(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					С	
		IL6008510	B. WING		06/2	7/2024
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ARC AT	NORMAL	NORMAL,	TH ADELAID IL 61761	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	FRI of 6/18/2024/IL	174723				
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations				
	300.610a) 300.1210b) 300.1210d)6) 300.3210t)					
	Section 300.610 Re	esident Care Policies				
	procedures governi facility. The written be formulated by a Committee consistin administrator, the a medical advisory confine of nursing and othe policies shall complete the facility and shall by this committee, cand dated minutes of the solution of the written policies the facility and shall by this committee, cand dated minutes of the solution of the written policies the facility and shall by this committee, cand dated minutes of the written policies the facility and shall by this committee, cand dated minutes of the written policies the written p	dvisory physician or the ommittee, and representatives r services in the facility. The y with the Act and this Part. shall be followed in operating I be reviewed at least annually documented by written, signed				
	Nursing and Persor					
	and services to atta practicable physical well-being of the res each resident's com plan. Adequate and care and personal of	provide the necessary care in or maintain the highest I, mental, and psychological sident, in accordance with aprehensive resident care properly supervised nursing care shall be provided to each a total nursing and personal				

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

07/09/24 **Electronically Signed** 

TITLE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL 6008510			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		B. WING			C <b>06/27/2024</b>		
	PROVIDER OR SUPPLIER	509 NOR	DDRESS, CITY, ST			-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
\$9999	care needs of the red d) Pursuant to sub care shall include, a and shall be practic seven-day-a-week 6) All necessary prassure that the resi as free of accident nursing personnel sthat each resident rand assistance to personal strate and assistance to personal strategies and assistance to personal str	esident.  section (a), general nursing at a minimum, the following set on a 24-hour, basis:  ecautions shall be taken to dents' environment remains hazards as possible. All shall evaluate residents to see receives adequate supervision revent accidents.  General  ensure that residents are not al, verbal, sexual or e, neglect, exploitation, or property.  ts were NOT MET as  , and record review the facility esident's (R2) right to be free by another resident (R1), social harm of R2. R1 and R2 sidents reviewed for abuse in	\$9999				

Illinois Department of Public Health

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Illinois Department of Public Health

NAME OF PROVIDER OR SUPPLIER  ARC AT NORMAL  STREET ADDRESS, CITY, STATE, ZIP CODE  509 NORTH ADELAIDE  NORMAL, IL 61761  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (2)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
ARC AT NORMAL  509 NORTH ADELAIDE  NORMAL, IL 61761			IL6008510	B. WING				
ARC AT NORMAL NORMAL, IL 61761	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
NORMAL, IL 61761	ARC AT	NORMAI	509 NOR	TH ADELAIDE				
(VALID SLIMMARY STATEMENT OF DEFICIENCIES ID DEGISITION OF CORRECTION OF	ARC AI	NORWAL	NORMAL	IL 61761				
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM		(EACH DEFICIENCY	MUST BE PRECEDED BY FULL		CROSS-REFERENCED TO THE AI	HOULD BE	(X5) COMPLETE DATE	
Seyes  Continued From page 2  taken to R1's room. R1 and R2 were interviewed and had no recollection of the incident.  R1's ongoing Diagnoses List includes Dementia with behavioral disturbance, restlessness, agitation, and Pseudobulbar Affect (inappropriate/involuntary laughter or crying). R1's Minimum Data Set (MDS) dated 5/20/24 documents a Brief Interview for Mental Status score of 12, the high end of moderate cognitive impairment, and R1 uses a wheelchair for mobility. R1's Care Plan dated 2/17/24 documents R1 likes to watch pornography and may express/display sexual advances towards staff.  R1's Nursing Note dated 6/18/2024 at 10:10 AM documents "resident (R1) was witnessed touching another resident's (R2) breast while in a common area, residents were separated by this nurse (V3) and management alerted."  R2's ongoing Diagnoses List includes Aphasia (difficulty speaking) and Alzheimer's Disease. R2's MDS dated 6/7/24 documents R2 does not speak, is rarely/never understands others. R2's MDS documents R2 has short and long term memory impairment, is dependent on staff for mobility/transfers, and does not recall current season, room location, staff names/faces, or that she is in a nursing home. R2's Psychosocial Assessment dated 6/18/24 documents R2 has no recollection of the event with R1.  On 6/27/24 at 9:23 AM V3 LPN stated V3 witnessed R1's/R2's incident (6/18/24) which happened mid-morning. V3 stated R2 was sitting in a wheelchair in the lounge area and R1 was in	S9999	taken to R1's room, and had no recolled R1's ongoing Diagn with behavioral dist agitation, and Pseu (inappropriate/invol Minimum Data Set documents a Brief I score of 12, the hig impairment, and R1 mobility. R1's Care documents R1 likes may express/display staff.  R1's Nursing Note of documents "resider touching another recommon area, resident ouching another reco	R1 and R2 were interviewed stion of the incident.  loses List includes Dementia urbance, restlessness, dobulbar Affect untary laughter or crying). R1's (MDS) dated 5/20/24 nterview for Mental Status h end of moderate cognitive uses a wheelchair for Plan dated 2/17/24 to watch pornography and y sexual advances towards dated 6/18/2024 at 10:10 AM at (R1) was witnessed sident's (R2) breast while in a dents were separated by this hagement alerted."  loses List includes Aphasia and Alzheimer's Disease. R2'de documents R2 does not er understood, and tands others. R2's MDS short and long term memory endent on staff for and does not recall current ion, staff names/faces, or that home. R2's Psychosocial 6/18/24 documents R2 has no event with R1.  AM V3 LPN stated V3 is incident (6/18/24) which ning. V3 stated R2 was sitting	S9999				

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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			_	
IL6008510		B. WING		C 06/27/2024			
NAME OF PROVIDER O	R SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ARC AT NORMAL 509 NORTH NORMAL, IL				E			
PREFIX (EACH	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
hand down asked Ridown fur breast. VR1 took knew wh R2's breadware of respond R2 has shave the On 6/27/V1 Admi R2 was seresident R2. V22 responde cognitive been "aghave pusfelt afraid The facil Reporting 2022 door the right neglect, property, staff or nunwanted the breadsexual coappears	I what R1 ther into R I stated W nimself ba at R1 was ast ) was w what was to being to evere cog ability to o  24 at 12:3 nistrator re sitting in th put his har was asked ed to this s impairem hast and r shed him (I I I I I I I I I I I I I I I I I I I	of R2's blouse. V3 stated V3 was doing, R1 put R1's hand 2's blouse and grabbed R2's 3 separated R1 and R2, and ck to R1's room. V3 stated R1 doing and knew it (touching rong. V3 stated R2 was not happening and did not buched by R1. V3 confirmed nitive impairment and does not consent to intimate touching.  1 PM V22 (R2's Family) stated excently contacted V22 to report e day room and a male and down R2's shirt and fondled thow R2 would have felt or situation if R2 did not have ent. V22 stated R2 would have mortified", R2 probably would R1) away, and R2 would have the following: The facility affirms dents to be free from abuse, in, misappropriation of on of goods and services by int. Sexual abuse includes touching of any kind, including rineal areas. Nonconsensual undes when the resident e contact to occur, but lacks to consent.	S9999				

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