

Illinois State Department of Health

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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>0054361</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                            |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><b>02/25/2026</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><b>LOFT REHABILITATION &amp; NURSING</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                         |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>700 NORTH MAIN STREET , EUREKA, Illinois, 61530</b> |                                                                                                                          |                                                 |                            |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                         |  | ID<br>PREFIX<br>TAG                                                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                 | (X5)<br>COMPLETION<br>DATE |
| S0000                                                                    | Initial Comments<br><br>Complaint #25212309/2694537<br><br>Complaint #25212260/2694066<br><br>Complaint #2620289/2711462                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                         |  | S0000                                                                                           |                                                                                                                          |                                                 |                            |
| S9999                                                                    | Final Observations<br><br>Statement of Licensure Violations<br><br>300.610a)<br>300.690b)<br>300.690c)<br>300.1210b)<br>300.1210d)6)<br><br>Section 300.610 Resident Care Policies<br><br>a) The facility shall have written policies and<br>procedures governing all services provided by the<br>facility. The written policies and procedures shall be<br>formulated by a Resident Care Policy Committee<br>consisting of at least the administrator, the advisory<br>physician or the medical advisory committee, and<br>representatives of nursing and other services in the<br>facility. The policies shall comply with the Act and<br>this Part. The written policies shall be followed in<br>operating the facility and shall be reviewed at least<br>annually by this committee, documented by written,<br>signed and dated minutes of the meeting.<br><br>Section 300.690 Incidents and Accidents<br><br>b) The facility shall notify the Department of any<br>serious incident or accident. For purposes of this<br>Section, "serious" means any incident or accident that<br>causes physical harm or injury to a resident.<br><br>c) The facility shall, by fax or phone, notify the<br>Regional Office within 24 hours after each reportable<br>incident or accident. If a reportable incident or |                                                                         |  | S9999                                                                                           |                                                                                                                          |                                                 |                            |

Office of Primary Care and Health Systems Management

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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Illinois State Department of Health

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| S9999                                                                    | <p>Continued from page 1</p> <p>accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. (Source: Amended at 37 Ill. Reg. 2298, effective February 4, 2013).</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to ensure adequate supervision and prevent an intermittently confused resident from exiting the facility, unannounced to staff, through alarmed exit doors after a visitor silenced the door alarm without staff knowledge. The facility failed to notify the state agency of a resident elopement. Staff failed to monitor the alarm system and failed to recognize the resident's elopement. The resident exited the building unsupervised, during freezing temperatures, wearing only a tee shirt and sweatpants. Approximately 13 minutes later, the resident was discovered by a patrolling police officer in the</p> |                                                                         |  | S9999                                                                                           |                                                                                                                          |                                                 |                            |

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| S9999                                                                    | <p>Continued from page 2<br/>facility parking lot, adjacent to an access road used by residents of a nearby apartment complex, creating a high risk for traffic- related injury. The resident was found lying on the ground next to an overturned wheelchair and had sustained multiple contusions and lacerations requiring an emergency room evaluation for one of four residents (R1), reviewed for accidents and supervision, in a sample of seven.</p> <p>The facility's failure to prevent unauthorized silencing of exit alarms; monitor alarm status; provide adequate supervision of an intermittent cognitively impaired resident and identify and respond promptly to an elopement placed the resident in immediate danger of serious injury or death, including hypothermia, trauma from falls or being struck by a vehicle.</p> <p>Findings include:</p> <p>The facility policy, Elopements and Wandering Residents, dated (revised) 2/2/26 directs staff, "This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Elopement occurs when a resident leaves the premises or a safe area without authorization and/or necessary supervision to do so. The facility is equipped with door locks/alarms to help avoid elopements. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. The facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement or unsafe wandering. Including identification and assessments of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks and monitoring for effectiveness and modifying interventions when necessary. Any staff member becoming aware of a missing resident will alert personnel using facility approved protocol. The designated staff will look for the resident. If the resident is not located in the building or on the grounds, Administrator or designee will notify the police department and serve as designated liaison between the facility and the police department. The administrator or designee should also notify the company's corporate office. Director of Nurses or designee shall notify the physician and family member or legal representative. Police will be given a description and information about the resident: include any photos. All parties will be notified of the outcome once the resident is located. Appropriate reporting</p> |                                                                         |  | S9999                                                                                           |                                                                                                                          |                                                 |                            |

