(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
W 0005700		B. WING		C 11/01/2024		
		IL6005722	B. WING		11/0	1/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LOFT RE	HABILITATION & NUI	RSING	TH MAIN STE	REET		
	OLIMANA DV. OTA	EUREKA,		DROVIDEDIO DI ANI OF CODDECTI	201	0.45
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Complaint Investiga	ation #2428123/IL#178970				
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations:				
	300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3) 300.1220b)7)8)					
	Section 300.610 Re	esident Care Policies				
	procedures governi facility. The written be formulated by a Committee consisting administrator, the a medical advisory conformation of nursing and othe policies shall complete the facility and shall	dvisory physician or the ommittee, and representatives r services in the facility. The y with the Act and this Part. shall be followed in operating the reviewed at least annually documented by written, signed				
	Section 300.1210 ( Nursing and Persor	General Requirements for nal Care				
	facility, with the part the resident's guard applicable, must de	sive Resident Care Plan. A ticipation of the resident and lian or representative, as velop and implement a e plan for each resident that				

**Electronically Signed** 

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

TITLE 11/08/24

STATE FORM 6899 8TO111 If continuation sheet 1 of 10

Illinois Department of Public Health

AND PLAN OF CORRECTION   IDENTIFICATION NOMBER:   A. BUILDING:		
C C	C	
IL6005722 B. WING 11/01/	/2024	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
LOFT REHABILITATION & NURSING 700 NORTH MAIN STREET EUREKA, IL 61530		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)    PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S9999 Continued From page 1 includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)  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:  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		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		A. BOILDING.		С		
IL6005722		B. WING		1	1/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LOFT RE	EHABILITATION & NU	RSING 700 NORT EUREKA,	TH MAIN STE IL 61530	REET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 2	S9999			
	Section 300.1220 Services	Supervision of Nursing				
		hall supervise and oversee the the facility, including:				
		g the care and services ts in the nursing facility.				
	8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out.					
	These requirement by:	s were not met as evidenced				
	review the facility far indwelling catheter and ensure an indw free of kinks and has of three residents (I catheters in a samp resulted in R5 being					
	Findings include:					
	The facility's Cathe	ter Care Policy, dated 1/24/23,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
IL6005722		B. WING			C <b>01/2024</b>		
LOFT REHABILITATION & NURSING 700 NORTH			DRESS, CITY, S F <b>H MAIN STF</b> IL 61530	STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S9999	documents, "Policy to ensure that resid receive appropriate their dignity and princatheters are in use Catheter care will be needed by nursing bag every shift main Ensure drainage bathe bladder to discondition to discondition the bladder to discondition to discondition the bladder to discondition to discondition the bladder discondition to the hospital documents R5 was on 10/10/24.  R5's Census List dowent to the hospital documents R5 was on 10/10/24.  R5's MDS (Minimum documents R5 has diagnosis of Obstruction) to the bladder Distention. For kinks frequently monitor/record/reposigns and symptom lifection): pain, bur cloudiness, no outpincreased pulse, incording the bladder bla	It is the policy of this ents with indwelling of catheter care and mayacy when indwelling ender performed every shapersonnel. 8. Empty of the performed below the	atheters aintain  1.  1.  1.  1.  1.  1.  1.  1.  1.  1	S9999			

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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
		A. BUILDING:		COIVII	COMPLETED		
		IL60057	22	B. WING			C <b>01/2024</b>
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			700 NOR1	TH MAIN STE	REET		
LOFT RE	EHABILITATION & NU	RSING	EUREKA,	IL 61530			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 4		S9999			
00000	change in eating pa documents R5 has Living) self-care de and lack of coordin	atterns." This s an ADL (Activ ficit as eviden	rities of Daily	3333			
	R5's Progress Note V24/LPN (Licensed "(R5) c/o (complain with catheter. (V24 and or symptoms of free from malodour swelling present. (Was no resistance output, which is at 2 have any blood clot Catheter bag was psecured." From 9/2 evidence of further catheter monitoring	Practical Nur ed of) pain an ) assessed th f infection or in ous scent and (24) flushed can brokage no 200 milliliters, s, or any abno placed below v 26/24 through documentatio	rse) documents and discomfort e area, no signs rritation. Area is a no redness or atheter and there oted. (R5) has urine does not ormality to color. vaist height and 10/2/24 no				
	R5's ED (Emergene 10/2/24 and signed Doctor, documents Illness): (R5) is an further evaluation. ambulance. (R5) we complaining of abd (Power of Attorney) (local nursing home more out of it and a same note docume distended, tender in "Genitals: (R5) has was noted to be twi untwisted no drainal has significant eryth groin and inguinal at the indwelling cather untwisted and nothin mucus/exudate was	by V14/Emer. "HPI (History) 33-year-old m. (R5) was brown or salittle obtuntoninal pain. (saw (R5) yese) and felt (R5) and felt (R5) and more lether suprapubic ran indwelling sted and when the same of the same	gency Room of Present ale comes in for ught in by ded is (V22/R5's POA terday at the ) was a little bit argic." This n: Abdomen is egion." catheter that n it was ng from it. (R5) ermatitis in the was discovered ed, it was hick				

