

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146026	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/05/2025
NAME OF PROVIDER OR SUPPLIER Arc at Sangamon Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 3400 West Washington Springfield, IL 62711	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to report an injury of unknown origin to the administrator for 1 of 3 residents (R2) reviewed for reporting allegations of abuse in the sample of 29.</p> <p>Findings include:</p> <p>R2's Face Sheet, print date of 4/1/25, documented R2 has diagnoses including stage 4 pressure ulcer of sacral region, methicillin susceptible staphylococcus aureus infection, metabolic encephalopathy, unspecified dementia, stable burst fracture of T11-T12 vertebra, hyperlipidemia, hypertension, atrial fibrillation, hyposmolality, and hyponatremia.</p> <p>R2's Minimum Data Set (MDS), dated [DATE], documented R2 is severely cognitively impaired and is dependent on staff for all ADLS (Activities of Daily Living).</p> <p>On 4/1/25 at 9:13 AM V15, R2's granddaughter, stated R2 developed a skin tear to her left upper arm and left hand during her two weeks stay at the facility.</p> <p>On 4/1/25 at 10:13 AM V16, daughter/POA (Power of Attorney), stated R2 developed a skin tear on her left upper arm around the middle of last week. V16 stated the skin tear was uncovered for a couple of days and then over the weekend it had a dressing over it. V16 stated R2 told her a CNA (Certified Nurse Assistant) was rough with her during her shower resulting in the skin tear. V16 stated this is the 3rd skin tear R2 has sustained at the facility since she was admitted on [DATE]. R2 was present during this interview and stated the CNAs are rough, and I think it happened during my bath. Surveyor observed an approximate 2 inch by 2-inch skin tear with pink tissue exposed to R2's left upper arm.</p> <p>On 4/1/25 at 10:27 AM V9 Certified Nurse Assistant (CNA) stated R2's arm had a dressing on it when she first saw her this morning and the dressing was off the second time, she went into R2's room. V9 stated she told the nurse, and the nurse informed her she couldn't do anything about it right now. V9 stated that nurse is already off for the day and now her nurse is V10. V9 stated she does not know how R2's skin tear occurred.</p> <p>On 4/1/25 at 10:29 AM V10 stated she is now R2's nurse and she did not know R2 has a skin tear.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/1/25 at 11:25 AM V16 stated she found a fresh skin tear to R2's left hand last weekend and that R2 told her it was from the CNA putting the handrail down on her hand. Surveyor observed an approximate quarter sized skin tear on R2's left hand. R2 was unable to recall the cause of this skin tear at the time of this interview.</p> <p>On 4/1/25 at 11:28 AM V10 stated she just applied a dressing to R2's left upper arm. V10 stated she does not know the cause of R2's skin tear and the nurse who initially found the skin tear should have completed an incident report for it.</p> <p>On 4/1/25 at 11:43 AM V4, Regional Nurse Consultant, stated the facility does not have any documentation of R2's skin tear and the facility will initiate an unknown injury investigation into it.</p> <p>The facility's Final Abuse Investigation Report, dated 4/7/25, documented the initial report of R2's skin tear of unknown origin was initially reported on 4/1/25 after Surveyor requested the unknown injury investigation for R2's skin tears.</p> <p>On 4/7/25 at 1:06 PM, V2, Director of Nursing, stated she expects the facility nurses and CNAs to report injuries of unknown origin to management so an investigation can be completed, and to complete an incident report on all skin tears, injuries, and falls.</p> <p>The facility's Abuse Prevention and Reporting policy, dated 11/2016, Injuries of Unknown Source: For resident injuries not involving an allegation of abuse or neglect, the administrator will appoint a person to gather further facts to make a determination as to whether the injury should be classified as an injury of unknown source. An injury should be classified as an injury of unknown source when both of the following conditions are met: The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury. If classified as an injury of unknown source, the person gathering facts will document the injury, the location and time it was observed, any treatment given and notification of the resident's physician, responsible party. The Department of Public Health will be notified. Time frames for reporting the injury, the location and time it was observed, any treatment given and notification of the resident's physician, responsible party. The appointed investigator will, as a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed along with any pertinent medical records or other documents. The resident's physician and representative, if necessary, shall be notified of any incident or allegation of abuse, neglect, exploitation, mistreatment, or misappropriation of resident property. If the resident complains of physical injuries or if resident harm is suspected, the resident physician will be contacted for further instructions.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to investigate an injury of unknown origin for 1 of 3 residents (R2) reviewed for abuse investigation in the sample of 29.</p> <p>Findings Include:</p> <p>R2's face sheet, print date of 4/1/25, documented R2 has diagnoses including unspecified dementia.</p> <p>R2's Minimum Data Set, MDS, dated [DATE], documented R2 is severely cognitively impaired and is dependent on staff for all ADLS (Activities of Daily Living).</p> <p>On 4/1/25 at 9:13 AM V15, R2's granddaughter, stated R2 developed a skin tear to her left upper arm and left hand during her two weeks stay at the facility.</p> <p>On 4/1/25 at 10:13 AM V16, daughter/POA (Power of Attorney), stated R2 developed a skin tear on her left upper arm around the middle of last week. V16 stated the skin tear was uncovered for a couple of days and then over the weekend it had a dressing over it. V16 stated R2 told her a CNA (Certified Nurse Assistant) was rough with her during her shower resulting in the skin tear. V16 stated this is the 3rd skin tear R2 has sustained at the facility since she was admitted on [DATE]. R2 was present during this interview and stated the CNAs are rough, and I think it happened during my bath. R2 had a 2 inch by 2-inch skin tear with pink tissue exposed to R2's left upper arm.</p> <p>On 4/1/25 at 10:27 AM V9 Certified Nurse Assistant, CNA, stated R2's arm had a dressing on it when she first saw her this morning and the dressing was off the second time, she went into R2's room. V9 stated she told the nurse, and the nurse informed her she couldn't do anything about it right now. V9 stated that nurse is already off for the day and now her nurse is V10. V9 stated she does not know how R2's skin tear occurred.</p> <p>On 4/1/25 at 10:29 AM V10 Licensed Practical Nurse, LPN, stated she is now R2's nurse and she did not know R2 has a skin tear.</p> <p>On 4/1/25 at 10:31 AM V11 CNA stated she does not anything about R2's skin tears.</p> <p>On 4/1/25 at 11:25 AM V16 stated she found a fresh skin tear to R2's left hand last weekend and that R2 told her it was from the CNA putting the handrail down on her hand. Surveyor observed an approximate quarter sized skin tear on R2's left hand. R2 was unable to recall the cause of this skin tear at the time of this interview.</p> <p>On 4/1/25 at 11:28 AM V10 stated she just applied a dressing to R2's left upper arm. V10 stated she does not know the cause of R2's skin tear and the nurse who initially found the skin tear should have completed an incident report for it.</p> <p>On 4/1/25 at 11:43 AM V4, Regional Nurse Consultant, stated the facility does not have any documentation of R2's skin tear and the facility will initiate an unknown injury investigation into it.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/7/25 at 1:06 PM, V2, stated she expects the facility nurses and CNAs to report injuries of unknown origin to management so an investigation can be completed, and to complete an incident report on all skin tears, injuries, and falls.