STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146003	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loft Rehab of Rock Springs, The	2530 North Monroe Street 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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 38780 Based on interview and record review, the facility failed to provide sufficient Registered Nursing (RN) hours on two of sixteen days reviewed for RN staffing. This failure has the potential to affect all 95 residents in the facility. Findings include: The facility Nursing Schedule (April 22, 2024 through May 7, 2024) document on 5/3/24 and 5/5/24, the facility scheduled zero (0) hours of RN coverage for a 24 hour period. On 5/7/24 at 12:05pm, V1 Administrator confirmed the hours listed on the facility nursing schedule were correct and the facility failed to have RN coverage on 5/3/24 and 5/5/24. The facility Resident Midnight Census dated 5/6/24 documents 95 residents reside in the facility.

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