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	02/21/2025

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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32172 Based on observation, interview, and record review the facility failed to maintain comfortable room temperatures for seven of seven residents (R37, R48, R55, R71, R80, R104, R105) reviewed for comfortable homelike environment on the sample list of 36. Findings Include: Resident Council Meeting Minutes dated 12/2/24 document resident complaints concerning it being too cold in the building. Resident Council Meeting Minutes dated 1/6/25 document resident complaints concerning resident rooms were really cold. Resident Council Meeting Minutes dated 2/3/25 document requests for plastic to be put on windows due to cold temperatures. On 2/18/25 at 11:00 AM the 100 Hallway was much colder than the common areas or other main hallways and dining rooms. On 2/18/25 at 10:35 AM the 101-115 Hallway registered a temperature of 66.2 degrees Fahrenheit (F). On 2/18/25 at 10:37 AM the temperature outside of room [ROOM NUMBER] registered at 65.7 degrees F. 1. R37's Minimum Data Set, dated dated dated [DATE] documents R37 is cognitively intact. On 2/18/25 at 11:18 AM R37 stated it is very cold in her room. R37 stated she likes to keep her door closed but it feels like an ice box in her room. R37 stated she isn't sure why the heat doesn't work right but she would like it to be warmer and more comfortable in her room. 2. R48's Minimum Data Set, dated dated dated [DATE] documents R48 is cognitively intact. On 2/18/25 at 10:39 AM R48's room registered a temperature of 63.2 degrees F. R48 stated her room was frequently cold and she has to request staff to provide extra blankets or get her a sweater to wear in order to try to stay warm. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. R55's Minimum Data Set, dated dated dated [DATE] documents R55 has a mild cognitive impairment. On 2/18/25 at 11:33 AM R55 stated it has been cold in her room for a few days and when the temperature drops outside it gets too cold in her room and she doesn't want to get out from under the covers. R55 stated she doesn't want to go into her bathroom because it is even colder in there. Her room temperature registered at 66 degrees F. R55 was in bed under three blankets. 4. R71's Minimum Data Set, dated dated dated [DATE] documents R71 is cognitively intact. On 2/18/25 at 11:21 AM R71 stated it is very cold in the room today and that is why she is under three big blankets. R71 stated it always get cold when it is very cold outside. R71 stated she is not sure why the facility can't keep it warm in the resident's rooms. 5. R80's Minimum Data Set, dated dated dated [DATE] documents R80 is cognitively intact. On 2/18/25 at 11:21 AM R80 stated it gets very cold in her room when the temperature drops outside. 6. R104's Minimum Data Set, dated dated dated [DATE] documents R104 is cognitively intact. On 2/18/25 at 11:35 AM R104 stated it is cold in her room and she wears warm clothes, has extra blankets and sometimes wears gloves in order to stay warm. R104 stated she isn't sure why the room can't be maintained at a comfortable temperature. 7. R105's Minimum Data Set, dated dated dated [DATE] documents R105 has a mild cognitive impairment. On 2/18/25 at 11:25 AM R105 stated it gets pretty cold in his room when the temperature drops outside. R105 stated he likes to stay in his room and wishes it was warmer in his room. On 2/18/25 at 12:50 PM V11 Maintenance Director confirmed the resident rooms are pretty chilly on very cold days. V11 stated he is aware of the cold temperatures in the resident rooms however V11 confirmed the heating system is a boiler unit and it is running correctly. He stated he took some temperatures in the rooms this morning and the lowest he got was 66 degrees F. V11 stated he just called the heating company and spoke with someone there familiar with this building. They suggested turning on the heating system in the parking garage below the building to see if it would heat up the building floor (concrete) and help warm up the resident rooms. Although he had not tried anything as of yet to warm up the resident rooms, V11 stated he would be turning on the heating system in the parking garage area now to see if it would help. Surveyor temperatures were taken temperatures were taken with a Humidity/Temperature Thermometer-Hygrometer.