STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145965	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab of Decatur	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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145965	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab of Decatur	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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145965	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab of Decatur	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 glovers 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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145965	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab of Decatur	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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145965	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab of Decatur	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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review the facility failed to ensure required personnel attended the Quality Assessment and Assurance committee meetings. The facility failed to provide documentation of its ongoing Quality Assurance & Performance Improvement Program meeting minutes for two quarters of 2025. This failure has the potential to affect all 91 residents.FindingsOn 5/4/26 at 09:25 AM, V1 Administrator provided Quality Assessment and Assurance (QAA) meeting attendance sheets for the first quarter 2026 and fourth quarter 2025 QAA meetings. V1 stated the QAA team meets quarterly to discuss issues/concerns.The January 2026 QAA meeting attendance signature sheet does not document the facility Administrator (administrator, owner, board member or other individual in a leadership role) was present for the meeting.On 5/4/26 at 9:30 AM, V1 Administrator confirmed that V1 Administrator was not in attendance for the January 2026 QAA meeting.There were no documented attendance sheets or QAA meeting minutes available in the second or third quarter of 2025.On 5/6/25 at 02:00 PM, V1 Administrator confirmed there were no minutes or attendance sheets for quarters two and three 2025. The Quality Assurance & Performance Improvement Policy dated 1/22/26 documents the following: The meeting is to systematically monitor performance indicators as part of the QAPI program. Performance indicators are established based on data analysis and monitored/evaluated in the QAA Committee meetings, which take place on a monthly basis and as needed.The Long-Term Care Facility Application for Medicare and Medicaid dated 5/3/2026 documents the facility has a census of 91 residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145965	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab of Decatur	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement their water management plan including an annual risk assessment, control measures, and testing protocols to reduce the risk of Legionella and other opportunistic pathogens in the facility's water systems. This failure has the potential to affect all 91 residents in the facility.Findings Include:The facility's Water Management Program, dated as revised 1/21/26, documents a risk assessment will be conducted by the water management team annually to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water systems. Based on the risk assessment, control points will be identified. The list of identified points shall be kept in the water management program binder. Control measures will be applied to address potential hazards at each control point. The measures shall be specified in the water management program action plan. Testing protocols and control limits will be established for each control measure. The water management team shall regularly verify that the water management program is being implemented as designed.On 5/5/26 at 9:25 AM, V15 Maintenance Director was turning pages in the facility's Water Management Program Binder. This binder did not include documentation of the facility's annual risk assessment, identification of control points, the control measures to address potential hazards at each control point, or the testing protocols and control limits for each control source. At this time, V15 confirmed that the binder lacked the documentation.On 5/5/26 at 3:30 PM, V6 Infection Preventionist/Assistant Director of Nursing, and V15 Maintenance Director stated an annual risk assessment was done last year, but they are unsure of the completion date and are unable to locate the assessment. V6 and V15 confirmed that they started an assessment on 5/5/26 but they were not able to complete the assessment or identify any risks at this time. The facility's Long-Term Care Facility