

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055376		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/01/2026	
NAME OF PROVIDER OR SUPPLIER LOFT REHAB & NURSING OF NORMAL				STREET ADDRESS, CITY, STATE, ZIP CODE 510 BROADWAY , NORMAL, Illinois, 61761			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments Complaint Investigations: 2662204/2784764 2662043/2747499		S0000			04/23/2026	
S9999	Final Observations Statement of Licensure Violations 1 of 2: 300.610a) 300.1210b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care 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. These Regulations are not met as evidenced by: Based on observation, interview, and record review the facility failed to promote dignity for three (R6, R15, R20) of three residents reviewed for dignity in a sample of 23 residents. This failure resulted in R15 experiencing increased anxiety and becoming upset as V53 was overheard yelling/cussing (using foul		S9999			04/23/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 language in a loud and derogatory manner) towards staff outside of R15's doorway. Findings Include: R6's Minimum Data Set (MDS) dated 1/1/2026 documents R6 has severe cognitive impairment. R6's Care Plan dated 10/18/2022 documents R6 is at potential risk for abuse due to Dementia. Despite R6's inability to comprehend interview questions, R6 was repeatedly observed independently propelling to and remaining near the nurse's station located by the facility's front door where V53 (Former Administrator), V32 Receptionist, and V41 Business Office Manager offices were located. This observation made R6 have the potential to place R6 at risk to hear when V53 Administrator was allegedly being verbally inappropriate and unprofessional towards staff in the hallway. On 3/23/2026 at 9:45am, R6 was in R6's wheelchair in the room and appeared to be clean and well-groomed. R6 was able to propel self in and out of the room independently. R6 could not fully participate in the interview due to decreased cognitive status. On 3/23/2026 at 11:00AM, R6 was observed sitting in a wheelchair in the hallway at the nurse station by the front door. On 3/24/2026 at 9:30AM, R6 was propelling self in the hallway towards the nurse's station by the front door. On 3/24/2026 at 3:52PM, R6 was observed sitting in a wheelchair in the hallway at the nurse's station by the front door. On 3/25/2026 at 10:42AM, R6 was observed sitting in a wheelchair at the nurse's station by the front door. On 3/30/2026 at 09:07AM, R6 was propelling self in the hallway towards the nurse's station by the front door. On 3/30/2026 at 09:26AM, R6 was observed sitting in a wheelchair at the nurse's station by the front door. On 3/30/2026 at 1:24PM, R6 observed sitting in a wheelchair at the nurse's station by the front door.			S9999			04/23/2026

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S9999	Continued from page 2 On 3/30/2026 at 3:56PM, R6 observed sitting in a wheelchair at the nurse's station by the front door. On 3/24/2026 at 1:00PM, V41 Business Office Manager stated V53 Former Administrator had been verbally inappropriate and unprofessional in the hallways towards staff members with residents present in the hallway. V41 stated V41 had heard V53 say cuss words like S*** (expletive) or A** (expletive) loudly towards staff members by the nurse station where R6 usually sits. V41 stated V41 would think R6 heard what V53 said although R6 has impaired cognition. V41 stated V41 did not report it to anyone because the incident was discussed during the morning meeting where V53 was present and aware of the concern. On 3/30/2026 at 9:34AM, V56 Receptionist stated V56 has heard V53 Former Administrator cuss loudly in V53's office. V56 stated V56 was not sure if there was another person in the office with V53. V56 stated that V53 then came out of office appeared angry as V53 loudly yelled and cussed while having a conversation over the phone. V56 stated R6 was in the hallway (closer to the reception area and V53's office) where R6 always sits and could hear V53 cussing and yelling. On 3/30/2026 at 10:12AM, V59 (R6's) family member stated V59 and R6 never discussed anyone being verbally inappropriate toward staff or residents. V59 stated R6 would be very upset if anyone was cussing or yelling around R6. On 3/24/26 at 9:20AM, R15 was lying in bed and stated R15 gets to move back to R15's regular room after being in isolation for Respiratory Syncytial Virus (RSV). R15 was clean and well-groomed. R15 stated R15 had heard V53 Former Administrator on one occasion when staff were bringing the crash cart down the hallway, and equipment was positioned on both sides of the hall. R15 stated that V53 began yelling loudly at staff, saying, "This is why all these items should be on one side of the hallway!" R15 felt anxious and became upset due to V53's yelling. R15 stated that R15 had already been anxious because of the emergency situation occurring at that time, and V53's yelling increased R15's anxiety. R15 also stated that V53 had cursed at staff members on previous occasions in the hallway, and R15 did not like that. On 3/24/2026 at 8:32AM, V32 Receptionist stated V32 has heard V53 cussing loudly in the hallway. V32 stated V32 does not remember the exact dates, but V32 knows that whenever V53 does not like what			S9999			04/23/2026