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32172 Based on observation, interview, and record review the facility failed to complete quarterly fall risk assessments and implement fall interventions and fall prevention measures for three of four residents (R10, R79, R96) reviewed for falls on the sample list of 36. These failures resulted in R79, who is cognitively impaired, falling from a high bed onto the tile floor. R79 was seen in the emergency room and kept for an overnight hospitalization related to the subarachnoid hemorrhage R79 sustained from the fall. Findings Include: The facility's Fall Prevention Program dated October 2024 documents the program's purpose is to assure the safety of all residents in the facility and is to include measures which determine the individual needs of each resident by assessing the risk of falls, implementing appropriate interventions to provide necessary supervision, and using assistive devices as necessary. A Fall Risk Assessment should be performed at least quarterly and with each significant change in mental or functional condition and after any fall incident. Safety interventions should be implemented for each resident identified at risk. The bed should be maintained in a position appropriate for resident transfers. 1. R79's Medical Diagnoses List dated February 2025 documents R79 is diagnosed with Vascular Dementia, Psychotic Disturbance, Anxiety, Alzheimer's Disease, Need for Assistance with Personal Care, Morbid Obesity, Unsteadiness on Feet, Abnormalities of Gait and Mobility, Lack of Coordination, Cognitive Communication Deficit. R79's Physician Order Sheet dated February 2025 documents R79 was prescribed an anti-platelet medication in of March 2024. R79's Minimum Data Set, dated dated dated [DATE] documents R79 is severely cognitively impaired and requires staff assistance for transfers, bed mobility, and activities of daily living. R79's Care Plan dated 10/11/24 documents R79 is at risk for falls related to confusion and gait/balance problems. V29's Licensed Practical Nurse (LPN) Progress Note dated 1/31/2025 documents R79 was found on the floor beside her bed at approximately 11:15 PM. R79 was observed with a pool of blood underneath her head. R79's bed was clearly in the up position with the head up in Semi Fowler's position and the lower part bent at the knee area. R79 rated her pain as a 7/10 in her head. Emergency Medical Services were notified and R79 was discharged to the hospital. The cause of the fall was the bed was not in the lowest position. R79 has cognitive limitations due to dementia and immobility. On 2/20/25 at 1:40 PM R79 was sitting in her wheelchair in the television room. R79 had a half dollar sized raised hematoma on the left side of her forehead. R79 also had fading bruises under both eyes and a red fading bruise on the left side of neck. R79 was only alert to person and place. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/20/25 at 1:30 PM R79's bed frame was an older bed frame with an air mattress on top. There is an old half metal side rail on the right side of the bed frame. The bed frame, when lowered all of the way, was still about a foot off of the ground. On 2/20/25 at 1:08 PM V27 Certified Nurses Assistant (CNA) stated she put R79 to bed around 9:00 PM on 1/31/25. V27 stated on 1/31/25 R79 had gotten a new air mattress and a new bed frame that was an older model frame. V27 stated she believed part of the reason R79 rolled out of the bed was because of the new air mattress. V27 stated R79 could roll by herself in bed and was confused and needs the assistance of a staff and sit to stand mechanical lift for transfers. Confusion. V27 stated she thought she put the bed in the lowest position after she laid R79 down. However when V27 found R79 on the floor, V27 realized she had not put the bed all the way to the lowest position. On 2/20/25 at 3:29 PM V29 LPN stated the head of R79's bed was up at a 45 degree angle and the bed was also bent at the knees. V29 stated he asked V27 why the bed was like that and she stated so R79 could watch television. V29 also stated R79's bed was not at its lowest position. V29 stated the beds of confused residents should always be at the lowest position but R79's bed was about a foot and a half or two feet off the floor. R79 had blood on her head and on the floor. V29 confirmed R79 has poor safety awareness and would not be aware of where the edge of the bed was if she attempted to turn in bed. V29 also confirmed R79 was in a new air mattress and new bed frame that day for the first time. V29 stated he feels the