Application for Medicare and Medicaid dated 5/3/26 documents a census of 91 residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145965	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab of Decatur	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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review the facility failed to document that narcotic medications were counted at the beginning and end of each shift and failed to destroy or send discontinued antibiotics back to the pharmacy. This failure affected 23 of 26 residents reviewed for medication storage on the sample list of 57 residents.Findings include:1. The facility's Controlled Drug Policy and Procedure, revised in August of 2024, documents that controlled drugs, as determined by the facility, are counted every shift by the nurse reporting on duty with the nurse reporting off-duty.On 05/04/2026 at 9:19 AM, the Northeast Medication cart was reviewed with V6 Assistant Director of Nursing (ADON). The Substance Controlled Check form dated May of 2026 did not contain documentation that narcotics were counted on 5/1/26 by the nurse coming off the 6 AM to 6 PM shift, 5/1/26 the nurse coming on and off the 6PM to 6AM shift, on 5/2/26 by the nurse coming on and off the 6AM to 6PM shift, on 5/2/26 by the nurse coming off the 6PM to 6AM shift, on 5/3/26 by the nurse coming on the 6AM to 6PM shift, on 5/3/26 by the nurse coming on and off the 6PM to 6AM shift, and on 5/4/26 by the nurse coming on the 6AM to 6PM shift. At this time, V6 ADON confirmed the missing entries on the form. In this medication cart was a medication card for R5 containing three patches of Buprenorphine 5 micrograms per hour, a card for R5 containing 19 tablets of Lorazepam 0.5 milligrams, a card for R7 containing 30 tablets of Tramadol 50 milligrams, a card for R7 containing 10 tablets of Tramadol 50 milligrams, a card for R22 containing 6 tablets of Norco 5-325 milligrams, a card for R22 containing 30 tablets of Norco 5-325 milligrams, a card for R28 containing 30 tablets of Lorazepam 0.5 milligrams, a card for R28 containing 14 tablets of Tramadol 50mg tablets, a card for R57 containing 15 Tramadol 50 milligrams, a card for R63 containing 30 tablets of Norco 5-325 milligrams, a card for R63 containing 30 tablets of Norco 5-325 milligrams, a card for R67 containing 11 tablets of Norco 5-325 milligrams, a card for R67 containing 30 tablets of Norco 5-325 milligrams, a card for R79 containing 8 Tramadol 50 milligrams, a card for R79 containing 15 tablets of Tramadol 50 milligram tablets, a card for R81 containing 16 Norco 5-325 milligrams, a card for R89 containing 24 tablets of Norco 5-325 milligrams, a card for R90 containing 30 tablets of Tramadol 50 milligrams, and a card for R91 containing 10 tablets of Lorazepam 0.5 milligram tablets.On 05/04/2026 at 9:19 AM, V6 ADON confirmed the Substance Controlled Check Form should be filled out at the beginning and end of each shift when narcotic medications are counted.On 05/04/2026 at 9:36 AM, the Southeast medication cart was reviewed with V9 Licensed Practical Nurse (LPN). The Substance Controlled Check Form dated May of 2026 did not contain documentation that narcotics were counted on 5/1/26 by the nurse coming off the 6am to 6PM shift. At this time, V9 LPN confirmed the missing entry on the form. In this medication cart was a medication card for R59 containing four patches of Fentanyl 25 microgram per hour, a card for R59 containing seven tablets of Norco 7.5-325 milligram tablets, a card for R15 containing 15 tablets of Tramadol 50 milligrams, a card for R16 containing seven tablets of Tramadol 50 milligrams, a card for R16 containing 30 tablets of Tramadol 50 milligrams, a card for R46 containing 27 tablets of Tramadol 50 milligrams, a card for R54 containing eight tablets of Tramadol 50 milligrams, a card for R54 containing 18 tablets of Tramadol 50 milligrams, a card for R70 containing 28 tablets of Lorazepam 0.5 milligrams, a card for R84 containing eight tablets of Lorazepam 0.5 milligrams, and a card for R84 containing 14 tablets of Lorazepam 1 milligram.On 05/04/2026 at 9:36 AM, V9 Licensed Practical Nurse confirmed that this should be completed at the beginning and end of every shift when narcotics are counted.On 05/05/2026 at 2:30 PM, an additional review of the Northeast Substance Controlled Check Form dated May of 2026 did not contain documentation that narcotics were counted on 5/4/26 by the nurse coming off of the 6AM to 6PM shift and on 5/4/26 of the nurse coming off of the 6PM to 6AM shift.On 05/04/2026 at 1:15 PM, V2 Director of Nursing, stated that the Substance Controlled Check Form nurse sign on and off sheets should be completed by the nurses each shift. There