Illinois Department of Public Health

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					С
		IL6005722	B. WING		09/25/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE	
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LOITIKLI	IABILITATION & NOROIN	EUREKA,	IL 61530		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
S 000	Initial Comments		S 000		
	Complaint Investigation	on: 2427305/IL177944			
S9999	Final Observations		S9999		
	procedures governing facility. The written p be formulated by a Re Committee consisting administrator, the advanced advisory comformation of nursing and other spolicies shall comply. The written policies shall be the facility and shall be	sident Care Policies all have written policies and gall services provided by the olicies and procedures shall esident Care Policy g of at least the visory physician or the nmittee, and representatives services in the facility. The with the Act and this Part. hall be followed in operating per reviewed at least annually cumented by written, signed			
	Section 300.1220 Services	upervision of Nursing			
	b) The DON sha nursing services of th	Il supervise and oversee the e facility, including:			
	education, embracing	nd overseeing in-service porientation, skill training, on for all personnel and of resident care and			
	ment of Public Health DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

10/09/24 **Electronically Signed**

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVE COMPLETED		
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I OET BEL	JADII ITATIONI 9 NIJIDON	700 NOR	TH MAIN STREE	τ		
LOFIKE	IABILITATION & NURSIN	EUREKA	, IL 61530			
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S9999	Continued From page	÷ 1	S9999			
S9999	programming. The edinclude training and prestorative/rehabilitative through out-of-facility programs. This persor programs personally out. Section 300.1210 Gether Nursing and Personal a) Comprehensificatility, with the particuthe resident's guardia applicable, must deveromprehensive care pincludes measurable meet the resident's mand psychosocial neer resident's comprehenallow the resident to a practicable level of incomprehensive setting bas needs. The assessmenthe active participation resident's guardian or applicable. (Section 3) b) The facility shear and services to a practicable physical, includes the provide of the section of the provide of the section of the secti	lucational program shall ractice in activities and ve nursing techniques or in-facility training on may conduct these or see that they are carried eneral Requirements for I Care We Resident Care Plan. A sipation of the resident and in or representative, as elop and implement a plan for each resident that objectives and timetables to edical, nursing, and mental eds that are identified in the esive assessment, which attain or maintain the highest dependent functioning, and planning to the least ed on the resident and the representative, as	S9999			
	plan. Adequate and p care and personal car resident to meet the t care needs of the res					
	c) Each direct ca	are-giving staff shall review				

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STATE FORM PB1011 If continuation sheet 2 of 12

Illinois Department of Public Health

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		IL6005722	B. WING		09/2	5/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZIP CODE		
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		EUREKA,	L 61530			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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				52.18.2.16.17		
S9999	Continued From page	e 2	S9999			
		e about his or her residents'				
	respective resident ca	are plan.				
	d) Pursuant to su	ubsection (a), general				
	nursing care shall inc	lude, at a minimum, the				
	following and shall be	practiced on a 24-hour,				
	seven-day-a-week ba					
	6) All necessary	precautions shall be taken				
	, ,	idents' environment remains				
		zards as possible. All				
		all evaluate residents to see				
		ceives adequate supervision				
	and assistance to pre	event accidents.				
	·	were not met as evidenced				
	by:					
		n, interview, and record				
	_	ed to ensure all facility door				
	alarms sounded loud	enough for immediate staff				
	response, immediatel	y search the premises for a				
	resident once a door	alarm was heard sounding				
	and provide adequate	supervision to a cognitively				
		n a history of exit seeking for				
	one of three residents	,				
		sample of five. These				
	I	I, a severely cognitively				
		n the diagnosis of Dementia, nout staff knowledge or				
		•				
		24, walking over 1635 feet				
		a tree that was located				
		t from a main street, causing				
		ctures to the end of the				
	forearm (at the wrist),	excruciating pain,				
	abrasions to the chin	- ·				
	hospitalization for trea					
	Findings include:					

