

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

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 05/06/2026
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)		
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 interview and record review the facility failed to protect residents' (R84, R10) right to be free from physical abuse by another resident (R70) for three of three residents (R84, R10, R70) reviewed for abuse in the sample list of 57 residents. This failure resulted in psychosocial harm of R84 as evidenced by R84 crying and avoidance of R70. Findings include: The facility's Abuse, Neglect, Exploitation Policy dated 1/23/26 documents abuse is the willful infliction of injury, intimidation or punishment that results in physical harm, pain or mental anguish. This policy documents staff will be trained on understanding behavioral symptoms of residents that may increase the risk of abuse/neglect including aggressive or catastrophic reactions, wandering/elopement behaviors, resisting care, outburst/yelling, or difficulty in adjusting to new routine or staff. 1.) The facility's State Report documents on 3/22/26 at 7:50 PM, a Certified Nursing Assistant (V25 CNA) witnessed R70 knock R84's glasses off R84's face while in the hallway as they passed each other. This report documents that R84 was interviewed and stated R70 told R84 that R84 didn't belong there and knocked R84's glasses off R84's face. R70's Minimum Data Set (MDS) dated [DATE] documents R70 has severe cognitive impairment. R70's active care plan documents R70's diagnoses include Dementia, Psychotic Disturbance, Mood Disturbance and Anxiety. R84's MDS dated [DATE] documents R84 has severe cognitive impairment. R70's Nursing Note dated 4/17/26 at 9:37 PM documents R70 became aggressive with staff after transferring R70 into the wheelchair. R70 grabbed the CNAs' wrists and hit their arms, and R70 threatened to punch staff in the face. On 5/3/26 at 1:43 PM, V25 Certified Nursing Assistant (CNA) stated the following: V25 CNA was coming down the southeast hallway at approximately 9:00 PM-9:30 PM and witnessed R70 swinging at R84's face and R70 hit R84's glasses off R84's face. V25 CNA stated R70's actions were intentional and not accidental. R84 said R70 hit R84 a few times, but V25 CNA did not witness this. There was a red mark on R84's nose and R84 cried after the incident. R70 and R84 both do a lot of yelling, but V25 CNA did not see what caused the incident and there were no other witnesses. R70 gets aggressive with staff during cares. Staff had to keep R70 and R84 separated the rest of the night, R84 didn't want to go near R70, R84 still seems to recognize R70 and avoids R70. 2.) R70's Nursing Note dated 4/24/26 at 5:31 AM documents the nurse (V26 Licensed Practical Nurse) heard screaming for help and found R70 in R10's bed and witnessed R70 open handed smack R10 in the face on the right side of R10's cheek. R10's Minimum Data Set (MDS) dated [DATE] documents R10 has severe cognitive impairment. R10's active diagnoses list includes Dementia, Anxiety, and Depression. The facility's State Report documents on 4/24/26, V26 LPN witnessed R70 sitting on R10's bed and open handed smacked R10 on the right cheek. Attempts were made to contact V26 LPN. On 5/04/2026 at 12:39 PM, V1 Administrator confirmed R70 and R10's altercation was witnessed by V26 LPN as described in the facility's State Report and R70's nursing note. V1 stated V26 LPN witnessed R70 make contact with the right side of R10's face.		