should not be any entries missing, but if there (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145965	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab of Decatur	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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	are the expectation is that the nurse should count with the previous shift and correct the missing entries. The nurses do get confused when filling out the sign-in and out sheets because we have a lot of split shifts here and staff should be re-educated. The Narcotic sign on and off sheet is audited daily by a nurse manager.2. The facility's Medication Destruction Policy, with an effective date of 10/25/2014 and no revision date, documents that discontinued medications and medications left in the facility after a resident's discharge, which do not qualify for return to the pharmacy for credit, are destroyed.On 05/04/2026 at 09:36 AM, while observing the South Medication storage room with V9 Licensed Practical Nurse, medications cards were observed in a cabinet for current and discharged residents. These medications were as follows:R50's Cephalexin 500 milligrams had 19 capsules remaining with a documented order completion date of 02/22/2026 and currently resides in the facility.R40's Tetracycline 500 milligrams had 16 tablets remaining with a documented order completion date of 03/02/2026, Amoxicillin- Potassium Clavulanate 875-125 milligrams had 12 tablets remaining with a documented order completion date of 02/23/2026, and Cephalexin 500mg had eight capsules remaining with a documented order completion date of 02/15/2026. R40 was discharged from the facility on 04/27/2026.R106's Cefuroxime 500 milligrams had 11 capsules remaining with a documented order completion date of 03/12/2026. This resident was discharged from the facility on 04/20/2026.R105's Cephalexin 500 milligrams had two capsules remaining with an order completion date of 03/18/2026. This resident was discharged from the facility on 04/17/2026.On 05/04/2026 at 09:36 AM, V9 Licensed Practical Nurse confirmed these medications should have been returned or destroyed after the antibiotic course was completed.On 05/04/2026 at 1:15PM, V2 Director of Nursing stated that when a resident is discharged their medications should be sent back to the pharmacy or with the resident. The discharging nurse is responsible for ensuring this is done. Medications that are no longer in use or for a discharged resident should be sent back to pharmacy the same day. Pharmacy comes daily to pick up medications. The nurse manager should verify that this is completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145965	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab of Decatur	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure medications were properly labeled and stored for five (R97, R28, R81, R73, R22) of 26 residents reviewed for medication storage on a sample list of 57 residents.Findings include:1. The facility's Vials and Ampules of Injectable Medications policy, with an effective date of 10/25/2015 and no revision date, documents that the date opened and the initials of the first person to use the vial are recorded on multidose vials.The product insert for Incruse Ellipta documents to discard six weeks after opening the foil tray or when the counter reads 0 (after all blisters have been used), whichever comes first.The product label for Systane Complete Preservative Free (PF) Ophthalmic Solution documents that it must be discarded 90 days after opening.On 05/04/2026 at 9:19 AM, the Northeast medication cart was reviewed with V6 Assistant Director of Nursing. Three unlabeled medication cups were observed in top of cart with medication in them. V6 stated these medications were for R97 and R28 for the 7 AM to 10 AM medication pass and that there were no narcotics in the cups. V6 stated that these residents were not yet ready to take their medication, so V6 put them in to top of the cart. V6 confirmed that the medications should not be kept unlabeled in cups in the top of the cart. At this time, the following medications were observed in the Northeast medication cart without dates: R81's Insulin Lispro Subcutaneous Solution Pen-injector 200 UNIT/ML (milliliter), R81's Insulin Glargine Subcutaneous Solution Pen-injector 100 UNIT/ML, R73's Systane Complete PF Ophthalmic Solution 0.6 % Propylene Glycol, and R22's Incruse Ellipta 62.5 MCG (microgram)/ACT Aerosol Powder. V6 confirmed these medications were not dated and should be. V6 then was observed placing all undated medications back into cart.On 05/04/2026 at 1:15 PM, V2 Director of Nursing confirmed that if medications are in cups and the resident is not ready to take