

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/22/2026
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a focus care plan for one (R2) of three residents reviewed for care plans in a total sample of 14. Findings include: R2's Care Plan (undated) documents R2's diagnosis of History of Ischemic Attack (TIA), Cerebral Infarction, Type 2 Diabetes Mellitus, Difficulty Walking, Communication Deficit, Reduced Mobility and Protein-Calorie Malnutrition. This Care Plan further documents R2's admission date of 3/27/2026. R2's Minimum Data Set (MDS) dated [DATE] documents R2 had moderate cognitive impairment. R2's Care Plan dated 3/27/2026 documents R2 was at risk for a skin impairment related to decrease mobility, post Cerebrovascular Accident (CVA), Left side weakness and incontinence. R2's Weekly Skin Observation dated 5/16/2026 documents R2 had a new skin concern; type of skin concern was blister-open with drainage located to Right Heel-open blister- 4.5 x 4.5 centimeter (cm) with opaque colored drainage. Treatments include cleanse with wound cleanser and applied Triple Antibiotic Ointment (TAO) and foam dressing. R2's Physician's Order dated 5/19/2026 documents an order for treatment to Right Heel Deep Tissue Injury (DTI): Cleanse with Dakins, apply medi honey to wound and cover with non-border foam dressing; wrap with Kerlex and apply pressure boots at all times. every evening shift for Wound Management. On 6/22/2026 at 11:11 a.m., V36 Certified Nursing Assistant (CNA) stated V36 refers to Point of Care (POC) or Kardex for interventions if V36 was not familiar with the resident caring for. On 6/22/2026 at 11:13 a.m., V37 Certified Nurse Assistant (CNA) stated V37 refers to POC if needing to look for interventions such as if the resident needs to wear boots, float heels or if they are heavy incontinent and needing frequent incontinence check. V37 stated V37 also refers to the nurses at times and V37 knows nurses will look at the care plan. On 6/22/2026 V9 Licensed Practical Nurse (LPN) stated V9 would refer to the Care Plan to verify resident's plan of care or if V9 was not familiar with the cares or treatment of the resident V9 was taking care of. V9 stated care plan are expected to be up to date with interventions for the staff to refer to. On 6/22/2026 at 12:22 pm., V2 Director of Nursing (DON) stated after the nurses notify the physician about skin issues, the physician will give some orders, and the nurses will process the orders to be implemented. V2 stated after the orders get processed, the resident's individual care plan should be updated with the new interventions. On 6/22/2026 at 11:19 a.m., V4 Wound Nurse stated if the facility developed an intervention, then the goals and interventions should be entered into the resident's individual Care Plan right away to be updated with the new interventions. V4 stated as a wound nurse, V4 enters the intervention for wounds directly into the resident's individual care plan. V4 confirmed staff may refer to POC or Kardex and care plan for interventions. V4 confirmed there was no care plan developed for R2's wounds to Right Heel after it was developed on 5/16/2026.		

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent a pressure ulcer from developing by failing to implement pressure relieving interventions for one (R2) resident and failed to complete pressure ulcer treatments as ordered for two (R2, R3) residents reviewed for pressure ulcers in the sample list of 14. This failure resulted in R2 developing a Deep Tissue Injury to the Right Heel. Findings include: 1) R2's Care Plan (undated) documents R2's diagnosis of History of Ischemic Attack (TIA), Cerebral Infarction, Type 2 Diabetes Mellitus, Difficulty Walking, Communication Deficit, Reduced Mobility and Protein-Calorie Malnutrition. This Care Plan further documents R2's admission date of 3/27/2026. R2's Minimum Data Set (MDS) dated [DATE] documents R2 had moderate cognitive impairment. R2's Care Plan dated 3/27/2026 documents R2 was at risk for a skin impairment related to decrease mobility, post Cerebrovascular Accident (CVA), Left side weakness and incontinence. R2's Care Plan dated 5/4/2026 documents R2 had an actual skin impairment of pressure area: blister on Left Plantar Heel. R2's Weekly Skin Observation dated 5/4/2026 documents R2 had a new skin concern; type of skin concern was blister located to Left Heel, grey in color reddened area around the wound. Treatments include apply skin prep twice a day (BID), apply pressure relieving boots at all times until healed. R2's Weekly Skin Observation dated 5/16/2026 documents R2 had a new skin concern; type of skin concern was blister-open with drainage located to Right Heel-open blister- 4.5 x 4.5 centimeter (cm) with opaque colored drainage. Treatments include cleanse with wound cleanser and applied Antibiotic Ointment (TAO) and foam dressing. On 6/18/2026 at 12:12 p.m., V22 Wound Care Provider confirmed R2's wounds to Left and Right heel were Deep Tissue Injuries (DTIs). V22 stated the order for pressure relieving boots to be applied to both heels was given when V22 saw R2 at the facility