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S9999	Continued from page 3 V53 sees in the hallway V53 will get mad and cuss at staff members. V32 stated V32 has heard V53 say to staff "you all are "F***** (expletive) S***** (expletive), why don't you take your head out of your "A***** (expletive)!" R15's Minimum Data Set (MDS) completed on 3/20/2026 documents R15 is cognitively intact. R15's Care Plan with revision date of 8/15/2025 documents R15 is at risk for altered well-being and/or psychological distress related to history of abuse. On 3/24/2026 at 10:06 AM, R20 stated R20 never heard V53 Administrator cuss or use vulgar words, but R20 knows V53 was not a nice person. R20 stated sometime in February R20 went to V53's office to tell V53 about a missing part on R20's wheelchair. R20 stated V53 got mad and walked out of the office. R20 stated V53 did not even look at R20's wheelchair. R20 stated R20 served in the military for 20 years, and R20 was respected but R20 never felt respected by V53 at that time. R20 stated that R20 felt upset because R20 knew what leadership was supposed to look like, and V53's reaction at that time did not reflect that. R20 stated that R20 felt as though V53 was looking down V53's nose at R20. On 3/24/2026 at 2: 28 PM, V32 Receptionist stated V32 has seen R20 going to V53 Former Administrator's office in the past but V32 never knew what was discussed. R20's Minimum Data Set (MDS) dated 1/5/2026 documents R15 has moderate cognitive impairment. The Facility's Conduct and Behavior Policy with a revised date of 2/11/2025 documents all team members must adhere to accepted professional standards. This includes displaying business conduct and behaviors and always exhibiting high integrity. Examples of conduct and behavior that are considered inappropriate and are prohibited by this company include, but not limited to the following: Using profanity, abusive or suggestive languages or gestures, or any other unprofessional behavior. Conflicts between employees should not be discussed in front of visitors or residents and should always be settled in a calm manner. (B)			S9999			04/23/2026

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S9999	Continued from page 4 Statement of Licensure Violations 2 of 2: 300.610a) 300.1010h) 300.1210b) 300.1210d)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall	S9999				04/23/2026	

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S9999	Continued from page 5 be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These Regulations are not met as evidenced by: Based on observation, interview, and record review, the facility failed to recognize and respond to a change in condition that required immediate intervention for two (R1, R8) of three residents reviewed for quality of care and failed to implement the physician's order for continuous oxygen therapy for one (R8) of three residents reviewed for oxygen in a sample of 23 residents. These failures resulted in R8 experiencing acute respiratory distress and being sent to the emergency department for hypoxia. R8 was diagnosed with Acute Respiratory Failure and Acute Congestive Heart Failure exacerbation. Findings Include: 1. On 3/24/26 at 9:36 AM, R8 was observed lying in bed with oxygen at two (2) liters per minute via nasal cannula. R8 appears frail and opens and closes R8's eyes in response to verbal stimuli but does not answer questions or follow commands. R8's lips were noted to be dry and cracked. R8 did not verbally respond during this interaction. R8's Minimum Data Set (MDS) dated 3/9/26 documents that R8 has the following active diagnoses: Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease, and Chronic Respiratory Failure with Hypoxia, and Congestive Heart Failure. This MDS documents that R8 has severe cognitive impairment and requires continuous oxygen therapy as well as non-invasive mechanical ventilation. R8's Care Plan dated 12/6/24 documents that R8 has altered respiratory status and difficulty breathing related to Pulmonary Edema, Sleep Apnea, chronic respiratory failure and COPD with an intervention for staff to monitor R8 for signs and symptoms of respiratory distress and report to medical doctor as needed if R8 has any of the following: increased respirations; decreased pulse oximetry; increased heart rate; restlessness; diaphoresis; headaches; lethargy; confusion; hemoptysis; cough; pleuritic			S9999			04/23/2026