them or does not want to take them until later, that the nurse is expected to destroy the medications at that time and get new ones ready when the resident is ready for their medication. V2 confirmed medications should not be left in the top drawer of the medication cart. On 05/05/2026 at 11:24 AM, V2 Director of Nursing stated that all medications besides medication cards, should be dated. Nurse managers audit carts to ensure this happens.2. The facility's Medication Storage policy, revised on 2/2/26, documents that during a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.On 05/03/2026 at 11:31 AM, Tums in a medication cup were observed on R97's bedside table. R97 stated that the nurse left them there for R97 to take.On 05/03/2026 at 11:32 AM, V32 Licensed Practical Nurse stated R97 was supposed to take the Tums right as V32 was walking out. V32 stated V32 thinks R97 has a self-administration order.On 05/03/2026 at 1:45 PM, V2 Director of Nursing stated V2 was unsure if R97 had a self-administration assessment, order, or care plan and would look for one in the chart, but V2 was unable to locate one at this time.On 05/04/2026 at 9:02 AM, V2 confirmed R97 did not have a self-administration of medications order, assessment, or care plan and R97 should not have medication left at R97's bedside.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145965	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab of Decatur	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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide bathing as scheduled for one (R9) of four residents reviewed for activities of daily living in the sample list of 57 residents. Findings include:The facility's Activities of Daily Living (ADLs) policy dated 1/20/26 documents bathing as part of the care and services provided by the facility, and residents who are unable to carry out ADLs will receive the necessary services to maintain grooming and personal hygiene. On 5/03/2026 at 9:43 AM, R9 stated R9 receives bed baths because R9 does not like to take showers. R9 stated R9 needs to be bathed more often because R9 does not receive baths weekly. R9 stated R9 did not think R9 had scheduled bath days. R9's Minimum Data Set, dated [DATE] documents R9 as cognitively intact and requires substantial/maximal staff assistance for bathing. R9's April and May 2026 Shower Documentation Survey Report documents R9's baths are scheduled on Wednesday and Saturday evenings but prompts for shower documentation on Tuesdays/Fridays. This report documents R9 was unavailable on 4/7/26, and not applicable on 4/10/26, 4/14/26, and 4/28/26. There is no documentation in R9's medical record as to why R9 was unavailable for shower on 4/7/26. On 5/5/26 at 2:03 PM, V29 Certified Nursing Assistant (CNA) stated R9's baths are scheduled for Wednesday and Saturday evening. On 5/6/26 at 9:33 AM, V29 CNA reviewed R9's shower documentation and confirmed the report does not document baths being given on the dates listed above. V29 CNA stated R9's bath days are Wednesday and Saturday, it shouldn't prompt for documentation on Tuesday and Friday. V29 CNA confirmed this is the only place bathing/showers are documented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145965	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab of Decatur	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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide podiatry services for one (R8) of four residents reviewed for activities of daily living in the sample list of 57 residents. Findings include:The facility's Skin Integrity-Foot Care policy dated 2/20/26 documents the facility will provide foot care and treatment according to professional standards of practice, including preventions of complications from the resident's medical conditions; and the facility will assist the residents in making appointments with a qualified person. This policy documents diabetes as a risk factor for impaired skin integrity of the foot, adequately trained nurses may perform nail care to diabetic resident determined by the podiatrist to be low risk, and podiatry referrals will be made when appropriate. On 5/03/2026 at 8:58 AM, R8 stated R8 needs to see a podiatrist as R8's toenails are long. On 5/5/26 at 11:35 AM, V23 Licensed Practical Nurse removed R8's right sock, R8's toenails were long past the edge of R8's toes. There was an adhesive dressing on R8's right great toe.R8's active care plan documents R8 was admitted to the facility on [DATE] and R8 has Type 2 Diabetes Mellitus. R8's Skin Check dated 3/27/26 documents R8's right great toenail fell off and there was swelling and redness around the nailbed. R8's Physician Order dated 3/28/26 documents to cleanse