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	09/05/2025

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 - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility repeatedly failed to ensure residents' right to be free from physical abuse of R8 by R9, R5 by R4, R12 by R11, and R13 by R9. R5, R8, R12 and R13, are four of 20 residents reviewed for abuse on the sample list of 25. Findings include:1.) R8's Minimum Data Set (MDS) dated [DATE] documents R8's Brief Interview of Mental Status (BIMS) score of six, out of a possible 15, indicating severe cognitive impairment . R8's same MDS documents R8 has had no delusions or hallucinations, and no behaviors directed towards self or others.R9's MDS dated [DATE] documents the following: R9's BIMS score of three out of a possible 15, indicating severe cognitive impairment. R9's same MDS documents R9 has had no delusions or hallucinations, and no behaviors directed towards self or others.The Facility Reported Incident (FRI) of 7/5/25/2601647 documents: Resident to Resident Physical Assault. The same FRI report documents the following: On 7/5/25 at 8:20 AM, (V4, Certified Nursing Assistant/CNA) was pushing (R25)'s wheelchair down the hall. (R8) was in (R8)'s wheelchair in the middle of the hall. (V4, CNA) went to move (R8) to the side, and while (V4, CNA) was moving (R8), (R9) approached (R8), and made contact with (R8)'s face.The facility Illinois Department of Public Health Initial dated 7/5/25, and corresponding Final Abuse Investigation Report, Resident to Resident Physical dated 7/10/25 documents the following conclusion:1. Based on the results of the investigation, the facility has found the following: a. Resident (R8) was seated in (R8's) wheelchair in the [NAME] unit hallway. b. Resident (R9) was observed walking by Resident (R8) and made contact with the left side of (R8's) face. c. Resident (R8) stated she was not upset by the alleged occurrence. (R8's interview was conducted 7/7/25, two days after the physical abuse occurred. R8's BIMs score documented above indicates R8 has severe cognitive impairment)d. Resident (R9) does not recall the alleged occurrence. (R9's interview was conducted 7/7/25, two days after the physical abuse occurred. R9's BIM's score documented above indicates R9 also has severe cognitive impairment).On 9/5/25 at 9:30 am V4 CNA stated V4 was the CNA that witnessed R9 hit R8 in the face. V4, CNA stated (R9) smacked (R8) in the face, hurting her eye. I (V4, CNA) immediately separated them and reported to the (V1, Administrator/Abuse Prevention Coordinator. (R9) was a one-on-one (individual staff supervision) the rest of the day. (R8)'s face was not red but her eye was, probably because she was rubbing it. I could tell it hurt but she couldn't verbalize that. I told the nurse (unidentified) right away. We monitored her the rest of the day for any signs of injury. It did not seem to bother her later. Her face never got red. The nurse did a skin assessment on both (R9) and (R8). (R9) never even realized what he did, I guess. It was deliberate and for no reason. (R8) did not provoke him (R9) in any way. He just walked right up to her, and slapped her. On 9/5/25 at 12:05 pm V1, Administrator/Abuse prevention Coordinator reviewed R8 and R9 abuse allegation investigation documented above and confirmed R9 intentionally slapped R8 in the face.2.) R4s Minimum Data Set (MDS) dated [DATE] documents the following: R4's Brief Interview of Mental Status (BIMS) score of three out of a possible 15, indicating severe cognitive impairment.The same MDS documents R4 has had no delusions or hallucinations, and no behavior directed towards self or others, during the seven day lookback period.R5's MDS dated [DATE] documents R5's BIMS score of 14 out of a possible 15, indicating no cognitive impairment.R5's same MDS documents R5 has had no delusions or hallucinations, and has had no behaviors directed towards self or others during the seven day lookback period.The Facility Reported Incident (FRI) of 8/17/25/2601814 documents: Resident to Resident Physical Assault. The same FRI report documents the following: On 8/17/25 R2 was sitting in front of the menu board making it difficult for residents to exit the dining room. (R5) told (R4) to move out of the way and then (R4) swatted at (R5) making contact with (R5's) arm.The facility's Illinois Department of Public Health Initial Report dated 8/17/25 and corresponding Final Abuse Investigation Report, Resident to Resident Physical dated 8/21/25 documents the following conclusion: 1. Based on the results of the investigation, the facility has found the following: a. Resident (R4) was observed sitting in front of the menu board after the Sunday afternoon church service. b. Resident (R5) believed (R4) was blocking the hallway and told her (R4) to move. c. Resident (R4) reached out and made contact with (R5's) arm in response to being told to move.On 9/02/25 at 2:50 pm V10, Social Service Designee/Dementia Unit stated V10 completed the psychosocial assessments on R4 and R5 after the resident-to-resident altercation. V10 stated on 8/17/25, R4 had hit R5 with a book.On 9/5/25 at 11:07 am (R5) stated (R4) is always out to get me. She is always making snide remarks and thinks people are talking about her. I just stay clear of her. The day we were coming out of church, I was talking to (V26, R20's Family

