

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057000		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/05/2026	
NAME OF PROVIDER OR SUPPLIER LOFT REHAB OF DECATUR				STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST MCKINLEY AVENUE , DECATUR, Illinois, 62526			
(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: 2661176/2728255 2660729/2734269 Investigation of a Facility Reported Incident of 1/25/26 / 2734483		S0000			02/13/2026	
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210c) 300.1210d)6) 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 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.		S9999			02/13/2026	

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 These Requirements were not met as evidenced by: Based on interview and record review the facility failed to implement fall interventions to prevent injury for one of three residents (R10) reviewed for falls in the sample list of 15. These failures resulted in R10 sustaining a fall with a head laceration that required staple closure. Findings Include: The facility's Fall Prevention Program dated 2/2/26 documents the facility will assess each resident's fall risk and implement interventions to decrease residents' risk of falls and subsequent injuries. R10's Medical Diagnoses list dated January 2026 documents R10 is diagnosed with abnormalities of gait and mobility, lack of coordination, muscle weakness, and altered mental status. R10's Minimum Data Set (MDS) dated 1/6/26 documents R10 is moderately cognitively impaired and requires moderate staff assistance for transfers. R10's care plan dated 1/7/26 documents R10 is at risk for falls related to muscle weakness. Interventions included floor mats placed on the side of the bed, which were implemented on 1/6/26. R10's nurses' notes dated 1/25/26 document R10 was found on the floor in her room. V29, Registered Nurse (RN), documented R10 was lying on the floor on the right side of her bed in the fetal position. R10 stated she fell from the bed and that her head and neck hurt. R10 had blood on the right side of her head. Emergency Medical Services (EMS) was called, and R10 was sent to the Emergency Room for evaluation. R10's computed tomography (CT) results dated 1/25/26 document, R10 fell and sustained mild subcutaneous soft tissue swelling and a hematoma in the right posterior parietal region, as well as subcutaneous emphysema, which suggests sequelae from a laceration. R10's Emergency Room notes dated 1/25/26 document, R10 sustained a fall resulting in a head laceration requiring five staples. On 2/5/26 at 1:40 p.m., V29, Registered Nurse (RN), stated she was R10's nurse overnight on 1/24/26–1/25/26. V29 confirmed that at approximately 3:00 a.m. on 1/25/26, R10 fell from her bed to the		S9999				

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S9999	Continued from page 2 floor. V29 stated R10 did not have fall floor mats in place on the side of the bed at the time of the fall. V29 confirmed R10 struck her head and sustained a right-sided laceration. V29 stated she sent R10 to the Emergency Department for evaluation. R10's progress notes dated 1/25/26 document, R10 returned to the facility with five staples to her head. On 2/5/26 at 2:45 p.m., V27, Vice President of Clinical Services, confirmed R10 had fall mats placed as a fall prevention intervention on 1/6/26 and that the mats should have been in place on the floor when R10 was in bed and at the time of the fall on 1/25/26. V27 confirmed fall mats help decrease the risk of injuries from falls and were a previously implemented intervention that should have been in place. (B)		S9999				