cause of R79's fall on 1/31/25 was likely R79 trying to adjust herself in bed, then falling head first from the bed due to elevated angle of the head of the bed. V29 confirmed R79's injury risk increased due to the elevated height of the bed at the time of the fall. On 2/21/25 at 9:30 AM V2 Director of Nurses (DON) confirmed there was no quarterly fall risk assessment completed for R79. V2 stated R79 is currently a fall risk and confirmed R79 was a fall risk prior to her fall on 1/31/25 due to her impaired cognition, poor safety awareness, ability to turn and move in bed, and inability to safely transfer on her own. V2 confirmed when R79 was transferred to bed, V27 CNA should have ensured R79's bed was lowered as low as possible and the head of the bed is not elevated. V2 also confirmed on 1/31/25, when R79 fell out of bed and sustained a subarachnoid hemorrhage, R79's bed was not placed in the lowest position and the head of the bed was elevated, increasing R79's risk of injury when she moved in bed and fell out of bed onto the tile floor below. 31642 2. R10's Minimum Data Set (MDS) dated [DATE] documents the following: R10's Brief Interview of Mental Status score of two (2) out of a possible 15, indicating severe cognitive impairment. The same MDS documents R10 had two or more, falls since the last quarterly assessment. R10's Care Plan dated 12/30/24 documents the following: Focus: (R10) is at risk for falls r/t (related /to) dementia, morbid obesity, muscle wasting and difficulty walking. HX (history) of hip FX's (fracture). Interventions include: Apply (name brand non-skid material) on top and under w/chair (wheelchair) cushion. Date Initiated: 07/05/2024. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/20/25 at 2:10 PM R10 was seated in his wheelchair bedside. V33, Certified Occupational Therapy Assistant (COTA) and an unidentified Certified Nursing Assistant assisted R10 to a standing position from R10's wheelchair. V30 and V31 (R10's Family Members) entered R10's room as R10 was being assisted. R10 had non-skid material under, but not on the top of his wheelchair cushion. V33, COTA confirmed R10 had no non-skid material on top as his wheelchair cushion. V30 and V31 also noticed R10 did not have the non-skid material on the top of his wheelchair cushion. V30 and V31 both stated the facility is good about notifying them of R10's falls and has notified them R10 has had falls from his wheelchair. On 2/20/25 at 2:50 PM V30 Assistant Director of Nursing reviewed R10's medical record and confirmed R10 is to have non-skid material above and below R10's wheelchair to prevent R10 from sliding out if his wheelchair. 52228 3. R96 was admitted to the facility on [DATE] with diagnoses including Neurocognitive Disorder with Lewy Bodies, Dementia with behavior disturbances and Hallucinations. R96's Quarterly Comprehensive assessment dated [DATE] documents R96 has severe cognitive impairment and history of falls. R96's Care Plan Dated 10/21/25 documents R96 is at risk for falls related to dementia and cognitive disorder. This same record documents the following fall intervention: [name brand non-skid material] in wheelchair. On 2/19/25 at 2:10 PM, R96's highback wheelchair did not have non-skid material. On 2/19/25 at 2:11 PM, V18 (Certified Nursing Assistant) confirmed R96's highback wheelchair did not have non-skid material in place.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 52228 Based on observation, interview and record review the facility failed to properly secure R96's indwelling catheter tubing to R96's wheelchair. R96 is one of two residents reviewed for urinary catheters on the sample list of 36. Findings Include: On 2/18/25 at 12:15 PM, R96 indwelling catheter tubing was dragging on the floor underneath R96 high back wheelchair. On 2/19/25 at 10:32 AM, R96 indwelling catheter tubing was dragging on the floor underneath R96 high back wheelchair. On 02/19/25 at 10:38 AM, V25 (Certified Nursing Aide) confirmed R96's indwelling catheter tubing was hanging underneath R96's highback wheelchair and stated that it should not be dragging on the floor. The facility Catheter Care Policy dated 10/2024 documents the following: to establish guidelines to reduce the risk of or prevent infections in residents with an indwelling catheter. Urinary drainage bags and tubing shall be positioned to prevent either from touching the floor directly.