STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145732	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at Normal	509 North Adelaide 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)
F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 40385 Based on interview, and record review the facility failed to protect a resident's (R2) right to be free from sexual abuse by another resident (R1), resulting in psychosocial harm of R2. R1 and R2 are two of seven residents reviewed for abuse in the sample list of seven. Findings include: The facility's Final Abuse Investigation Report dated 6/21/24 documents the following: On 6/18/24 at approximately 10:00 AM V3 Licensed Practical Nurse (LPN) witnessed R1 and R2 sitting beside each other in the [NAME] living area. V3 witnessed R1's hand on R2's chest, V3 immediately separated R1 and R2, and R1 was taken to R1's room. R1 and R2 were interviewed and had no recollection of the incident. R1's ongoing Diagnoses List includes Dementia with behavioral disturbance, restlessness, agitation, and Pseudobulbar Affect (inappropriate/involuntary laughter or crying). R1's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status score of 12, the high end of moderate cognitive impairment, and R1 uses a wheelchair for mobility. R1's Care Plan dated 2/17/24 documents R1 likes to watch pornography and may express/display sexual advances towards staff. R1's Nursing Note dated 6/18/2024 at 10:10 AM documents resident (R1) was witnessed touching another resident's (R2) breast while in a common area, residents were separated by this nurse (V3) and management alerted. R2's ongoing Diagnoses List includes Aphasia (difficulty speaking) and Alzheimer's Disease. R2's MDS dated [DATE] documents R2 does not speak, is rarely/never understood, and rarely/never understands others. R2's MDS documents R2 has short and long term memory impairment, is dependent on staff for mobility/transfers, and does not recall current season, room location, staff names/faces, or that she is in a nursing home. R2's Psychosocial assessment dated [DATE] documents R2 has no recollection of the event with R1. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145732	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at Normal	509 North Adelaide 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)
F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 6/27/24 at 9:23 AM V3 LPN stated V3 witnessed R1's/R2's incident (6/18/24) which happened mid-morning. V3 stated R2 was sitting in a wheelchair in the lounge area and R1 was in a wheelchair next to R2. V3 stated R1 had R1's hand down the top of R2's blouse. V3 stated V3 asked R1 what R1 was doing, R1 put R1's hand down further into R2's blouse and grabbed R2's breast. V3 stated V3 separated R1 and R2, and R1 took himself back to R1's room. V3 stated R1 knew what R1 was doing and knew it (touching R2's breast) was wrong. V3 stated R2 was not aware of what was happening and did not respond to being touched by R1. V3 confirmed R2 has severe cognitive impairment and does not have the ability to consent to intimate touching. On 6/27/24 at 12:31 PM V22 (R2's Family) stated V1 Administrator recently contacted V22 to report R2 was sitting in the day room and a male resident put his hand down R2's shirt and fondled R2. V22 was asked how R2 would have felt or responded to this situation if R2 did not have cognitive impairement. V22 stated R2 would have been aghast and mortified, R2 probably would have pushed him (R1) away, and R2 would have felt afraid. The facility's Abuse Prevention and Reporting-Illinois policy dated as revised October 2022 documents the following: The facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. Sexual abuse includes unwanted intimate touching of any kind, including the breasts and perineal areas. Nonconsensual sexual contact includes when the resident appears to want the contact to occur, but lacks the cognitive ability to consent.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145732	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at Normal	509 North Adelaide 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)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview, and record review the facility failed to care plan and develop/implement behavior tracking and interventions to address and prevent behaviors of inappropriate touching/sexual abuse for R1. R1 and R2 are two of seven residents reviewed for abuse in the sample list of seven. Findings include: The facility's Final Abuse Investigation Report dated 6/21/24 documents the following: On 6/18/24 at approximately 10:00 AM V3 Licensed Practical Nurse (LPN) witnessed R1 and R2 sitting beside each other in the [NAME] living area. V3 witnessed R1's hand on R2's chest, V3 immediately separated R1 and R2, and R1 was taken to R1's room. R1 and R2 were interviewed and had no recollection of the incident. R1 was placed on one to one supervision and (Psychiatry Company) was consulted. R1's ongoing Diagnoses List includes Dementia with behavioral disturbance, restlessness, agitation, and