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| S9999                                                                    | <p>Continued from page 3<br/>requirements to the State Survey Agency shall be conducted.</p> <p>R1's facility Admission Record documents that R1 was admitted to the facility on 12/2/25 with the following diagnoses: Sepsis, Pneumonia, Acute Respiratory Failure, Type 2 Diabetes Mellitus, Abnormalities of Gait and Mobility, Acute on Chronic Combined Systolic and Diastolic Heart Failure, Parkinson's Disease, Polyneuropathy, Repeated Falls and Weakness.</p> <p>R1's Clinical Admission note, dated 12/2/25 and signed by V17/Licensed Practical Nurse documents mental status: resident is confused.</p> <p>R1's Advanced Skilled Evaluation, completed by V18/Registered Nurse on 12/4/25 documents R1 is (chronically) confused.</p> <p>R1's Consultation Note, dated 12/9/25 and signed by V19/Nurse Practitioner documents, "(R1) sitting up in wheelchair today and in no apparent distress. Wife/POA (Power of Attorney) is present at bedside. (R1) is confused/disoriented to time."</p> <p>R1's Nursing Progress Notes, dated 12/10/25 at 6:54 PM by V4/Licensed Practical Nurse document the administration of Lorazepam (anti-anxiety) 0.5 MG (milligrams) by mouth due to exit seeking and upset.</p> <p>R1's facility form, Unwitnessed Fall, dated 12/10/25 at 7:30 PM and completed by V4/licensed Practical Nurse documents, "(R1) was laying down, R1's wheelchair was on his left side. Bleeding present from left arm and abrasion present to top of left side of head. (R1) was helped by EMS (Emergency Medical Services) and taken to (local hospital). (R1) told staff he was trying to go home. Injuries observed include: Abrasion to forehead, skin tear to back of left hand and left forearm."</p> <p>V7/Police Officer's report of (R1's) 12/10/25 incident documents, "On 12-10-25 at 1922hrs (7:22 P.M.), I (V7/Police Officer)) was on routine patrol for the city. While patrolling the area of (facility), I observed (R1) an elderly white male laying on the ground, with a tipped over wheelchair nearby. I exited my patrol vehicle and made contact with the elderly male, who stated he fell out of his wheelchair. It</p> |                                                                         |  | S9999                                                                                           |                                                                                                                          |                                                 |                            |

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| S9999                                                                    | <p>Continued from page 4</p> <p>should be noted that at the time I found the male, it was 38 degrees, with a real feel of 26 degrees and it was starting to snow. The elderly male was only wearing a thin t-shirt and sweatpants. While I stayed with the elderly male, my ride along Police recruit, along with an on-break employee (V5/Certified Nursing Assistant) ran inside (the facility) to get assistance. I asked (R1) how he got outside, and he said he just pushed the lobby door open and left and he wanted to go home. I advised dispatch to have (city) EMS (Emergency Medical Services) respond to the scene (R1), who was alert, conscious and breathing had blood coming from a laceration on his head, a laceration on his left elbow and a laceration on his right hand. (R1) complained of head pain and stated he thought he had a concussion. At no time did I move or touch (R1) due to a possible head injury. (R1) was laying left lateral recumbent position upon initial contact. (Facility) staff members arrived and had (R1) sit up from his recumbent position. They placed a blanket around (R1) due to the cold temperatures. EMS Paramedics arrived for further care. It was determined that (R1) would be transported to (local hospital) for evaluation. I then followed the (facility) employees back into the building to gather information. The (facility) employees were identified as (V6/Licensed Practical Nurse) and (V5/Certified Nursing Assistant). (V5/CNA) was on break at the time this incident occurred and was sitting in her vehicle in the parking lot and ran into the (facility) with (the police) recruit to get further assistance. Also present was (V4/Licensed Practical Nurse). (V4/LPN) advised that prior to this incident, (R1) was sitting in the main lobby conversing with other residents. (V4/LPN) said that he left the lobby for a brief moment, went down the 300 Hall to give meds (medications) to a resident and when he returned back to the main lobby, that is when he saw (V5/CNA) and (the police) recruit running inside. (V4/LPN) stated he believes that (R1) could have been outside for about 10 minutes. I asked (V4/LPN) if the staff even knew that (R1) was gone prior to (V5/CNA) and (the police) recruit coming inside and (V4/LPN) stated they did not know that (R1) was missing and had pushed the door open and was outside unsupervised. When asking (V4/LPN) about (R1)'s medical history, he stated that (R1) has Parkinson's and also has confusion. (V4/LPN) stated that (R1) has been a resident of (the facility) since 12/02/25."</p> <p>R1's Emergency Department report, dated 12/10/25 documents, "Encounter Diagnosis: Fall, Contusion of left hip, Multiple skin tears to left elbow and Contusion to scalp."</p> |                                                                         |  | S9999                                                                                           |                                                                                                                          |                                                 |                            |