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S9999	Continued from page 6 pain; or if observed using accessory muscle; and any skin color changes to blue/grey. An additional intervention for this problem area dated 1/27/26 documents that R8 is to have oxygen via nasal prongs at 2 liters continuously and that R8 will have no complications related to shortness of breath (SOB) though the review date. R8's Electronic Health Record (EHR) contains a hospital discharge summary documenting that R8 was hospitalized from 2/8/26–3/3/26 and intubated for acute respiratory failure with hypoxia and acute on chronic diastolic heart failure; discharged back to the facility 3/3/26. R8 returned to the facility on 3/3/26 with a physician's order for continuous Oxygen at 2 liters via nasal cannula. On 3/24/26 at 11:42 AM, V20 Licensed Practical Nurse (LPN) stated V20 recalls the night of 3/14/26 when R8 was drowsy and complained of shortness of breath (SOB) with a respiratory rate (RR) of 44. V20 stated V20 administered a nebulizer treatment and rechecked R8's vital signs and notified the oncoming nurse of the resident's condition. R8's Electronic Health Record (EHR) documents the post-nebulizer-treatment respiratory rate on 3/14/26 at 7:18 AM was 36 breaths per minute. No provider notification is documented at that time. R8's EHR contains a progress note dated 3/16/26 by V42 LPN and documents that V42 entered R8's room and observed R8 experiencing SOB. This note documents that V42 performed an assessment and R8 was noted to have wheezing with evaluated respirations at 28 breaths per minute. This progress note documents that R8 has a known history of Chronic Obstructive Pulmonary Disease (COPD). V42 documented that she obtained R8's vital signs with the following abnormal findings: heart rate (HR) 109 bpm (beats per minute), RR 28 breaths per minute and oxygen saturation 93% on five (5) liters of oxygen via nasal cannula. V42 documents that a nebulizer treatment was administered to R8. V2 documented that R8's vital signs were reassessed post treatment with the following findings: HR 102 bpm, and RR 24 breaths per minute. No provider notification is documented at that time. On 3/24/26 at 12:36 PM, V42 LPN stated the day prior to R8 being sent to the hospital V42 was the nurse taking care of R8 on the night shift. R8 stated it was around 5:00 AM when V42 went into R8's room to give R8's morning medication when V42 found R8 struggling to breathe. V42 stated V42			S9999			04/23/2026

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S9999	Continued from page 7 asked R8 if R8 was having a hard time breathing and R8 shook R8's head yes. V2 stated V2 works through an agency and was unsure of the facility protocol regarding how to handle a resident experiencing SOB, so V2 asked the registered nurse (RN) working the floor and the RN told her to give the resident breathing treatment and pass along to the day shift. On 3/25/26 at 11:07 AM, V47 RN stated R8 had been in and out of the hospital recently, so V47 had been monitoring R8's vital signs closely during the night shift. V47 stated that on the night prior to R8's admission to the hospital on 3/17/26, V47 observed that R8's respirations were fast and shallow, but R8's other vital signs appeared stable, so V47 was not concerned. V47 stated that when V47 assessed R8's respirations and obtained a respiratory rate of 31, V47 was not concerned because he did not notice "any dramatic change" from R8's usual presentation. On 3/24/26 at 4:14 PM, V51 RN for V64 Nephrologist stated R8 had an appointment with V64 on 3/17/26 and that according to V64's progress notes from this visit it documents that "R8 presented to the office in acute respiratory failure" 911 was called and R8 was sent to the emergency department for further evaluation. On 3/25/26 at 10:07 AM, V52 Transport Driver stated that on 3/17/26, when V52 transported R8 to V64's office, R8 did not appear to be doing well. V52 stated that R8 was breathing fast, and R8's breathing became worse during the drive to the clinic. V52 reported that V52 was concerned about R8's condition, and upon arrival at the appointment, V52 informed the receptionist that R8 was not doing well. V52 was unsure if R8 was wearing oxygen. On 3/24/26 at 12:04 PM, V38 Assistant Director of Nursing (ADON) stated that a floor nurse (unsure of name) informed V38 that R8 had been at a routinely scheduled appointment, and that the doctor sent R8 to the emergency room because R8 was lethargic. V38 stated that R8 had been in and out of the hospital recently for Congestive Heart Failure exacerbations. V38 stated that the nurse should have called the physician or sent R8 out with a respiratory rate of 44 breaths per minute and complaints of shortness of breath. V38 stated a respiratory rate of 44 breaths per minute is a significant clinical finding. On 3/25/26 at 3:34 PM, V51 the RN for V64 (Nephrologist) called back to report that V51 had spoken with V64, who was currently on vacation.			S9999			04/23/2026