Pseudobulbar Affect (inappropriate/involuntary laughter or crying). R1's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status score of 12, the high end of moderate cognitive impairment, and R1 uses a wheelchair for mobility. R1's Nursing Note dated 6/18/2024 at 10:10 AM documents resident (R1) was witnessed touching another resident's (R2) breast while in a common area, residents were separated by this nurse (V3) and management alerted. R1's Care Plan dated 2/17/24 documents R1 likes to watch pornography and may express/display sexual advances towards staff and includes an intervention for behavioral health evaluations and counseling. R1's Care Plan revised 6/20/24 does not document R1's sexual abuse of intimate touching of R2 as noted on 6/18/24, or any interventions to address this behavior or prevent it from happening again. R1's June 2024 Behavior Monitoring and Interventions Report does not document a targeted behavior of inappropriate touching/sexual abuse of other residents or specific interventions to prevent/address this. On 6/27/24 at 9:23 AM V3 LPN stated V3 witnessed R1's/R2's incident (6/18/24) which happened mid-morning. V3 stated R2 was sitting in a wheelchair in the lounge area and R1 was in a wheelchair next to R2. V3 stated R1 had R1's hand down the top of R2's blouse. V3 stated V3 asked R1 what R1 was doing, R1 put R1's hand down further into R2's blouse and grabbed R2's breast. V3 stated V3 separated R1 and R2 and R1 took himself back to R1's room. V3 stated R1 knew what R1 was doing and knew it (touching R2) was wrong. V3 stated after the incident we increased monitoring of R1 and R1 was placed on 15 minute checks, which ended a couple days ago. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145732	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at Normal	509 North Adelaide 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)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/24 at 10:51 AM V6 Social Services Director stated R1 had not had any prior history of inappropriately touching other residents before the incident with R2. V6 stated V6 updated R1's care plan after the incident with R2. V6 stated R1's behavior care plan previously included watching pornography and making sexual advances to female staff. V6 confirmed R1's care plan does not include inappropriate touching/sexual abuse after the incident with R2, or interventions to address/prevent this. V6 stated It only happened one time and he (R1) had no prior history of that (inappropriate touching/sexual abuse of resident). V6 stated R1 continues to see (Psychiatric Company), which is not a new intervention, and was evaluated by a psychiatrist after the incident. V6 stated after the incident with R2, we provided one to one monitoring then switched to 15 minute checks, which was stopped after clearing it with (Psychiatric Company). V6 stated R1 has been spending more time in R1's room and R1 is supposed to be supervised if R1 is out in the common areas. On 6/27/24 at 2:01 PM V1 Administrator reviewed R1's June 2024 Behavior Monitoring and Interventions Report and confirmed it does not identify targeted behavior of inappropriate touching/sexual abuse towards other residents or interventions to prevent/address this behavior. The facility's Behavioral Health Services Program revised January 2023 documents the following: Purpose: To establish a system for identifying behaviors and implementing appropriate interventions consistent with the individualized plan of care and to ensure that each resident receives appropriate treatment and services to attain the highest practicable mental and psychosocial well-being. When inappropriate or distressed behaviors occur, interventions should be implemented by utilizing the least restrictive or least intrusive measures first, and evaluating the effectiveness of these interventions before utilizing more restrictive or intrusive interventions. The facility will attempt to identify, to the extent possible, any previous history of mental illness, trauma, abuse, substance use, comorbidities, pattern of behaviors, preferences, interests, daily routines, medication use and effective behavior management interventions in developing an individualized plan of care. The care plan should include a well-defined problem-statement and should outline the goals of care. It should include measurable objectives and timetables for individualized interventions. It should also identify the responsibilities of various staff to implement the approaches effectively. In developing the plan of care, the interdisciplinary team, in collaboration with the resident or family/representative, reviews the results of the assessment and cause identification above in order to develop individualized, person-centered interventions. The plan of care shall be reviewed and/or updated at least quarterly and with a change in condition such as a new or worsening behavior or a behavior event requiring increased monitoring, reporting to Risk Management or state agencies, or implementation of new interventions.