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32172 Based on observation, inteview, and record review the facility failed to implement side rails only after completing a side rail assessment and obtaining informed consent for three of three residents (R10, R79, R88) reviewed for side rails on the sample list of 36. Findings Include: The facility's Side Rail/Bed Rail policy dated October 2024 documents the purpose of the policy is to ensure the appropriate, safe and correct installation, use, and maintenance of bed rails. The facility shall ensure that prior to the installation of bed rails, the facility has attempted to use alternatives. After alternatives to bed rails have been attempted and determined that these alternatives do not meet the resident's needs, the facility shall assess the resident for the risks of entrapment and possible benefits of bed rails. After alternatives have been attempted and prior to installation, the facility shall obtain informed consent from the resident or if applicable, the resident representative for the use of bed rails. 1. R79's Medical Diagnoses List dated February 2025 documents R79 is diagnosed with Vascular Dementia, Psychotic Disturbance, Anxiety, Alzheimer's Disease, Need for Assistance with Personal Care, Morbid Obesity, Unsteadiness on Feet, Abnormalities of Gait and Mobility, Lack of Coordination, Cognitive Communication Deficit. R79's Minimum Data Set, dated dated dated [DATE] documents R79 is severly cognitively impaired. R79's Care Plan dated 10/11/24 documents R79 has impaired bed mobility and requires assistance of staff members with bed mobility. R79 uses side rails to maximize independence with turning and repositioning in bed. R79's Side Rail assessment dated [DATE] documented side rails were not indicated for R79. On 2/20/25 at 1:30 PM R79's bed frame appeared to be an older bed frame with an air mattress on top. There was an old half metal side rail on the right side of the bed frame next to the wall. There was another half metal side rail laying on the other bed in the room. On 2/21/25 at 9:30 AM V2 Director of Nurses (DON) confirmed R79 had no recent quarterly side rail assessment completed. The last Side Rail Assessment was completed on 7/26/24 and documented side rails were not indicated for R79. V2 stated he completed an assessment last night and determined R79 would benefit from one side rail to assist her with bed mobility. V2 confirmed R79 already had one side rail on her bed prior to this assessment being completed. 31642 (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R10's Current Diagnoses Sheet documents the following: Alzheimer's Disease With Early Onset, Dementia in Other Diseases Classified Elsewhere, Moderate With Agitation, Other Abnormalities of Gait and Mobility, and Age-Related Osteoporosis With Current Pathological Fracture, Unspecified Femur, Sequela. R10's Minimum Data Set (MDS) dated [DATE] documents the following: R10's Brief Interview of Mental Status score of two (2) out of a possible 15, indicating severe cognitive impairment. R10's Care Plan dated 12/30/24 documents the following: Focus: (R10) has an ADL (Activities of Daily Living) self-care performance deficit r/t (related/to) dementia, confusion and FX (fracture) to l (left) hip; NWB (No Weight Bearing) to LLE (Left Lower Extremities). Interventions include: BED MOBILITY: The resident requires assist of (2) staff member with bed mobility. The resident uses side rails to maximize independence with turning and repositioning in bed. Date Initiated: 01/14/2024 (thirteen months prior to survey). R10's Quarterly Side Rail assessment dated [DATE] documents R10 does not use side rails, though they are care planned as of 1/14/24. There are no other quarterly side rail assessments until 2/20/25 during this survey. On 2/20/25 at 2:10 pm R10 had bilateral quarter side bedrails attached to R10's bed. On 2/20/25 at 2:50 pm V30 Assistant Director of Nursing confirmed R10 has bilateral quarter side rails but does not have quarterly side rail assessments since 7/31/24. V30 also stated the side rail assessment 7/31/24 is incorrect, because R10 had quarter side rails at that time. 3. R88's Current Diagnoses sheet documents the following: Hallucinations Unspecified, Other Specified Disorders of Muscle, Difficulty In Walking Not Elsewhere Classified, Unsteadiness On Feet, Other Abnormalities Of Gait And Mobility, and a History of Fracture of Unspecified Part Of Neck of Right Femur, Subsequent Encounter For Closed Fracture, With Routine Healing. R88's Minimum Data Set, dated dated dated [DATE] documents the following: R88's Brief Interview of Mental Status score of six out of 15, indicating severe cognitive impairment. R88's Care Plan dated 1/5/25 documents the following: Focus: (R88) is at risk for falls (due to) confusion, dementia and wandering. Intervention include: Bed rails for positioning and transfers. Date Initiated: 01/02/2025. On 2/20/25 at 2:25 pm R88 also had bilateral, quarter side bed rails, secured to R88's bed. On 2/20/25 at 2:50 pm V30, Assistant Director of Nursing confirmed R88 has bilateral quarter side rails, but does not have quarterly side rail assessments since 6/4/24.