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	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at Normal	509 North Adelaide Normal, IL 61761

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, interview, and record review the facility failed to care for a resident in a manner that promotes maintenance or enhancement of his or her quality of life for one (R5) of three residents reviewed for quality of care out of a sample list of 17 residents.Findings:R5's undated Care Plan documents an admission date of 12/05/2024 with the following diagnosis: Non-St Elevation Myocardial Infarction, Encounter for Palliative Care, Weakness, Acute on Chronic Systolic (Congestive) Heart Failure, and Hyperlipidemia. This Care Plan also documents R5 requires assistance from one staff member for dressing.R5's Minimal Data Set (MDS) dated [DATE] documents R5 with a Brief Assessment of Mental Status (BIMS) score of eight indicating moderate cognitive impairment. R5's admission Packet dated 12/05/2/025 documents:1. The right to live in an environment that promotes and supports each resident's dignity,individuality, independence, self-determination, privacy, and choice and to be treated withconsideration and respect.2. The right to respect for bodily privacy and dignity at all times, especially during care andTreatment.On 1/20/2026 at 1:06 PM, R5 observed lying in R5's bed with only an ill-fitting adult brief, one flat sheet available for resident to cover self, and R5 was visible from open entry doorway leading into R5's room.On 1/20/2026 at 1:06 PM, R5 stated R5 has been waiting to get pants put on since 7:00 AM.On 1/20/2026 at 2:54 PM, R5 was lying in bed with a sheet half covering body. Door to R5's room open. R5 was dressed in an adult brief only. No clothing on.On 1/21/2026 at 2:15 PM, R5 stated the staff do not like me because I can be an a****** (expletive). I experience long wait times for help with getting dressed a couple of times a week.On 1/22/2026 at 1:45 PM, V3 Director of Nursing (DON) stated that a resident request for care should not exceed a wait time of more than one hour and dignity should always be considered.Facility Policy Resident Rights dated 08/2017 documents the facility must provide services to keep resident's physical and mental health, at their highest practical levels.

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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(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. Based upon observation, interview, and record review, the facility failed to protect residents from abuse for seven (R3, R4, R5, R6, R9, R12, and R14) of eleven residents reviewed on a sample list of 17 residents.R3's undated Care Plan documents R3's diagnosis of Hyperlipidemia, Major Depressive Disorder, Alzheimer's Disease with Early Onset, Unspecified Glaucoma, Essential (Primary) Hypertension, Unspecified Protein-Calorie Malnutrition, Anxiety Disorder, and Dementia in Other Diseases Classified Elsewhere, Mild, With Other Behavioral Disturbance. Care Plan also documents R3 at high risk for abuse. R4's undated Care Plan documents R4's diagnosis as Age-Related Osteoporosis without Current Pathological Fracture, Alzheimer's Disease with Late Onset, Hyperlipidemia, Localized Edema(R60.0), Chronic Kidney Disease, Displaced Fracture of Second Cervical Vertebra, Fracture of Nasal Bones, Major Depressive Disorder, Essential (Primary) Hypertension, Unspecified Dementia, Severe, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety, Chronic Kidney Disease, Stage 3a, and Unspecified Protein-Calorie Malnutrition.R5's undated Care Plan documents an admission date of 12/05/2024 with the following diagnosis: Non-St Elevation Myocardial Infarction, Encounter for Palliative Care, Weakness, Acute on Chronic Systolic (Congestive) Heart Failure, and Hyperlipidemia. R6's undated Care Plan documents R6 is cognitively intact and has increased risk for abuse. R9's undated Care Plan documents R9 is at moderate risk for abuse due to a Dementia diagnosis and R9 is moderately cognitively impaired.R12's undated Care Plan documents R12 has impaired cognitive function, is at a high risk for abuse, trauma informed