>saying no one called her names, she just didn't like the care she was getting. V12 didn't think it qualified as an abuse allegation, but they still moved V6 and V7 to a different floor so they wouldn't work with R2 anymore. Both V4 and V12 confirmed that V6 and V7 weren't suspended pending an investigation, and they didn't document the incident, interview other staff or residents, or write up an official investigation. On 3/20/26 at 1:50 PM, R2 stated she reported to V3/ADON around a month ago, that two CNA's (V6 and V7) were saying mean things to her and called her a c**t. R2 stated, After I reported to (V3) what (V6 and V7) did too me, two older ladies (probably in their 60's with gray hair) (identified as V4 and V12) pulled me into the office and asked me directly what happened. I told them both that (V6 and V7) had taken care of me a few nights prior and called me a c**t. I did not tell (V4 and V12) who the two CNAs were because I had already told (V3/ADON) the name of the employees and wasn't going to keep repeating it. (V4 and V12) told me they were going to move (V6 and V7) to a different hallway, so they would no longer be working with me. On 3/20/26 at 2:07 PM, V6/CNA stated she was called to the office by V4/President of Operations and V12/Regional Director of Operations on 2/11/26. When V6 arrived at the office, V4 and V12 kept saying, You tell her what (R2) said, then the other corporate lady would say no you tell her. V6 stated finally one of the corporate ladies spelled out R2 reported V6 called her a c**t. V12 reported to V6 they didn't believe it because R2's story kept changing, so they switched V6 to another hall and instructed her to not work on that side where R2 resides any longer. On 3/21/26 at 1:09 PM, V7/CNA stated, On 2/11/26 I was calling the office by (V4/President of Operations) and (V12/Regional Director of Operations) and was told (R2) reported I called (R2) a c**t. Both (V4 and V12) stated since (R2) is targeting (V6) and myself that we had to be assigned to a different hallway. They didn't send me home.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on record review and interview, the facility failed to report an allegation of employees to resident verbal abuse to the State Agency for one of three residents (R2) reviewed for abuse in the sample of six. Findings include: The facility's Abuse, Neglect, Exploitation Policy, dated 1/23/26, documents, Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Policy Explanation and Compliance Guidelines: 2. The facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. VII. Reporting/Response- A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (example: law enforcement when applicable) within specified timeframes: Immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or a result in serious body harm. On 3/20/26 at 11:19 AM, V3/ADON (Assistant Director of Nursing) stated, On 2/11/26 (R2) caught me in the dining room and reported to me that two CNA's (V6 and V7) had used foul language towards (R2) and called (R2) a c**t. I told (R2) I would investigate the situation. I immediately went and reported the allegation to (V2/DON) who told me I had to report it to the corporate staff (V4 and V12). I then immediately reported the alleged allegation to (V4 and V12). After (V4 and V12) spoke to (R2), they instructed (V6 and V7) to be removed from (R2's) hallway and place them on a different hallway at the other side of the building. (V6 and V7) were at the facility working during that time and never was suspended to my knowledge. As of 3/20/26 at 11:05 AM, the facility's reports to the local State Agency did not contain documentation of an alleged verbal abuse altercation from two CNA's (V6 and V7) to R2 on 2/11/26 as being reported. On 3/20/26 at 12:55 PM, the Regional Director (V12) and the President of Operations (V4) mentioned they were covering for the Administrator (V1) during the week of 2/11/26. V12 said on 2/11/26, the DON (V2) told her that apparently, R2 claimed to the ADON (V3) two CNAs (V6 and V7) called her a c**t and were being mean to her. Once they heard this, they (V4 and V12) pulled R2 into an office to talk. R2 then changed her story, saying no one called her names, she just didn't like the care she was getting. V12 didn't think it qualified as an abuse allegation, but they still moved V6 and V7 to a different floor so they wouldn't work with R2 anymore. Both V4 and V12 confirmed they did not send a report to the State Agency (Illinois Department of Public Health) regarding R2's allegation of V6 and V7 calling her a c**t. On 3/20/26 at 1:50 PM, R2 stated she reported to V3/ADON around a month ago that two CNA's (V6 and V7) were saying mean things to her and called her a c**t. R2 stated, After I reported to (V3) what (V6 and V7) did too me, two older ladies (probably in their 60's with gray hair) (identified as V4 and V12) pulled me into the office and asked me directly what happened. I told them both that (V6 and V7) had taken care of me a few nights prior and called me a c**t. I did not tell (V4 and V12) who the two CNAs were because I had already told (V3/ADON) the name of the employees and wasn't going to keep repeating it. (V4 and V12) told me they were going to move (V6 and V7) to a different hallway, so they would no longer be working with me.</p>		