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S9999	Continued from page 8 V51 stated that V64 confirmed R8 was only arousable to verbal stimuli during R8's appointment on 3/17/26. V51 also stated that V64 told him that R8 had been slumped in R8's wheelchair, R8's respirations were fast and shallow, and R8 was not wearing oxygen at the time of the appointment. On 3/30/26 at 9:05 AM, V61 Nurse Practitioner (NP) stated R8 had been hospitalized in February 2026 for Congestive Heart Failure, Respiratory Failure, and COPD, and that R8 was intubated during that hospitalization. V61 stated that if V20 documented R8's respirations correctly, a respiratory rate of 44 was "much too fast," and one of the providers should have been notified immediately. V61 also stated that R8 should not have been sent out of the facility without oxygen on 3/17/26, especially considering her recent hospitalizations and diagnoses. V61 stated that because there was an active physician's order for continuous oxygen, R8 should have been wearing oxygen to prevent oxygen saturation levels from dropping below 90%, which may lead to hypoxia, shortness of breath, and fast, shallow breathing. An Emergency Department Physician Note dated 3/17/26 at 1:53 PM documented that R8 presented to the emergency department with shortness of breath, had an oxygen saturation of 86 percent and was hypoxic upon arrival. The note documented that R8 was diagnosed with Acute Respiratory Failure and a Congestive Heart Failure Exacerbation, was placed on BiPAP, and was admitted to the hospital. 2. R1's Electronic Health Record (EHR) documents that R1 was admitted to the facility on 2/3/2026 for rehabilitation after a fall at R1's assisted living facility that resulted in a left femur fracture. R1's Minimum Data Set (MDS) dated 2/9/2026 documents that R1 requires partial to moderate assistance with transfers and is independent with feeding. This MDS also documents that R1 is cognitively intact. On 3/31/2026 at 9:14 AM, V67 Certified Nurse Assistant (CNA) stated V67 cared for R1 on the night of 2/17/26 and that R1 was at baseline that night. V67 stated R1 was alert and able to voice R1's needs. V67 stated R1 slept through the night and only woke up during rounds. V67 stated R1 was not in any distress and did not complain of any discomfort that night. On 3/31/26 at 9:20 AM, V68 Registered Nurse (RN) stated V68 was the nurse who cared for R1 on the			S9999			04/23/2026

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S9999	Continued from page 9 day prior to R1's passing on 2/17/2026. V68 stated that V68 was familiar with R1, having cared for R1 on previous occasions. V68 stated that R1 was stable throughout that day on 2/17/26. V68 stated V68 was very surprised the next time V68 returned to work and learned that R1 had passed away. V68 further stated that CNAs are responsible for obtaining residents' vital signs and that V68's role is to document the vital signs provided to her. V68 stated that V68 was unaware that the vital signs documented on 2/16/2026 and 2/17/206 were the exact same readings both days (Blood Pressure 133/52, Pulse 61). On 3/31/26 at 8:44 AM, V66 CNA stated that V66 was very familiar with R1 and had been assigned to R1 the night prior to R1's passing on 2/18/26. V66 reported that V66 assisted R1 to bed that evening and recalled having a pleasant conversation with R1 as V66 helped R1 get ready. V66 stated that nothing unusual occurred during the shift and that R1 appeared to be at R1's baseline and comfortable when R1 was put to bed. V66 added that V66 was completely surprised when V66 returned to work the following evening and was informed that R1 had passed away. R1's EHR documents that on 2/18/26 R1 had multiple indicators of a change in condition. R1's EHR documents that on 2/18/26 at 07:08 AM, R1's blood pressure was obtained with a reading of 98/45 with a pulse of 61 and documented that R1's blood pressure was taken in the left arm while R1 was lying in bed. R1's Medication Administration Record (MAR) dated 2/18/26 at 7:07 AM documents that R1's blood pressure was 98/45. This MAR documents that V23 held R1's Metoprolol 100 milligrams (mg). R1's physician order includes Metoprolol parameters to hold if Systolic Blood Pressure is less than 120 or heartrate less than 60 beats per minutes. This MAR also documents that V23 held R1's Adolophine 10mg, which had no parameters, but was held and there was no documentation that the physician had been notified that this medication was held. R1's EHR did not include any documentation showing there was any follow-up assessment, monitoring, or notification to R1's doctor regarding R1's hypotensive episode. R1's EHR also showed no Certified Nursing Assistant (CNA) documentation on 2/16/26 and 2/17/26 regarding R1's meal consumption. R1's EHR does not show that any skilled			S9999			04/23/2026