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: 145965	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2026
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)		
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement pressure relieving interventions, evaluate nutritional status, and prevent cross contamination during pressure ulcer treatments for one (R11) of four residents reviewed for pressure ulcers in the sample list of 57 residents. These failures resulted in R11 developing bilateral heel deep tissue injuries that deteriorated to stage three and stage four pressure ulcers. Findings include: The facility's Skin Integrity- Foot Care policy dated 2/20/26 documents the following: Interventions will be based on the identified risk assessment, skin assessment and assessment of foot ulcers. Interventions include offloading or use of pressure-relieving devices, and interventions will be modified in the resident's care plan. Consider modifications if there are new onset foot ulcers, lack of progression of healing, or resident non-compliance. The facility's Pressure Injury Prevention and Management policy dated 2/10/26 documents an avoidable means the resident developed a pressure ulcer/injury and the facility did not implement at least one of the following: evaluate clinical condition and risk factors, define and implement interventions, monitor/evaluate the impact of the interventions, or revise the interventions as appropriate. The facility's Hand Hygiene policy dated 2/10/25 documents staff will perform hand hygiene when indicated, consistent with standards of practice and the use of gloves does not replace hand hygiene. This policy documents to perform hand hygiene immediately after removing gloves. The facility's Referrals to the Dietitian policy dated 1/23/26 documents between consulting visits the facility is responsible for notifying the dietitian of new clients whose medical condition may place them at nutritional risk, which include pressure injuries. R11's admission Minimum Data Set (MDS) dated [DATE] documents R11 has moderate cognitive impairment, requires dependence on staff for rolling/turning in bed, and has no pressure ulcers. R11's MDS dated [DATE] documents R11 has severe cognitive impairment, has one facility acquired stage three pressure ulcer and one facility acquired stage four pressure ulcer. R11's Braden assessment dated [DATE] documents R11 is at risk for developing pressure ulcers. R11's Skin Assessments dated 12/19/25 - 12/24/25 document R11's skin as intact and does not identify any pressure relieving interventions were implemented as prompted by the assessment. R11's Care Plan dated 12/20/26 documents R11 is at risk for developing pressure ulcers related to immobility secondary to spinal stenosis. This care plan includes interventions for a dietitian consultation, heel protectors as resident will allow (1/2/26), use pillows or foam wedge to avoid direct contact with bony prominences, and use pressure relieving devices on appropriate surfaces. This care plan documents R11's diagnoses include Muscle Weakness/Atrophy and Dementia. R11's December 2025 Treatment Administration Record (TAR) does not document any treatments for R11's heels prior to 12/25/25. R11's January 2026 TAR documents pressure reducing boots on at all times every shift starting on 1/5/26 and remains as an active order as of 5/5/26. R11's Certified Nursing Assistant tasks document pressure relieving boots at night was added on 1/14/26. There is no documentation the facility developed and implemented pressure relieving interventions to address heel pressure or repositioning needs prior to R11 developing heel wounds on 12/25/25, and no documentation that R11 refused to wear pressure relieving boots. R11's Nursing Note dated 12/19/2025 at 12:50 PM documents R11 admitted from home due to stenosis of vertebrae, R11 has back pain that increases with movement and R11 requires assistance with activities of daily living and transfers. R11's Nursing Note dated 12/25/25 at 3:17 AM documents R11 turned call light on and complained of heel pain and burning. There was drainage on R11's sheet underneath R11's right heel. R11's socks were removed and there was a darkened area approximately 4 centimeters (cm) by 4 cm on right heel and a fluid filled blister with darkened red area on the left heel that measured 6 cm by 6 cm. Treatment orders were obtained. R11's Nursing Note dated 12/28/2025 at 7:35 PM documents area assessed and is consistent with positioning and immobility, wound nurse to assess during rounding, physician aware, treatment entered, and care plan updated. (continued on next page)		