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Illinois Department of Public Health					TORWIA	WITHOULD
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
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NAME OF PI				TE, ZIP CODE		
LOFT REF	ABILITATION & NURSIN	G	TH MAIN STREE	: I		
		EUREKA,	IL 61530	T		
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TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
S9999	Continued From page	3	S9999			
	The facility's Elopeme	ents and Wandering				
	Residents policy date	d 5-6-24 documents,				
	,	nsures that resident who				
		navior and/or are at risk for				
	•	equate supervision to				
		d receive care in accordance				
	with their person-cent					
	•	e factors contributing to				
	wandering and eloper					
		en a resident leaves the				
		ea without authorization				
	-	supervision to do so. d compliance guidelines: 1.				
		ed with door locks/alarms to				
		s. 2. Alarms are not a				
		ssary supervision. Staff are				
	=	nding to alarms in a timely				
	_	ity shall establish and utilize				
	a systematic approac					
	managing residents a	t risk for elopement or				
	unsafe wandering, inc	cluding identification and				
	assessment of risk, ev	valuation and analysis of				
		lementing interventions to				
		isk, and monitoring of				
		difying interventions when				
	necessary. 4. Monito					
	residents at risk for el	- ' - '				
		ents will be assessed for				
		unsafe wandering upon				
	admission and throug					
		b. The interdisciplinary				
	team will evaluate the					
	contributing the risk in	i order to develop a				

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person-centered care plan. c. Interventions to increase staff awareness of the resident's risk, modify the residents' behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. d. Adequate supervision will be

