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	06/18/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to implement a comprehensive care plan with interventions for one (R2) resident in five residents reviewed for care plans and failed to prevent abuse for one resident (R1) of four residents reviewed for abuse. This failure resulted in R1 being physically abused with a cane causing a bruise to her neck, nightmares, and exacerbating R1's PTSD (Post Traumatic Stress Disorder) and anxiety. This past noncompliance, which involved R1 and R2, occurred from 5/20/2026 to 5/28/26. Findings include:The facility policy, Comprehensive Care Plans, revised 1/20/26, documents, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. The facility policy, Abuse, Neglect, Exploitation, revised 1/23/26, documents, It is the policy of this facility to provide protections for 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. The Final 5 (five) Day Follow-up Abuse Investigation Report sent to (the State Agency), documents R1 a [AGE] year-old female was physically abused by R2. On 5/20/26, Certified Nursing Assistant (CNA) responded to (R1) calling out for help from her room which was occupied by R1 and R2. CNA observed R2 holding a cane to R1's throat and pulling R1's hair. No acute injuries were noted upon assessment of R1. R1's admission record documents R1's date of admission to the facility was 5/8/26 and her diagnoses included but are not limited to: Chronic Obstructive Pulmonary Disease, Unspecified, Post-Traumatic Stress Disorder, Unspecified, Panic Disorder, Anxiety Disorder, Unspecified, Bipolar Disorder, Unspecified, and Sleep Disorder, Unspecified. R1's current care plan documents R1 is cognitively intact. On 6/16/26 at 10:30am, R1 stated on 5/20/26 her old roommate (R2) came up behind her when she was bent over arranging her belongings on her bed, put a whooping stick to my throat and was pulling back on it. She (R2) was stating this is how we do it. I started screaming for help and they came right away and pulled her off me. She left a bruise to my throat and the whole experience (R1 tearing up) has really ramped up my PTSD (Post Traumatic Stress Disorder) and anxiety. I have nightmares, can't sleep, I keep my door closed and I don't go down for meals because I don't know if I will run into her. If I go to activities I always face forward and do not have my back to anyone. The facility has been good in fixing the situation and trying to help me but (R2) should never have had anything like that (cane) in our room in the first place. She would get agitated and belligerent with staff prior to this. 6/17/26 at 1:00pm, V22 (Certified Nursing Assistant) stated she was in the clean utility room on the 300 hall when she heard R1 screaming for help. V22 immediately went to R1's room and saw R2 behind R1 holding a cane to her (R1) neck and pulling it back with both hands as if she was choking (R1). V22 stated she called for help and went over to get the cane from R2 and separate them, as she got the cane R2 grabbed a hold of R1's hair and V22 had to disentangle R2's finger from R1's hair. V22 stated another staff member came in (cannot recall who) and took R2 from the room (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
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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 0600 Level of Harm - Actual harm Residents Affected - Few	with her cane. (R2) was yelling at (R1) about taking her glasses. While at the nurse's station (R2) was bragging and laughing about what she did to (R1) to another resident (unsure of resident). On 6/17/26 at 2:30pm, V1 (Administrator) stated she had just got home from work on 5/20/26 when she received a call from V19 (Licensed Practical Nurse) reporting the altercation between R1 and R2 stating R2 was witnessed holding her cane to R1's neck. V1 stated she told V19 to notify police and call medics, then called V2 (Director of Nursing) to notify of allegation. V1 returned to the facility to investigate further and noted police and emergency medical transport were already at the facility. R2 was sitting in her wheelchair up by the nurse's station and R1 was in her room. V1 stated R2 was talking nonsensically about [NAME] and [NAME] were part of something and were going to be murdered by (R1) and (R1) took her glasses to impersonate her (R2) to take all of her money form (local bank). The police decided not to arrest R2, so she was sent to local emergency department for a psychiatric evaluation. R1 was assessed by the emergency medical crew and nursing with no injuries noted. R1 was moved to a different room, referral to psychiatry, and had an emergency telehealth appointment the following morning. V8 (Social Service Director) checks on R1 frequently to see how she is doing. R2 returned from the emergency department after being cleared by psychiatry and was found to have a Urinary Tract Infection and was given orders for antibiotic therapy, placed in room by herself, emergency appointment the following morning with psychiatric services, and is being monitored closely when around other residents. R2's Face Sheet documents R2 admitted to the facility on [DATE] and her diagnoses included but are not limited to: Heart Disease, Unspecified, Heart Failure, Unspecified, Depression, Unspecified, and Anxiety Disorder, Unspecified. R2's Psychotropic Evaluation, dated 2/14/26, documents that R2 has chronic behavior potentially causing harm to self or others. R2's current care plan lacked a behavior focused plan of care until 5/20/26. On 6/17/26 at 2:30pm, V1 verified R2's current care plan did not have documentation or interventions in place for behaviors prior to 5/20/26 and verified R2's admission psychotropic evaluation, dated 2/14/26, documented R2 was chronic harm to herself and others. Prior to the survey date of 6/16/2026, the facility had taken the following actions to correct the non-compliance:1.Immediate actions taken: immediate separation of residents, nursing assessment, notification of law enforcement and emergency medical services, nursing and emergency medical services evaluation, emergency department evaluation of R2, treatment of UTI (Urinary Tract Infection), roommate separation upon return, review and update of care plans, psychiatric follow-up, increased staff monitoring of resident interactions and R1 continued support from facility staff (Social Services and Activities).2. All residents have the potential to be affected; no others were identified at this time. R1 and R2's care plans revised to include psychosocial risks identified.3. Measures put into place/systems changed: Ad hoc QAPI (Quality Assurance and Performance Improvement meeting held to discuss resident-to-resident physical aggression and threatening behavior. Clinical startup tool implemented with audits to be done twice weekly for four (4) weeks to ensure resident care plans identify psychosocial risk.