

Illinois Department of Public Health

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>IL6000244 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY COMPLETED<br><br>R<br>01/25/2023 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>LOFT REHAB & NURSING OF NORMAL | STREET ADDRESS, CITY, STATE, ZIP CODE<br>510 BROADWAY<br>NORMAL, IL 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) COMPLETE DATE |
|--------------------|---|---------------|---|--------------------|
| S 000              | Initial Comments  | S 000         |   |                    |
| S9999              | <p>Final Observations</p> <p>Statement of Licensure Violations:<br/>300.610a)<br/>300.1010h)<br/>300.1210b)<br/>300.1210d)6)<br/>300.3240e)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.1010 Medical Care Policies</p> <p>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</p> | S9999         | <p><b>Attachment A</b><br/><b>Statement of Licensure Violations</b></p>   |                    |

Illinois Department of Public Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>IL6000244 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>R<br>01/25/2023 |
|--|---|---|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>LOFT REHAB & NURSING OF NORMAL | STREET ADDRESS, CITY, STATE, ZIP CODE<br>510 BROADWAY<br>NORMAL, IL 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) COMPLETE DATE |
|--------------------|---|---------------|---|--------------------|
| S9999              | <p>Continued From page 1</p> <p>plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.</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>Section 300.3240 Abuse and Neglect</p> <p>e) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of</p> | S9999         |   |                    |

Illinois Department of Public Health

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>IL6000244 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>R<br>01/25/2023 |
|--|---|---|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>L OFT REHAB & NURSING OF NORMAL | STREET ADDRESS, CITY, STATE, ZIP CODE<br>510 BROADWAY<br>NORMAL, IL 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) COMPLETE DATE |
|--------------------|---|---------------|---|--------------------|
| S9999              | <p>Continued From page 2</p> <p>the facility. (Section 3-612 of the Act)</p> <p>These Regulations are not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to protect the resident's right to be free from verbal and physical abuse by another resident for one of five residents (R14) reviewed for abuse on the sample list of 23. This failure resulted in R14 being cursed at and hit in the chest by R15 causing increased pain and psychosocial harm.</p> <p>Findings Include:</p> <p>The facility Abuse, Neglect and Exploitation Policy dated 12/5/22 documents the following:<br/>Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Residents must not be subject to abuse by anyone, including, but not limited to; facility staff, other residents, consultants, contractors, volunteers, or staff of other agencies serving the resident, family members, legal guardians, friends or other individuals. "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. "Willful" means the individual deliberately, not that the individual must have intended to inflict injury or harm.</p> | S9999         |   |                    |

Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                   |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>IL6000244       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____   | (X3) DATE SURVEY COMPLETED<br><br>R<br>01/25/2023 |
|--|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>LOFT REHAB & NURSING OF NORMAL |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>510 BROADWAY<br>NORMAL, IL 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) COMPLETE DATE                                |
| S9999  | <p>Continued From page 3</p> <p>"Verbal Abuse" means the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. "Physical Abuse" includes, but not limited to hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment.</p> <p>R14's ongoing Diagnosis List documents R14 has the following: Chronic Pain Syndrome, Other Intervertebral Disc Degeneration of the Lumbosacral Region, Fibromyalgia, Anorexia Nervosa, and Difficulty in Walking.</p> <p>R14's MDS (Minimum Data Set) dated 12/8/22 documents R14 is alert and oriented.</p> <p>On 1/24/23 at 10:20 am, R14 was walking out of the bathroom. R14's gait was very slow and stiff but steady. R14 stated, R14 has had three neck/back surgeries and just hurts all the time. R14 stated about two weeks ago at around 5:30 in the morning, R15 (R14's roommate at the time) was yelling for R14 to come and help R15. R14 stated against R14's better judgement, R14 approached R15's foot of the bed and stated, "I (R14) can't help you (R15), put your call light on." R14 stated R15 then started yelling "I'm deaf, I can't hear you, come help me" so R14 then approached the side of R15's bed and at that time, R15 swung R15's arm at R14 hitting R14 in the chest causing R14 to fall and slide across the floor, hitting R14's back against R14's bed. R14's bed is four feet away from R15's bed. R14 stated R15 is a large woman and very strong, and R14 is very small, and when R15 made contact with R14, R14's feet literally came up off the floor and R14 went sliding. R14 stated after R14 was on</p> | S9999   |   |   |