</p> <p>The facility's Final Abuse Investigation Report, dated 4/7/25, documented IDPH (Illinois Department of Public Health) Surveyor in the building and spoke with V16, the daughter of R2 which showed her a skin-tear approximately a 2 x 2 cm area to the left shoulder area. The information of the skin tear was not recorded on a skin wound change of condition report. Nurse V10 stated that she was preparing R2 for discharge to home with Hospice per family request when she noted the skin tear approximately a 2 x 2 cm with no drainage and no skin flap. Daughter, V16, was at bedside and stated that I knew it was there after her shower the other day and I took a picture but didn't tell anyone about it and wanted you guys to find it. V10 cleansed and measured the area and provided a foam dressing to cover. Administrator notified and due to resident leaving discharging to home after the skin tear was noted unable to interview the resident. However, V16 did say she knew it was transferring after her shower earlier in the week and wasn't telling anyone anything else as she had been taking pictures. CNA interviewed and stated she heard it was obtained after her last shower when they were transferring her. Medical Director and resident's primary Physician is aware that incident occurred, and resident had area cleansed and covered before discharge with no signs of infection. It continues, Summary and Analysis of the Evidence: Noted that resident had a shower on 3/28/25. CNA stated that she was transferring her and accidentally caused a skin tear to her left inner shoulder area with her fingernail as she was assisting her to reposition in the shower chair. Area was reported to nurse on duty which was an agency nurse, and she did treat and cover the area but did not do the skin change of condition which would have documented and recorded the episode. It continues, Conclusion and Action Taken: Based on the results of the investigation the facility has found the following: a. Nurse V10 interviewed and stated that the area on R2's left inner shoulder dressing was intact when she took it off noting that the area was clean with a 2 x 2 cm skin tear with no skin flap and pink in area. Area redressed. b. POHC (Power of Health Care) verified per statement to the nurse that the injury was of known cause because she took a picture after the shower when it was noticed the previous shower and that the CNA must have done it transferring her because it was difficult, but she wasn't saying anything else. c. Discharge instructions did include the skin tear and location. d. Medication reviewed and plan of care with doctor which notes that resident takes Eliquis treatment would cause the skin to be injured easily due to the blood thinner use. e. Other staff members were interviewed and had not witnessed or aware of this allegation of any physical abuse with resident concerning the skin tear to her left inner shoulder area 2 x 2 cm with no skin flap or signs of infection. 2. Investigation concluded that the skin tear was not of unknown origin and was caused by a staff member after transferring out of the shower and a fingernail or pressure holding her arm would cause the injury. V16 prior to R2's discharge stated that was the cause of the tear. 3. Staff re-educated on change of condition of skin with investigation and risk management to be initiated right after the event when noted. 4. Education to licensed staff to note and change or new bruising developed with incident tracking for root cause and analysis of any event. 5. Results of the investigation shared to IDPH with final, MD (Medical Doctor), and family notifications. Ombudsman and local police department with notifications, all agreed with the plan of care. 6. Administrator will monitor.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Abuse Prevention and Reporting policy, dated 11/2016, documented Injuries of Unknown Source: For resident injuries not involving an allegation of abuse or neglect, the administrator will appoint a person to gather further facts to make a determination as to whether the injury should be classified as an injury of unknown source. An injury should be classified as an injury of unknown source when both of the following conditions are met: The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury. If classified as an injury of unknown source, the person gathering facts will document the injury, the location and time it was observed, any treatment given and notification of the resident's physician, responsible party. The Department of Public Health will be notified. Time frames for reporting the injury, the location and time it was observed, any treatment given and notification of the resident's physician, responsible party. The appointed investigator will, as a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed along with any pertinent medical records or other documents. The resident's physician and representative, if necessary, shall be notified of any incident or allegation of abuse, neglect, exploitation, mistreatment, or misappropriation of resident property. If the resident complains of physical injuries or if resident harm is suspected, the resident physician will be contacted for further instructions.</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3.R9's Care Plan, dated 10/23/2024, documents that R9 has the potential for alteration in skin condition r/t (related to) impaired mobility/incontinence. It continues Goal: The Resident will not develop a skin injury through next review. Interventions: Administer medications as ordered and monitor for adverse effects. Administer Treatments as ordered. Weekly skin checks. It also documents the resident has the potential for pressure injury development r/t (related to) immobility / incontinence. It continues Administer medications as ordered and monitor for adverse effects. Administer treatments as ordered.</p> <p>R9s Minimum Data Set, dated [DATE], documents that R9 is cognitively intact, has 2 stage III pressure ulcers, and does not reject care.</p> <p>R9's Medication/Treatment Administration Record (MAR/TAR), dated January 2025, documents Cleanse coccyx with generic wound cleanser, pat dry, skin prep periwound, allow to dry, apply hydrocolloid 3 x (times) weekly, MWF (Monday, Wednesday, Friday), and PRN (as needed). every day shift every Mon, Wed, Fri for wound -Start Date 12/06/2024 0700 -D/C (discontinue) date 02/11/2025. There is no documentation on the TAR that R9's treatment was completed on 1/20, 1/27 and 1/29/2025.</p> <p>R9's Progress Notes, dated 2/11/2025 10:31 PM, documents Skin/Wound Note Text: Resident was seen on 2/10/25 by V24, Wound Nurse, for her wounds. She has a stage 3 on her coccyx with moderate serosanguinous drainage noted. It has 100% gran (granulation) tissue. Tx (treatment). of collagen and bordered gauze dressing daily and PRN (as needed). Prealbumin to be done by next visit.</p> <p>R9's Medication/ Treatment Administration Record, dated February 2025, documents Cleanse coccyx with generic wound cleanser, pat dry, skin prep periwound, allow to dry, apply hydrocolloid 3x weekly, MWF, and PRN. every day shift every Mon, Wed, Fri for wound -Start Date 12/06/2024 0700 -D/C Date 02/11/2025 2146. There is no documentation on the MAR/TAR that this treatment was completed on 2/5/25.</p> <p>R9's Medication/Treatment Administration Record, dated February 2025, cleanse coccyx with generic wound cleanser, pat dry, skin prep periwound, allow to dry, apply collagen and bordered gauze daily and PRN. every day shift for wound. -Start Date 02/12/2025 0700. There is no documentation R9 received this treatment on 2/19, 2/21, and 2/22/25.</p> <p>R9's Progress Note, dated 2/19/2025 at 8:36 PM, documents Skin/Wound Note Text: Resident was seen on 2/17/25 by (V24), Wound Nurse, for her wounds. She has a stage 3 on her coccyx with moderate serosanguinous drainage noted. It has 100% necrotic tissue. Tx. (treatment) of Santyl, calcium alginate and bordered gauze dressing daily and PRN. IDT, PCP, and resident updated.</p> <p>R9's Medication/Treatment Administration Record, dated February 2024, documents Santyl Ointment 250 UNIT/GM (Collagenase) Apply to coccyx topically everyday shift for wound Cleanse coccyx with generic wound cleanser, pat dry, skin prep periwound, allow to dry, apply Santyl, calcium alginate and bordered gauze daily and PRN. -Start Date 02/18/2025 0700 -D/C Date 02/23/2025 1802. There was no documentation that R9 received this treatment on 2/19 and 2/22 and 2/23/25.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 4/3/25 at 2:20PM, V4, (Regional Nurse Consultant), stated there have been changes since the change of ownership. V4 stated staffing is a problem, they have gotten 2-3 admissions, and management doesn't come out to help. V4 stated the wounds have gone downhill. V4 stated they have a full-time wound nurse, but she only does rounds with the wound doctor once a week, she doesn't do the wound care any other time, not even the pressure ulcers, which would help. V4 stated that with short staff this causes things to be missed.</p> <p>On 4/9/2025 at 4:05 PM V1, Administrator, stated that she would expect the nurses to sign off the medication/treatment record when the treatment is completed.