care, and impaired visual function.R14's undated Care Plan documents R14 can be physically and verbally aggressive. Facility Abuse Prevention and Reporting Policy dated 11/2016 documents physical abuse as the infliction of injury that occurs other than by accidental means, verbal abuse as the use of oral, written, or gestured communication or sounds to residents within hearing distance regardless of age, ability to comprehend or disability such as yelling or hovering over residents, deprivation or threatening of deprivation of goods, harassing, mocking, insulting, or ridiculing. Documents exploitation as taking advantage of a resident for personal gain through use of manipulation, intimidation, threats or coercion, and neglect as the failure to provide goods and services necessary to avoid physical harm, pain, or mental anguish.Facility File dated 1/9/26 documents R3 threw water on R14 and R14 hit R3 on R3's arm.Facility File dated 12/8/25 documents V4 Assistant Dietary Manager was slamming doors on R6 and R9 stating I'm the boss! This file documents on 12/15/25 V4 was terminated for disorderly behavior and misconduct after the allegation was substantiated.Facility file dated 12/11/25 documents R3 burst into bathroom while V15 Certified Nursing Assistant (CNA) was providing care for R4. R3 smacked R4 on buttock two times.Facility file dated 12/7/25 documents R6 stated to R5 to stop calling R6 names or R5 would get R6. R6 proceeded to kick R5 in the shin.Facility file dated 12/11/25 documents V5 CNA received a verbal warning on 12/15/25 for cutting R12's hair without permission and that V5 must obtain consent next time prior to cutting a resident's hair. V5 was in-serviced on resident grooming. V5 is not a licensed cosmetologist or barber. This file documents that V14, R12's guardian, gave consent to cut R12's hair.On 1/22/26 at 10:15AM, R12 was sitting in a recliner in the common room watching television. R12 was well groomed. No visible signs of bruising noted. R12 stated they cut my hair, and I didn't want them to, they did a bad job.On 1/22/26 at 10:30AM, V30 Licensed Practical Nurse (LPN) stated the facility has a cosmetologist that comes every Wednesday. V30 stated that V30 was instructed by V2 Regional Director to call all Power of Attorneys (POAs) and obtain consent for haircuts by staff as needed. V30 LPN stated V30 then called all POA's and documented it in residents' charts. R12's Progress Notes dated 12/11/25 at 3:47 PM documents V14, R12's guardian, gave (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	consent for haircut written by V30 LPN.On 1/22/26 at 10:43 AM, V13 CNA stated that V5 CNA and herself gave R12 a shower and after the shower they were combing through R12's hair when knots were found in R12's hair. At that time V5 CNA cut the bottom of R12's hair to remove the knots. V13 denied holding R12 down to cut R12's hair.Attempts to contact V5 were unsuccessful.On 1/22/26 at 11:00AM, V14, R12's guardian, stated that V14 was notified of the incident on 12/11/25. V14 did not give consent prior to the incident. V14 stated she was told by V17 LPN that V17 was a former beautician, and V17 cuts other residents' hair. V14 was unaware that V5 CNA was person who cut R12's hair. V14 stated V14 was never told of the option of a licensed cosmetologist coming to the facility. V14 stated that if R12 was traumatized, R12 would absolutely remember the incident and could give an accurate description of the incident. V14 also stated V14 was not notified of R12's bruises when they found. V17 LPN's professional license documents no cosmetology or barber license within the State of Illinois.R12's admission Contract dated 1/3/25 documents R12 has the right to refuse services unless court ordered.R12's undated Care Plan documents impaired cognitive function, high risk for abuse, trauma informed care, and impaired visual function.R12's Skin Sheet dated 12/11/25 documents new bruise to back of left hand.R12's Skin Sheet dated 12/7/25 documents bruising to bilateral hands.