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 05/06/2026
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)		
F 0686 Level of Harm - Actual harm Residents Affected - Few	R11's Wound Weekly Observation Tools dated 12/25/25 documents R11's heel wounds as deep tissue injuries acquired on 12/25/25. R11's left heel measured 3 cm by 3 cm by 0.1 cm depth, and right heel measured 4 cm by 4 cm by 0.1 cm. R11's Initial Wound Evaluation & Management dated 1/5/26, recorded by V17 Wound Physician, documents stage two pressure ulcer right heel measured 2 cm by 3 cm by 0.1 cm and stage three pressure ulcer left heel measured 4 cm by 5.5 cm by 0.2 cm, with 40% slough (dead tissue/fibrin). The estimated time to heal both wounds is noted as two to four months. This evaluation includes recommendations for offloading wounds, repositioning per facility protocol, turn side to side, floating heels in bed, and pressure off-loading boots. R11's Wound Evaluation & Management Summary dated 1/12/26 documents right heel wound deteriorated to stage three pressure ulcer and measured 3.3 cm by 3.8 cm by 0.1 cm, with 30 % slough, and exacerbated due to infection. R11's left heel stage three pressure ulcer measured 4 cm by 5.5 cm, depth was immeasurable due to being covered with nonviable tissue, 40 % slough, and 60% necrotic (dead) tissue. R11 was not wearing pressure-relieving boots and was educated on the importance. R11's prealbumin level was 15 grams/liter on 1/12/26. Recommendations included the same as 1/5/26 with the addition of dietitian consultation. R11's Wound Evaluation & Management Summary dated 1/26/26 documents R11's right heel wound deteriorated to stage four pressure ulcer, measured 2.5 cm by 3.4 cm with depth immeasurable due to being covered with nonviable tissue. R11's left heel stage three pressure ulcer measured 3.7 cm by 4.3 cm by 0.4 cm. V17's recommendations included a dietitian consultation and the same interventions as 1/5/26. R11's Wound Evaluation & Management Summary dated 5/4/26 documents right heel stage four pressure ulcer measured 1.8 cm by 1.3 cm by 0.2 cm. R11's left heel stage three pressure ulcer measured 2 cm by 1.5 cm by 0.2 cm. V17's recommendations are the same as previously noted. R11's Physician's Order dated 1/6/26 documents Tetracycline Hydrochloride (antibiotic) 500 milligrams (mg) by mouth twice daily for fourteen days for wound. R11's Physician's Order dated 1/13/26 documents Levaquin (antibiotic) 750 mg by mouth daily for ten days for wound. There is no documentation in R11's medical record that R11's nutritional status was evaluated by a dietitian after 12/22/25. On 5/3/26 at 11:16 AM, V20 (R11's) Family Member stated R11's heel wounds started developing at home prior to admission. V20 stated R11 was treated for wound infection after being admitted to the facility. R11 was sitting in a wheelchair in R11's room, R11 was not wearing pressure relieving boots. V20 stated R11 only wears the boots when in bed. R11's bed contained a standard foam mattress. On 5/04/2026 at 10:32 AM, V17 Wound Physician, V2 Director of Nursing, and V30 Certified Nursing Assistant (CNA) entered R11's room to provide wound care. V17 applied multiple pairs of gloves. V17 cleansed R11's heel wound with the same gauze and same pair of gloves. V17 administered R11's wound treatment as ordered, removing the outer layer gloves after dressing each wound. V17 did not perform hand hygiene after cleaning the wounds or between each wound treatment administration. R11's bed contained a standard mattress. On 5/05/2026 at 9:46 AM, R11 still had a standard foam mattress on R11's bed. On 5/4/26 at 10:45 AM, V17 Wound Physician confirmed the same gauze and gloves were used to cleanse both wounds. V17 confirmed V17 wore multiple pairs of gloves removing with the outer pairs removed after cleansing the wounds and after each dressing change, with no hand hygiene during the wound treatment. V17 stated V17 performed hand hygiene prior to applying the gloves. On 5/05/2026 at 9:37 AM, V31 Licensed Practical Nurse (LPN) stated heel protector boots or floating heels are only implemented if there are wounds or redness and R11 didn't have any wounds or redness when V31 LPN assessed R11's skin on 12/20/25 and 12/21/25. V31 LPN stated the heel boots are entered for the nurse to sign off on the TAR and to prompt the CNAs to apply. V31 stated an alternating pressure mattress is implemented once they develop a wound and to prevent the wound from getting worse, but usually for coccyx wounds. V31 stated R11 is cooperative with wearing pressure relieving boots. On 5/05/2026 at 10:00 AM, V2 Director of Nursing (DON) stated R11's heel wounds were closed when R11 admitted, they were deep tissue injuries and had skin protectant wipes in place. V2 DON confirmed this would be documented on the TAR and there was no documented treatment for this. V2 (continued on next page)		

