

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145452	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
NAME OF PROVIDER OR SUPPLIER Arc at Dwight		STREET ADDRESS, CITY, STATE, ZIP CODE 300 East Mazon Avenue Dwight, IL 60420	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32853 Based on interview and record review the facility failed to report an allegation of sexual abuse to the state survey agency for two of three residents (R1, R2) reviewed for sexual abuse in the sample list of three. Findings include: The facility's Abuse Prevention and Reporting - Illinois policy with a revised date of October/2022 documents, Internal Reporting Requirements and Identification of Allegations: Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, or to an immediate supervisor who must then immediately report it to the administrator. In the absence of the administrator, reporting can be made to an individual who has been designated to act as administrator in the administrator's absence. External Reporting Initial Reporting of Allegations: When an allegation of abuse, exploitation, neglect, mistreatment or misappropriation of resident property has occurred, the resident's representative and the Department of Public Health's regional office shall be informed by telephone or fax. R1's Minimum Data Set (MDS) dated [DATE] documents R1 is severely cognitively impaired. R2's MDS dated [DATE] documents R2 has moderately impaired cognition. On 7/29/24 at 9:10 AM, V1 (Administrator) stated that she got a call from V3 (Registered Nurse-RN) that said R2 was touching R1 inappropriately. V1 stated that she couldn't remember if it was last weekend or the weekend before but confirmed she did her own investigation and did not report it to the state survey agency. V1 stated that she did not think it was abuse so she did not report it. On 7/29/24 at 10:00 AM, V5 (Certified Nursing Assistant/CNA) stated on Saturday the 20th, V5 was in the bathroom next to R1's room assisting another resident and she heard R1 say No, No, No which V5 stated R1 often did if she was falling out of bed. V5 stated as soon as she could she went to R1's room and R2 was in his wheelchair next to R1's bed and appeared to have his hand between her legs and V5 asked him what he was doing. V5 stated that R2 told her he was trying to push her back into bed as she was falling out. V5 stated that R1 had to sleep without any clothing on as she has [NAME] and will eat her clothing and the briefs so she was naked. V5 stated that she reported it to her nurse V3. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/29/24 at 10:35 AM, V3 stated that on 7/20/24 V5 came to her and told her that she walked into R1's room and R2 appeared to have his hand between R1's legs. V3 stated that V3 called V1 and reported it to her. V3 stated that V1 told her not to document anything about it. On 7/29/24 at 11:11 AM, V8 (Hospice Social Worker) stated that one of the hospice Certified Nursing Assistants (CNA) reported to her that when the CNA was visiting R1 over the weekend that one of the facility CNAs reported to her that R2 (R1's husband and roommate) was touching R1 inappropriately. V8 stated that V8 went to the facility to follow up and V1 (Administrator) and V2 (Director of Nursing) told V8 that they were handling the investigation internally and that they had moved R1 to a different room. On 7/29/24 at 1:24 PM, V1 confirmed she did not report the allegation, she stated that she thought about reporting it but did not.		