</p> <p>The facility's Medication Administration policy, dated 5/2025, documents that Policy I. LEVEL OF RESPONSIBILITY: Licensed nurse (RN, LPN) may: a) prepare, b) administer, and c) record the administration of medications (prescription ointments are considered medicines) Medications shall always be prepared, administered, and recorded by the same licensed nurse or CMA. Documentation of medication administration is recorded on the Medication Administration Record (MAR.) or Treatment Record and includes the date, time, time, and initials of the licensed nurse or CMA who administered the medication. II. ADMINISTRATION OF MEDICATIONS: Medications must be administered in accordance with a physician's order, e.g., the right resident, right medication, right dosage, right route, and right time.</p> <p>The facility's Pressure Ulcer Prevention policy, dated 5/2025, documents that the purpose is to prevent and treat pressure sores/pressure injury.</p> <p>Based on interview and record review, the facility failed to assess and identify a residents impaired skin integrity, failed to document weekly skin assessments, and failed to follow physician orders for pressure ulcer treatment for 3 of 4 residents (R7, R9, R14) reviewed for pressure ulcers in a sample of 29. This failure resulted in R7 developing pressure ulcer that upon identification was classified as an unstageable/stage 4, required significant debridement on multiple occasion, osteomyelitis and 7-day hospital stay.</p> <p>The Immediate Jeopardy began on 2/27/25 when the facility failed to assess and treat a high-risk resident who was readmitted on [DATE] without any pressure injuries, resulting in R7 developing a facility acquired unstageable/stage 4 pressure ulcer that was identified on 02/27/25 on her ischial tuberosity with infection present. V6, Crisis Administrator, V32, Mobile Administrator, and V2, Director of Nurses was notified of the Immediate Jeopardy on 4/30/25 at 2:16 PM. The surveyor confirmed by record review and interview that the Immediate Jeopardy was removed on 5/2/2025 but remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.</p> <p>Findings include:</p> <p>1.R7's Face sheet documents R7 was admitted on [DATE] with a readmission date of 4/7/25 with diagnoses of Type 2 Diabetes, other symptoms and signs involving cognitive function and awareness, hydronephrosis, enterococcus, pulmonary embolism, sacrococcygeal disorders, not elsewhere classified, and presence of urogenital implants.</p> <p>R7's Braden scale dated 9/20/2022 obtained during admission assessment, documented a score of 17 indicating R7 is at risk for developing pressure ulcer.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R7's Minimum Data Set (MDS) dated [DATE] documented that R7 is moderately cognitively impaired, no pressure ulcer/injury on admission. The MDS further documents R7 is at risk of developing a pressure ulcer with skin treatments recommended including a pressure reducing device for chair and for bed. R7 is at risk for developing a pressure injury and had no pressure ulcers present.</p> <p>R7's MDS dated [DATE] documents R7 remains at risk for pressure injury but currently has no unhealed pressure wounds.</p> <p>R7's MDS dated [DATE] documented that R7 is severely cognitively impaired, dependent on staff for all activities of daily living (ADL)'s. The MDS documents R7 is incontinent of bladder and bowel and is at risk for pressure ulcers and has one stage 4 pressure ulcers.</p> <p>R7's MDS dated [DATE] documents R7 as moderately impaired cognition and dependent on staff for all ADL's, including turning and repositioning. The section regarding skin conditions documented yes to the question resident has pressure ulcer/injury, a scar over bony prominence, or non-removable dressing, unhealed pressure ulcer.</p> <p>R7's MDS dated [DATE] documents R7's cognition as (left blank), short-term memory ok, no behaviors or inattention, disorganized thinking or altered level of consciousness. R7's MDS further documents R7 is dependent on staff for ADL's, including turning and repositioning.</p> <p>R7's Social Service Note dated 3/6/25 documented R7 has clear speech, understands verbal content with severe impairment memory to recall after 5 minutes.</p> <p>R7's Care Plan dated 10/4/22 documented R7 has the potential for pressure injury development related occasional incontinence and decreased mobility. The goal is the resident will have intact skin, free of redness, blisters, or discoloration. Interventions include to apply skin barrier as needed, educate the resident and family on the causes of skin breakdown, educate the resident/family on the importance of change in position for prevention of pressure injuries, encourage appropriate hydration, encourage increased activity, if the resident refuses positioning, talk with the resident regarding the importance of positioning, maintain clean and dry skin, monitor nutritional status, and document/report changes in skin appearance and color. R7's care plan dated 12/11/2024 documents a potential for pressure injury development. The goal is that she will have intact skin and be free of open areas related to pressure. The interventions include air loss mattress with safety cover bolsters, air pressure redistribution, administer treatments as ordered, assist with position changes on rounds, barrier cream as directed, elevate/float heels while in bed, encourage to avoid lying or sitting on affected area, offer toileting assistance before and after meals, requires pressure relieving reduction devices on bed and chair.</p> <p>R7's Shower sheet dated 2/3/25 documented dry flaky skin but no wounds.</p> <p>R7's Shower sheet dated 2/9/25 documented no wounds.</p> <p>There is no other documentation in R7's Clinical records of R7's skin assessment.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R7's progress notes dated 2/27/25 at 10:57 am documented a Certified Nursing Assistant (CNA), came to nurse this morning, and notified nurse of a right-side coccyx wound/ulcer. Nurse went in to see the coccyx, cleaned it, and covered it. wound nurse notified and informed to look at it. change in condition assessment completed and doctor as well a family updated.</p> <p>R7's progress notes dated 2/27/25 The Change in Condition (CIC) documented a skin wound. The skin status evaluation documented a pressure ulcer/injury. R7 was reported to have pain with the wound. Nursing observations, evaluation, and recommendations are open wound/ulcer on coccyx.</p> <p>R7's Situation, Background, Assessment, Recommendation (SBAR) Summary for Providers dated 2/27/25 at 10:25 AM documents Situation: The Change in Condition/s reported on this CIC Evaluation are/were Skin wound or ulcer.</p> <p>R7's Wound Assessment Details dated 2/27/25 documents: site left ischial tuberosity, active, pressure, ulceration, facility acquired, unstageable, tissue: necrotic soft, adherent 100%, probable decline, size: 5.5 centimeters (cm) x 6.5cm x 0cm, area: 35.75cm, exudate: moderate serosanguineous, odor: yes, signs of infection present: unable to determine.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146026	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/05/2025
NAME OF PROVIDER OR SUPPLIER Arc at Sangamon Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 3400 West Washington Springfield, IL 62711	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R7's Specialized Wound Management Physician Notes dated 3/3/25 document Wound Evaluation and Management Summary. Chief complaint: R7 has a wound on her left ischium and a rash. At the request of the referring provider, a thorough wound care assessment and evaluation was performed today .Past Medical History: atherosclerotic heart disease of native coronary artery with angina pectoris, essential(primary) hypertension, anemia, hyperlipidemia, Type 2 Diabetes mellitus with diabetic neuropathy. Genitourinary- intermittent incontinence, appetite fair, supplements none, no medication found to be affecting wound healing in clinical context. Oriented to person, place, time, and situation, calm and cooperative. Etiology- pressure, MDS 3.0 stage: 4, Duration: greater than one day, Wound size: 9.5 x 7 x not measurable cm, Depth: unmeasurable due to presence of nonviable tissue and necrosis, Surface area: 66.50 cm, Peri wound radius: odor, Exudate: heavy serous, Thick adherent devitalized necrotic tissue: 80%, Granulation tissue: 20%. Additional Wound detail: R7 states she has some type of cancer, dg(diagnosis) not found, not enough information in R7 chart; pending notes from PCP (primary care physician) or oncology; on exam today, no mass noticed on her back, sacrum, or legs. Expanded Evaluation Performed: The development of this wound and the context surrounding the development were considered in greater detail today. Relevant conditions including anemia, malnutrition, infection was considered and addressed through treatment changes or investigations. Thorough review of history performed, including speaking with Nursing staff for further information. Coordination of care and plan for this wound discussed with Nursing staff for further information. Dressing Treatment Plan: Primary dressing(s): sodium hypochlorite solution (Dakin's) and apply twice daily for 30 days; Dakin's sol (solution) &frac14; strength; gauze apply twice daily for 30 days. Secondary Dressing(s) Gauze Island with border apply twice daily for 30 days. Plan of care reviewed and addressed: Recommendations Off load wound; reposition per facility protocol; air cell wheelchair cushion; low air loss mattress. Indication for Procedure: Remove necrotic Tissue and Establish the margins of Viable tissue. Procedure Note: The wound was cleansed with normal saline, and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, 15 blade, pick-ups were used to surgically excise 26. 