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 05/06/2026
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)		
F 0686 Level of Harm - Actual harm Residents Affected - Few	DON assessed R11's wounds on 12/25/26, heel boots and offloading heels were implemented as interventions. V2 confirmed heel boots were not added to R11's TAR until 1/5/26 or R11's tasks until 1/14/26. V2 DON stated R11 was not referred to V17 until after R11's heel wounds opened. V2 DON stated V2 updates the dietitian weekly regarding wounds and implement Vitamin C, Zinc and Prostat. V2 stated V2 does not look at V17's Wound Physician notes, V27 LPN, who works at (sister facility), rounds with V17 and enters V17's orders. V2 stated V2 thought R11 had an alternating pressure mattress, usually this type of mattress is put in place for all wounds. V2 DON stated each wound should be done from start to finish, cleaning each wound separately. V2 stated V17 Wound Physician had on multiple pairs of gloves. V2 stated staff should change gloves and perform hand hygiene during each wound treatment, after cleansing and applying the clean dressing. On 5/5/26 at 11:47 AM, V2 confirmed R11's care plan was not updated with pressure relieving interventions for R11's heels until heel protectors were added on 1/2/26. On 5/6/26 at 10:50 AM, V2 confirmed there was no documentation that R11 refuses heel boots. On 5/5/26 at 12:53 PM, V13 CNA stated R11 wears pressure relieving boots in bed, and occasionally in the wheelchair if R11 is complaining of R11's feet hurting. V13 CNA stated R11 is cooperative in wearing the boots. On 5/05/2026 at 2:07 PM, V25 CNA stated R11 admitted with back pain and had no complaints of heel pain or wounds until about a week after R11 admitted to the facility. V25 CNA stated R11 wasn't using the pressure relieving boots when R11 first admitted , the boots weren't implemented until after R11's wounds developed. V25 CNA stated R11 wears the boots when R11 is in bed and occasionally when R11 is in the wheelchair. V25 CNA stated R11 is cooperative in wearing the boots. On 5/5/26 at 10:40 AM, V27 LPN stated V27 rounds with V17 Wound Physician and enters the treatment orders, but that is all. V27 LPN stated I know there was noncompliance with (R11) not wearing (R11's) boots at one point but was unsure if it was related to staff not putting them on or R11 refusing. V27 LPN stated V27 reviews V17's notes but V27 does not notify the dietitian, V2 should have been sending a weekly wound report on Thursdays to V21 Dietitian. V27 stated V27 does not enter orders for offloading or pressure relieving boots. On 5/5/26 at 11:11 AM, V21 Dietitian stated usually the facility sends a weekly wound report, but that hasn't happened for several months. V21 stated V21 just runs V21's own reports and looks at assessments to determine who has wounds. V21 stated R11 is on V21's list to be seen today, but V21 has not evaluated R11 since R11's admission in December. V21 stated V21 was not aware that R11 had wounds. V21 Dietician stated usually the facility sends a weekly wound report to V21, but that hasn't happened for several months. V21 is just running her own reports and looking at assessments to determine who has wounds. V21 has R11 on V21's list to see today, but V21 hasn't evaluated R11 since admission in December. V21 was not aware that R11 had wounds. V21 stated V21 would have ordered Vitamin C, Zinc and multivitamin to aid in wound healing. On 5/5/26 at 11:34 AM, V22 Physician stated R11 had been in the hospital and was declining which continued once R11 returned home, leading to long term care placement. V22 stated R11 was wheelchair bound and R11's ability to be independent had declined, and Dementia contributed to this. V22 Physician stated preventative measures include offloading heels or cushioning heels, and R11 would benefit from having an alternating pressure mattress. V22 confirmed the dietitian should have been consulted. V22 stated V22 would agree that R11's pressure ulcers were avoidable and wound deterioration prevented if these interventions were implemented. On 5/5/26 V1 Administrator provided R11's mattress information. The specification for this mattress documents the mattress is recommended for high risk level up to stage two pressure ulcers.		