provided to help prevent accidents or

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH MAIN STREET EUREKA, IL 61530 CMAIND PREFIX SUMMARY STATEMENT OF DEFICIENCIES FUREKA, IL 61530 CMAIND PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES FUREKA, IL 61530 CONTINUED FROM THE ARREST OF DEFICIENCY OF DEFICIENCY OF DEFICIENCY OF THE ARREST OF DEFICIENCY OF DEFICIE		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
B. WIND Department Depart	AND FLAN	A. BUILDING:		E I E D			
LOFT REHABILITATION & NURSING (X4,) ID (X4,) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 4 elopements. e. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff." R1's Admission Record documents R1 is a 77-year-old that was admitted to the facility on 1-31-24 with the diagnoses of Parkinsonism, Dementia, Neurocognitive Disorder with Lewy Bodies, Altered Mental Status, Depression, Muscle Weakness Unsteadiness on Feet, Lack of Coordination, Hallucinations, and a History of Falling. R1's current Order Summary Report documents, "Order date 1-31-24; (electronic monitoring bracelet) check for function and placement daily. R1's current Care Plan documents, "Focus 2-2-24; I (R1) wander with no rational purpose, seemingly oblivious to my needs or safety throughout the healthcare center. Goal: I will wander safely within the facility by next review, Interventions: I wear an (electronic monitoring)			IL6005722	B. WING		1	
(A) ID PREFIX TATION & NURSING EUREKA, IL 61530 (A) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG (EACH DEFICIENCY) S9999 Continued From page 4 elopements. e. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff." R1's Admission Record documents R1 is a 77-year-old that was admitted to the facility on 1-31-24 with the diagnoses of Parkinsonism, Dementia, Neurocognitive Disorder with Lewy Bodies, Altered Mental Status, Depression, Muscle Weakness Unsteadiness on Feet, Lack of Coordination, Hallucinations, and a History of Falling. R1's current Order Summary Report documents, "Order date 1-31-24; (electronic monitoring bracelet) check for function and placement daily. R1's current Care Plan documents, "Focus 2-2-24: I (R1) wander with no rational purpose, seemingly oblivious to my needs or safety throughout the healthcare center. Goal: I will wander safely within the facility by next review. Interventions: I wear an electronic monitoring	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
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elopements. e. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff." R1's Admission Record documents R1 is a 77-year-old that was admitted to the facility on 1-31-24 with the diagnoses of Parkinsonism, Dementia, Neurocognitive Disorder with Lewy Bodies, Altered Mental Status, Depression, Muscle Weakness Unsteadiness on Feet, Lack of Coordination, Hallucinations, and a History of Falling. R1's current Order Summary Report documents, "Order date 1-31-24: (electronic monitoring bracelet) check for function and placement daily. R1's current Care Plan documents, "Focus 2-2-24: I (R1) wander with no rational purpose, seemingly oblivious to my needs or safety throughout the healthcare center. Goal: I will wander safely within the facility by next review. Interventions: I wear an (electronic monitoring	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETE
routinely to ensure my safety. I am at risk for falling due to lack of coordination, limited mobility, forgetting my limits, the diagnosis of Parkinsonism, and due to psychotropic medication use." R1's Fall Assessment dated 7-9-24 documents R1 was at a high risk for falls. R1's MDS (Minimum Data Set) Assessment dated 7-20-24 documents R1 is severely cognitively impaired. R1's Elopement Risk Assessment dated 3-20-24	\$9999	elopements. e. The interventions will be de be made as needed. interventions will be de staff." R1's Admission Reco 77-year-old that was 1-31-24 with the diag Dementia, Neurocogi Bodies, Altered Ment Muscle Weakness Ur Coordination, Hallucin Falling. R1's current Order Su "Order date 1-31-24: bracelet) check for fu R1's current Care Pla 2-2-24: I (R1) wande seemingly oblivious to throughout the health wander safely within Interventions: I wear bracelet) to my left wir routinely to ensure m falling due to lack of forgetting my limits, the Parkinsonism, and due medication use." R1's Fall Assessment R1 was at a high risk R1's MDS (Minimum dated 7-20-24 docum cognitively impaired.	effectiveness of evaluated, and changes will Any changes or new communicated to relevant admitted to the facility on noses of Parkinsonism, nitive Disorder with Lewy al Status, Depression, neteadiness on Feet, Lack of nations, and a History of aummary Report documents, (electronic monitoring netion and placement daily. In documents, "Focus r with no rational purpose, or my needs or safety care center. Goal: I will the facility by next review. an (electronic monitoring rist. Please check it works by safety. I am at risk for coordination, limited mobility, ne diagnosis of the to psychotropic at dated 7-9-24 documents for falls. Data Set) Assessment tents R1 is severely	S9999			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE COMF	SURVEY
		II 6005722	B. WING			C
		IL6005722			09	/25/2024
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
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		EUREKA	, IL 61530			
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S9999	Continued From page	= 5	S9999			
	documents R1 was a was fully ambulatory,	high risk for elopement, wanders aimlessly, and has s (Dementia, any type of				