60cm of devitalized tissue and necrotic muscle level tissues were removed at a depth of 1.2cm and healthy bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 80% to 40%. Hemostasis was achieved and a lean dressing applied. Post operative recommendations and updates to the plan of care are documented in the Assessment and plan section below. Deep swab technique performed on stage 4 pressure wound of the left ischium on 3/3/25. Procedure Today: surgical excisional debridement was performed today on this wound. Additional Recommendations related to performed expanded evaluation: lab name: white blood count (WBC), Deep wound culture, prealbumin.</p> <p>R7's Skin/Wound Note dated 3/3/25 documents: Resident was seen by V24, Wound Physician on 3/3/25 r/t (related to) her wound. R7 has a stage 4 to her left buttock with heavy serous drainage noted. It has 80% necrotic tissue and 20% gran tissue. Treatment of Dakin's moistened kerlix lightly packed in wound, abdominal (ABD) pad and secure with tape twice daily (BID) and as needed (PRN), glycated hemoglobin (HBA1C), prealbumin, complete blood count (CBC), hemoglobin (HGB) and [NAME] Blood Count (WBC) to be done for next visit. Interdisciplinary team (IDT), primary care physician (PCP), power of attorney (POA) and resident aware.</p> <p>R7's Skin/Wound Note dated 3/3/25 documents: Tetracycline 500 milligrams (mg) 1 tab PO twice BID for 14 days and wound culture to be done.</p> <p>R7's Physician orders dated 3/3/25 documented treatment of Dakin's moistened kerlix lightly packed in wound, ABD pad and secure with tape BID and PRN, tetracycline 500mg BID and labs including a wound culture.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R7's Physician order dated 3/3/25 at 9:44 PM documented orders also to apply Santyl ointment to left buttock topically every day and evening shift for wound to left buttocks. Cleanse with normal saline apply Santyl ointment, calcium alginate and bordered gauze BID and PRN.</p> <p>R7's March Treatment Administration Record (TAR) did not document R7 received treatments on 3/6/25(evening), 3/7/25 (morning), 3/8/25 (evening), 3/12/25 (morning) and 3/13/25 (evening). Treatment orders consisted of Apply Dakin's &frac14; strength to left buttock topically every day and evening shift for wound. Cleanse left buttock with generic wound cleanser, pat dry, skin prep peri wound, allow to dry, pack wound lightly with Dakin's moistened kerlix, ABD pad and secure with tape BID and PRN.</p> <p>R's Physician orders dated 3/3/25 documented an order for a wound culture.</p> <p>R7's Wound Assessment Details dated 3/7/25 documents: site: left ischial tuberosity, active, pressure, ulceration, facility acquired, date identified: 2/27/25 healed stage 4, tissue: bright beefy red; 20%, necrotic soft, adherent 80%, has been debrided: no, probable decline, size: 9.5cm x 7.0cm x 0cm, area: 66.5cm, exudate: heavy serosanguineous, odor: yes, signs of infection present: yes. Is patient on antibiotic: no. Although R7's physician Order Sheet documents R7 was on antibiotic.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R7's Specialized Wound Management Physician Notes dated 3/10/25 document Wound Evaluation and Management Summary. Chief complaint: R7 has a wound on her left ischium and a rash. At the request of the referring provider, a thorough wound care assessment and evaluation was performed today .Past Medical History: atherosclerotic heart disease of native coronary artery with angina pectoris, essential(primary) hypertension, anemia, hyperlipidemia, Type 2 Diabetes mellitus with diabetic neuropathy. Genitourinary- intermittent incontinence, appetite fair, supplements none, no medication found to be affecting wound healing in clinical context. Oriented to person, place, time, and situation, calm and cooperative. Focused Wound Exam (Site 1) Stage 4 Pressure wound of the left ischium full thickness: Etiology- pressure, MDS 3.0 stage: 4, Duration: greater than 8 days, Wound size: 9.5 x 6.5 x not measurable cm, Depth: unmeasurable due to presence of nonviable tissue and necrosis, Surface area: 62.70 cm, Exudate: heavy serous sanguinous, Thick adherent devitalized necrotic tissue: 70%, Granulation tissue: 30%. Additional Wound detail: Recommend increase protein intake with each meal and addition supplements three times a day, pending notes from PCP or oncology, importance of performing the dressing as per order discussed with rounding nurse. Expanded Evaluation Performed: The development of this wound and the context surrounding the development were considered in greater detail today. Patient not following reposition or offloading recommendations and counseling provided. Impaired nutritional status discussed with patient, family, nursing staff and/or dietician. Recommend consult/reconsult with dietician to review current nutritional status. Reviewed offloading surfaces and discussed surfaces care plan. Thorough review of history performed, including speaking with Nursing staff for further information. Coordination of care and plan for this wound discussed with Nursing staff for further information. Dressing Treatment Plan: Primary dressing(s): sodium hypochlorite solution (Dakin's) and apply twice daily for 23 days; Dakin's sol (solution) &frac14; strength; gauze apply twice daily for 23 days. Secondary Dressing(s) Gauze Island with border apply twice daily for 23 days. Plan of care reviewed and addressed: Recommendations Off load wound; reposition per facility protocol; pillow cushion; low air loss mattress. Site 1: Surgical Indication Debridement Procedure: Indication for procedure: Remove necrotic Tissue and Establish the margins of Viable tissue. Procedure Note: The wound was cleansed with normal saline, and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, 15 blade, pick-ups were used to surgically excise 25.08cm of devitalized tissue and necrotic muscle level tissues were removed at a depth of 1.5cm and healthy bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 70% to 30%. Hemostasis was achieved and a clean dressing applied. Post operative recommendations and updates to the plan of care are documented in the Assessment and plan section below. Investigations: Recommended and/or Reviewed: Deep wound culture pending on pressure wound of the ischium as of 3/10/25.</p> <p>R7's Skin/Wound Note dated 3/10/25 documents: Resident was seen by V24 on 3/10/25 r/t (related to) her wound. R7 has a stage 4 to her left buttock with heavy serous drainage noted. It has 70% necrotic tissue and 30% gran tissue. It has improved. Tx. Of Dakin's moistened kerlix lightly packed in wound, ABD pad and secure with tape IDT, PCP, and POA and resident aware. There is no documentation regarding the wound culture.</p> <p>R7's Wound Assessment Details dated 3/13/25 documents: site: left ischial tuberosity, active, pressure, ulceration, facility acquired, date identified: 2/27/25 healed stage 4, tissue: bright beefy red; 30%, necrotic soft, adherent 70%, has been debrided: no, probable improvement, size: 9.5cm x 6.6cm x 0cm, area: 62.7cm, exudate: heavy serosanguineous, odor: yes, signs of infection present: yes. Is patient on antibiotic: no.</p> <p>R7's shower sheet dated 3/13/25 documents R7 did not have any wounds.