on 5/19/2026. V22 stated some interventions such as an air loss mattress could have been put in place given R2's condition. V22 confirmed there was no order for an air loss mattress prior to R2's right heel wound and V22 was going to give an order but R2 was already sent out to the hospital on 5/24/2026. On 6/22/2026 at 7:18 a.m., V28 Certified Nurse Assistant (CNA) stated the only time V28 saw the pressure relieving boots applied to R2's left and right heels was after R2 developed the wounds to both feet. V28 stated the usual interventions to prevent pressure wounds would be turning and repositioning at least every two hours, frequent checks especially if residents were heavily incontinent or had impaired mobility, floating the heels or applying boots to the heels, and good hygiene. On 6/22/2026 at 7:10 a.m., V9 Licensed Practical Nurse stated V9 observed the pressure relieving boots applied to R2's feet only after R2 already developed the wound to the other foot. V9 stated some of the interventions that can be implemented to prevent developing pressure ulcers were applying skin prep to the area, turn and repositioning at least every two hours, good hygiene, close monitoring such as frequent skin checks and an air loss mattress. V9 confirmed V9 did not apply skin prep to the right heel prior to development of the wound. V9 stated there was no other treatment V9 applied to the right heel other than the treatment after R2 developed the new wound to right heel. On 6/22/2026 at 11:19 a.m., V4 Wound Nurse confirmed the wounds to R2's left and right heels were Deep Tissue Injuries (DTIs). V4 confirmed both DTIs were facility acquired pressure wounds. V4 confirmed the wound to the left heel was developed first which was on 5/4/2026 and the right heel developed later on 5/16/2026. V4 stated there was an order to apply a pressure relieving boot to the left heel after the wound was developed but not on the right heel because there was nothing on the right heel to treat. V4 confirmed R2 has impaired mobility related to history of stroke. V4 stated R2 liked to press both R2's heels on the mattress when R2 was in bed or R2 pressed heels on the floor when R2 was up in the wheelchair. V4 stated there should be some preventative measures for residents with impaired mobility to prevent development of pressure ulcers. V4 stated there were no interventions in place for R2's right heel because there was nothing there. On 6/22/2026 at 12:22 p.m., V2 Director of Nursing (DON) stated V2 does not know what the facility did different after R2 (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	developed the pressure wound to the Left Heel to prevent the skin break down to R2's Right Heel. V2 stated V2 would need to check with V4 Wound Nurse. On 6/22/2026 at 2:30 p.m., V30 Licensed Practical Nurse (LPN) stated V30 did not apply any treatment or interventions to R2's right heel other than after the right heel already developed an opened wound. On 6/22/2026 at 2:45 p.m., V32 Regional Nurse Consultant stated there were interventions in place for the wound to the left heel but there were no interventions in place to the right heel prior to the development of the pressure wound because there was nothing on the right heel. The facility's Pressure Ulcer Prevention Policy dated 12/2025 documents several guidelines to prevent and treat pressure sores/pressure injuries. Some of the Guidelines: 5. Turn dependent residents approximately every two hours or as needed and position resident with pillow or pads protecting bony prominence as indicated, 9. Pressure reducing (foam) mattresses are used for all residents unless otherwise indicated. Specialty mattresses such as low air loss, alternating pressure, etc. (etcetera) may be used as determined clinically appropriate. Specialty mattresses are typically used for residents who have multiple Stage 2 or one or more Stage 3 or Stage 4 wounds. 11. Use positioning devices or pillows, rolled blanket, etc. to reduce pressure and friction/shearing from heels, toes, and malleoli as indicated. 2) R2's Care Plan (undated) documents R2's diagnoses including History of Ischemic Attack (TIA), Cerebral Infarction, Type 2 Diabetes Mellitus, Difficulty Walking, Communication Deficit, Reduced Mobility, and Protein-Calorie Malnutrition. This Care Plan further documents R2's admission date of 3/27/2026. R2's Minimum Data Set (MDS) dated [DATE] documents R2 had moderate cognitive impairment. R2's Care Plan dated 3/27/2026 documents R2 was at risk for a skin impairment related to decrease mobility, post Cerebrovascular Accident (CVA), Left side weakness and incontinence. R2's Care Plan dated 5/4/2026 documents R2 had an actual skin impairment of pressure area: blister on Left Plantar Heel. R2's Physician's order dated 5/19/2026 documents an order for treatment to the Left Heel Deep Tissue Injury (DTI): Cleanse with diluted bleach solution, apply medicinal honey to the wound and cover with non-border foam dressing; wrap with rolled gauze and apply pressure boots at all times, every evening shift for wound. R2's Treatment Administration Record (TAR) dated 