	and signed by V10 (S "(R1) admits for long with (V6/R1's Family progression of Deme for (R1) at home safe answer conversation times seems to not u answer that goes with is in the memory unit seeking behaviors ge nights. (R1) does have device bracelet) for so new to her environments	Note dated 2-2-24 at 1:26 PM Social Services) documents, term care. (R1) did reside member) but due to (R1's) ntia, (V6) is unable to care ely. (R1) at times is able to appropriately (and) other nderstand or articulate in conversation at hand. (R1). (R1) also has displayed exit enerally toward afternoon and we an (electronic monitoring afety measures as (R1) is ent and does have episodes and exit seeking behavior."				
	and signed by V3 (Lo documents, "On 9-10 PM, I (V3) was on roo (facility campus) and (V4/Chief Executive (regard to a missing rothat I was not notified advised that I was just would help locate (Ribeen reported missin facility within (the facto (V4) flagging med were on foot looking While searching the aflagged me down and resident (R1) had been	dated 9-10-24 at 4:55 PM				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IL6005722	B. WING		C 09/25/2024
			DRESS, CITY, STA H MAIN STREE IL 61530		, 30.20.20.
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
\$9999	appeared that (R1) halaceration on her right chin, had bit her tong mouth to bleed, and was pain. It should be not staff that she was tryit building on purpose, on everyone to leave planning her escape was successful at an about 15 minutes beff was gone from the factor of facility laying assessment (R1) has abrasion to her chin apain and states she is assistance. When as fall (R1) states that shappointment, when shanding on her back. Transport) contacted (Emergency Room), also notified of (R1's) waiting along with (Ratransport. Will continually the factor of the factor	Il and has several injuries. It ad a broken left wrist, a telbow, a laceration on her ue which was causing her was complaining of back ted that (R1) told nearbying to escape from the (R1) said she was waiting for the day, and she was out the doors, which (R1) did had been missing for ore it was noticed that (R1) cility." The dated 9-10-24 at 5:09 (Agency LPN/Licensed iments, "(R1) noted outside ing on her backside. Upon a swollen left wrist and an area. (R1) c/o (complains of) is unable to stand with sed what occurred prior to the was on her way to her the lost her balance and fell, AMT (Advanced Medical for transportation to ER (V6/R1's Family Member) fall and elopement. Staff it) until AMT is here for the dated 9-10-24 at 5:22 (Agency LPN) documents, sport (R1) to (local hospital) is sible treatment. All otified. Bed hold sent with	\$9999		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S		
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		IL6005722	B. WING		09/	25/2024
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET A			TE, ZIP CODE		
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	CLIMMADV CT	EUREKA,				0.5
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S9999	Continued From page	e 7	S9999			
	was reported that elogathe parking lot. (V8) won the ground. (R1) wopen areas on her elthoticed that (R1's) lef (Emergency Medical (V6/R1's Family Mem Physician) notified. (Vsee how (R1) escape fire exit door alarm woupstairs and noted the (was) going off at the staff to call maintenar alarm system."	pement of (R1) outside of went to observe (R1) laying vas on her back side with bow and knee. (V8) also the wrist was swollen. EMT Transport) were called and liber) and (V7/R1's (V8) went to check doors to door to do (V8) noticed that hall six as going off. (V8) came back at no sound of alarm or light nurse's station. (V8) notified ince man to come assess the				
	documents, "Chief Co (facility) and was four down/sliding down a l Medical Service) repo wrist. (R1) complaine provided 50 mcg (mic mg (milligrams) of Zo (R1) has dementia. (out to get her car who slid down a hill and hi wrist but denies furthe chin noted. Clinical In of distal end of left ulr forearm bones at the	nd lying down after rolling hill. EMS (Emergency orts deformity to the left ed a 10/10 pain and EMS crograms) of Fentanyl, four fran, and splint the left wrist. R1) states she was going en she began to stumble and it a tree. Has pain in her left er pain. Abrasion to midline impressions: Closed fracture in a and left radius (end of wrist)."				
	documents, "Impress fractures with associal R1's Health Status No AM and signed by V9 arrived back to facility am via transport from	the Left Wrist dated 9-11-24 ion: Acute distal forearm ited soft tissue swelling." ote dated 9-11-24 at 4:35 (LPN) documents, "(R1) of at approximately 3:30 this (V6). (R1) has an ulnar well as a radial (wrist)				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
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		IL6005722	B. WING			25/2024
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LOFT REF	IABILITATION & NURSIN	IG	, IL 61530	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
S9999	Continued From page	e 8	S9999			
	fracture. (R1) also ha	s an abrasion of the face. ade with (Orthopedics). (V6) on exact date of				