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AND DI AN OF CORRECTION TO TREATMENT AND DI AND DI ANTONIA NI IMPERI		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6005722	B. WING		<b>I</b>	C <b>01/2024</b>
	PROVIDER OR SUPPLIER	700 NORT	H MAIN STR	REET		
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\$9999	showed greater that bladder, a large CB Irrigation) catheter bladder started to defor Sepsis: Yes, So Infection Source: Ushock."  On 10/28/24 at 10: with his catheter drof R5's trashcan. No catheter tubing. R5 the hospital.  On 10/30/24 at 1:15 worked with (R5) for being sent to the hoof some discomfort went to observe (Rocatheter and the tule untwisted the catheter and the drainage based on the drainage based of the drainage based on t	ge 5 In 1200 cc/cubic centimeters in all (Continuous Bladder was placed and finally the larin thick exudate." "Concernurce of infection: Sepsis rinary, Sepsis/severe/septic  10 AM R5 was lying in his bed ainage bag secured to the side lo kinks were noted in R5's was unable to recall going to  5 PM V12/LPN stated, "I but or five days prior to (R5) pospital. (R5) was complaining with his catheter. When I 5's) indwelling catheter, the bing was kinked. As soon as I ster, urine started flowing back ag." V12/LPN stated she does tor a resident's catheter when lated, "I sign out the order for the CNAs (Certified Nursing posed to perform catheter hey are. I don't monitor on them unless an issue is	S9999			
	(the licensed nurse monitor resident's care supposed to do We do not chart on the catheter as I do issue is reported to that R5 had a physic every shift, but the	catheter every shift. The CNAs that, and I assume they do. clarity or color or patency of not check them unless an me by a CNA." V6 also stated cian order for catheter care nurses do not perform the just mark it off as complete				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION		E SURVEY PLETED		
		A. BUILDING:			COIVII LETED		
		IL6005722	1	B. WING			C <b>01/2024</b>
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
LOFT RE	EHABILITATION & NUI	RSING	700 NORT EUREKA,	TH MAIN STF IL 61530	REET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE  YMUST BE PRECEDE  SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From pa	ige 6		S9999			
	assuming the CNAs	s are doing it.					
	On 10/31/24 at 12: care of (R5) on 10/ or himself so I went wasn't acting right, the hiccups. I did n catheter whether it	10 PM V21/CNA 1/24. (R5) wasn' t and told (V19/L was having diarr not pay attention	t acting right PN) that (R5) rhea, and had to (R5's)				
	On 10/31/24 at 12:10/1/24 (V22/R5's Frequested for us to having diarrhea. (V: diarrhea and was nwent and changed thick reddish draina was also not normal was, (R5) is usually building. I reported urine to (V19/LPN) having diarrhea as in 10/10/10/10/10/10/10/10/10/10/10/10/10/1	Power of Attorne clean (R5) up do 22) stated (R5) of acting himself (R5) I noticed (R5) I noticed (R5) for (R5) to lay a up moving around the thick reddistant let her known	ey/POA) ue to (R5) was lying in f. When I R5) had some heter bag. It around like he und the h colored v (R5) was				
	On 10/31/24 at 11:4 worked with (R5) a sent to the Hospital (R5) did not leave h for him. Staff report eating or drinking a of output. (R5) did h diarrhea and hiccup monitored him. I di (R5) or observe (R5 V19/LPN also state perform catheter canot monitor catheter is free of kinks or donly time I will look have a complaint so assess (R5's) cathe when staff reported	few shifts prior to the complete shifts and the complete shifts and the complete shifts and the complete shifts are on any resident to me that (Romything and was complete shifts) indwelling cased, "We (the nurse on any resident tubing or cather raining appropriation at anyone's cathomething hurts, eter bag or drains	to (R5) being and 10/1/24 so not normal R5) was barely son't having a lot odes of orked so I just essment on atheter." ses) never ent, and I do eters to see if it ately. The neter is if they I did not age tubing				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6005722	B. WING			C <b>01/2024</b>
