STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0054361	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOFT REHABILITATION & NURSING	**700 NORTH MAIN STREET , EUREKA, Illinois, 61530**

(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 Incident of 10/29/25/2656760	S0000		11/24/2025
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.3240a) 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.	S9999		11/17/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on record review, observation, and interview, the facility failed to protect a resident from physical abuse for one of four residents (R1) reviewed for abuse in the sample of four. This failure resulted in V3 and V4 being physically abusive during cares to R1 resulting in R1 sustaining finger tipped shaped bruising to both of R1's upper arms. Findings include: The facility's "Abuse, Neglect, and Exploitation" policy, revised 2/11/2025, documents: ""Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. 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." R1's Electronic Medical Record/EMR document the following: R1 was admitted, to the facility, 10/21/25; Diagnosis to include- Acute Pyelonephritis, Urinary Tract Infection, Cerebral Infarction, Rheumatoid Arthritis, Congestive Heart Failure, Age-Related Osteoporosis, Cognitive Communication Deficit, Lack of Coordination, Abnormalities of Gait and Mobility, Atrial Fibrillation, Gastro-Esophageal Reflux Disease, Hypertension, Presence of Cardiac (implantable) Defibrillator, Cardiomegaly, and Urge Incontinence; and R1's Brief Interview for Mental Status is 15/15 which indicates R1 is cognitively intact. The local police department "Officer Incident Report", written by V7/Police Officer, dated 10/29/25, documents: "At 1659hrs [4:59 p.m.], I [V7] made contact with [V2/Director of Nursing]on the phone. The following is a summary of my [V7] conversation with [V2]: She advised that she is the Director of Nursing for [the facility] and had received a phone call from [V5/Certified Nursing Assistant-CNA], who told her that [R1] had reported to [V5] that two CNAs from dayshift,	S9999		

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S9999	Continued from page 2 identified as [V4/CNA and V3/CNA] had been forceful with [R1] and threw [R1] into a recliner. [V2] reported that [V5] told [V2] that [R1] has visible bruising on both arms. [V2] said that [V2] is no longer at work, but that [V5] is currently working 2nd shift and would be able to tell me [V7] in more depth as to what happened and what was reported to her. I [V7] advised [V2] that I [V7] would be going out to [the facility] to speak with [V5] and to [R1] if possible. At 1716hrs [5:16 p.m.], I [V7] arrived [the nursing home name] and initially spoke with [V8/Licensed Practical Nurse-LPN] at the main nurse's station. [V8] advised that she would be taking me to [R1's] room, where [V5/CNA] and [V6/LPN] were currently with [R1]. I [V7] entered the room and began speaking with [R1] about what she had reported to [V5]. [R1] said that after breakfast this morning, she went to physical therapy from 9:00-9:30 am. [R1] said when she was done with physical therapy, the therapist wheeled her into the hallway to wait for the CNAs to come and get her and take her back to her room. [R1] said the (V3 and V4) arrived and wheeled (R1) back to her room. [R1] said that the CNAs were verbally forceful with her and demanding that she get up from her wheelchair and sit in her reclining chair. (R1) said that she tried to tell (V3 and V4) that due to her physical limitations from osteoarthritis and osteoporosis, she was not physically capable of getting up from her wheelchair and getting into her recliner. [R1] said that (V3 and V4) started yelling at her and telling her she was being uncooperative and started getting very angry at her. [R1] said that was when (V3 and V4) grabbed her under her arms, squeezed her, and then forcefully threw her down in her recliner. [R1] said she told (V3 and V4) to stop being so forceful with her and told (V3 and V4) that they hurt her. [R1] said after (V3 and V4) got her in the chair, they left and she never saw anyone else throughout the day until [V5] came in to check on her at the start of 2nd shift. I [V7] asked [R1] if I [V7] could take pictures of her bruises that were caused by the earlier incident with (V3 and V4). [R1] told me I [V7] could take pictures. Those pictures have been attached to this report. I [V7] then asked [R1] what she would like to see happen with this incident that was reported. [R1] said that [R1] does not want to have [V4] or [V3] as her CNAs anymore and requested that they [V3 and V4] stay away from her [R1]. [R1] further said that she did not want [V4] and [V3] to get in trouble with the Police, but she would be okay if they got suspended or removed from their position at [the facility] so they are not able to hurt anyone else. After general conversation with [R1], I [V7] asked [R1] again before I [V7] left [R1's] room if [R1] wanted to file charges against the CNA's and [R1] said "no" and just wanted them disciplined	S9999		

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S9999	Continued from page 3 through [the facility]. I advised [R1] that I would be doing a report and sending the report to the [State] Department of Public Health, as would [V2] after [V2's] report is completed, so that [State Agency] could investigate this incident." R1's "Skin check" document, dated 10/29/25, at 6:21 p.m., document R1's "New Skin Issue" "in-house acquired" bruises: Right front axilla 3 centimeters/cm by 3 cm; Left front axilla 4 cm by 4 cm; Left upper outer arm 3 cm by 3 cm; Right upper outer arm (no measurement); Left front axilla 3 cm by 3 cm; Left front axilla 3 cm by 3 cm; and Left front axilla 1 cm by 1 cm. On 10/31/25, at 1:25 p.m., R1 was observed to have bruising on R1's upper inner arms and right forearm. Bruising is the shape of the pads of a person's fingers, purplish in color. When advised about the reason for the State Agency visit, R1 stated "I did not want it to go this far"; "I just don't want (V3 and V4) taking care of me again." R1 also stated, "They (V3 and V4) tried to physically put me in bed", "grabbed around [R1 put her hands around her upper arms] and I yelled ouch and they threw me in bed". On 10/31/25, at 10:50 a.m., V2 confirmed the investigation, into the abuse allegation, is on-going, however, the plan is termination [of V3 and V4]. On 11/4/25, at 10:05 a.m., V2 confirmed due to the completed facility investigation, V3 and V4 are being terminated. On 11/4/25, at 10:24 a.m. and 10:34 a.m., V3 and V4, respectively, both confirmed: providing cares to R1 on 10/29/25 during day shift and being suspended due to R1's abuse allegation. (B)	S9999		