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R7's Specialized Wound Management Physician Notes dated 3/17/25 documented Wound Evaluation and Management Summary. Chief complaint: R7 has a wound on her left ischium and a rash. At the request of the referring provider, a thorough wound care assessment and evaluation was performed today .Past Medical History: atherosclerotic heart disease of native coronary artery with angina pectoris, essential(primary) hypertension, anemia, hyperlipidemia, Type 2 Diabetes mellitus with diabetic neuropathy. Genitourinary- intermittent incontinence, appetite fair, supplements none, no medication found to be affecting wound healing in clinical context. Oriented to person, place, time, and situation, calm and cooperative. Focused Wound Exam (Site 1) Stage 4 Pressure wound of the left ischium full thickness: Etiology- pressure, MDS 3.0 stage: 4, Duration: greater than 15 days, Wound size: 9.5 x 6.3 x not measurable cm, Depth: unmeasurable due to presence of nonviable tissue and necrosis, Surface area: 59.85 cm, Exudate: heavy serous sanguinous, Thick adherent devitalized necrotic tissue: 50%, Granulation tissue: 50%. Additional Wound detail: Wound culture not performed yet, discussed with rounding nurse . Dressing Treatment Plan: Primary dressing(s): sodium hypochlorite solution (Dakin's) and apply twice daily for 16 days; Dakin's sol (solution) &frac14; strength; gauze apply twice daily for 16 days. Secondary Dressing(s) Gauze Island with border apply twice daily for 16 days. Plan of care reviewed and addressed: Recommendations Off load wound; reposition per facility protocol; air cell wheelchair cushion; low air loss mattress. Site 1: Surgical Indication Debridement Procedure: Indication for procedure: Remove necrotic Tissue and Establish the margins of Viable tissue. Procedure Note: The wound was cleansed with normal saline, and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, 15 blade, was used to surgically excise 17.96 cm of devitalized tissue and necrotic periosteum and bone were removed at a depth of 1.6cm and healthy bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 50% to 20%. Hemostasis was achieved and a clean dressing applied. Post operative recommendations and updates to the plan of care are documented in the Assessment and plan section below. Investigations: Recommended and/or Reviewed: Deep wound culture pending on pressure wound of the ischium as of 3/17/25.</p> <p>R7's progress note dated 3/17/25 at 9:31 pm documented resident was seen by V24 on 3/17/25 related to her wound. She has a stage 4 to her left buttock with heavy serous drainage noted. It has 50% necrotic tissue and 50% granulated tissue. It has improved. Treatment. of Dakin's moistened kerlix lightly packed in wound, ABD pad and secure with tape BID. There is no documentation for the wound culture.</p> <p>R7's Wound Assessment Details dated 3/20/25 documents: site: left ischial tuberosity, active, pressure, ulceration, facility acquired, date identified: 2/27/25 healed stage 4, tissue: bright beefy red; 50%, necrotic soft, adherent 80%, has been debrided: no, probable improvement, size: 9.5cm x 6.3cm x 0cm, area: 59.85cm, exudate: heavy serosanguineous, odor: yes, signs of infection present: yes. Is patient on antibiotic: no.</p> <p>R7's Dietary note dated 3/21/25 documents Diet: Low Concentrated Sweet (LCS), Regular, Thin; fortified ice cream four times per day (QID); liquid protein Intake: 50-100% Skin: Stage 4 wound on left ischial tuberosity Review: Resident is eating 50-100%of meals. Stage 4 wound noted, receiving liquid protein and fortified ice cream for wound as of 3/21/25.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R7's Specialized Wound Management Physician Notes dated 3/24/25 document Wound Evaluation and Management Summary. Chief complaint: R7 has a wound on her left ischium and a rash. At the request of the referring provider, a thorough wound care assessment and evaluation was performed today .Past Medical History: atherosclerotic heart disease of native coronary artery with angina pectoris, essential(primary) hypertension, anemia, hyperlipidemia, Type 2 Diabetes mellitus with diabetic neuropathy. Genitourinary- intermittent incontinence, appetite fair, supplements multivitamins, protein, no medication found to be affecting wound healing in clinical context. Oriented to person, place, time, and situation, calm and cooperative. Focused Wound Exam (Site 1) Stage 4 Pressure wound of the left ischium full thickness: Etiology- pressure, MDS 3.0 stage: 4, Duration: greater than 22 days, Wound size: 9.5 x 8 x not measurable cm, Depth: unmeasurable due to presence of nonviable tissue and necrosis, Surface area: 76.00 cm, Peri wound radius: odor, Exudate: heavy serous sanguinous, Thick adherent devitalized necrotic tissue: 40%, Granulation tissue: 40%. Other viable tissues: 20% (bone) Additional Wound detail: Wound culture report never received. Performed another one today. Expanded Evaluation Performed: The progress of this wound and the context surrounding the progress were considered in greater detail today counseling offered to optimize wound healing and relevant conditions (or possible conditions) were addressed through management changes or investigation regarding conditions including anemia, noncompliance, malnutrition. Patient not following reposition or offloading recommendations and counseling provided. Impaired nutritional status discussed with patient, family, nursing staff and/or dietician. Recommend consult/reconsult with dietician to review current nutritional status. Medications affecting wound healing reviewed and considered. Reviewed offloading surfaces and discussed surfaces care plan. Coordination of care and plan for this wound discussed with Nursing staff for further information. Dressing Treatment Plan: Primary dressing(s): sodium hypochlorite solution (Dakin's) and apply twice daily for 9 days; Dakin's sol (solution) &frac14; strength; gauze apply twice daily for 9 days. Secondary Dressing(s) Gauze Island with border apply twice daily for 9 days. Plan of care reviewed and addressed: Recommendations Off load wound; reposition per facility protocol; air cell wheelchair cushion; low air loss mattress. Site 1: Surgical Indication Debridement Procedure: Indication for procedure: Remove necrotic Tissue and Establish the margins of Viable tissue. Procedure Note: The wound was cleansed with normal saline, and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, 15 blade, pick-ups were used to surgically excise 7.60cm of devitalized tissue and necrotic periosteum and bone were removed at a depth of 1.6cm and healthy bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 40% to 30%. Hemostasis was achieved and a clean dressing applied. Post operative recommendations and updates to the plan of care are documented in the Assessment and plan section below. Investigations: Recommended and/or Reviewed: Deep wound culture technique cancelled on stage 4 pressure wound of the left ischium on 3/24/25 (R7's record did not document the 3/3/25 orders result and thus cancelled on 3/24/25) Prealbumin recommended on 3/24/25. Deep swab technique performed on stage 4 pressure wound of the left ischium on 3/24/25.</p> <p>R7's progress note dated 3/24/25 at 9:57 pm documented R7 was seen by V24 on 3/24/25 related to her wound. She has a stage 4 to her left buttock with heavy serous drainage noted. It has 40% necrotic tissue, 20% bone and 40% granulation tissue. It has exacerbated. R7 is noncompliant with off-loading wound and with wound care. Treatment of Dakin's moistened kerlix lightly packed in wound, ABD pad and secure with tape BID and PRN. Prealbumin and a deep swab performed and collected to be done for next visit.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R7's progress notes dated 3/26/25 documents R7 received intravenous infusion of Derma IV-DRIPT IV therapy infusion (500.9% normal saline with 5 gm Vitamin C, B Complex, biotin 10 mg, Arg 300 mg, Om150mg, [NAME] 150mg, Cit 150 mg and zinc 10 mg.) due to Acute/Chronic Wounds It continues to document R7 received intravenous (IV) infusion d/t acute/chronic wounds. No adverse reaction noted upon post IV infusion. no bruising noted at IV site.</p> <p>R7's Wound Assessment Details dated 3/29/25 documents: site: left ischial tuberosity, active, pressure, ulceration, facility acquired, date identified: 2/27/25 healed stage 4, tissue: bright beefy red; 50%, necrotic soft, adherent 50%, has been debrided: no, probable improvement, size: 9.5cm x 7.0cm x 0cm, area: 66.5cm, exudate: heavy serosanguineous, odor: yes, signs of infection present: yes. Is patient on antibiotic: no.</p> <p>R7's shower sheet 3/31/25 documents shower given and no wounds present.</p> <p>R7's Specialized Wound Management Physician Notes dated 3/31/25 document the patient visit had been rescheduled. R7 not in the facility currently.</p> <p>R7's Specialized Wound Management Physician Notes dated 4/7/25 document the patient not seen due to wound related hospitalization since last visit.</p> <p>R7's Wound Assessment Details dated 4/10/25 documents: site: left ischial tuberosity, active, pressure, ulceration, facility acquired, date identified: 2/27/25, unstageable, tissue: slough non adherent 10%, necrotic soft, adherent 90%, has been debrided: yes, probable decline, size: 10cm x 6.0cm x 0cm, area: 60.00cm, exudate: heavy purulent and malodorous , odor: yes, signs of infection present: yes. Is patient on antibiotic: no.