

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/17/2026
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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietitian. Based on observation, interview, and record review, the facility failed to employ a clinically qualified Director of Food and Nutrition Services. This failure has the potential to affect all 89 residents in the facility. Findings: On 6/14/2026 at 8:43 a.m., V7, Dietary Manager (DM), was actively supervising dietary services in the facility's kitchen. At this time, V7 stated that V7 serves as the full-time manager of the facility's food service department. V7 further stated that V7 had not yet obtained the qualifications of a Certified Dietary Manager (CDM) or Certified Food Protection Professional (CFPP), nor had V7 completed equivalent training. V7 reported that V7 enrolled in a certification program in April 2026 and was currently working on the first lesson. On 6/16/26 at 10:24 a.m., V7, Dietary Manager (DM) denied: being a dietitian being a certified dietary manager having an associate's or higher degree in food service management or in hospitality having two or more years of experience in the position of director of food and nutrition services in a nursing facility setting being a graduate of a dietetic and nutrition school or program authorized by the Accreditation Council for Education in Nutrition and Dietetics, the Academy of Nutrition and Dietetics, or the American Board of Nutrition being a graduate, prior to July 1, 1990, of a Department (Illinois Department of Public Health) approved course that provided 90 or more hours of classroom instruction in food service supervision and having experience as a supervisor in a health care institution which included consultation from a dietitian or having completed an Association of Nutrition & Foodservice Professionals approved Certified Dietary Manager or Certified Food Protection Professional course. On 6/16/26 at 10:33 a.m., V13, Human Resources Director, provided employment records for V7, DM. These records indicated that V7 was hired on 12/03/25 and was promoted to the position of Dietary Manager on 2/16/26. On 6/16/26 at 10:49 a.m., V1, Administrator, stated that V1 was aware of the regulatory requirements and qualifications for the facility's Dietary Manager position. V1 confirmed that the facility was not currently in compliance with those requirements. On 6/16/26 at 10:52 a.m., V7, DM stated that the facility's dietitian visits the facility approximately every two to three months. V7 further stated that V7 discusses residents' diets and weight-related concerns with the dietitian by telephone on a monthly basis. V7 confirmed that food prepared in the facility's kitchen is available to all residents. The facility's Dietary Manager Job Description dated May 2026 documents that the qualifications to perform this job successfully an individual must be able to perform each essential duty satisfactorily. The requirements below are representative of the knowledge, skill, and/or ability required: must have, as a minimum three years' experience in a supervisory capacity in a hospital, nursing care facility, or other related medical facility. must be knowledgeable of dietary practices and procedures as well as the laws, regulations, and guidelines governing dietary functions in nursing care facilities. The facility Long-Term Care Facility Application for Medicare and Medicaid dated 6/14/26 documents 89 residents reside in the facility.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 145452	If continuation sheet Page 1 of 4

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to provide a Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) to notify residents of potential financial liability when Medicare-covered services ended for three of three residents (R38, R67, and R97) reviewed for Medicare notification requirements on the sample list of 36. Findings include: R38's Beneficiary Protection Notification Review, provided by V14, Social Service Director, documents that R38 began a Medicare Part A covered stay on 3/4/26, with a last covered date of 5/15/26. The facility provided a SNF ABN for R38 signed and dated 3/5/26 but did not provide evidence that a SNF ABN was issued when Medicare Part A coverage ended. R67's Beneficiary Protection Notification Review, provided by V14, documents that R67 began a Medicare Part A covered stay on 11/12/25, with a last covered date of 2/9/26. The facility provided a SNF ABN signed and dated 11/26/25 but did not provide evidence that a SNF ABN was issued when Medicare Part A coverage ended. R97's Beneficiary Protection Notification Review, provided by V14, documents that R97 began a Medicare Part A covered stay on 4/21/26, with a last covered date of 5/7/26. The facility provided a SNF ABN signed and dated 5/2/25 but did not provide evidence that a SNF ABN was issued when Medicare Part A coverage ended. On 6/16/26 at 11:52am, V14 stated residents receive a Notice of Medicare Non-Coverage (NOMNC) but do not receive a SNF ABN when Medicare Part A coverage ends. V14 stated the SNF ABN is included in the admission packet and completed only upon admission. On 6/16/26 at 12:04pm, V15, Admissions Coordinator, stated the SNF ABN is included in the admission packet and is only completed on admission. V15 confirmed the facility does not issue the SNF ABN to residents when Medicare Part A coverage ends. On 6/16/26 at 12:10pm, V16, Business Office Manager, confirmed that all residents sign a SNF ABN upon admission and that is the only time the SNF ABN is completed. On 6/16/26 at 12:22pm, V17, Regional Financial Coordinator, confirmed that the SNF ABN should be issued to residents when Medicare-covered services are ending and the resident is remaining in the facility.