	and determine the diswhere R1 exited the R1 was found lying on There were two router measured both router 1635 feet from the existence the parking lot, and dother route measured door to the left and an bottom of the tree. To located was approximative tin (City facility in Con 9-13-24 at 3:15 Polocal hospital. R1 has	suring wheel to measure stance from the door of building on 9-10-24 to where in the ground by the tree. It is R1 could have taken. V23 is with one route measuring it door to the right, through own a hill to the tree. The II 2475 feet from the exit round the building to the the tree where R1 was nately 25 feet from the main is located). MR1 was lying in bed at a did a four-centimeter scabbed				
	purple bruise to the ri abrasions to the right forearm was in a rem was confused to time	ovable casting splint. R1				
	"On 9-10-24 around 4 Supervisor) heard an device) alarm going of basement level. (V11 alarm off and could n (V11) grabbed me to around outside and d (V22/Human Resource yellow' over the interce	#:47 PM, (V11/Housekeeping (electronic monitoring off at the north door of the l) was trying to shut the ot get the alarm to shut off. help. We initially looked id not see any residents. The Director) called a 'code com and we did a head count ced (R1) was missing. (V11)				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION NUMBER: A. BUILDING:	COMPLETED
A. BOILDING.	
IL6005722 B. WING	09/25/2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CO	DDE
LOFT REHABILITATION & NURSING 700 NORTH MAIN STREET EUREKA, IL 61530	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE
S9999 Continued From page 9 and I went outside and searched the entire perimeter of the facility. Other staff helped look for (R1) and (V12/CNA/Certified Nursing Assistant) found (R1) down by the road, on the ground by a tree. It appeared (R1) had fractures her wrist and was sent to the emergency room. After the incident I watched the cameras and saw (R1) go to the elevator and go downstairs at approximately 4:20 PM. I saw (R1) go down the hallway and around to the back. There are no cameras in the back hallway to see what (R1) did after that. Since the (electronic monitoring device) alarm was sounding we determined (R1) had exited out of the north door. That door has a delayed egress of 15 seconds but there is no alarm hooked up to sound when the door opens except for the (electronic monitoring device) alarm." On 9-13-24 at 6:30 AM V14 (CNA) stated, "(R1) says frequently that she wants to go home. (R1) forgets her walker and we must remind her to use it." On 9-13-24 at 6:40 AM V18 (CNA) stated, "(R1) is not safe to go outside unattended and forgets to use her walker." On 9-13-24 at 8:00 AM V20 (Activity Director) stated, "(R1) tries to exit seek and gets confused. (R1) goes to the lobby doors and tries to go out." On 9-13-24 at 8:10 AM V11 (Housekeeping Director) stated, "I heard an alarm that sounded muted like a phone alarm going off (on 9-10-24). It was around 4:45 PM. I had to look around to find where the alarm was sounding off. I found the north basement door (electronic monitoring device) alarm sounding at the north door in the	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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NAME OF DROVIDED OR SURDI IED				1 09/25/2024	
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LOFT REHABILITATION & NUR	SING EUREKA,				
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
to shut the alarm of to shut off. I found with me to try to show meantime, two CN and were looking for (V1) then said may (V1) and I went our 'code yellow' was so (V1) and I searche could not find (R1) found (R1) on the good for the good f	and sounded the alarm. I tried if and could not get the alarm (V1) and had (V1) go down but the alarm off. In the As (V12 and V21) came down or (R1) to give (R1) a shower. Side to look for (R1) and a counded over the intercom. If the entire perimeter and A little while longer (V12) ground, down the bottom of a was by the road. (R1) had without her walker and had be sent to the emergency close to the road." O AM V12 (CNA) stated, "I was from 2:00 PM to 10:00 PM. supper (V21) was looking for shower and could not locate searched all the hallways and could not find (R1). We went ked for (R1) and could not find found (V11) by the back door. Simum Data Set Coordinator) I have been a CNA for a could not hill, lying by a tree for left leg crossed over her blood on her chin, had bit her ons to her arms, and her left need. I got help from (V1 and	S9999	DELIVERYOT)		

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _	A. BUILDING:		150
		IL6005722	B. WING		09/2	5/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
I LOFT REHABILITATION & NURSING		700 NORTH EUREKA, II	I MAIN STREE L 61530	ĒΤ		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
\$9999	emergency room and that day (R1) had ask through the front door she wanted to go hon for more security bec another facility prior to is not safe to be outsi. On 9-14-24 at 10:10 Member) stated, "I was was told (R1) was be because she had got fell. (R1) had broken had abrasions on her put (R1) in the nursin needed more supervi worsening. I put (R1) had got outside of the so that nursing home supervision. So, back transferred to this face	had a broken wrist. Earlier ted for a code to try to leave r. (R1) was always saying ne. (R1) came to this facility ause she had eloped from to her admission here. (R1) de unattended by staff." AM V6 (R1's Family as called on 9-10-24 and ing sent to the hospital out of the building and had her wrist in two places and legs, arms, and chin. I had g home because (R1) sion and her dementia was in a nursing home and (R1) at nursing home unattended, decided (R1) needed more k in January (R1) was ility. (R1) cannot be outside (R1) does not even know	S9999			

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