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based upon interview and record review, the facility failed to prevent a resident from misappropriation by staff for one (R13) of three residents reviewed on a sample list of 17 residents.Facility file dated 12/11/25 documents V6 Certified Nursing Assistant (CNA), transported R13 to R13's home which was 30 miles away from the facility to get clothing for R13. R13 gave $50.00 to V6 for compensation. V6 informed the nurse after returning to the facility. V6 was terminated for exploitation of a resident. V6 placed R13 in V6's personal car. V6 had no training from the facility related to transportation of a resident. R13 did not have permission to leave the facility. R13's Progress Notes do not document R13 out of facility at any time.R13's Minimum Data Set (MDS) section C dated 12/3/25 documents R13 has no cognitive impairments.R13's MDS section GG dated 12/2/25 documents R13 ambulates with a wheelchair and requires maximum assist from staff for transfers.R13's undated Care Plan documents R13 has hemiplegia related to a stroke and is at increased risk for falls.R13's Physician Order Sheet (POS) documents no order to leave the facility.On 2/2/26, R13 stated that on 12/11/25 V6 took R13 home to get clothes. V6 was off duty and R13 had told staff several times R13 was planning to go home. R13 stated R13 was gone from facility from 7:30AM to 11:30AM. Facility Abuse Prevention and Reporting Policy dated 11/2016 documents physical abuse as the infliction of injury that occurs other than by accidental means, verbal abuse as the use of oral, written, or gestured communication or sounds to residents within hearing distance regardless of age, ability to comprehend or disability such as yelling or hovering over residents, deprivation or threatening of deprivation of goods, harassing, mocking, insulting, or ridiculing. Documents exploitation as taking advantage of a resident for personal gain through use of manipulation, intimidation, threats or coercion, and neglect as the failure to provide goods and services necessary to avoid physical harm, pain, or mental anguish. Facility Transportation for Residents Policy dated 11/2012 documents all personnel must be trained prior to transporting residents. Facility Incidents and Accidents Policy dated 4/2019 documents a report will be completed for residents leaving the premises without authorization, and documentation in nurse's notes is to include a description of the event and 72-hour documentation must be completed.

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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. Based upon interview and record review the facility failed to develop and implement a baseline care plan for one (R1) of three residents reviewed for quality of care out of a sample list of 17 residents.R1's care plan documents an admission date to the facility as 12/24/2025 with the following diagnosis: Wedge Compression Fracture of Fourth Thoracic Vertebra, Subsequent Encounter for Fracture with Routine Healing (S22.040d), and Unspecified Fracture of Fourth Thoracic Vertebra.R1's care plan documents a focus assessment was initiated on 12/24/2025 regarding R1 having an Activity of Daily Living (ADL) deficit with no goals nor interventions documented.On 02/03/2025 at 10:30 AM, V10 Minimal Data Set (MDS)/Care Plan Coordinator stated R1's care plan did not document goals nor interventions for the multiple focus areas withing R1's care plan. V10 stated care plans are considered comprehensive given there are appropriate goals and interventions in place.The facility's Comprehensive care plan policy dated 11/2012 documents: the interdisciplinary team should attempt to schedule an initial meeting with the resident and/or resident representative within five days of admission to review the baseline plan of care.