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
LOFT RE	EHABILITATION & NU	RSING 700 NOF	RTH MAIN STR	EET		
		EUREKA	A, IL 61530			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 7	S9999			
	was not acting right reporting something to 10/1/24 and (R5) being kinked, but th (V26/R5's Primary I	t. (V12/LPN) had been g was a little off with (R5) prior had issues with his catheter he only thing I reported to Physician) on 10/1/24 was ng diarrhea and hiccups for				
	Doctor stated that we Emergency Room, abdomen was distered R5, R5's catheter to a pretzel and dirty. Unable to be flushed finally able to remove thick pus was coming showed more than urine in (R5's) black drain because of he abdomen which caudown and (R5) had Care Unit. The urine	AM V14/Emergency Room when R5 arrived in the R5 was lethargic and R5's ended. Upon assessment of ubing was severely twisted into R5's indwelling catheter was d. V14 stated, "When I was we (R5's) indwelling catheter, ng out. (R5's) bladder scan 1200 cc/cubic centimeters of der. (R5's) bladder couldn't ow much pus was in his used (R5's) kidneys to shut to be admitted to Intensive ne was thick and foul smelling der irrigation for (R5).				
	Attorney) stated, "T to the Emergency F when I was visiting diarrhea when I arri pants were pulled h was dried as if no o (R5) was not acting reported it to his nu and told them my c she would do an as clean him up. Whe clean (R5) up and I I had not heard any	O AM V22/R5's POA (Power of the day before (R5) was sent Room (R5) was not acting righ him. (R5) was laying in fived at the facility and (R5's) halfway down. (R5's) diarrhead one had even checked on him. I right and was very out of it. I wrse (not aware of her name) oncerns. The nurse stated assessment and have the CNA en a CNA finally came in to ended up leaving for the day. It would be the control of the day of the day of the day of the day of the day. It would be the control of the day of t	t			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
II 6005722		B. WING		C		
		IL6005722			11/0	1/2024
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S T <b>H MAIN STF</b>	STATE, ZIP CODE		
LOFT RE	HABILITATION & NU	RSING EUREKA,		KEEI		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOSED TO THE APPROPOSED CORRECTION (CROSS)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 8	S9999			
S9999	day to check on (Rithere motionless, a was in from the day (R5) has dementia himself. The staff t (R5) needs to be massistance more from the documenting on catheter tubing being V2 stated, "I know so (R5) can empty his take care of his own (R5) has Demential should be monitore no kinks are in (R5) its draining normal. There is a lot of train the on indwelling catherem.	5). (R5) was lethargic, laying nd in the same position he before. (R5) was very sick. and cannot take care of hink (R5) can, but he can't. onitored and provided with	S9999			
	indwelling catheter	draining bag or tubing. They uring the catheter tubing is				
	patent and draining	urine freely. I know they are				
		We (the facility) have a lot of elieve it's caused by lack of working on now."				
	"When I arrived on report that (R5) had hiccupping, and bel days and that (R5)	6 PM V23/Agency LPN stated, my shift on 10/2/24, I received been having diarrhea, liching for at least the past two was not acting like himself. R5) you could see (R5's)				

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	(X3) DATE SURVEY COMPLETED	
	C <b>01/2024</b>	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LOFT REHABILITATION & NURSING 700 NORTH MAIN STREET EUREKA, IL 61530		
(X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S9999 Continued From page 9 abdomen was clearly distended. I did not check (R5's) catheter tubing or urinary drainage during that time, I just sent him out to the Emergency Room."  (A)		

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