

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145732	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2025
NAME OF PROVIDER OR SUPPLIER Arc at Normal		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain medical evaluation and treatment following a resident's fall. This failure resulted in R2 experiencing aches, sharp pains, and a significant decline in cognitive, continence, and ambulatory status. R2 was one of three residents reviewed for accidents on a sample list of three.</p> <p>Findings include:</p> <p>R2's Census Detail dated [DATE] documents R2 was admitted to the facility [DATE], hospitalized from [DATE] through [DATE], re-admitted to the facility [DATE], and expired [DATE].</p> <p>R2's Medical Diagnoses List dated [DATE] documents R2 had health conditions upon her admission including Malnutrition, History of Transient Cerebral Ischemia, and Chronic Kidney Disease. This same Diagnoses List documents, after R2's re-admission on [DATE], R2's diagnoses included a Displaced Right Femoral Neck Fracture, and Acute Respiratory Failure.</p> <p>R2's Nursing Progress Notes dated [DATE] document R2 experienced a fall in her room while ambulating with her walker and began complaining of new onset of pain R2 described initially as an ache. R2's Nurses Notes dated [DATE] and [DATE] document R2 had subsequent pain complaints described as sharp, and with numerical rating of 2 and 3.</p> <p>On [DATE] at 11:55 AM, V5, Licensed Practical Nurse, stated she had taken care of R2 after the fall, that R2 was alert and was telling staff about her pain. V5 additionally stated she had noted R2 was having right hip pain and was also walking funny on [DATE] and [DATE]. V5 then stated R2 was also experiencing a new onset of increased confusion on [DATE]. V5 concluded by stating she did not notify R2's physician until [DATE] when the physician ordered x-rays for R2.</p> <p>On [DATE] at 2:33 PM, V10, Certified Nursing Assistant, stated that on the weekend of [DATE] and [DATE], R2 was lying in bed moaning, complaining of pain, and sleeping a lot. V10 further stated R2 was incontinent of bowel and bladder, which was a change for R2 since prior to the fall R2 could take herself to the bathroom, and was complaining of increased pain in her right hip when V10 was turning and positioning R2 to change R2's soiled depends and linens.</p> <p>R2's Radiology Report dated [DATE] documents R2 experienced a displaced right femoral neck fracture.</p> <p>(continued on next page)</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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F 0684 Level of Harm - Actual harm Residents Affected - Few	<p>R2's Hospital History and Physical dated [DATE] documents R2's abnormal laboratory values mimicking a heart attack and low oxygen levels were the result of R2's fall and the increased physical bodily oxygen demands resulting in a low oxygen level. This History and Physical documents R2 received a computed tomography of the right hip and R2's fracture was described as an impacted fracture displaced superiorly (broken smaller pieces around the fracture and the lower portion of the broken bone was moved upwards). This History and Physical documents R2 was to be placed as non-weight bearing status.</p> <p>R2's Minimum Data Set (MDS) dated [DATE] documents R2 had a Brief Interview for Mental Status (BIMS) score of 12, rating R2 as cognitively intact. This MDS documents R2 had no limitations in range of motion in any of her four extremities, only required set up assistance to accomplish daily living activities such as eating, toileting, ambulation over 150 feet with a walker, upper and lower body dressing, donning footwear, and personal hygiene.</p> <p>R2's MDS dated [DATE] documents R2 had a BIMS score of 1, rating R2 as severely cognitively impaired. This MDS documents R2 had an impairment in range of motion of one lower extremity, and was dependent upon staff to accomplish all daily living activities. There was no evaluation of R2 ambulatory status in this MDS due to R2 being placed as non-weight bearing status.</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to manage new onset pain for a resident after a fall. This failure resulted in R2 experiencing aches, sharp pains, low oxygen levels, and a significant change in cognitive status. R2 was one of three residents reviewed for accidents on a sample list of three.</p> <p>Findings include:</p> <p>R2's Nursing Notes dated 4/12/25 at 3:25 AM, documents R2 experienced a fall in her room while ambulating with her walker. A subsequent note at 3:27 AM documents R2 was complaining of an achy pain with a numerical value of 2 or 3 out of 10 which was a new onset for R2.</p> <p>R2's Nurses Note dated 4/13/25 at 5:59 PM, documents R2 was complaining of increased sharp pain of her right hip.</p> <p>R2's Medication Administration Record dated for April 2025 documents from 4/1/25 through 4/12/25 day shift, R2 had rated her pain each and every shift as zero. This Record documents on 4/12/25, 4/13/25, and 4/14/25, R2 was rating her pain at 4.</p> <p>R2's Medication Administration Record and Treatment Administration Records dated for April 2025 documents no administration of any type of pain medication nor treatment from the time of R2's fall on 4/12/25 through the time of R2 being sent to the emergency room on 4/14/25.</p> <p>R2's Physician Order Sheet dated 6/13/25 documents none of R2's pain medication orders were initiated prior to 4/18/25 when R2 returned from her hospital admission after R2's fall and fracture on 4/12/25.</p> <p>On 6/12/25 at 11:55 AM, V5, Licensed Practical Nurse, stated she had taken care of R2 after the fall on 4/12/25. V5 stated R2 was alert and was telling staff about her pain. V5 further stated she had noted that R2 was having right hip pain and was walking funny on 4/12/25 and 4/13/25. V5 then stated R2 was also experiencing increased confusion on 4/13/25. V5 concluded by stating she had not notified R2's physician of the increased pain and confusion until 4/14/25 when R2's physician ordered the x-rays and subsequent transfer to the emergency room.</p> <p>On 6/12/25 at 2:33 PM, V10, Certified Nursing Assistant, stated she had provided care for R2 on 4/12/25 and 4/13/25. V10 further stated R2 was lying in bed all weekend moaning and complaining of pain. V10 stated R2 was usually continent of bowel and bladder, and able to take herself to the bathroom walking with a walker. V10 concluded by stating that R2 was incontinent that weekend and was making increased complaints of pain when V10 was turning and repositioning R2 to clean R2's soiled briefs and linens.</p> <p>R2's Radiology Report dated 4/14/25 documents R2 experienced a displaced fracture of the right femoral neck as a result of her fall on 4/12/25.</p> <p>R2's Nurses Notes dated 4/14/25 at 2:18 PM document R2 was sent to the emergency room for further evaluation.</p> <p>(continued on next page)</p>		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	<p>R2's Hospital History and Physical dated 4/18/25 documents R2 was admitted to the hospital for pain management, abnormal laboratory values, and surgical orthopedic consult. R2's hospital computed tomography scan dated from 4/14/25 documents R2's right femur fracture was impacted (lots of small pieces of bone) and displaced superiorly (upwards). This History and Physical documents R2's abnormal laboratory values were mimicking of a heart attack and were caused by R2's fall, pain, and increased bodily oxygen demands creating ischemia (lack of blood flow).</p> <p>R2's Minimum Data Set (MDS) dated [DATE] documents R2 had a Brief Interview for Mental Status (BIMS) score of 12, rating R2 as cognitively intact.</p> <p>R2's MDS dated [DATE] documents R2 had a BIMS score of 1, rating R2 as severely cognitively impaired.</p>		