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately encode minimum data sets for antipsychotic medications and falls, and failed to complete the correct minimum data set for a discharged resident. These failures affect two residents (R6 and R1) out of thirteen reviewed for minimum data sets on a sample list of 25.Findings include: 1. R6's Physician Order Sheet dated [DATE] documents R6 has a physician order to receive the antipsychotic medication Quetiapine in a dose of 100 milligrams daily, an order initiated on [DATE], the day of R6's admission to the facility. R6's Medication Administration Record dated for [DATE] documents R6 received this antipsychotic medication as ordered. R6's admission Minimum Data Set, dated [DATE] section N0450 documents R6 did not receive antipsychotic medications since admission to the facility. This section, when coded as affirmative, serves as a prompt for further questions about required dosage reduction attempts On [DATE] at 3:40 PM, V16, Minimum Data Set Coordinator, stated she was aware R6 takes Quetiapine and must have been in a hurry to make a mistake coding the wrong section at the bottom of the page for R6. V16 further stated she would need to submit a correction for R6's Minimum Data Set. 2. R6's Nursing Progress Note dated [DATE] at 9:30 PM documents R6 was found on the floor of her own room at 9:00 PM stating she had fallen off of the bed, hit her shoulder, was complaining of right shoulder pain, and stating needed to go to the hospital. This note further documents R6 left the facility with emergency medical technicians to go to the hospital at 9:22 PM. R6's Nursing Progress Note dated [DATE] at 2:58 AM documents R6 had returned to the facility from the hospital with a diagnosis of a right humerus fracture which was immobilized. R6's Care Plan for a focus area of ADL (activities of daily living) self-care deficit dated as initiated [DATE] documents R6's right shoulder fracture as a contributing factor. The facility's Fall Investigation Report dated as initiated [DATE] with an initial report to IDPH [DATE] and final report dated [DATE], includes R6's Nursing Progress Notes from [DATE] and [DATE], R6's Care Plan revisions, and x-ray reports documenting a displaced fractured right humerus. R6's admission Minimum Data Set, dated [DATE] section J1800 and J1900 documents R6 had experienced 1 fall with an injury that was not a major injury since her admission to the facility. Section J1900 clarifies injuries not considered major include skin tears, abrasions and bruises, while major injuries include fractures. On [DATE] at 3:40 PM, V16, Minimum Data Set Coordinator, stated when she coded the section for R6's falls she had obtained her information from the facility's risk management section of the electronic medical records which listed R6's injuries as swelling and edema and had no further revisions. V16 clarified she was aware R6 went to the hospital but missed the part about a fracture. V16 further stated she had missed a lot of things on the Minimum Data Set for R6 and would need to submit a correction. 3. R1's Minimum Data Set, dated [DATE] for Death in Facility documents R1 expired on [DATE] in the facility. R1's State of Illinois Certificate of Death certified [DATE] documents R1 expired [DATE] at 9:40 PM at (local hospital). On [DATE] at 11:58 AM and 1:10 PM, V16, Minimum Data Set Coordinator, stated R1 was discharged to the hospital but was never admitted to the hospital and so R1 was still considered to be a resident of the facility when he expired, and that was why V16 completed a 'Death in Facility' assessment. At 1:40 PM, V16 referenced the Centers for Medicare and Medicaid Services Long Term Care Facility Resident Assessment Instrument 3.0 Users Manual dated from [DATE] (current Minimum Data Set manual) which documents (page 31) The Death in Facility assessment must be encoded when a resident dies in the facility or while on a leave of absence. This same manual (page 35) defines a leave of absence to include, IF the resident was in a hospital for observation for less than 24 hours, AND the hospital does not admit the resident. This same manual (page 32) documents a Discharge Minimum Data Set must be completed If a resident has a hospital observation period for greater than 24 hours, regardless if the hospital admits the resident. R1's Nursing Progress Note dated [DATE] documents R1 was sent to the emergency room at 12:45 PM on this date. At 2:50 PM on this same date, R6's Nursing Progress Note documents a facility nurse received an update from the hospital that R1 was pending an admission to an ICU (intensive care unit) bed. On [DATE] at 1:40 PM, V16 agreed from 12:45 PM on [DATE] until 9:40 PM on [DATE] was something like 32 hours, more than the 24 hours referenced in the Minimum Data Set manual. V16 stated the appropriate Minimum Data Set to complete for R1 would have been a Discharge with Return Anticipated and she would need to submit a corrected Minimum Data Set for R1.