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S9999	Continued from page 10 assessments or nursing progress notes were completed for R1 on 2/17/26 and 2/18/26. Last skilled documentation on record was 2/16/26. R1's EHR documents that R1 refused breakfast at 8:35 AM on 2/18/26, and this refusal was recorded on the Certified Nursing Assistant (CNA) eating task in the EHR by V60 CNA. R1 experienced a large, loose incontinent bowel movement at 9:09 AM on 2/18/26, as documented by V60 CNA on the CNA Bowel and Bladder record in R1's EHR. On 3/25/2026 at 10:17AM, V60 CNA stated R1 was pale, lethargic, weak, and refused breakfast on the morning of 2/18/26 and that R1 complained of not feeling well. V60 CNA stated V60 reported these findings to V23 Licensed Practical Nurse (LPN) at approximately 9:09 AM but stated V60 did not observe any further follow-up to R1's condition after V60 reported it to V23. On 3/30/26 at 10:00 AM, V62 Nurse Practitioner (NP) stated on 2/18/26 at 10:12 AM, V62 assessed R1 and noticed R1 was pale, weak, had a dry mouth, and exhibited decreased alertness compared to baseline. V62 stated V62 immediately reported this to V23 and told V23 that R1 was not feeling well and requested nausea medication. V62 stated V62 then called V61 NP and reported V62's concerns related to R1's change in condition. On 3/23/26 at 9:14 AM, V23 LPN, confirmed that V23 was aware of R1's low blood pressure and that R1 was ill on the day of R1's passing. V23 stated V23 did not physically assess R1 prior to going to lunch at 11:01 AM on 2/18/26, and instead only visually observed R1 from outside the room because R1 was sleeping and V23 "didn't want to bother her (R1)." V23 stated V23 did not notify the provider regarding R1's condition, stating that was V23's "nursing judgment." V23 also stated V23 administered anti-nausea medication, but no documentation of anti-nausea medication administration was found in the electronic medical record at the time of review; V23 confirmed the lack of documentation and stated V23 was unsure of the time the medication was given. R1's EHR contains a late entry nursing progress note on 2/18/26 at 3:10 PM by V23 LPN which stated: "V23 checked in on resident to assess pain and nausea. Resident noted sleeping in the bed on her left side. Respirations even and unlabored. Call light in reach." On 03/24/2026 at 9:35 AM, V37 Director of Nursing	S9999				04/23/2026	

