

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 09/21/2025
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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to implement and revise a comprehensive care plan to address falls for two (R1, R3) of three residents reviewed for falls in a sample list of four. Findings Include: Fall Policy dated 10/2024 documents the program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. The same policy documents the care plan addresses each fall, Interventions are changed with each fall, as appropriate. 1. On 09/19/25, R1's record review of undated care plan documents an admission date of 08/15/25 with diagnosis Fracture of Left Calcaneus, Type 1 Diabetes Mellitus with Other Skin Ulcer, Fracture of Shaft of Right Tibia, Closed Fracture with Nonunion, and Muscle Wasting and Atrophy. The same care plan documents: R1 is at risk for falls related to the fracture to right shoulder Date Initiated: 08/16/2025 Revision on: 08/18/2025. R1 will have decreased risk of falls by next review date. Date Initiated: 08/16/2025 Revision on: 09/10/2025 Target Date: 11/27/2025. Anticipate and meet the resident's needs. Date Initiated: 08/18/2025. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Date Initiated: 08/18/2025. Environmental rounds to ensure the resident is in the middle of bed to help prevent accidental exits from bed. Date Initiated: 08/17/2025. Sent to Emergency Department (ED) Date Initiated: 08/15/2025. On 09/19/25, R1's record review of Minimum Data Set (MDS) completed on 09/15/25 documents a Brief Interview for Mental Status (BIMS) score of 15. A score of 15 indicates R1 is cognitively intact. The same MDS documents R1 is dependent on a total body mechanical lift for transfers. On 09/19/25, R1's record review of progress note dated 9/12/2025 at 6:35am V9 Nurse, documented R1 sustained a fall on 09/12/2025 at 5:15AM. Documents the incident occurred outside on the driveway and R1, who is alert and oriented to time, person, place and situation, attempted to pull straps of the total body mechanical lift sling out from her front right wheel and slipped off the wheelchair. On 09/19/25, R1's record review of progress note dated 9/12/2025 at 09:59am, V3 Director of Nursing, documents the Interdisciplinary Team (IDT) met to discuss the fall. R1 was outside waiting for the van to take R1 to dialysis and she called the west desk at approximately 05:15AM and asked this writer for help removing the straps of lift sling from R1's wheels of R1's power wheelchair. The same progress note documents the root cause: resident slipped out of the chair pulling the lift sling out from under her. Intervention: educate resident regarding asking for assistance with Sling placement. This intervention was not documented as completed. On 09/19/25, R1's record review of Comprehensive Incident Fall assessment dated [DATE] at 06:13AM completed by V9 documents under section C number four (4) list new intervention initiated immediately to prevent further falls documents to tuck straps to sling under resident. This intervention was not transcribed to the care plan. On 09/21/25 at 11:30AM, V1 Administrator, confirmed R1's care plan had not been revised/updated with new intervention. 2. On 09/19/25, R3's record review of undated care plan documents an admission date of 10/06/2023 with diagnosis Vascular Dementia, Unspecified Severity, with Other Behavioral Disturbance, Presence of Other Specified Functional Implants, REM Sleep Behavior Disorder, Visual Hallucinations, Dementia, Unspecified Severity, with Agitation, Dementia in Other Diseases Classified Elsewhere, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety, History of Falling, Acute Kidney Failure, and Major Depressive Disorder. The same care plan documents: R3 is at risk for fall related to weakness and needs assist with mobility. History of falls. Date Initiated: 10/09/2023 Revision on: 01/10/2025. R3 will reduce his risk of injuries from falls by the next review date. Date Initiated: 10/07/2023 Revision on: 07/31/2025 Target Date: 11/27/2025. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Date Initiated: 10/09/2023. Encourage resident to be in common area during mealtimes Date Initiated: 05/15/2024. Encourage resident to lay down when visibly tired Date Initiated: 03/24/2025. Ensure all supplies are within reach when providing cares Date Initiated: 02/14/2025. Environmental rounding to ensure resident is positioned in the middle of the bed. Date Initiated: 03/11/2025. R3 has stated verbally R3 prefers to sit/lay on the floor directly, and at times will move himself to the floor. Date Initiated: 05/21/2024 Revision on: 05/21/2024. Offer alternate seating when patient is visibly tired or restless Date Initiated: 09/04/2025. Offer resident fluids and snack after early a.m. get up Date Initiated: 06/24/2024. Offer to adjust positioning of chair when resident visibly tired as he allows Date Initiated: 01/10/2025. Place floor mat on the floor next to bed. Date Initiated: 10/13/2023 Revision on:</p>		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to initiate resident centered interventions to prevent falls for one resident (R1) of three residents reviewed for falls in a sample list of four residents. This failure resulted in R1 falling from the wheelchair. Findings Include: Fall Policy dated 10/2024 documents that the program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. The same policy documents the Director of Nursing or Designee is responsible for monitoring the Fall Prevention Program, including further staff education programs, purchase of additional equipment, or other appropriate environmental alterations. The same policy also documents Malfunctioning equipment will be immediately reported to maintenance for repair or removed from service. Nursing personnel will be informed of residents who are at risk of falling. The fall risk interventions will be identified on the care plan. On 09/19/25, R1's record review of undated care plan documents an admission date of 08/15/25 with diagnosis Fracture of Left Calcaneus, Type 1 Diabetes Mellitus with Other Skin Ulcer, Fracture of Shaft of Right Tibia, Closed Fracture with Nonunion, and Muscle Wasting and Atrophy. The same care plan documents: R1 is at risk for falls related to the right shoulder Date Initiated: 08/16/2025 Revision on: 08/18/2025. R1 will have decreased risk of falls by next review date. Date Initiated: 08/16/2025 Revision on: 09/10/2025 Target Date: 11/27/2025. Anticipate and meet the resident's needs. Date Initiated: 08/18/2025. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Date Initiated: 08/18/2025. Environmental rounds to ensure resident is in the middle of the bed to help prevent accidental exits from bed. Date Initiated: 08/17/2025. Sent to Emergency Department (ED) Date Initiated: 08/15/2025. On 09/19/25, R1's record review of Minimum Data Set (MDS) completed on 9/15/25 documents a Brief Interview for Mental Status (BIMS) score of 15. A score of 15 indicates R1 is cognitively intact. The same MDS documents R1 is dependent on a total body mechanical lift for transfers. On 09/19/25, R1's record review of progress note dated 9/12/2025 at 6:35am V9 Nurse, documented R1 sustained a fall on 09/12/2025 5:15AM. 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On 09/19/25, R1's record review of Comprehensive Incident Fall assessment dated [DATE] at 06:13am completed by V9 documents under section C number four (4) lists new interventions initiated immediately to prevent further falls. Documents to tuck straps of sling under resident. This intervention was not transcribed to the care plan. On 9/19/25 at 12:26pm, R1 stated on 09/12/25 R1 was rolling in R1's power wheelchair outside to wait on the van to take R1 to dialysis when the strap of the total body lift sling became tangled into the front wheel of the wheelchair and pulled the lift sling forward pulling R1's body forward. When R1 leaned forward R1 slid forward from the wheelchair to the ground. R1 further stated the seat belt on the wheelchair is broken and unable to be fastened. R1 stated R1 is unsure of the date the seatbelt broke but was it broke after admission to the facility. R1 stated nursing staff are aware the seat belt is broken. On 9/19/25 at 12:59pm, V9 stated R1 called V9 from R1's cell phone indicating R1 needed help with the straps of the lift sling as they were caught under the wheel of the wheelchair. V9 stated V9 delivered the coffee V9 had and then proceeded outside to R1's location and R1 was sitting on the ground. V9 stated R1 stated R1 fell from the wheelchair due to the straps of the sling being under the wheels of the power chair. V9 stated R1 was assessed and gotten off the ground and returned to the wheelchair and the straps were then tucked under R1 to prevent further incidents. V9 stated R1 should be care planned to have the straps of the lift sling tucked under R1 to prevent further incidents. On 09/21/2025 at 08:54am, V4 Maintenance Director, stated V4 was unaware of the broken seatbelt on R1's wheelchair. V4 stated staff use the TELS computer program (maintenance request platform) to request service/repair orders for equipment needing repair. On 09/21/2025 at 09:43am, R1 stated that R1</p>		