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review the facility failed repeatedly to maintain complete and accurate medical records for two of 14 residents (R2 and R14) reviewed for accuracy of medical records on the sample list of 25.Findings include: 1.) R2's Physician Order Sheet dated 9/1/25 documents the following diagnosis and medication order: Ativan (name brand), (antianxiety- Lorazepam) Oral Tablet 0.5 MG (Milligrams), Give 0.5 mg by mouth (PO) every 8 (eight) hours as needed (prn) for anxiety/agitation related to Anxiety Disorder, Unspecified for 14 months (inaccurate duration, exceeds the 14 day limit for prn anti-anxiety medication). Start date 07/29/25, end date of 9/26/26 (two-thousand twenty-six). R2 ‘s Consent dated 7/29/25, is incomplete, as it does not document the duration of time for Lorazepam 0.5 mg by mouth (PO) every 8 (eight) hours as needed (prn) for anxiety. R2's (Private Company) Psychiatry Note dated 8/22/25 documents the following: Type of Visit: Follow-up Visit :Chief Complaint: Per staff, patient exhibits agitation, aggression, and behavioral changes. The same (Private Company) Psychiatry Note documents the following a current medication list with no changes to the physician ordered Ativan ordered 7/29/25. R2's current medication list documents the same error in the duration of Ativan prn which exceeds the 14 days. The note documents R2's Ativan PRN (as needed) order as follows: Lorazepam 0.5 mg PO q (every) 8 hrs (hours) PRN X (times)14 days, end dated 9/29/26 (two-thousand twenty-six). The documented Ativan order has the correct 14 day duration, but also documents inaccurately, the end date which is incongruent with the end date of a 14 month duration. R2's electronic Medication Administration Record (MAR) dated 9/1/25- 9/30/25 continued unrevised, with the same 7/29/25 Ativan PRN order that should have been replaced or discontinued on 8/11/25, after the 14-day required limit. R2's MAR dated 8/1/25 – 8/31/25 documents R2 was administered one dose of Ativan 0.5 mg on 8/29/25, (18 days after R2's Ativan was due to be revised or discontinued on 8/11/15). On 9/3/25 at 2:35 pm V2, Director of Nursing (DON) confirmed R2's electronic medical records. V2, DON stated R2's Physician Ordered for Ativan 'was a transcription error and should have been caught before the order went unrevised for the additional 23 days. V2 then clarified the order should not have exceeded 14 days. The documented 14 months was triggered in error. This error resulted in the wrong duration of 14 months documented throughout R2's chart (included above) and R2's Ativan 0.5 mg dose being administered on 8/29/25, when the Ativan should have been discontinued or revised on 8/11/25. The facility policy “ Psychotropic Medication- Gradual Dosage Reduction” dated 04/2025 documents the following: “Purpose: To ensure that residents are not given psychotropic drugs unless psychotropic drug therapy is necessary to treat a specific or suspected: condition as per current standards of practice and are-prescribed at the lowest therapeutic dose to treat such conditions. The plan to alternatives to psychotropic medication and/or use of psychotropic shall be incorporated into the care plan with suitable goals and approaches. This will be initiated by the resident's needs/ problems, goals and approaches as it relates to the use of psychotropic drug use.” (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The same policy Psychotropic Medication- Gradual Dosage Reduction document: PRN (as needed) Psychotropics: “PRN hypnotic, antianxiety or antidepressant medications shall not be used beyond 14 days unless the prescribing practitioner indicates the clinical rationale for extended use and the expected duration for PRN use of the medication. The duration of use should not extend beyond 6 (six) months unless re-evaluated by the attending physician or prescribing practitioner and clinical rationale is provided.” 2. R14's Hospital Progress Notes dated for 8/9/25 through 8/25/25 documents R14 had experienced a urinary tract infection from the multi-drug resistant bacteria Klebsiella. These progress notes document R14 was simultaneously experiencing sepsis and a bacterial infection of his left knee hardware, all treated with the intravenous antibiotics Cefepime and Ceftriaxone. R14's Hospital Discharge Orders dated 6/26/25 document R14 was to continue the intravenous antibiotic Ceftriaxone daily beginning on 8/27/25, the day after R14's return to the facility as R14 had received a dose for 8/26/25 at the hospital. R14's Medication Administration Record dated for August 2025 does not document administration of Ceftriaxone to R14 on 8/27/25, 8/28/25, and 8/29/25. This lack of administration was noted as blank spaces where the administering nurse should place their initials when the medication was administered. On 9/3/25 at 9:40 AM, V2, Director of Nursing, stated he was the administering nurse as the intravenous medications are administered by a Registered Nurse. V2 stated he did administer the intravenous antibiotic and did not go into R14's record to document the administration. R14's Medication Administration Record dated for September 2025 did not document the administration of R14's intravenous antibiotic Ceftriaxone for 9/3/25, leaving R14's antibiotic administrations undocumented for a total of 4 out of 7 days between 8/27/25 through 9/3/25. On 9/5/25 at 1:45 PM, V2 again stated he had administered R14's intravenous antibiotic on 9/3/25 and had not gone into R14's record to document the administration.