</p> <p>R7's Laboratory Report dated 4/1/25 documents a wound culture with gram stain was collected on 3/25/25 with final report of heavy growth of proteus mirabilis and light growth of enterococcus faecalis. The Sensitivity report to medications does not indicate tetracycline, that was ordered for R7 on 3/3/25, as medication of choice sensitive to organisms.</p> <p>R7's Progress notes dated 3/25/25 document R7 making loud moaning sound. Upon entering room, observe pt lying in bed with pillows surrounding her, lifted slightly off left hip. Call bell in reach. R7 stated Why won't anyone help me? Writer instructed that R7 has not used her call bell to alert any staff that she wanted or needed any help. R7 looked directly at call bell that was laying by her right hand on the bed and stated, I'm so weak Offered pain medication and R7 opened her mouth as in wanting pill dropped in. Asked R7 why she wasn't holding the pill cup and R7 stated I'm so weak in my legs.</p> <p>R7's Progress notes dated 3/26/25 documents R7 continues to hold on to call bell but instead is hollering out and becomes agitated that no one answers her. Writer has explained on each occasion that she should be using call bell because staff cannot always hear her yells.</p> <p>R7's Progress note dated 3/26/25 documents R7 received IV infusion d/t acute/chronic wounds. No adverse reaction noted upon post IV infusion. no bruising noted at IV site.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R7's Follow up assessment post fall note dated 4/1/25 documents R7 is alert and orientated. R7 has sad worried facial expression. Pain scale 3 of 10, R7 has chronic pain though nights d/t hip wound. R7 has preexisting wound to hip.</p> <p>R7's IDT note dated 4/1/25 documents Late entry: Root cause for fall on 4/1: R7 restless in bed due to pain. R7 sent to hospital per R7 and family request for pain control brief Interview for Mental Status (BIMS) 12. Care plan updated. Medical Doctor (MD) and POA aware.</p> <p>R7's Nursing Note dated 4/1/25 documents R7 grandson came to writer and reported that he overheard a female not talking very k[TRUNCATED]</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to complete incident investigations, root cause analysis of skin tears, and failed to implement interventions as documented on resident care plans to reduce the risk of further skin tears and/or falls for 3 of 3 residents (R2, R10, R13) reviewed for supervision to prevent accidents in the sample of 29.</p> <p>Findings Include:</p> <p>1.R2's face sheet, print date of 4/1/25, documented R2 has diagnoses including stage 4 pressure ulcer of sacral region, methicillin susceptible staphylococcus aureus infection, metabolic encephalopathy, unspecified dementia, stable burst fracture of T11-T12 vertebra, hyperlipidemia, hypertension, atrial fibrillation, hyposmolality, and hyponatremia.</p> <p>R2's MDS (Minimum Data Set), dated 4/2/25, documented R2 is severely cognitively impaired and is dependent on staff for all ADLS (Activities of Daily Living).</p> <p>On 4/1/25 at 9:13 AM V15, R2's granddaughter, stated R2 developed a skin tear to her left upper arm and left hand during her two weeks stay at the facility.</p> <p>On 4/1/25 at 10:13 AM V16, daughter/POA (Power of Attorney), stated R2 developed a skin tear on her left upper arm around the middle of last week. V16 stated the skin tear was uncovered for a couple of days and then over the weekend it had a dressing over it. V16 stated R2 told her a CNA (Certified Nurse Assistant) was rough with her during her shower resulting in the skin tear. V16 stated this is the 3rd skin tear R2 has sustained at the facility since she was admitted on [DATE]. R2 was present during this interview and stated the CNAS are rough, and I think it happened during my bath. Surveyor observed an approximate 2 x 2 skin tear with pink tissue exposed to R2's left upper arm.</p> <p>On 4/1/25 at 10:27 AM V9 CNA (Certified Nurse Assistant) stated R2's arm had a dressing on it when she first saw her this morning and the dressing was off the second time, she went into R2's room. V9 stated she told the nurse, and the nurse informed her she couldn't do anything about it right now. V9 stated that nurse is already off for the day and now her nurse is V10. V9 stated she does not know how R2's skin tear occurred.</p> <p>On 4/1/25 at 10:29 AM V10 LPN (Licensed Practical Nurse) stated she is now R2's nurse and she did not know R2 has a skin tear.</p> <p>On 4/1/25 at 10:31 AM V11 CNA stated she does not know anything about R2's skin tears.</p> <p>On 4/1/25 at 11:25 AM V16 stated she found a fresh skin tear to R2's left hand last weekend and that R2 told her it was from the CNA putting the handrail down on her hand. Surveyor observed an approximate quarter sized skin tear on R2's left hand. R2 was unable to recall the cause of this skin tear at the time of this interview.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Arc at Sangamon Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 3400 West Washington Springfield, IL 62711	
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/1/125 at 11:28 AM V10 LPN stated she just applied a dressing to R2's left upper arm. V10 stated she does not know the cause of R2's skin tear and the nurse who initially found the skin tear should have completed an incident report for it.</p> <p>On 4/1/25 at 11:43 AM V4, Regional Nurse Consultant, stated the facility does not have any documentation of R2's skin tear and the facility will initiate an unknown injury investigation into it.</p> <p>The facility's Final Abuse Investigation Report, dated 4/7/25, documented R2 had a shower on 3/28/25 and that a CNA stated she was transferring R2 and accidentally caused a skin tear to R2's left inner shoulder area with her fingernail as she was assisting her to re-position in the shower chair. Area was reported to nurse on duty which was an agency nurse, and she did treat and cover the area but did not do the skin change of condition which would have documented and recorded the episode. It continues, staff re-educated on change of condition of skin with investigation and risk management to be initiated right after the event when noted. Education to licensed staff to note and change or new bruising developed with incident tracking for root cause and analysis of any event.</p> <p>2.R10's face sheet, print date of 4/3/25, documented R10 has diagnoses including dementia with behavioral disturbance, hypertensive heart and chronic kidney disease, macular degeneration, dysphagia, and gastroesophageal reflux disease.</p> <p>R10's MDS, dated [DATE], documented R10 is severely cognitively impaired.</p> <p>R10's care plan, undated, documented R10 has the potential for alteration in skin condition related to altered mobility, dementia, and incontinence. R10's skin care plan was last updated with skin tear prevention interventions on 12/8/24.</p> <p>R10's progress note, dated 2/25/25 at 8:50 PM, documented new skin tear to rear RLE (right lower extremity), resident says she bumped it on WC (wheelchair); MD notified; New order given to cleanse with wound cleanser, pat dry with gauze, cut xeroform to fit open area, apply xeroform to open area; cover with bordered gauze, change daily and prn (as needed).</p> <p>R10's progress note, dated 3/10/25 at 2:52 PM, documented skin tear to L (left) upper thigh, resident, and CNA unsure how it happened; MD and POA (Power of Attorney) notified; communication sent to wound nurse.</p> <p>R10's progress note, dated 3/18/25 at 8:05 PM, documented CNA reported to this writer resident had s/t (skin tear) of rear L shoulder received while being combative with HS (evening) cares. This writer assessed s/t, notified MD, POA, & wound nurse, cleansed & dressed wound.</p> <p>On 4/3/25 at 2:03 PM V2, DON (Director of Nursing), stated she did not add any interventions to R10's care plan after her skin tears on 2/25/25, 3/18/25, nor 3/31/25.</p> <p>3. R13's face sheet, print date of 4/3/25, documented R13 has diagnoses including heart failure, emphysema, history of left femur fracture, history of right fibula fracture, collapsed vertebra, peripheral vascular disease, diabetes mellitus, and atherosclerotic heart disease.</p> <p>R13's MDS, dated [DATE], documented R13 is mildly cognitively impaired.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R13's fall risk assessment, dated 3/6/25, documented R13 is high risk for falls.</p> <p>R13's care plan, undated, documented R13 is at risk for falls related to history of falls with fractures, poor safety awareness, use of high-risk medications, and compromised cardiorespiratory status. This care plan documents interventions including call don't fall sign placed in the room (date initiated 5/3/24), motion sensor placed in room (date initiated 3/17/25), and dycem to wheelchair (date initiated 7/1/24).</p> <p>R13's progress note, dated 1/3/25 at 7:20 PM, documented time of incident 1/3/25 at 6:40 PM, resident was sitting on floor in bathroom on buttocks with legs stretch out in front of toilet and head towards the sink in an upright position.