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 31642 Based on observation, interview, and record review, the facility failed to employ the services of a qualified director of food and nutrition services. This failure has the potential to affect all 105 residents residing in the facility. Findings Include: On 02/18/25 at 08:35 am V7, Dietary Manager (DM) was actively supervising dietary staff during breakfast meal service. V7 stated he has worked at the facility, as the dietary manager, since November 2024. V7 DM stated he has not taken the required classes to qualify as the dietary manager. On 2/19/25 at 2:45 pm V14, Regional Dietary Manager confirmed V7 DM has not had the training to qualify as the dietary manager. The facility's Centers for Medicare and Medicaid Services Long Term Care Facility Application for Medicare and Medicaid dated 2/18/25 documents 105 residents reside in the facility.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 31642 Based on observation, interview, and record review, the facility failed to prevent the potential for cross-contamination and food-borne illness, by failing to maintain clean food contact areas, free of grease-like substances, rust, dangling strands of accumulated dust-like substance, loose caulking and chipped paint. These failures have the potential to affect all 105 residents residing in the facility. Findings Include: On 2/19/25 at 12:30 pm during the follow- up kitchen tour with V7, Dietary Manager (DM)there was an approximate eight-foot long metal shelf, above the three well sink. The metal shelf above the three well sink had copious amounts of rust and brown and black grease-like debris adhering to the underside surface. Directly below the underside, soiled metal shelf are approximately twenty hanging brackets. There are presumably clean kitchen serving utensils, spoons, tongs, whisk, all hanging in groups from each of these bracket. The three-well sink has loose chipped caulking dangling into the wash and sanitization wells of the sink. There are two electrical outlet boxes on the wall above the three-well sink. Both electrical outlet boxes have thick, grease- like build up and crusted food-like substance adhering to the surface. Adjacent to the three well sink is a metal food preparation table. Approximately four feet above the food preparation table, is a suspended metal pipe. The suspended metal pipe hangs parallel and approximately two feet below the ceiling. The metal pipe is approximately 12 feet long. The metal pipe has a large amount of stringy dust-like substance, hanging strands of two and three inches, directly over the food preparation table. V7, DM stated he had not noticed how dirty these areas were and will make sure they are all cleaned better. The ceiling above this same metal pipe, over the food preparation table has an approximate ten- inch by ten- inch cluster of hanging paint strips that have pulled away from the painted ceiling. V7 stated he will have to get maintenance to fix the paint on the ceiling and the caulking around the three-well sink. V7 confirmed all the soiled areas pose a risk to contaminate food served to the residents from the facility kitchen. The facility General Sanitation Practices policy dated September 2023 documents the following: POLICY: The kitchen will be maintained in a clean and sanitary condition. The state and/or federal food code will be maintained on file within the food service department, and will be the basis of all sanitation and food safety practices. PROCEDURE: 8. Work surfaces will be kept neat and clean during food preparation and service. The (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	department philosophy is Clean as you go. 13. Sanitation is the entire department's responsibility. The facility's Centers for Medicare and Medicaid Services Long Term Care Facility Application for Medicare and Medicaid dated 02/18/25 documents 105 residents reside in the facility.