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	06/12/2026

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 0689 Level of Harm - 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** Based on observation, interview, and record review, the facility failed to ensure adequate supervision was provided and to implement individualized fall prevention interventions for two of three (R1 and R2) reviewed for falls in a sample of three. This failure resulted in R1 sustaining a displaced transcervical left femoral neck fracture, a left iliopsoas hematoma, and a Lumbar 3 vertebral body fracture, and being admitted to the hospital requiring surgical intervention. This failure also resulted in R2 being admitted to the hospital with a subdural hematoma. Findings include: The facility's Accidents and Supervision policy, reviewed 1/25/26, documents the resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This form documents all staff (e.g., professional, administrative, maintenance, etc.) are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident. Evaluation and Analysis-the process of examining data to identify specific hazards and risks and to develop targeted interventions to reduce the potential for accidents. This form documents that supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. The facility's Fall Prevention Program, reviewed 2/2/2026, documents each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. 1.R1's Fall Risk evaluation, dated 8/2/25, documents a score of 18. This form documents a score of 10 or higher indicates the resident is at high risk of falls. R1's electronic care plan documents R1 is at risk for falling related to impaired cognition, moves about the room during the night without a noted purpose, and safety awareness associated with Alzheimer's dementia. R1's Unwitnessed Fall, dated 8/2/25 at 8:00pm, documents R1 was noted lying in the middle of the floor of her bedroom. R1 stated she was trying to go to the toilet but fell in the process of trying. R1's fall intervention was to encourage R1 to remain in a supervised area when up in a wheelchair. This form documents R1 was last assisted with cares 1 1/2 hour prior. R1's Unwitnessed Fall, dated 8/19/25 at 10:45am, documents R1 was observed sitting on the floor on her buttocks, feet flat on the floor, knees bent, between both beds in the room facing the wall with the sink. R1's wheelchair was not within reach, and R1 had socks on. R1 stated, I fell out of bed. R1 stated she did not know why she was attempting to get out of bed. R1's fall intervention put into place was when R1 is noted to be awake in bed, move to a supervised area for observation. This form documents R1 was last provided cares 45 minutes prior. R1's Unwitnessed Fall, dated 10/7/25 at 1:30pm, documents a Dietary Aide stated R1 was on the floor mat beside another resident's bed with feces on her hands. R1 was in a sitting position in front of her wheelchair. R1's fall intervention was to toilet before and after meals. This form documents R1 was last assisted 1 1/2 hours prior to the incident. R1's Unwitnessed Fall, dated 10/16/25 at 9:45pm, documents tV7, Licensed Practical Nurse, heard R1 call for help. Upon approach, observed R1 laying on the floor face up. R1 stated she fell and hit her head. R1's head to toe assessment performed and was within baseline for R1 except for R1 stating she hit her head. R1's fall intervention put into place was to (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 0689 Level of Harm - Actual harm Residents Affected - Few	monitor to ensure R1 was in the middle of the bed after cares. This form documents R1 was last assisted 1 hour prior. R1's Unwitnessed Fall, dated 11/21/25 at 6:35pm, documents R1 was observed on the floor in the left lateral position; R1 admitted to hitting her head and stated she was trying to go to the bathroom. Assessment revealed a small, soft, non-tender bump on the top of her scalp. No other injuries were noted. R1 stated she was trying to go to the bathroom. R1's fall intervention put into place was to during times of restlessness, offer toileting. This form documents R1 was last assisted with care 30 minutes prior. R1's Unwitnessed Fall, dated 4/8/26 at 6:50am, documents upon entering R1's room, R1 was laying on her right side facing the door with the wheelchair laying on its back. R1 stated that she was trying to go to the bathroom and fell. While attempting to turn R1, she yelled out in pain, stating her hip hurt. V10, R1's Family, did not want R1 sent to the emergency room at that time; she wanted to wait for Hospice to assess. R1. R1's fall intervention put into place is to toilet before breakfast. R1's Unwitnessed Fall, dated 4/30/26 at 7:10am, upon entering R1's room, R1 was sitting on the floor, giving her back to the toilet, wheelchair was in front of her. R1 had her pants halfway down; R1 was holding them with one hand. R1 was not wearing any shoes at the moment. R1 stated that she just wanted to go to the bathroom. There were no injuries noted except for R1, complaining of lower back pain. R1's fall intervention put into place was to remain in the dining area after breakfast. This form documents R1 was last assisted 1 hour prior. R1's Unwitnessed Fall, dated 5/1/26 at 6:50am, R1 was sitting on the floor in her room, in the seated position with her back against the wall. R1 had her pants pulled down to her knees. R1's wheelchair was next to the door. R1 stated she did not know what happened, just get her up. R1's fall intervention was to offer R1 to get up in the first group in the mornings. R1's Unwitnessed Fall, dated 5/11/26 at 1:55pm, alerted by another resident that a resident needed assistance. Upon arrival to room, R1 was observed on the floor lying on her left side with her head under the bedside table and her feet toward the closet. R1's feet were tangled in her cover. R1's fall intervention was to ensure R1 was in the middle of the bed before exiting the room. R1 was last assisted with cares approximately 1 hour prior to the incident. R1's Unwitnessed Fall, dated 5/16/26 at 6:30pm, R1 was in another residents room on the floor. R1's fall intervention was to monitor for wandering. R1 was last observed approximately 30 minutes prior to the incident. R1's Unwitnessed Fall, dated 5/16/26 at 9:45pm, R1 was observed on the floor mat curled up lying on her right side. R1 was assisted up with three staff members. R1's pants were pulled down halfway and incontinent brief was off and next to her. This form documents R1 was incontinent at the time of the incident. R1's fall interventions were to monitor closely for impulsive behaviors. R1 was last assisted with cares approximately 90 minutes prior. R1's Progress Notes, dated 5/17/26, documents around 7:20am, V4, Licensed Practical Nurse, was called to R1's room by a Certified Nursing Assistant, stating R1 appeared to be in pain, grabbing at her left lower extremity. Upon entering the room, R1 was observed in the fetal position laying on the right side. V4 attempted to do a full body skin assessment; however, R1 started to scream once the writer tried to reposition R1's legs. V4 offered R1 pain medication and she refused. V4 notified V10, R1's Family at 7:20am and she agreed to send R1 to the emergency room for an evaluation. This form documents Hospice was notified, and they state they would send a nurse out, but if R1 needed further evaluation, it was ok to send her to the hospital. Hospice notified the facility that ETA (estimated time of arrival) would be 45 minutes. R1 agreed to take the pain medication and appeared to be resting. V4 and Hospice staff attempted another assessment that was unsuccessful due to leg pain. R1 was transferred to the emergency room at 9:30am. R1's Progress Notes, dated 5/18/26, documents R1 was admitted to hospital on [DATE]. R1's Emergency Department Note, dated 5/17/26 documents a clinical impression of a closed fracture of the left hip. R1's Computed Tomography (CT) Scan, dated 5/17/26, documents an acute displaced transcervical left femoral neck fracture and a left iliopsoas hematoma. This form also documents a possible Lumbar 3 vertebral body fracture, not seen on the prior CT. This form documents R1 had an acute fracture, which was discussed with orthopedics and ultimately admitted to inpatient services. R1's Progress Notes, dated 5/27/26, documents R1 was readmitted to (continued on next page)

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