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 05/06/2026
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)		
F 0689 Level of Harm - Minimal harm or potential for 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 interview and record review the facility failed to re-assess elopement risk, identify wandering/exit seeking as targeted behaviors, and develop a care plan for wandering/exit seeking behaviors and risk for elopement for one (R70) resident reviewed for elopement/wandering in the sample list of 57 residents. Findings include: The facility's Elopement and Wandering Residents policy dated 2/2/26 documents the facility will use a systematic approach to monitor and manage residents at risk for elopement and unsafe wandering, including identification and assessment of risk, implementing interventions to reduce hazards and risks, monitoring for effectiveness, and modifying interventions as necessary. This policy documents residents will be assessed for risk of elopement and unsafe wandering on admission and throughout their stay and the interdisciplinary team will evaluate factors contributing to risk in order to develop a person-centered care plan. R70's Minimum Data Set (MDS) dated [DATE] documents R70 has severe cognitive impairment. R70's active care plan does not include a problem, goals, and interventions to address R70's wandering behaviors or risk for elopement. R70's last documented Elopement Evaluation dated 3/2/26, documents R70 is at risk for elopement but does not include any goals or interventions as prompted by the assessment. This assessment documents no to R70 verbally expresses the desire to go home, packs belongings to go home or stays near exit doors; and wandering behaviors likely affects the safety, well-being, or privacy of others. The facility's State Report documents on 4/24/26 V26 Licensed Practical Nurse witnessed R70 sitting on R10's bed and open handed smacked R10 on the right cheek. V1 Administrator interviewed R70 who reported R70 was confused, R70 thought R70 was in R70's room and that someone was in R70's bed. R70's Nursing Notes document the following: On 4/16/26 at 9:00 PM, R70 pulled the fire alarm twice after 6:00 PM stating R70 wanted to leave the facility. On 5/3/26 at 2:02 AM, R70 had been up in R70's wheelchair since 12:15 AM, R70 was confused and was exit seeking. R70 was redirected multiple times but continued to roam around in R70's wheelchair. R70's February-May 2026 Behavior Tracking does not identify wandering/exit seeking behaviors as a targeted behavior. R70's active Certified Nursing Assistant (CNA) tasks only lists monitoring and interventions for physical/verbal aggression towards staff/residents and does not identify wandering/exit seeking behavior as a targeted behavior. On 5/3/26 at 1:43 PM, V25 Certified Nursing Assistant (CNA) stated R70 does wander/exit seek, and staff usually bring R70 to the nurse's station or offer R70 a snack. V25 stated R70 usually gets really confused, roams the halls and talks about leaving and wanting to go to see R70's family. V25 stated R70 wanders into other resident rooms. On 5/04/2026 at 1:14 PM, V10 Social Services Director stated there is an elopement risk binder at the front desk that the receptionist checks. V10 stated V10 notifies staff when V10 adds a resident to the binder. V10 stated V10 is responsible for updating the care plan with elopement risk and interventions and V10 reviews the CNAs tasks and nurses charting for behaviors. V10 confirmed R70's Elopement Evaluation documents R70 is at risk, and R70's care plan does not address R70's wandering behaviors or elopement risk. V10 confirmed R70 should have targeted behavior monitoring for wandering/exit seeking behaviors. On 5/4/26 at 1:30 PM V10 confirmed 3/2/26 was R70's last documented elopement risk assessment and confirmed no was answered to the question regarding voicing desire to go home, which would affect the risk score. V10 stated V10 completes the elopement risk assessments quarterly and with any changes in between. On 5/4/26 at 1:25 PM the elopement risk binder at the front desk was reviewed and did not contain R70's information, this was confirmed with V11 Receptionist. V11 stated R70 is an elopement risk as R70 tried to go out the front door today just a little while ago, and V11 noticed today that R70's information was not in the binder.		