Illinois Department of Public Health

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>IL6000244 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY COMPLETED<br><br>R<br>01/25/2023 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>LOFT REHAB & NURSING OF NORMAL | STREET ADDRESS, CITY, STATE, ZIP CODE<br>510 BROADWAY<br>NORMAL, IL 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) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
| S9999              | <p>Continued From page 4</p> <p>the floor, R15 continued to yell at R14 saying, "get up you f***ing c***, you aren't hurt, help me." R14 explained R14 pulled herself up, using R14's bed frame, put the call light on and reported the situation to an unidentified CNA (Certified Nursing Assistant). R14 stated there was a red mark on R14's chest, at the point of impact but unsure if any redness on R14's back from hitting the bed, "even though it really hurt", as R14 isn't able to see there. R14 stated V16 LPN (Licensed Practical Nurse) didn't come to assess R14 until about two hours after the incident and the red mark on R14's chest had resolved at that point but isn't sure if R14 had any bruising or reddened areas to R14's backside because V16 didn't check that. R14 stated R14 hurts all the time and that R14 takes routine pain medications but R14 "was definitely hurting worse after the fall, for several days." R14 explained that R15 has yelled at R14 in the past but had never hit R14 before. R14 stated the facility moved R15 out of the room that same day, several hours after the incident, and "it's a good thing because I {R14} wasn't willing to room with her {R15} after that, I {R14} don't know what {R15} would have done to {R14} the next time. I {R14} would have lived on the streets before I {R14} trusted to be in a room with {R15} still." R14 again stated, R15 is a lot bigger than R14 and "(R15) hurt (R14)."</p> <p>R14's ongoing vital signs document R14 is 65 inches tall and weighs 110 pounds as of January 2023.</p> <p>R15's ongoing vital signs document R15 is 66 inches tall and weighs 212 pounds (more than 100 pound heavier than R14) as of January 2023.</p> <p>R14's Progress Notes dated 1/10/23 at 1:15 pm by V14 SSD (Social Service Director) documents</p> | S9999         |   |                    |

Illinois Department of Public Health

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>IL6000244 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>R<br>01/25/2023 |
|--|---|---|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>LOFT REHAB & NURSING OF NORMAL | STREET ADDRESS, CITY, STATE, ZIP CODE<br>510 BROADWAY<br>NORMAL, IL 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) COMPLETE DATE |
|--------------------|---|---------------|---|--------------------|
| S9999              | <p>Continued From page 5</p> <p>V14 met with R14 at the bedside to check in after R14's fall in the room this morning. R14 is tearful and sitting up in bed. R14 explained what had happened earlier and V14 offered emotional support and reassured R14 that R15 will not be coming back into their room but that a new roommate will move in tomorrow.</p> <p>On 1/24/23 at 12:10 pm, V18 CNA stated V18 was working the night of the incident between R14 and R15, which occurred around 4:30 am - 5:00 am. V18 explained V18 heard R15 yelling so V18 went to R14 and R15's room and saw R14 standing but unsteady and needing to grab onto the curtain to steady R14's self. V18 stated at that time, R14 reported that R15 had hit R14 and R14 had fallen and just got R14's self-up off the floor. V18 stated R14 then wheeled into the hallway and was talking to V18 and V14 LPN about the situation. V18 stated V18 did not assess R14 for injuries and doesn't know if V14 did or not. V18 stated V18 reported to both V14 LPN and V2 DON (Director of Nursing) that R14 stated R15 had hit R14.</p> <p>On 1/24/23 at 12:30 pm, V15 Corporate Nurse Consultant along with V2 DON stated V15 and V14 SSD are the staff that completed the investigation between R14 and R15 but that V15, V2 DON and V14 SSD all had spoken to R14 about the situation and R14 did not report being hit by R15.</p> <p>On 1/24/23 at 12:45 pm, the surveyor along with V2, V14 and V15 spoke to R14 about the situation due to there being conflicting information between the administrative staff and R14. At this time, R14 again stated R15 hit R14 across the chest, knocking R14 up off of R14's feet and causing R14 to fall. R14 stated, "I {R14} told all of</p> | S9999         |   |                    |

Illinois Department of Public Health

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>IL6000244 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY COMPLETED<br><br>R<br>01/25/2023 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>LOFT REHAB & NURSING OF NORMAL | STREET ADDRESS, CITY, STATE, ZIP CODE<br>510 BROADWAY<br>NORMAL, IL 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) COMPLETE DATE |
|--------------------|---|---------------|---|--------------------|
| S9999              | Continued From page 6<br><br>you that, which one of you don't understand that?"<br>R14 then replied, "they hear what they want."<br><br>(B) | S9999         |   |                    |