STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146026	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at Sangamon Valley	3400 West Washington Springfield, IL 62702

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 0686 Level of Harm - Minimal harm or potential for 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** 45302 Based on observation, interview and record review the facility failed to assess a resident's skin upon admission, failed to document weekly skin assessments, and failed to notify the physician for treatment orders when a pressure ulcer was documented for 1 of 4 residents (R1) in a sample of 10. Findings include: R1's Face Sheet documents he was initially admitted to the facility on [DATE] with diagnoses including a stage 2 pressure ulcer. R1's CNA (Certified Nurse Aide) Skin Attention Form, dated 4/1/2025 documents his buttocks was circled and staff documented S2 (stage 2) bilateral buttocks. The form was signed by V2, Director of Nursing (DON.) R1's Physician's Order Sheet (POS) dated 4/1/2025 documents weekly skin assessments. No pressure ulcer treatment was on the POS at that time. R1's Progress Note, dated 4/1/2025 at 3:49 PM, no documentation of admission skin assessment. Staff documented, see admission assessment. R1's History and Physical Progress Note, dated 4/2/2025 at 3:26 PM, documents skin: warm and dry. R1's Treatment Administration Record (TAR), dated 4/2/2025 a nurse documented a weekly skin assessment was completed. R1's Care Plan, dated 4/4/2025 documents at risk for skin impairment r/t (related to) coronary artery disease (CAD), high blood pressure (HTN), decline in mobility and type 2 diabetes. Goal: I will maintain or develop clean and intact skin by the review date. Interventions: monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal. s/sx (signs and symptoms) of infection, maceration ect. to MD (physician.) Provide diet as ordered and monitor nutritional status and dietary needs. Report pertinent changes in skin status to physician. R1's POS, dated 4/4/2025 cleanse r (right) buttock with wound cleanser et apply hydrocolloid every day shift Monday, Wednesday and Friday. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Progress Note, dated 4/7/2025 at 4:01 PM, documents skin: wound/skin concerns noted, but no changes in skin integrity. Resident has treatable wounds. R1's Wound Summary, dated 4/9/2025 at 1:18 PM, documents Stage 2 pressure ulcer on resident's right buttocks measured 1.30 centimeters (cm) x 1.8 cm x 0.1 cm. Skin intact with 90% epithelial tissue and 10% pink or red tissue with scant serosanguineous exudate. The wound summary documents the Stage 2 pressure ulcer date identified was 4/1/2025 and it was present on admission. On 4/17/2025 at 11:46 AM R1 sat up in a regular wheelchair and stated he has a wound on his butt but declined observation from survey team. On 4/18/2025 at 10:22 AM V5, (Licensed Practical Nurse) LPN stated she started as the wound nurse on 4/7/2025. V5 stated they have a lot of agency nurses that work here and they skip the admission assessment and sometimes document the skin admission in the resident's nurse progress notes if it's not there she doesn't know where it is. Nurse's document on the resident's TAR that weekly skin assessment are completed but there is no where in the computer system to document the weekly skin assessment, some nurse's document the weekly skin assessment in the resident's progress notes. When a resident is initially admitted to the facility she expects the admission nurse to assess the resident's skin within 2 hours and to document the skin assessment in the resident's medical record and then she assesses new admission residents skin within 24 hours of admission to the facility during the week and 72 hours of arrival if admitted on the weekend. When a resident is initially admitted to the facility the admitting nurse is expected to do a skin assessment and document all skin abnormalities including wounds and the documentation should include the location of the wound, measurement and what the wound looked like. On 4/18/2025 at 11:56 AM V2, DON stated upon initial admission the admitting nurse should document the resident's skin assessment in the nurse admission assessment or at least document it in the resident's progress notes. The admission skin assessment should be completed within the same shift the resident is admitted to the facility and the admitting nurse is expected to document the location of any wounds including pressure ulcers and to document a description of the wound. If the resident is admitted to the facility in the morning she expects the wound nurse to assess the resident's skin the same day and if the resident is admitted in the afternoon she expects the wound nurse to assess the resident's skin the next day. The admitting nurse is not responsible for documenting the wound measurements, the wound nurse is responsible for taking a picture of the wound and assessing and documenting the wound measurements. On 4/1/2025 the facility did a full house skin sweep and that was when she signed off on R1's skin assessment that documented he had a Stage 2 pressure ulcer on his buttocks. She handed the documents for the residents that had pressure ulcers to the former wound nurse and she expected her to assess each resident's pressure ulcer, take a picture of it, document the assessment in the resident's medical record, notify the physician of the pressure ulcer and get a treatment for it. V2 stated after they found out the former wound nurse didn't document or assess resident's pressure ulcers after the 4/1/2025 facility skin sweep she was removed from the wound nurse position and is currently a floor nurse. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/18/2025 at 12:20 PM V4, Regional Nurse stated she knows there are issues with (R1's) pressure ulcer. The admission skin assessment was completed and there is no skin assessment documented until 4/9/2025. V4 stated her and V1 have discussed these issues in a quality assurance meeting the other day and they are hiring a admission nurse to do admission assessments which includes a head to toe skin assessment. V4 stated she doesn't know why (R1's) skin wasn't assessed upon admission the facility but she is putting corrective measures in place so resident's skin is assessed upon admission from here on out. The Facility's Pressure Injury and Skin Condition Assessment Policy revised 1/2018 documents a skin assessment will be completed at the time of admission. Resident identified will have a weekly skin assessment by a licensed nurse. A wound assessment will be initiated and documented in the resident chart when pressure are identified by licensed nurse. At the earliest sign of a pressure injury the resident, legal representative, and attending physician will be notified. The initial observation of the ulcer will also be described in the nursing progress notes. Pressure injuries will be measured at least weekly and recorded in centimeters in the resident's clinical record. A wound assessment for each identified open area will be completed and will include site location, size (length x width x depth) stage of pressure ulcer, odor, drainage, description, date and initials of the individual performing the assessment. The resident's care plan will be revised as appropriate, to reflect alteration of skin integrity, approaches and goals for care.