right great toe, apply Bacitracin ointment and cover with adhesive bandage daily. There is no documentation in R8's medical record that R8 has been seen by a podiatrist after being admitted to the facility. On 5/5/26 at 12:33 PM, V2 Director of Nursing stated the facility recently switched podiatry companies and toenails are an issue. V2 stated R8 is diabetic.On 5/5/26 at 12:40 PM, V10 Social Services Director stated the facility changed podiatry companies in March and the prior podiatrist was coming monthly and in between visits if V10 reached out to them as needed. V10 stated the new company has rounded once so far in April but did not see R8 as the podiatrist started with residents on the opposite side of the building. V10 stated R8 is on the podiatry list for May 27th. V10 confirmed V10 schedules the podiatry visits and maintains the podiatry list. V10 stated V10 was not aware that R8's toenail fell off. V10 was unsure if R8 had seen a podiatrist since admission. On 5/5/26 at 1:36 PM, V10 stated V10 reached out to request podiatry consent and notes for R8. On 5/5/26 at 3:10 PM, V1 Administrator stated R8 was initially supposed to be a short stay, so R8 was never seen by a podiatrist.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145965	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab of Decatur	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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review the facility failed to apply range of motion devices used for contractures for two (R57, R73) of 24 residents reviewed for range of motion on the sample list of 57 residents.On 5/3/26 at 9:27 AM, R57 was resting in a high back reclining chair in the room. R57's right hand was closed in a fist and bent towards R57's chest. R57 was not wearing a splint to the right hand. On 5/3/26 at 1:30 PM, V3 Licensed Practical Nurse stated she is not aware that R57 needs a brace and has never seen a brace for R57. At this time, V3 looked up R57's physician orders and stated that R57 does have an order for a brace. R57's physician order dated 9/30/25 documents an order to apply splint to right hand when resting, may take off for meals per therapy. On 05/04/26 at 10:50 AM, V5 Certified Nurse's Aide stated V5 has never seen a brace for R57. On 5/4/26 10:54 AM, R57 was resting in R57's room in the reclining geriatric chair. A blue splint was lying on the side table next to R57. R57's therapy notes dated 9/30/25 documents R57 requires placement of resting hand splint on right upper extremity during time of rest to prevent contractures. R57's therapy notes dated 1/15/26 documents R57 will safely wear a resting hand splint on right hand for up to four hours with minimal signs and symptoms of redness, swelling, discomfort, or pain. On 5/3/2026 at 9:00 AM, R73 was sitting in a wheelchair in R73's room. R73's right arm was bent with R73's hand laying on R73's chest. R73's right hand was closed with nothing in it. When asked if the staff put something in R73's hand R73 stated sometimes they do put lotion in it.ˆ R73's physician orders dated 12/7/2021 document an order to monitor right elbow splint upon application and removal for any skin changes daily and as needed every shift. R73's physician orders dated 5/19/2022 documents to apply palm protector at nighttime or as tolerated, release, and check skin routinely and to apply right hand splint in the PM (afternoon) for up to four hours or as tolerated, release and check skin routinely every evening shift. On 5/3/2026 at 1:44 PM, R73 was sitting in R73's wheelchair in R73's room. There was no splint applied to R3's right elbow or right hand. When asked about the palm protector R73 replied they don't put it in, and they haven't for a long time. R73 stated, when asked about R73's right elbow and hand splint, R73 reported some ask to put them on, but some don't. I (R73) haven't worn those in a while. ˆ On 5/5/2026 at 09:31 AM, R73 stated when asked if staff applied R73's palm protector, right elbow sling or right-hand splint yesterday evening or night R73 stated no, they never do. On 5/5/2026 at 9:55 AM, V5 Certified Nurse's Assistant, stated V5 has never seen R73 with a palm protector when V5 arrives in the mornings. When asked if V5 had seen R73's palm protector, right elbow splint or right-hand splint V5 stated no, but V5 stated V5 will look in R73's room soon and see if V5 can find anything. On 5/5/25 at 10:02 AM, V5 was checking drawers in R73's room. V5 then came into the hallway and stated that V5 did not see anything that looked like a brace or a palm protector.ˆ

