

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 12/09/2025
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based upon interview and record review, the facility failed to protect one resident (R3) of four residents reviewed for physical abuse in a sample list of six residents. R2's Progress Note dated 9/6/25 documents a Psychosocial assessment was reviewed for R2. The assessment completed related to Physical Altercation - Resident to Resident. Behavioral diagnosis include: Unspecified Dementia, Moderate, Without Behavioral Disturbance; Psychotic Disturbance, Mood Disturbance, And Anxiety; Dysphagia, Oral Phase; Alzheimer's Disease With Early Onset, Dementia In Other Diseases Classified Elsewhere, Moderate, With Agitation; Unspecified Fracture Of Left Femur, Subsequent Encounter For Closed Fracture With Routine Healing; Fracture Of Unspecified Part Of Neck Of Left Femur, Subsequent Encounter For Closed Fracture With Routine Healing; Lumbago With Sciatica, Right Side, and Benign Prostatic Hyperplasia With Lower Urinary Tract Symptoms.R2's undated Care Plan documents R2 has aggressive behaviors related to dementia, resistive to care; physical aggression related to dementia; impaired cognitive function, at risk for falls, and moderate risk for abuse.R2's Progress Note dated 9/4/25 documents R2 is agitated and aggressive at this time. R2 is constantly getting up and down from wheelchair, R2 is cussing at staff and swinging at staff. Yelling at staff to stop bothering him and leave him alone. R2 is being rude and shouting in the lounge.R2's Progress Note dated 9/4/25 documents V3 reported a physical altercation. MD, POA, ombudsman, and local police department notified of the allegation. Investigation initiated.Police Report dated 9/4/25 documents Facility reported physical altercation between R2 and R3. R3's Social Service Progress note dated 9/6/25 documents R3's Psychosocial Assessment completed related to Physical Altercation - Resident to Resident. Behavioral diagnosis includes: Type 2 Diabetes Mellitus With Diabetic Polyneuropathy, Pan Lobular Emphysema, Major Depressive Disorder, Single Episode, Unspecified, Polyneuropathy, Dementia In Other Diseases Classified Elsewhere, Mild, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, And Anxiety, Other Disorders Of Phosphorus Metabolism, Restless Legs Syndrome, Obstructive Sleep Apnea, Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, And Anxiety.R3's undated care plan documents R3 is at risk for abuse related to cognition, has Impaired Cognitive Function with Hallucinations, Aggressive Behavior including throwing liquids, and Behavioral issues related to Dementia.R3's progress note dated 9/4/25 documents V3 LPN reported a physical altercation. MD, POA, ombudsman, and local police department notified of the allegation. Investigation initiated.On 11/18/25 at 10:45AM, V1 and V2 provided behavior tracking with personalized interventions for R2. Documents R2's behaviors and interventions that were utilized and response to interventions. R2's interventions match Care Plan interventions and show staff knowledge of appropriate interventions to match R2's behaviors. Behavior tracking does not document R2 was removed from area causing agitation.Observations were conducted on 11/17/25 and 11/18/25 between the hours of 8:30 AM and 4:00 PM.On 11/17/25 at 9:35AM, R2 sitting in wheelchair in unit lounge. Old brown crescent shaped bruise approximately 1 inch by 1/4 inch noted to right upper cheek bone directly under glasses frame. No other visible abnormalities noted. R2's room noted to have fall mat on floor next to low bed. Call light within reach. Toilet riser noted and stable. Floor free of debris and obstacles to bathroom and to door entrance.On 11/17/25 at 9:55AM, R3 was in R3s room walking independently. R3s room was cluttered, but R3 stated this is how R3 keeps her things.General observations during survey include: R2 was observed multiple times in common areas and interactions with others including staff and residents. Interviews include V1 Administrator, V2 Director of Nursing (DON), V3 Licensed Practical Nurse (LPN), V7 LPN, V8 R2 Family Member, V11 Admin in Training (AIT), R2, R3, and R5.At 9:40AM on 11/17/25, R2 stated that everyone treats him well at the facility. R2 has no issues with any staff nor residents. R2 stated he has not had any altercations with any residents nor arguments.On 11/17/25 at 9:45AM, V3 Licensed Practical Nurse (LPN) stated that on 9/4/25, V3 heard R3's elevated voice in the lounge area while V3 was passing medications down the hall. V3 heard R3 state R3 was going to throw R3s hot chocolate on R2 and R2 responded you better not. At that point, V3 stated V3 witnessed R3 throw the liquid from R3s cup toward R2 and R2 placed both hands, in a choking motion and made contact with R3's neck, V3 stated they were immediately separated, R3 was moved to another wing in the facility. On 11/17/25 at 9:55AM, R3 stated R3 had an incident with another resident on the stairs by the kitchen. R3 stated resident is a hot head and you never know when he's going to blow his top. R3 stated the other resident (R2) was trying to come into R3s room and R3 told him that it was a girls room and that if he didn't back up, she'd throw the pot of water on</p>		