</p> <p>R13's progress note, dated 1/5/25 at 1:47 PM, documented staff heard a noise and Ow from pt. (patient) room. Observed pt. sitting on floor with back resting on wardrobe door, legs in front of body, with w/c pulled down over his legs. Pt. was holding onto the wheelchair handles. Once croc style shoe on, one under the front of the w/c. Pt. stated, I was turning to reach the shoe and over I went.</p> <p>R13's progress note, dated 1/8/25 at 4:03 PM, documented resident observed sitting on the floor on buttocks with legs stretched out in front of toilet and head toward the sink. Writer assessed and had resident move all extremities and was able to without pain or discomfort.</p> <p>R13's local hospital emergency room records, dated 1/8/25, documented falls; head injury; lumbar pain; shoulder pain. History of Present Illness: PMH (prior medical history) of falls, it continues presents with EMS (Emergency Medical Services) from NH (nursing home) for 3 falls this week. Struck his head earlier in week, today hit right shoulder on door, and lumbar pain from earlier fall as well.</p> <p>R13's physician progress note, dated 3/6/25, documented frequent falls - continue PT/OT (Physical Therapy/Occupational Therapy) to gain strength, balance, and endurance. Continue to use assistive devices to safely complete ADLs. Fall precautions in place.</p> <p>R13's progress note, dated 3/15/25 at 12:15 PM, documented resident sustained a fall. The incident occurred in the resident room. Resident is alert and oriented to time, person, place, and situation. No changes in range of motion from normal baseline.</p> <p>R13's progress note, dated 3/15/25 at 12:17 PM, documented observed laying on floor between closet and wc; denies pain; vs (vital sign) wnl (with in normal limit), rom (range of motion) wnl, md notified. Said he was leaning on wc to change his pants and the wc fell.</p> <p>R13's progress note, dated 3/17/25 at 10:22 AM, documented IDT (Interdisciplinary Team), Root Cause; resident was leaning on W/C to change his pants causing him to fall. Resident has a history of being non-compliant with fall and safety interventions. He previously had a wheelchair seat belt; however, he became non complaint with it and refused to keep it buckled. The seat belt was removed related to patient request and documented non-compliance. Intervention: Motion sensor alarm installed in room. Care plan updated.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R13's progress note, dated 3/18/25 at 9:21 PM, documented resident sustained a fall on 3/18/25 at 1:00 PM. The incident occurred in the resident room. Resident is alert and oriented to time, person, place, and situation. It continues, a new skin concern or change in skin condition noted new orders received to cleanse skin tear with wound cleanser, apply xeroform to open area, cover with bordered gauze, change daily and PRN until healed.</p> <p>R13's progress note, dated 3/29/25 at 2:00 PM documented resident sustained a fall on 3/29/25 at 2:00 PM. This incident occurred in the resident room. Resident is alert and oriented. No changes in range of motion from normal baseline.</p> <p>R13's progress note, dated 3/30/25 at 9:42 AM, documented 72-hour charting follow up, post fall assessment. It continues, new injury noted on assessment. L ankle swollen, bruised, tender to touch.</p> <p>On 4/7/25 at 10:51 AM surveyor observed R13 sitting on his bed. R13 did not have a motion alarm, no dycem was observed in his wheelchair, and no call, don't fall sign was observed anywhere in R13's room nor bathroom. R13 stated he does not have an alarm. V18, CNA, was present in R13's room during this observation and V18 stated R13 does not have an alarm, sign, nor dycem in his wheelchair. V18 stated she is not aware of what fall precautions R13 is to have in place.</p> <p>On 4/7/25 at 11:12 AM V2, DON, stated R13 is supposed to have a non-slip pad in his wheelchair, a call don't fall sign on his wall, and stated she was not sure if R13 is still supposed to have the motion monitor in his room or not.</p> <p>On 4/7/25 at 1:06 PM, V2 stated she expects the facility nurses and CNAS to report injuries of unknown origin to management so an investigation can be completed, and to complete an incident report on all skin tears, injuries, and falls. V2 also stated all interventions should be in place according to the resident's care plan including fall interventions.</p> <p>The facility's Skin Condition Assessment & Monitoring - Pressure and Non-Pressure policy, dated 11/2012, documented Purpose: To establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown, pressure injuries and other non-pressure skin conditions and assuring interventions are implemented. Non-pressure skin conditions (bruises/contusions, abrasions, lacerations, rashes, skin tears, surgical wounds, etc.) will be assessed for healing progress and signs of complications or infection weekly. It continues, residents 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 and/or other non-pressure skin conditions are identified by licensed nurse. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment. Care givers are responsible for promptly notifying the charge nurse of skin breakdown.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Fall Prevention Program policy, dated 11/2012, documented Purpose: To assure the safety of all residents in the facility, when possible. The program will include measure which determine the individuals needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Guidelines: The Fall Prevention Program includes the following components: methods to identify risk factors, methods to identify residents at risk, educate resident and resident representative to fall prevention program at time of admission, throughout residents stay, and when changes occur, assessment time frames, use and implementation of professional standards of practice, immediate change in interventions that were unsuccessful, notification of physician, family/legal representative. It continues, care plan incorporates: Identification of all risk/issues, addresses each fall, interventions are changed with each fall as appropriate, and preventative measures.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure sufficient nursing staff to provide nursing and related services to meet the residents' needs for 3 of 29 residents (R9, R16, R17) reviewed for staffing.</p> <p>Findings include:</p> <p>1. On 4/1/2025 1:50 PM V12, Certified Nurse's Assistant (CNA), stated that that food is late a lot. V12 stated that the residents complain about the food being cold. V12 stated that the food is cold. V12 stated that they are frequently warming up food using the microwave on the hall. V12 stated that they have staffing problems. V12 stated that they work together and get everything done but it takes longer to get it done. It takes longer to pass trays when there are 2 staff and 1 is caring for someone and the other is passing the trays or care. It may take longer to get to a resident than it would if there were more staff.</p> <p>R16's Minimum Data Set (MDS) dated [DATE], documents that R16 is moderately cognitively impaired.</p> <p>On 4/1/2025 the facility provided a document that indicated R16 was interview able.</p> <p>R16's Progress Note, dated 3/31/2025 at 3:19 PM, documents Skilled Charting Narrative: Mental Status: Resident is alert. Oriented to: Oriented to Person, place, time, and situation. Short-term memory impairment.</p> <p>On 4/1/2025 at approximately 2:30 PM R16 stated that her food was not hot. R16 stated that it was lukewarm. R16 stated that it was not ice cold, but it surely was not hot. R16 stated that she has not had hot food at the facility. R16 stated that the food was very late and that she did not get her food until after 1:00 PM and surely the food would not be hot. R16 stated that they don't have enough staff here. R16 stated that the wait time for everything is very long as you can see it was almost 2:00 PM when the trays were served.</p> <p>2. R17's MDS, dated [DATE] documents that R17 is cognitively intact.</p> <p>On 4/1/2025 at approximately 2:35 PM, R17 stated that her food was delivered after 1:00 PM today and was cold. R17 stated that the food is horrible it's always cold and if you send it back then it takes forever to get the food back. R17 stated that they don't have enough staff. R17 stated that this is not new. R17 stated that it can take an hour to get care, food, anything if it gets done at all.</p> <p>3. R9's Minimum Data Set, dated [DATE], documents that R9 is cognitively intact, has 2 stage III pressure ulcers, and does not reject care.