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S9999	Continued from page 11 (DON) stated V23 LPN should have documented the change in R1's condition and notified the physician promptly after V60 CNA reported that R1 appeared more lethargic, pale, and weak. On 3/31/26 at 8:38AM, V2 Regional Nurse Consultant confirmed the nurses should have assessed, followed up and documented R1's condition. R1's EHR contains a progress note completed by V62 NP dated 2/18/26 at 10:12 AM documenting that R1 was seen resting in bed, appearing ill. V62 documented that R1 was drowsy but arousable to voice, reported not feeling well, appeared pale, and had a dry mouth. V62 further documents that R1 continued to complain of nausea and fatigue, and V62 advised nursing staff to administer a dose of Compazine, as R1 had not yet requested that morning. V62 documented that R1's vital signs were reviewed and appeared stable, with the exception of a blood pressure of 98/45, noted as low. V62 documented that R1's clinical presentation was discussed with V61 NP, and that laboratory testing and/or further evaluation was recommended. On 3/30/26 at 8:59 AM, V61 Nurse Practitioner (NP), stated V61 received a call on 2/18/26 at approximately 10:20 AM from V62 Hospital Nurse Practitioner, who reported concerns that R1 was paler, had a dry mouth, and "didn't feel good." V61 stated that when V61 arrived at the facility and was walking past R1's room, R1's family friends stopped V61, appearing visibly upset and telling her they believed something was wrong with R1. V61 stated V61 entered R1's room and immediately observed R1 lying on her left side in bed. V61 stated V61 checked R1 for a pulse and found that R1 had no pulse, was cold, and was unresponsive. V61 stated V61 then immediately went to the office of V38 Assistant Director of Nursing (ADON), and a Code Blue was called. Cardiopulmonary resuscitation (CPR) was initiated. V61 stated that if staff had notified V61 earlier regarding R1's condition, interventions such as laboratory testing, intravenous hydration, or hospital transfer could have been initiated, which had the potential to prevent this outcome. On 4/1/2026 at 10:26AM, V71Oncologist stated that R1 has been seeing him since August 2024 with continued treatment for anemia, cancer of the liver and colon which was diagnosis in March 2025. V71 stated that while R1 was in the hospital with a fracture, V71 observed R1 in stable/baseline condition when seeing R1 at the end of January. R1			S9999			04/23/2026

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S9999	Continued from page 12 had to discontinue treatment due to admitting to acute rehab and was planning on restarting chemotherapy on discharge from the facility. V71 stated R1's diagnosis was not curable but V71 stated the last time V71 saw R1 she was stable. On 4/1/2026 at 09:46 AM, V62 Nurse Practitioner stated V62 had seen R1 on 2/18/2026 and reported V62's concerns about R1 immediately to V61 Nurse Practitioner and suggested that R1 would benefit from a total work up because of the changes in condition. V62 stated that per V61, V61 will see R1 that day. V62 stated V62 was concerned about the changes in R1's condition enough to call V61 immediately. V62 stated V62 can give an order, but V62 only takes care of pain and bowels, V62 leaves everything else to the facility nurse practitioner or physician. On 4/1/2026 at 10:21 AM, V61 stated V62 called V61 on 2/18/2026 at around 10:20 AM and reported V62's concern about R1's changes in condition. V61 stated V62 asked if V61 can look at R1 that day. V61 put R1 first on the list to see when arriving at the facility. V61 stated V61 was not aware that two blood pressure medicines were held the morning of 2/18/2026 by V23 Licensed Practical Nurse (LPN) due to blood pressure being 98/45. V61 stated V23 LPN did not provide any notification from the facility about R1's blood pressure of 98/45. V61 stated if V23 LPN would have notified V61, V61 would have ordered V23 to encourage R1 to drink more fluids and recheck blood pressure after an hour and go from there. On 2/18/26 at 12:18 PM, R1 was found unresponsive in bed by V61. Cardiopulmonary resuscitation was initiated, and emergency services were contacted. R1 was subsequently pronounced deceased at 12:33 PM on 2/18/2026. The facility's Notification of Changes Policy dated 2/2/26 documents that the purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies consistent with his or her authority, the resident's representative when there is a change requiring notification. Compliance guidelines for this policy documents that circumstances requiring notification include: 1. Accidents a. Resulting in injury.	S9999				04/23/2026	

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S9999	Continued from page 13 b. Potential to require physician intervention. 2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: a. Life-threatening conditions, or b. Clinical complications. The facility's Oxygen Administration Policy dated 2/10/26 documents that oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the residents' goals and preferences. Definitions: "Oxygen therapy" is the administration of oxygen at concentrations greater than that in ambient air (2.9%) with the intent of treating or preventing the symptoms and manifestations of hypoxia. "Hypoxia" means decreased perfusion of oxygen to the tissues. Policy Explanation and Compliance Guidelines: Oxygen is administered under orders of a physician, except in the case of an emergency. In such case oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control. 2. Personnel authorized to initiate oxygen therapy include physicians, Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and respiratory therapists. 3. Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy. 12. Staff shall notify the physician of any changes in the resident's condition, including changes in vital signs, oxygen concentrations, or evidence of complications associated with the use of oxygen. (A)		S9999			04/23/2026	