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| S9999                                                                    | <p>Continued from page 5</p> <p>R1's facility Fall IDT (Intra Disciplinary Team) Note, dated 12/15/25 documents that R1 fell, unwitnessed, and was found on his side, in the facility parking lot on 12/10/25 at 7:30 PM, after exiting the building without letting staff know. R1 stated he was looking for a car with keys in it so he could go home. Interventions taken: (wandering alert bracelet) placed on (R1)'s right wrist to ensure safety when (R1) is actively exit seeking.</p> <p>On 2/19/26 at 12:06 P.M., V11/Certified Nursing Assistant stated she had been employed at the facility for the past year. States the front door is alarmed and when an alarm goes off, she turns off the alarm. During this time, a facility visitor was observed to enter the sounding facility front door alarm, by entering a code in the alarm panel. At that time, V11/CNA stated all resident family members are given the code to enter and exit the facility.</p> <p>On 2/19/26 at 12:09 P.M., V3/Assistant Director of Nurses (ADON)/Wound Nurse stated that all residents are assessed upon admission for being an elopement risk per the admitting nurse. If a resident is determined to be at risk of eloping, a (wandering alert bracelet) is placed, which is checked for placement and function every shift by the nurse and documented. V3 states the facility policy is if a door alarm is sounded, staff immediately respond to the door and if a resident is unable to be located, they announce a Code Yellow. A code yellow includes facility staff surveying the surrounding area, locating the missing resident and performing a whole house head count to account for all residents. At that time, V3 stated the facility had not had a resident elopement within the past 6 months. V3 further stated that all resident family members and visitors are given the code to the facility front door to enter and exit the building, at which time any alarm would be silenced. States R1 was assessed upon admission as not being an elopement risk. States on 12/4/25, V12/Former MDS Coordinator completed a BIMS (Brief Interview of Mental Status) which documented that R1 was cognitively intact. At that time, R1 was determined to not be an elopement risk. When asked why R1 had documentation in his medical record that includes licensed staff documenting R1 was confused, V3 stated that R1's confusion was intermittent.</p> <p>On 2/19/26 at 12:18 P.M., V1/Administrator stated R1</p> |                                                                         | S9999               |                                                                                                                          |  |                                                 |  |