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145965	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab of Decatur	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145965	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab of Decatur	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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent cross contamination during urinary catheter care for one (R9) of two residents reviewed for urinary catheters in the sample list of 57 residents. Findings include: The facility's Catheter Care policy dated 1/26/26 documents the following steps for female urinary catheter care: 9. Gently separate the labia to expose the urinary meatus. 10. Wipe from front to back with a clean cloth moistened with water and perineal cleaner (soap). 11. Use a new part of the cloth or a different cloth for each side. 12. With a new moistened cloth, starting at the urinary meatus moving out, wipe the catheter making sure to hold the catheter in place so as to not pull on the catheter. 13. Dry area with towel.On 5/3/26 at 8:52 AM, R9 received antibiotics for blood-tinged urine, symptoms have come and gone with additional antibiotic treatment. R9 stated staff don't clean R9's catheter daily, only intermittently. R9 stated R9 has occasional diarrhea with incontinence at times and requires staff assistance with toileting. On 5/05/2026 at 1:36 PM, V29 and V28 Certified Nursing Assistants entered R9's room and provided urinary catheter care. V29 used disposable wipes and cleansed R9's urinary catheter tubing in a downward motion. V29 then used separate wipes to wipe each inner labia and each inner thigh while coming into contact with R9's catheter during each wipe. V29 did not clean R9's urinary catheter last. On 5/5/26 at 2:03 PM, both V29 and V28 stated they used to clean the tubing last as part of catheter care until corporate staff recently instructed them to clean the tubing first. Both stated cleaning the labia and thighs causes cross contamination of the catheter tubing if the tubing is cleaned first. R9's Minimum Data Set, dated [DATE] documents R9 as cognitively intact and R9 requires substantial/maximal staff assistance with toileting hygiene. R9's Physician Order dated 2/2/26 documents to ensure catheter care is completed every shift. R9's urine culture dated 2/27/26 documents greater than 100,000 colony forming units per milliliter (CFU/mL) of Klebsiella Pneumoniae Extended Spectrum Beta-Lactamase (multidrug resistant organism) and 70-99,000 CFU/mL of Pseudomonas Aeruginosa, indicating an infection. R9's Physician's Orders dated 1/24/26, 2/26/26, 2/28/26, and 3/5/26 document orders for Meropenem-Sodium Chloride 1 gram/50 mL intravenously for Urinary Tract Infection. On 5/5/26 at 2:51 PM, V2 Director of Nursing confirmed the facility's policy documents to clean the catheter tubing as the last step during female catheter care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145965	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab of Decatur	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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review the facility failed to accurately document the refusal of protective arm sleeves on the treatment administration record for one (R73) of one resident reviewed for accidents on the sample list of 57 residents. On 5/3/2026 at 9:00 AM, R73 was sitting in a wheelchair in R73's room. R73's right arm was bent with R73's hand lying on R73's chest. R73 was wearing a sweater; R73's left arm was in the arm of the sweater but R73's right arm was bare. R73's physician order dated 7/2/2025 documents an order to apply protective arm sleeves when up in wheelchair as resident allows. On 5/3/2026 at 1:44 PM, R73 was sitting in R73's wheelchair in R73's room. R73 was not wearing protective arm sleeves. When asked if staff offered to apply the protective skin sleeves, R73 stated, no. On 5/4/2026 at 9:30 AM and 2:35 PM and on 5/5/2026 at 09:31 AM, R73 was sitting up in the wheelchair and was not wearing protective skin sleeves. R73's Treatment Administration Record dated April of 2026 and May of 2026 documents that R73's protective skin sleeves were applied every day. R73's care plan dated 2/8/26 does not include interventions for the use of the skin sleeves. On 5/5/2026 at 09:57 AM, V3 Licensed Practical Nurse, stated R73 is already up, dressed and sitting at the cart when V3 arrived at work. On 5/5/2026 at 11:10 AM, V2 Director of Nursing stated the protective skin sleeves are to prevent skin tears and abrasions. The intervention for skin sleeves should be on the care plan.^ When asked about the refusal of R73 to wear the skin sleeves V2 stated that staff should let V2 know if R73 is refusing so V2 can contact the physician for a discontinue order. V2 also stated if R73 does not wear the skin sleeves the nurses should not sign it off.