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R9's Medication/Treatment Administration Record (MAR/TAR), dated January 2025, documents Cleanse coccyx with generic wound cleanser, pat dry, skin prep periwound, allow to dry, apply hydrocolloid 3 x (times) weekly, MWF (Monday, Wednesday, Friday), and PRN (as needed). every day shift every Mon, Wed, Fri for wound -Start Date 12/06/2024 0700 -D/C (discontinue) date 02/11/2025. There is no documentation on the TAR that R9's treatment was completed on 1/20, 1/27 and 1/29/2025.</p> <p>R9's Medication/ Treatment Administration Record, dated February 2025, documents Cleanse coccyx with generic wound cleanser, pat dry, skin prep periwound, allow to dry, apply hydrocolloid 3x weekly, MWF, and PRN. every day shift every Mon, Wed, Fri for wound -Start Date 12/06/2024 0700 -D/C Date 02/11/2025 2146. There is no documentation on the MAR/TAR that this treatment was completed on 2/5/25.</p> <p>R9's Medication/Treatment Administration Record, dated February 2025, cleanse coccyx with generic wound cleanser, pat dry, skin prep periwound, allow to dry, apply collagen and bordered gauze daily and PRN. everyday shift for wound. -Start Date 02/12/2025 0700. There is no documentation R9 received this treatment on 2/19, 2/21, and 2/22/25.</p> <p>R9's Medication/Treatment Administration Record, dated February 2024, documents Santyl Ointment 250 UNIT/GM (Collagenase) Apply to coccyx topically everyday shift for wound Cleanse coccyx with generic wound cleanser, pat dry, skin prep periwound, allow to dry, apply Santyl, calcium alginate and bordered gauze daily and PRN. -Start Date 02/18/2025 0700 -D/C Date 02/23/2025 1802. There was no documentation that R9 received this treatment on 2/19 and 2/22 and 2/23/25.</p> <p>On 4/3/25 at 2:20PM, V4, LPN, stated there have been changes since the change of ownership. V4 stated staffing is a problem, they have gotten 2-3 admissions, and management doesn't come out to help. V4 stated the wounds have gone downhill. V4 stated they have a full-time wound nurse, but she only does rounds with the wound doctor once a week, she doesn't do the wound care any other time, not even the pressure ulcers, which would help. V4 stated on Monday 3/31/25, she was supposed to be off at 3PM, at 3:15PM, her relief had not shown up and she knew she wasn't going to because her relief was starting a new schedule and wasn't supposed to work until Tuesday, 4/2/25. V4 stated she notified V2, DON, that her relief hadn't shown up and V2 told her okay she would check on it. At 4:00PM, V4's relief still hadn't shown up, she went to V2 and was told oh I forgot and my relief was made to come in at 6:30PM. V4 stated they needed more staff, it's not the quality of staff, it's that they don't have enough.</p> <p>On 4/7/2025 at 6:48 PM V2, Director of Nursing, stated that We don't have an actual staffing policy. We follow CMS (Centers for Medicare & Medicaid Services) guidelines.</p>		

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NAME OF PROVIDER OR SUPPLIER Arc at Sangamon Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 3400 West Washington Springfield, IL 62711	

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>Based on interview, and record review, the facility failed to provide consecutive 8-hour Registered Nurse (RN) coverage in the facility. This has the potential to affect all 122 residents residing in the facility.</p> <p>Finding includes:</p> <p>The Facility Schedule for March of 2025 documents no consecutive 8-hour RN coverage in 24 hours for the following dates: 3/7, 3/14, 3/21, and 3/31/25.</p> <p>On 4/3/2025 at 12:50 PM V1, Administrator, stated that they are actively hiring staff. V1 stated that they have recently hired 31 staff. V1 stated that they are giving bonuses for nurses and increased wages. V1 stated that she is performing open interviews and accommodating schedules.</p> <p>On 4/1/2025 the facility provided a list, dated 4/1/2025 at 10:04 AM, documents that census is 122.</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide residents with food that was served a palatable temperature for 3 of 5 residents (R16, R17, and R18) reviewed for food palatability in the sample of 29.</p> <p>Findings include:</p> <p>1. R16's Minimum Data Set (MDS) dated [DATE], documents that R16 is moderately cognitively impaired.</p> <p>On 4/1/2025 the facility provided a document that indicated R16 was interview able.</p> <p>R16's Progress Note, dated 3/31/2025 at 3:19 PM, documents Skilled Charting</p> <p>Narrative: Mental Status: Resident is alert. Oriented to: Oriented to Person, place, time, and situation. Short-term memory impairment.</p> <p>On 4/1/2025 at approximately 2:30 PM R16 resided on the 500-hall and received a hall tray. R16 stated that her food was not hot. R16 stated that it was lukewarm. R16 stated that it was not ice cold, but it surely was not hot. R16 stated that she has not had hot food at the facility. R16 stated that the food was very late and that she did not get her food until after 1:00 PM and surely the food would not be hot.</p> <p>2. R17's MDS, dated [DATE] documents that R17 is cognitively intact.</p> <p>On 4/1/2025 at approximately 2:35 PM, R17 resided on the 500-hall. R17 stated that her food was delivered after 1:00 PM today and was cold. R17 stated that the food is horrible it's always cold and if you send it back then it takes forever to get the food back.</p> <p>3. R18's MDS, dated [DATE] documents that R18 is cognitively intact.</p> <p>On 4/1/2025 at 10:00 AM R18 stated that the food is always delivered cold. R18 stated that the food is never hot.</p> <p>4. On 4/1/2025 at 11:30 AM food temperatures were taken on the steam table and with a calibrated digital thermometer and registered 121.8 degrees Fahrenheit (F), the carrots registered at 190 degrees F, mash potatoes 150.8 degrees F, gravy registered 179.2 degrees f, and meatballs registered at 158.0 degrees F and at 12:40 PM a second batch of meatballs registered at 159.6 degrees F.</p> <p>On 4/1/25 at 12:50 PM the 500-hall tray cart was started. At 1:14 PM the 500 Hall Cart was started. After the last resident tray was placed on hall tray cart a surveyor test tray was placed on the cart. At 1:40 PM after the last resident was served a surveyor test tray was temped. Using a calibrated digital thermometer the meat registered 118.1 degrees F, the mash potatoes 111.3 degrees F and the carrots registered at 116.3 degrees F. The test tray was tasted and was cold. The food cart did not have a thermometer in place and the food was not temped after the food arrived on the 500-hall.</p> <p>(continued on next page)</p>		

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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)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/1/2025 at 11:35 AM V5 dietary aide/cook, stated that the food is prepared and temped in the kitchen and then brought out to the steam table. V5 stated that she does not temp the food at all while on the steam table.</p> <p>On 4/1/2025 V12, Certified Nurse's Assistant (CNA), stated that that food is late a lot. V12 stated that the residents complain about the food being cold. V12 stated that the food is cold. V12 stated that they are frequently warming up food using the microwave on the hall.</p> <p>On 4/7/2025 at 10:12 AM V1, Administrator, stated that they had electrical problems with the steam table on 500-hall. V1 stated that they are working to get it fixed. V1 stated that it should be up and running shortly.</p> <p>The Facility's Monitoring Food Temperatures for Meal Service, dated 9/2024, documents Guideline: Food temperatures will be monitored to prevent foodborne illness and ensure foods are served at palatable temperatures. 3. Proper procedures are followed to ensure that food temperatures are accurately) and safely obtained according to safe food handling practices. These procedures include the following steps: g. Meals that are served on room trays may be periodically checked at the point of service for palatable food temperatures. Food temperatures of hot foods on room trays at the point of service are preferred to be at 120&deg;F or greater to promote palatability for the resident. Any complaint regarding food temperatures by residents</p> <p>will be documented on the Food Temperature Log. Complaints will be investigated by conducting a test tray for that meal to determine if foods are remaining above 120&deg;F. The investigation is recommended to be completed within 72 hours of the complaint.</p> <p>The facility's Maintaining Food Temperatures During Transportation, dated 11/2024, documents Policy: Food temperatures will be maintained during transportation to prevent food borne illness. 4. Food will be placed in appropriate containers, put into the food carriers, and transported in clean trucks. The internal temperature of the food will be taken: Before the food is placed in the food carrier o After the food is received at the remote site.</p>		