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| S9999                                                                    | <p>Continued from page 6</p> <p>did not have a (wandering alert bracelet) in place on 12/10/25 when he exited the facility door, around seven pm, unannounced to staff, in freezing temperature conditions with only a tee shirt and sweatpants on, and was found by a patrolling police officer in the middle of the facility parking lot with his wheelchair over turned, lying injured on the road. V1 states R1's BIM (Brief Interview for Mental status) was 13:15, despite licensed staff documentation of confusion. States she reviewed the facility camera footage of the front door on 12/10/25 at it shows R1 open the first door at 7:08 PM, the outside door at 7:09 PM and the front door alarming until 7:13 PM, when a facility visitor (unable to clearly see who that was) entered a code in the alarm pad, shutting off the alarm. V1/Administrator states no facility staff responded to the alarm, no Code Yellow was announced to alert staff to a missing resident, and no head count was performed to determine who the missing resident was. V1 states V5/Certified Nursing Assistant was observed leaving the facility through the front door at 7:15 PM. V1 stated that V5 reentered the facility sometime later, but she doesn't remember what time that was. When V1 was asked to share the video footage of R1 leaving the facility on 12/10/25 unattended, V1 stated she no longer was able to view the footage, as it is deleted after 3 days. V1 stated when R1 was questioned by staff after the incident he told staff he was looking for a car to steal, as he wanted to go home. V1 then stated a local police officer found R1 lying on the ground, approximately 1/10th of a mile from the entrance of the facility, in an unlit area of the facility parking lot, that is used as an access road for occupied, independent apartments. V1 states she doesn't know who the officer was and does not have a copy of the officer's report despite the officer coming into the facility to interview staff after the incident. V1 states R1 was transported to the local emergency room with a contusion to the top of his head, his left hip and his left elbow. At that time, V1 states she does not consider R1 leaving the facility as an elopement and did not report the incident to the state regional office.</p> <p>On 2/19/26 at 12:34 P.M., V5/Certified Nursing Assistant (CNA) stated she had been a CNA since 2019, working at the facility. States she recalls R1 on the evening of 12/10/25 as being agitated and wandering. States she witnessed the day shift nurse (V13/Licensed Practical Nurse) go to the front door during shift change and turn R1's wheelchair around and bring him back to the nurse's station, as R1 was attempting to leave the facility. States she frequently worked with</p> |                                                                         |  | S9999                                                                                           |                                                                                                                          |                                                 |                            |

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| S9999                                                                    | <p>Continued from page 7</p> <p>R1, and he had definite periods of confusion and agitation. States as far as she recalls, R1 did not have a (wandering alert bracelet) in place. States she was assigned 500 Hall on the evening of 12/10/25 and R1 was her resident. States no one told her to monitor R1 closely that evening or to do anything different for R1. States she doesn't recall hearing the front door alarming prior to her leaving around 7:15 P.M. to go to her car in the parking lot to take a break. States she recalls it was very cold outside; the wind was blowing, and it was snowing. States as she was walking towards her car, she saw a police car down by the facility mailboxes stopped in the road, and a wheelchair overturned and a person lying in the road. States she had no idea it was a facility resident. States when she ran towards the scene, she realized it was R1. States that V7/Police Officer was providing care for R1 and stated she had called an ambulance for R1 as he was bleeding from his head and his elbow. States she ran back to the facility to get R1's nurse (V4/Licensed Practical Nurse) and some blankets, as R1 was laying on the ground, stating he was cold, in only a tee shirt and a pair of sweatpants. States after R1 left via ambulance, V7 came into the facility, and she was required to give a statement of the details.</p> <p>On 2/19/26 at 12:55 P.M., V13/Licensed Practical Nurse (LPN) stated she has worked at the facility for the past two years as a nurse. States she worked day shift the day of 12/10/25 and (R1) was her assigned resident. States R1 had recently admitted, had periods of confusion and agitation and liked to wander in his wheelchair. States she recalls the night nurse (unable to recall who) told her R1 had been agitated most of the night (12/9/25) and was still agitated during the morning of 12/10/25. States during shift change, at 6:00 P.M. she had to go to the front door and turn R1's wheelchair around, as he was trying to leave. States she passed on to V4/Licensed Practical Nurse the oncoming nurse about R1's agitation.</p> <p>On 2/19/26 at 1:27 P.M., V9/R1's spouse stated R1 had been in the hospital prior to being brought to the facility, for a period of time with pneumonia. States she had to hire help to sit with R1 around the clock as he was restless, confused and agitated. States she told facility staff about R1's confusion upon his admission to the facility and they told her they could not provide one to one care for him. States she had been to the facility the day of 12/10/25 and R1 kept stating he wanted to go home and had tried to get out the door. V9 states that R1 frequently stated he wanted to go home</p> |                                                                         | S9999               |                                                                                                                          |  |                                                 |  |

