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 05/20/2025

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 2564153/IL192126	S0000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1620a) 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. Section 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile, or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. Based on interview and record review the facility failed to follow physician orders for one (R1) of three	S9999		

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

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S9999	Continued from page 1 residents reviewed for physician orders from a total sample list of 103 residents. This failure resulted in R1 being hospitalized with high ammonia levels that could have resulted in permanent harm. Findings include: R1's undated diagnosis sheet includes the following diagnoses: unspecified convulsions, alcohol dependence with alcohol-induced persisting dementia, fracture of right acetabulum, fracture of rib, malnutrition, fracture of anterior wall of right acetabulum, traumatic subarachnoid hemorrhage with loss of consciousness, and diabetes. The facility provided admission/discharge report documents that R1 was admitted to the facility on 2/21/25. R1's hospital discharge orders dated 2/21/25 document medications to be continued including: Lactulose 10 gram/15 milliliter (ML) oral solution. Take 30 ML by mouth three times daily. R1's physician orders for February 2025 do not include an order for Lactulose. R1's February 2025 Medication Administration Record does not document that Lactulose was administered. R1's progress notes document on 2/22/25 that R1's mental status is alert and oriented to person, place, time, and situation. R1's progress notes document on 2/23/25 that R1's family member was concerned because R1 was not responding appropriately/like himself and seems extremely weak. R1 was unable to hold his head up and confusion was noted. R1's family member requested that R1 be sent to the emergency department for evaluation and treatment. R1's hospital records dated 2/23/25-3/3/25 document that R1 was admitted to the hospital with Hepatic Encephalopathy with hyperammonemia secondary to not	S9999		

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S9999	Continued from page 2 receiving Lactulose at the facility. While hospitalized, R1 received Lactulose in various amounts to bring the ammonia level down with the result of improving mentation. On admission to the hospital on 2/23/25, R1's ammonia level was documented as 116 with significant confusion and decreased to 82 on 3/1/25 with lactulose administration resulting in improved mentation and the recommendation to continue lactulose for ammonia management. On 5/19/25 at 10:30AM, V3 RN (Registered Nurse) stated that she recalled having a conversation with R1's family member regarding not providing R1 Lactulose in the facility and that it was missed because of a system issue with the way that they look at discharge records and that they didn't look at the paper discharge records for R1. "The staff are supposed to look at the paper discharge that comes with the resident, as well as the electronic discharge paperwork." On 5/19/25 at 1:10PM, V8 Nurse Practitioner stated that it was her expectation that the facility completed medication reconciliation with the discharge paperwork that comes with the resident from the hospital as soon as the resident arrives at the facility to ensure that nothing has changed. On 5/19/25 at 1:16PM, V7 Discharging Medical Doctor stated that R1 was mentally altered from the ammonia and it could have resulted in a coma. "The family and patient told me that (R1) had not received his Lactulose in the facility and this certainly could have permanently harmed him." (A)	S9999		