

Illinois State Department of 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 02/18/2026	
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 Investigation of Facility Reported Incidents of: 01-17-2026/2719985 01-06-2026/2717261		S0000			03/04/2026	
S9999	Final Observations Statement of Licensure Violations 1 of 2: 300.610 a) 300.1210b) 300.1210d)1) 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.		S9999			03/04/2026	

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 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. These Regulations are not met as evidenced by: Based on Observation, Interview, and Record Review the facility failed to prevent esophageal obstruction during medication administration by administering multiple medications at a time for one (R2) resident of three residents reviewed for medication administration on the sample list of three residents. This failure resulted in R2's esophagus becoming obstructed, with an inability to breath, the Heimlich maneuver was performed, and R2 was transferred to the local emergency room for further evaluation. Findings Include: Nursing Progress note dated 1/17/2026 at 8:00 PM documents at approximately 7:45 PM V13 Registered Nurse (RN) was called to room by a Certified Nursing Assistant (CNA) who reported the resident (R2) was not able to breathe. Writer entered room and observed the resident's lips being cyanotic; (R2's) Oxygen level was observed at 64% and the writer asked the resident (R2) if she could breathe and the resident (R2) shook her head side to side indicating no. Writer assessed airway and could not see anything obstructing the airway, the resident (R2) put hands to her throat indicating she was choking. Writer sent CNA to go get another nurse and the crash cart. Writer began performing the Heimlich maneuver on resident (R2), resident then went unresponsive. Writer continued the Heimlich maneuver an additional three times and observed resident (R2) throw up what appeared to be applesauce and undigested food. Resident (R2) was unconscious less than one minute and was able to start answering questions approximately two minutes after regaining consciousness. 911 was activated upon second RN entering the room. Resident (R2) gagged and appeared to swallow and forcibly coughed with a gurgle sound, writer leaned resident onto right side and resident threw up a second time. Writer applied high flow nasal cannula and observed residents' oxygen saturation increase to 96%. Resident (R2) was able to answer questions via her communication board. Resident wrote on her board that "I (R2) laid my bed down too fast after having a snack." Resident immediately educated to keep head of bed elevated at		S9999				

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S9999	Continued from page 2 minimum 45 degrees and to tuck her chin when she is experiencing difficulty swallowing. Resident (R2) shook her head up and down indicating understanding. Resident wrote she feels better but still feels like "Something is in her lungs." EMS/emergency medical service arrived and was given report, copy of face sheet, SBAR (Situation-Background-Assessment-Recommendation), bed hold policy and POLST (Practitioner Order Form Life-Sustaining Treatment) form. Voicemail left for contact on residents (R2's) profile via the other nurse. Writer called and spoke to ER charge at the local hospital and gave an additional verbal report. Writer also called the on-call provider for the facility and notified her of this occurrence. Resident agreeable to going to the hospital for further evaluation. Resident left with EMS on room air at 95% and shaking her head and using her tablet to answer questions for EMS. Resident transferred out at approximately 8:10 PM. Physician answering service notified resident was sent out with voicemail to call the facility back with any further questions." R2's Emergency Department Notes dated 1/17/2026 at 9:31 PM document R2 was seen for choking episode/aspiration. R2's Minimum Data Set assessment dated 1/18/2026 documents R1 is cognitively intact. The GG assessment reports R2 is dependent with transferring, turning, and repositioning. R2 is also set up/supervision with eating. Physician Orders Dated 12/21/2025 documents Speech therapy Clarification: Swallowing evaluation completed on R2. Patient with mild lingual weakness but able to score a seven on the Functional Oral Intake Scale indicating regular texture with thin liquids, however, four minutes status post swallow patient noted to cough stating it was due to texture with thin liquids, however, four minutes status post swallow R2 was noted to cough when R2 consumed anything by mouth, stating it was due to dryness but maybe reflux response based on latency of cough. Speech therapy recommended two times a week for four weeks to address safe swallowing strategies and muscle strengthening. Speech Evaluation Therapy Notes dated 1/15/26 documents that R2 was seen for a swallowing evaluation due to concerns R2 could not swallow multiple pills over the weekend when presented by the agency nurse. R2's able to safely swallow one pill at a time with applesauce. This document also states R2 is concerned about swallowing pills on the weekend when agency staff is present.			S9999			