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon interview and record review, the facility failed to assess and control a resident's pain for one (R2) of three residents reviewed on a sample list of 17 residents.R2's face sheet dated 1/15/26 documents R2 was admitted to the facility on [DATE] and expired 12/29/25. R2's undated Care Plan documents R2's medical diagnosis to include Unspecified Dementia, Unspecified Severity, with Other Behavioral Disturbance, Unspecified Convulsions, Atrioventricular Block, First Degree, Essential (Primary) Hypertension(I10), Peripheral Vascular Disease, Unspecified, Spinal Stenosis, Lumbosacral Region, Unspecified Osteoarthritis, Unspecified Site, Benign Prostatic Hyperplasia without Lower Urinary Tract Symptoms, Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris, Hyperlipidemia, Unspecified, Restless Legs Syndrome, Polyneuropathy, Unspecified, Unspecified Protein-Calorie Malnutrition, Acidosis, Unspecified, Edema, Unspecified, Gastro-Esophageal Reflux Disease without Esophagitis, Displaced Intertrochanteric Fracture of Left Femur, Subsequent Encounter for Closed Fracture with Routine Healing, Aftercare Following Joint Replacement Surgery, Muscle Wasting and Atrophy, Not Elsewhere Classified, Multiple Sites, Other Specified Disorders of Muscle, Dysphagia, Oral Phase, Other Abnormalities of Gait And Mobility, Other Lack of Coordination, Urinary Tract Infection.R2's undated Care Plan documents dementia, moderate risk for abuse, Activities of Daily Living (ADL's) self-care deficit, incontinent of bladder, elopement risk with wander guard present, behavior issues of agitation, anxiety, restlessness, aggression (verbal and physical), and resistant to care, unspecified convulsions and restless leg syndrome, antipsychotic and Parkinson medications, hip fracture, and seizure disorder.Facility investigation file dated 12/27/25 documents R17 stated R17 could hear R2 yelling in pain but no one listens to her. V20 Certified Nursing Assistant (CNA), stated on 12/25/25 R2 was in a lot of pain. V21 CNA stated that on 12/25/25 R2 had bruising on R2's left chest and was in a lot of pain and V21 reported this to V23 Licensed Practical Nurse (LPN). V22 LPN stated on 12/25/25 noted bruising to left chest but was unaware V22 had to report that to anyone. V23 LPN, stated on 12/25/25 at 6:00PM, V21 CNA reported R2 had bruising and was in a lot of pain, V23 stated V23 did not assess the bruises, gave pain medication, and did not notify anyone. V24 CNA, stated on 12/25/25, R2 was hollering in pain. V25 LPN stated that on 12/22 and 12/23/25, R2 was spitting out food, stopped feeding himself, had a low-grade temperature, left leg contracture, and had increase in pain. V25 did not notify anyone of changes. On 12/27/25 V26 CNA reported R2's bruises to V27 LPN. V27 LPN reported to the Abuse Coordinator, and V3 Director of Nursing as well as the physician and V27 obtained orders for an Xray and hospice care.R2's December Medication Administration Record (MAR) documents R2 started receiving pain medication regularly on 12/22/25. No Physician notification was documented. This MAR also documents R2's rate of pain as follows: On 12/24/25 at 1:34AM R2 rated pain at six out of ten with 10 being the highest level of pain. On 12/24/25 at 12:21PM rated pain at eight out of ten, on 12/24/25 at 8:30PM rated pain at eight out of ten, on 12/25/25 at 1:17 AM eight out of ten, on 12/25/25 at 8:38 AM seven out of ten, on 12/25/25 at 7:32 PM six out of ten, on 12/26/25 at 10:39 AM eight out of ten, on 12/26/25 at 12:09 PM eight out of ten, on 12/26/25 at 4:17 PM five out of ten, on 12/27/25 at 10:28 AM eight out of ten, on 12/27/25 at 11:59 AM nine out of ten, on 12/28/25 at 8:14 AM six out of ten, and on 12/28/25 at 2:39 PM nine out of ten.R2's Progress Notes do not document physician notification of R2's increased pain prior to 12/27/25.On 1/22/26 at 1:45PM, V3 Director of Nursing (DON), stated the medical doctor should be notified of a change in pain, and waiting five days for notification is a delay in care. V3 stated that the bruising was first noticed on 12/22/25 for R2 however no notification was made until 12/27/25. V3 stated that R2 had a fall on 12/7/25 and could have (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	caused the bruising to R2's chest. V3 stated that Interdisciplinary Team (IDT) discussed R2's fall, however, the fall was not considered when the bruising was noticed.Facility Pain Management Program policy dated 11/2012 documents the facility is to notify the Medical Doctor of a change in condition. Also documents nursing to assess and reassess pain control measures for effectiveness.