

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145965	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/14/2025
NAME OF PROVIDER OR SUPPLIER  Loft Rehab of Decatur		STREET ADDRESS, CITY, STATE, ZIP CODE  500 West McKinley Avenue Decatur, IL 62526	

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 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>51951</p> <p>Based on interview and record review the facility failed to report allegations of abuse to the state survey agency for one (R4) of three residents reviewed for abuse on a sample list of eight.</p> <p>Findings include:</p> <p>The facility's Abuse, Neglect and Exploitation policy dated 2/11/25 documents the facility will have written procedures that include: reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.</p> <p>On 5/14/25 at 10:26 AM, V1 Director of Nursing (DON) stated that she received an allegation of verbal abuse towards R4 on 5/5/25 from V10 (R4's daughter) and an allegation of physical abuse towards R4 on 5/12/25 from V11 Certified Nurse Assistant (CNA). V1 stated that she didn't know the abuse policy and should have reported these allegations to the state agency immediately.</p> <p>On 5/14/25 at V2, VP of Clinical Operations stated V1 DON should have reported both abuse allegations to the state agency immediately.</p> <p>Neither V1 or V3 could provide documentation showing that the state agency had been notified of any abuse allegations since February.</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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