

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/12/2025
NAME OF PROVIDER OR SUPPLIER McLean County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 901 North Main Normal, IL 61761	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>52228</p> <p>Based on interview and record review the facility failed to report an allegation of abuse to the State Agency for one (R1) of three residents reviewed for abuse in the sample list of 11.</p> <p>Findings include:</p> <p>R1's Investigation of Occurrence dated 4/30/25 documents, (V7, Certified Nurse's Assistant) called (V1, Administrator) to report that (R1) had reported to (V7) that (R1) had a small nightgown, and the girl behind the desk took it from me .snatched it out of my hand and claimed the staff member (V3, Certified Nursing Assistant) bruised her right inner arm.</p> <p>On 5/12/25 at 1:45 PM, V7 stated on 4/30/25 at 7:15 PM, R1 told her that V3 took a gown away from her causing a scratch to her hand. V7 stated she saw a red spot on R1's forearm. V7 stated she called V1 to report the incident.</p> <p>On 5/12/25 at 1:10 PM, V1 (Administrator) stated he received a call from V7 (Certified Nursing aide) on 4/30/2025 at 7:15 PM. V1 stated V7 reported that R1 told her that V3 snatched a gown out of her hand and bruised her right inner arm. V1 stated he did not notify the state agency.</p> <p>R1's medical record does not document the state agency was notified of R1's allegation of abuse.</p> <p>The Facility's Abuse Prevention Policy dated 1/2025 documents upon receiving an allegation of abuse the facility will immediately notify the state agency.</p>

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
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