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| S9999                                                                    | <p>Continued from page 8</p> <p>and was restless. V9 states when she got the call from the facility that R1 was found outside of the facility she wasn't surprised. V9 states she met with V1/Administrator, V2/Director of Nurses and another nurse she is unable to recall whom, in the DON's office after the incident. V9 states she asked V1 why R1 didn't have a (wandering alert bracelet) in place prior to his leaving the facility unattended and V1 states that in hindsight, he should have had an alarm on.</p> <p>On 2/23/26 at 9:25 A.M., V14/Maintenance Director stated all facility exit doors are alarmed and a code must be entered to enter or exit the facility. States the facility front door has two doors to enter/exit. States the first door is for the (wandering alert bracelet) system, which will not allow a resident with a (wandering alert bracelet) to exit, as it locks the door if a resident with a bracelet gets too close. States the second door is locked at all times and a code must be entered. States he conducts routine weekly checks of all facility doors. States if the door alarm is sounding and someone entering the facility enters the code, the door is unlocked, and the alarm is silenced. States as far as he is aware, most family members have been given the code to the doors so they can enter and exit as desired.</p> <p>On 2/23/26 at 9:32 A.M., V1/Administrator stated staff are trained during orientation by the Social Services Director (V16) on the facility Code Yellow protocol. States the facility does Code Yellow drills but is unable to state how frequently. States when a door alarm is sounding, the facility protocol is for someone to respond to the alarm and do a preliminary search of the area, if no resident is seen, Code Yellow is announced, and the nurses are responsible for completing a facility wide head check. If a missing resident is noted, then a wider facility perimeter check is completed and if the resident is unable to be located at that time, the police are called.</p> <p>On 2/23/26 at 9:38 A.M., V16/Social Services Director stated most (facility) family members have the code to the front door so they can enter and exit anytime.</p> <p>On 2/23/26 at 9:47 A.M., V4/Licensed Practical Nurse stated he was working the evening of 12/10/26 and R1 was assigned to him. States he had been assigned to R1 in the past and knew R1 was confused at times. States he had witnessed R1's spouse enter the code to the</p> |                                                                         | S9999               |                                                                                                                          |  |                                                 |  |

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| S9999                                                                    | <p>Continued from page 9</p> <p>front door in front of R1 many times during the evening. States R1 even knew the code to the front door as V4 had overheard R1 repeat it. States when he came to work on 12/10/25 at 6 PM, he was told in report that R1 was very agitated and anxious. States when he talked with R1, that R1 was very fixated and adamant that he had to be somewhere. States R1 was wandering around, going to the front door repeatedly. States he made the decision to administer Lorazepam 0.5 MG (milligrams) by mouth to R1 in an effort to get R1 to calm down. States after he administered the Lorazepam at 6:54 PM, R1 remained in the lobby, in his wheelchair while V4/LPN headed down the hall to pass evening medications to other residents. States he did not place R1 on 1:1 supervision. States he did not inform R1's assigned CNA to increase supervision of R1. States he did not hear the door alarm when he was down the hall taking care of other residents and did not know that R1 had exited the facility. States he only became aware of the situation when V5/Certified Nursing Assistant ran back into the facility to alert him that R1 was injured in the parking lot. States it is common practice in the facility for resident family members to be given the code to the door alarm, so they can come and go as they want.</p> <p>On 2/23/26 at 10:10 A.M., V7's spouse entered the facility front doors by entering a code into the two doors. At that time, stated his spouse has been a resident since last fall and facility staff provided him with the code to the doors upon her admission.</p> <p>On 2/23/26 at 11:29 A.M., V8 and V9's daughter entered the facility front doors by entering a code into the doors. At that time, she stated how else am I supposed to get in and out. They gave me the code a long time ago.</p> <p>(A)</p> |                                                                         | S9999               |                                                                                                                          |  |                                                 |  |