5/1/2026 - 5/31/2026 documents a physician's order with a start date 5/13/2026 for treatment to Left Heel (plantar) Blister: cleanse with wound cleanser, apply Antibiotic Ointment and cover with a Foam Dressing and place pressure boot at all times, every evening shift and as needed for wound healing. R2's Treatment Administration Record (TAR) dated 5/1/2026 - 5/31/2026 documents a physician's order with a start date 5/08/2026 for treatment to left heel (plantar): cleanse with wound cleanser and cover with Foam Dressing and place pressure boot at all times every evening shift for wound healing. R2's Physician's Order dated 5/19/2026 documents an order for treatment to Right Heel Deep Tissue Injury (DTI): Cleanse with diluted bleach solution, apply medicinal honey to the wound and cover with non-border foam dressing; wrap with rolled gauze and apply pressure boots at all times, every evening shift and AS NEEDED for Wound Management. R2's Treatment Administration Record (TAR) dated 5/1/2026 - 5/31/2026 documents ordered treatments to the Left Heel Deep Tissue Injury (DTI) were not signed off as completed on 5/11/2026, 5/15/2026, 5/17/2026, 5/18/2026 and 5/22/2026. R2's Treatment Administration Record (TAR) dated 5/1/2026 - 5/31/2026 documents treatments to Right Heel Deep Tissue Injury (DTI) was not signed off as completed on 5/22/2026. On 6/22/2026 at 2:30 p.m., V30 Licensed Practical Nurse (LPN) stated V30 came to work on the evening of 5/24/2026 and observed R2 sitting at the lounge area and noticed R2's dressings to both feet were saturated with drainage. V30 stated V30 applied the dressing to both R2's heels when V30 last worked on the evening of 5/23/2026. V30 stated V30 was not sure how often the treatments were supposed to be done but there should be an as needed (PRN) order for the treatments. 3) R3's undated Care Plan documents R3's diagnoses including Cerebrovascular Disease, History of Ischemic Attack (TIA), Cerebral Infarction, Weakness, Hemiplegia affecting Right Dominant Side, Type 2 Diabetes Mellitus, Pressure Ulcer to Left Heel and Pressure Ulcer to Right Heel. This Care Plan further documents an admission date of 11/26/2025. R3's Minimum Data Set (MDS) dated [DATE] (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	documents R3 had moderate cognitive impairment.R3's Care Plan dated 1/16/2026 documents R3 had an unstageable pressure ulcer to the Right Heel and stage 4 pressure ulcer on the Left Heel development related to immobility. This Care Plan further documents an intervention to administer treatments as ordered and monitor for effectiveness.R3's Treatment Administration Record (TAR) dated 5/1/2026 - 5/31/2026 documents a physician order with a start date of 3/4/2026 for a treatment to Cleanse left heel with NS (normal saline) apply betadine and leave open to air (OTA) after application-Daily and as needed (PRN) everyday shift for wound care.R3's Treatment Administration Record (TAR) dated 6/1/2026 - 6/30/2026 documents a physician order with start date 6/12/2026 for a treatment to Cleanse DTI (Deep Tissue Injury) to bilateral heels with wound cleanser, apply medicinal honey to DTI's cover with Foam Dressing. Leave pressure boots in place at all times every day and evening shift for wound healing.R3's Treatment Administration Record (TAR) dated 5/1/2026 - 5/31/2026 documents the treatments to the left heel were not signed off as completed on 5/5/2026, 5/19/2026, 5/20/2026, 5/21/2026 and 5/22/2026.R3's Treatment Administration Record (TAR) dated 6/1/2026 - 6/30/2026 documents treatments to the bilateral heels were not signed off as completed on 6/15/2026 and 6/18/2026.On 6/22/2026 at 11:08 a.m., V29 Licensed Practical Nurse (LPN) stated the way to know if the wound treatment was done was by checking on the TAR. V29 stated nurses should follow the treatment order on the TAR and then sign off the orders on the TAR after providing the wound treatment to document the completion of the treatment.On 6/22/2026 at 11:19 a.m., V4 Wound Nurse stated the way to know if the wound treatments were being done was by checking the TAR. V4 stated V4 expects the nurses to follow the orders based on the TAR and nurses should sign off on the TAR after providing treatment.On 6/22/2026 at 12:22 p.m., V2 Director of Nursing stated V2 expects the nurses to follow physician's orders for wound treatments and sign off on the TAR after providing wound care to document the treatment was provided.On 6/22/2026 at 1:00 p.m., V21 Licensed Practical Nurse (LPN) stated treatments should be signed off on the TAR to document that the treatment was administered.Facility's Medication Administration Policy dated 01/2026 documents Medication must be administered in accordance with a physician's order, for example the right resident, right medication, right dose, right route, and right time. This Policy further documents documentation of medication administration is recorded on the Medication Administration Record (MAR) or Treatment Record and includes the date, time, and initials of the licensed nurse or CMA (Certified Medical Assistant) who administered the medication.		