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S9999	Continued from page 3 On 2/10/26 at 8:07AM, R2 wrote on R2's white communication board that V13 Registered Nurse was giving R2 multiple medications, and R2 takes one medication pill at a time with applesauce. R2 stated R2 tried to raise R2's hand at V13 instructing one pill at a time. R2 stated R2 was scared and frightened as V13 left the room due to R2 still swallowing the medication. V14 Certified Nursing Assistant came in to change R2 due to R2 is incontinent of urine. R2 continued that R2 was still trying to swallow the pills (medications) administered by V13 when V14 laid the head of the bed down from an elevated position to a flat position to change R2 and R2 then began choking. R2 stated V13 came back into R2's room where V13 completed the Heimlich maneuver and R2 stated R2 went to the Emergency Room. On 2/10/26 at 2:45PM, V6 Director of Rehab stated R2 prefers one medication pill at a time due to swallowing complications. R2 has been on Speech Therapy since 7/2025 due to R2's swallowing difficulties. V6 stated speech therapy recommendations were recommended to the physician. On 2/11/26 at 3:15PM, V14 Certified Nursing Assistant stated V14 was completing rounds and V13 Registered Nurse had just come out of R2's room. V14 went into R2's room to change R2 due to urine incontinence and noticed R2 started to cough and drool. V14 stated V14 went to lay R2 down to change R2 and R2 started gasping, coughing, and drooling. V14 stated V13 was still outside the room and V14 went and got V13. V13 instructed V14 to go get the crash cart and another nurse. Facility Resident Rights Policy revised on 2/2/26 documents the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside of the facility. The Policy also documents the resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights. This policy also documents that the resident has the right to be informed of, and participate in, his or her treatment, including: the right to participate in the development and implementation of his or her person-centered plan of care. Facility Medication Administration Policy Revised on 2/2/2026 documents The qualified employee who is giving medication must Position resident to accommodate administration of medication and observe resident			S9999			

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S9999	Continued from page 4 consumption of medication. (A) Statement of Licensure of Violations 2 of 2: 300.610a) 300.1210b) 300.1210d)6) 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. 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. These Regulations are not met as evidenced by:		S9999				

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S9999	Continued from page 5 Based on Interview and Record Review the facility failed to answer a call light in a timely manner that resulted in a fall with injury for one (R1) resident of three residents reviewed for falls in a sample list of three residents. This failure resulted in R1 rolling from the bed, complaining of pain, requiring transfer to the local emergency room and diagnosed with multiple left and right rib fractures. Findings Include: R1's Progress Note written by V7 Licensed Practical Nurse dated 1/6/26 at 6:15 PM, documents R1 was observed lying face down between R1's bed and the wall. R1's roommate was yelling for help when the Certified Nurse Assistant entered the room and observed resident on the floor. It appeared R1 was reaching for something and rolled out of the bed. The bed was regular height. R1 was turned over carefully and R1's head was placed on a pillow. R1 didn't answer when asked what she was doing. 911 was called as R1 did say she was in pain all over. R1 was transported to a local Emergency Room Department at 6:40PM on 1/6/26. R1's Emergency Department Notes dated 1/6/26 at 10:58PM document R1 has a nondisplaced right lateral fifth through ninth rib fracture and nondisplaced acute fractures of the anterior left sixth, seventh, eighth and tenth ribs. R1's Minimum Data Set assessment dated 12/31/2025 documents R1 is cognitively intact. R1's Care Plan documents a fall intervention to ensure bedside table is next to R1's bed, where R1 can reach R1's items dated 12/8/25 and to keep call light within reach at all times dated 5/12/2025. On 2/09/26 at 10:38AM, R1 and V12 (R1's Family) stated R1 was transferred to another facility due to this incident. V12 stated R1 put on R1's call light to get someone to help R1 get popcorn off the floor that R1 wanted to eat. R1 stated R1's call light was on for approximately 40 minutes. R1 went to reach for the popcorn and rolled out of bed onto the floor. R1 stated R1's roommate started yelling for help. On 2/09/26 at 11:45 AM, V6 Director of Rehab stated at times the call lights go off for over 30 minutes as there are only two Certified Nursing Assistants on second and third shift at times. On 2/09/26 at 12:15PM, V7 Licensed Practical Nurse,		S9999				

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S9999	Continued from page 6 stated there were two Certified Nursing Assistants on the floor and a trainee. V7 stated that R1 was reaching for something on the floor when R1 rolled out of bed. V7 stated, the facility staff try to answer call lights in a reasonable time, but at times facility staff are with other residents or in the dining room. V7 stated that R1 had a pressure relieving mattress for R1's wound and when R1 went to reach for something, R1 most likely slid off the bed. On 2/09/26 at 1:30PM, V4 Registered Nurse stated that at times the staff can't get to the resident soon enough after the call light is activated. V4 stated R1 was also a mechanical lift and had a pressure relieving mattress. On 2/10/26 at 9:30AM, V8 Certified Nursing Assistant stated that there were two certified nursing assistants for 27 residents due to a Certified Nursing Assistant was going with another resident to a doctor's appointment. V8 stated especially at nighttime and during dinner time and bedtime, the call lights can go off for over 20 to 40 minutes. On 2/10/26 at 10:00AM, V2 Director of Nursing stated the facility staff should be answering call lights in a reasonable time frame which would be less than 10 minutes. Facility Call light Policy revised on 1/26/2026 documents the facility will be equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. This policy also documents response times should be a priority. The Facility Incident and Accidents policy revised on 2/2/2026 documents that assuring that appropriate and immediate interventions are implemented, and corrective actions are taken to prevent recurrences and improve the management of resident care. (A)			S9999			