STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058297	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC AT NORMAL	509 NORTH ADELAIDE , NORMAL, Illinois, 61761

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Complaint Investigation: 2565076/IL193840	S0000		
S9999	Final Observations Statement Of Licensure Violations: 300.1210b) 300.1210d)6) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These regulations were not met as evidenced by: Based on interview and record review, the facility failed to obtain medical evaluation, treatment, and manage new onset of pain following a resident's fall. This failure resulted in R2 experiencing aches, sharp	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 pains, and a significant decline in cognitive, continence, and ambulatory status. R2 was one of three residents reviewed for accidents on a sample list of three. Findings include: R2's Census Detail dated 6/13/25 documents R2 was admitted to the facility 3/21/25, hospitalized from 4/14/25 through 4/18/25, re-admitted to the facility 4/18/25, and expired 5/22/25. R2's Medical Diagnoses List dated 6/13/25 documents R2 had health conditions upon her admission including Malnutrition, History of Transient Cerebral Ischemia, and Chronic Kidney Disease. This same Diagnoses List documents, after R2's re-admission on 4/18/25, R2's diagnoses included a Displaced Right Femoral Neck Fracture, and Acute Respiratory Failure. R2's Nursing Progress Notes dated 4/12/25 document R2 experienced a fall in her room while ambulating with her walker and began complaining of new onset of pain R2 described initially as an ache. R2's Nurses Notes dated 4/12/25 and 4/13/25 document R2 had subsequent pain complaints described as sharp, and with numerical rating of 2 and 3. On 6/12/25 at 11:55 AM, V5, Licensed Practical Nurse, stated she had taken care of R2 after the fall, that R2 was alert and was telling staff about her pain. V5 additionally stated she had noted R2 was having right hip pain and was also walking "funny" on 4/12/25 and 4/13/25. V5 then stated R2 was also experiencing a new onset of increased confusion on 4/13/25. V5 concluded by stating she did not notify R2's physician until 4/14/25 when the physician ordered x-rays for R2. R2's Medication Administration Record dated for April 2025 documents from 4/1/25 through 4/12/25 day shift, R2 had rated her pain each and every shift as zero. This Record documents on 4/12/25, 4/13/25, and 4/14/25, R2 was rating her pain at 4. R2's Medication Administration Record and Treatment Administration Records dated for April 2025 documents no administration of any type of pain medication nor treatment from the time of R2's fall on 4/12/25 through	S9999		

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S9999	Continued from page 2 the time of R2 being sent to the emergency room on 4/14/25. R2's Physician Order Sheet dated 6/13/25 documents none of R2's pain medication orders were initiated prior to 4/18/25 when R2 returned from her hospital admission after R2's fall and fracture on 4/12/25. On 6/12/25 at 11:55 AM, V5, Licensed Practical Nurse, stated she had taken care of R2 after the fall on 4/12/25. V5 stated R2 was alert and was telling staff about her pain. V5 further stated she had noted that R2 was having right hip pain and was walking "funny" on 4/12/25 and 4/13/25. V5 then stated R2 was also experiencing increased confusion on 4/13/25. V5 concluded by stating she had not notified R2's physician of the increased pain and confusion until 4/14/25 when R2's physician ordered the x-rays and subsequent transfer to the emergency room. On 6/12/25 at 2:33 PM, V10, Certified Nursing Assistant, stated that on the weekend of 4/12/25 and 4/13/25, R2 was lying in bed moaning, complaining of pain, and sleeping a lot. V10 further stated R2 was incontinent of bowel and bladder, which was a change for R2 since prior to the fall R2 could take herself to the bathroom, and was complaining of increased pain in her right hip when V10 was turning and positioning R2 to change R2's soiled depends and linens. R2's Radiology Report dated 4/14/25 documents R2 experienced a displaced right femoral neck fracture. R2's Nurses Notes dated 4/14/25 at 2:18 PM document R2 was sent to the emergency room for further evaluation. R2's Hospital History and Physical dated 4/18/25 documents R2 was admitted to the hospital for pain management, abnormal laboratory values, and surgical orthopedic consult. The Hospital History and Physical documents R2's abnormal laboratory values were mimicking of a heart attack and were caused by R2's fall, pain, and increased bodily oxygen demands creating ischemia (lack of blood flow). This History and Physical documents R2 received a computed tomography of the right hip and R2's fracture was described as an impacted fracture displaced	S9999		

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S9999	Continued from page 3 superiorly (broken smaller pieces around the fracture and the lower portion of the broken bone was moved upwards). This History and Physical documents R2 was to be placed as non-weight bearing status. R2's Minimum Data Set (MDS) dated 3/28/25 documents R2 had a Brief Interview for Mental Status (BIMS) score of 12, rating R2 as cognitively intact. This MDS documents R2 had no limitations in range of motion in any of her four extremities, only required set up assistance to accomplish daily living activities such as eating, toileting, ambulation over 150 feet with a walker, upper and lower body dressing, donning footwear, and personal hygiene. R2's MDS dated 4/25/25 documents R2 had a BIMS score of 1, rating R2 as severely cognitively impaired. This MDS documents R2 had an impairment in range of motion of one lower extremity and was dependent upon staff to accomplish all daily living activities. There was no evaluation of R2 ambulatory status in this MDS due to R2 being placed as non-weight bearing status. (A)	S9999		