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect a resident's right to be free from sexual abuse by another resident. This failure affected two (R23 and R71) of three residents reviewed for abuse in the sample list of 36 residents. Findings: The facility's Abuse Prevention and Reporting - Illinois Policy, dated November 2016 and revised March 2026, states that the facility affirms each resident's right to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff, and mistreatment. Accordingly, the facility prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. The policy further states that the facility strives to establish and maintain a resident-sensitive and resident-secure environment. The purpose of the policy is to ensure that the facility takes all reasonable measures within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff, and resident mistreatment. This policy defines sexual abuse as including, but not limited to, sexual harassment, sexual coercion, or sexual assault, including non-consensual sexual activity or sexual activity involving an individual who lacks the capacity to consent. On 6/14/2026 at 9:24 a.m., R71 was sitting in R71's wheelchair. R71 stated that a few weeks prior, R23 was kicking the back of R71's wheelchair. R71 stated when R71 turned around to ask R23 to stop, R71 observed R23 holding or grabbing R23's genital area. R71 stated that it appeared to R71 that R23 was scratching R23's self. R71 stated that R71 was bothered by R23 deliberately bumping and kicking the wheels of R71's wheelchair to get R71's attention. R71 pointed to the doorway of R71's room and stated that the incident occurred in that location. R71 also stated that V8, Certified Nursing Assistant (CNA), witnessed the incident. R71's Minimum Data Set (MDS) dated [DATE] documents that R71 is cognitively intact. R71's Care Plan, dated 9/26/24, documents R71 as being at low risk for abuse and neglect. This Care Plan included a goal initiated on 7/1/25 stating that R71 will feel safe and secure in the facility through the next review period. On 6/14/2026 at 10:13 a.m., R23 was sitting in R23's wheelchair in R23's room watching television. R23 stated they accused R23 of being a bad boy and that someone reported R23 for exposing R23's private areas in public. R23 denied the allegation and stated that R23 respects women. R23's MDS dated [DATE] documents that R23 is cognitively intact. R23's Care Plan dated 4/22/24, with a revision on 2/18/26, documents that R23 is an older adult male with multiple medical conditions and cognitive deficits, including Dementia. This Care Plan documents a history of impaired boundaries and sexually inappropriate behavioral symptoms toward others. This Care Plan also documents that R23 demonstrates poor impulse control and has limited self-regulation skills. It also documents that R23 has been reported to make inappropriate, sexually oriented, and suggestive remarks to others. Interventions include staff being direct with R23 and, in a calm and professional manner, informing R23 that inappropriate sexual behavior is not acceptable and must stop. Additional interventions include continued staff monitoring of R23's behavior. R23's Electronic Health Record (EHR) contains a progress note dated 6/10/26 that documents a failed Gradual Dose Reduction (GDR) of Prozac (antidepressant), in which the dosage was reduced from 40 milligrams (mg) to 20 mg. The documentation indicates that following the dose reduction, R23 exhibited sexually inappropriate behaviors. A Preliminary 24-Hour Abuse Investigation Report dated 5/30/26, provided by V1 Administrator, documents that an allegation was reported on that date indicating that R23 made an inappropriate gesture toward R71. According to the investigation details documented in the report, R23 was positioned behind R71 and was pushing R71's wheelchair toward R71's room with R23's foot. The report further documents that, while doing so, R23 had R23's genital area exposed and was holding it in R23's hand. R71's Electronic Health Record (EHR) contains an Incident Note dated 5/30/26 documenting that a male resident was observed blocking R71's doorway, (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	preventing R71 from entering R71's room, and making an inappropriate sexual gesture toward R71. The male resident was identified as R23. R71's Electronic Health Record (EHR) contains a Social Services Note dated 5/30/26 that documents a psychosocial assessment completed in response to a resident-to-resident sexual allegation reported by R71. As a result of the assessment, an intervention was implemented that included providing R71 with one-to-one staff supervision and support. On 6/14/2026 at 9:32 a.m., V8, Certified Nursing Assistant (CNA), stated that on the day of the incident involving R23 and R71, V8 was walking down the hall looking for a plunger when V8 observed R23 in R23's wheelchair following R71 down the hallway. V8 stated R23 had R23's right foot on the back of R71's wheelchair and was holding R23's exposed penis in R23's right hand. V8 stated V8 immediately separated R23 and R71. V8, CNA stated R23 was not aware that anyone was observing the interaction. On 6/16/26 at 9:29 a.m., V10, CNA, stated V10 is familiar with R23 and has provided care to R23. V10 stated V10 has not personally witnessed R23 behaving inappropriately toward other residents; however, V10 has heard reports that such behavior has occurred. V10 stated R23 is known to exhibit inappropriate behavior toward staff members and has made inappropriate comments to V10, including stating, You are very well preserved. V10 stated staff routinely provide care in pairs due to R23's history of inappropriate behavior toward staff. On 6/16/2026 at 3:07 p.m., V18, Registered Nurse (RN) stated R23 has a long history of inappropriate behavior toward staff and other residents. V18 stated due to R23's history of inappropriate behaviors, staff currently provide care in pairs when assisting R23. V18 stated that R23's behavior had improved for an extended period until the most recent incident. V18 also stated R23 is able to independently propel R23's self in a wheelchair throughout the facility. On 6/16/26 at 3:30 p.m., V2, Director of Nursing (DON), stated that 15-minute checks were implemented following the most recent allegation of sexual abuse. V2 stated that R23 has a history of inappropriate sexual behavior, including incidents involving his wife. V2 further stated that providing care in pairs is an intervention implemented in response to R23's inappropriate sexual behaviors. On 6/16/26 at 3:40 p.m., V1, Administrator stated 15-minute checks remain in place and were initiated following the recent allegation. V1, Administrator stated that R23 and the resident involved (R71) denied sexual contact, while staff reported observing R23 with exposed genitalia. V1 acknowledged that R23 is independently mobile in R23's wheelchair and moves freely throughout the facility.		