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	05/15/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a baseline care plan within the first 48 hours of admission to the facility and failed to provide the baseline care plan to the resident within 48 hours of admission for 1 of 4 residents (R11) reviewed for baseline care plans in the sample of 16. Findings Include: R11's clinical census sheet, print date of 5/13/25, documented R11 was admitted to the facility on [DATE]. R11's medical diagnosis form, print date of 5/12/25, documented R11 has diagnoses including laceration of esophagus, history of anaphylaxis, gastrostomy status, hypertension, depression, anxiety, and anemia. R11's [NAME] Data Set/MDS, dated [DATE], documented R11 is cognitively intact and dependent on staff for all ADLS (activities of daily living). On 5/12/25 at 12:56 PM R11 stated no facility staff have discussed her care plan with her, she has not received a copy of it, and she has not been invited to a care plan meeting. R11's progress note, dated 4/25/25, documented baseline care plan has been completed. Resident/POA (Power of Attorney) have received a copy. On 5/14/25 at 12:00 PM V3, Regional Nurse, stated the facility Social Service department is supposed to give residents a copy of their baseline care plan within 48 hours of admission to the facility. V3 confirmed that R11's progress note dated 4/25/25 documented R11 was given her baseline care plan on 4/25/25, 23 days after admission. (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Baseline Care Plan policy, dated 11/2012, documented Purpose: to develop a baseline care plan within 48 hours of admission to direct the care team while a comprehensive care plan is developed that incorporates the resident's goals, preferences, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Guidelines: Upon admission, the admitting nurse will initiate the development of the baseline care plan as part of the admission assessment. The baseline care plan will continue to be developed by the interdisciplinary team and be completed within 48 hours of admission. It continues, the resident and/or their representative shall receive a summary of the baseline care plan prior to completion of the comprehensive care plan that includes: the initial goals of the resident, a summary of the resident's medications and dietary instructions, any services and treatments to be administered by the facility and personnel acting on behalf of the facility, any updated information based on the details of the comprehensive care plan, as necessary. As a best practice, the interdisciplinary team should attempt to schedule an initial meeting with the resident and/or resident representative within 5 days of admission to review the baseline plan of care and make updates or revisions as indicated based on feedback and input of the resident and/or representative prior to the development of the comprehensive care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents who require assistance receive a shower or bath for 3 of 4 residents (R2, R11, R14) reviewed for Activities of Daily Living assistance in the sample of 16. This failure has the potential to affect all 126 residents residing at the facility. Findings Include: 1.R2's diagnosis sheet, print date of 5/12/25, documented R2 has diagnoses including acute hematogenous osteomyelitis of left ankle and foot, type 2 diabetes mellitus, chronic kidney disease, hypertension, and heart disease. R2's MDS (Minimum Data Set), dated 4/18/25, documented R2 is cognitively intact and requires partial to moderate assistance with transfers to and from wheelchair. R2's care plan, undated, documented R2 has an ADL (activities of daily living) self-care performance deficit related to generalized weakness and requires assistance with all ADLS including bathing and toileting. On 5/13/25 at 10:12 AM R2 stated she has not been receiving showers on a regular basis since she was admitted to the facility on [DATE]. R2 stated she would like to get at least 2 showers per week, but she has only received 1 a week and sometimes none. R2 stated the facility does not have enough CNA'S (Certified Nurse Assistants) to get everything done. R2's CNA Skin Attention Forms documented R2 received showers on 4/17/25, 4/24/25, and 5/1/25. R2's Skin Attention Form, dated 5/8/25, documented R2 refused her shower. On 5/13/25 at 10:14 AM R2 stated she refused the shower on 5/8/25 because the CNA offered it to her late in the evening and that she was supposed to get a shower the following day on 5/9/25 but no staff ever came to give her one. 2. R11's medical diagnosis form, print date of 5/12/25, documented R11 has diagnoses including laceration of esophagus, history of anaphylaxis, gastrostomy status, hypertension, depression, anxiety, and anemia. R11's MDS, dated [DATE], documented R11 is cognitively intact and dependent on staff for all ADLS. On 5/12/25 at 9:27 AM R11 stated she has not received a shower in over 2 weeks, and she is used to taking a shower every day when she is at home. On 5/12/25 at 2:15 PM surveyor requested R11's shower record documentation from 4/1/25 to 5/12/25 and R11's last documented shower was on 4/29/25. 3.R14's census sheet, print date of 5/13/25, documented R14 was admitted to the facility on [DATE]. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R14's medical diagnosis sheet, print date of 5/13/25, documented R14 has diagnoses including acute kidney failure, hypertension, hyperlipidemia, type 2 diabetes mellitus, heart failure, anemia, and lymphedema. R14's MDS, dated [DATE], documented R14 is cognitively intact and requires partial to moderate assistance with ADLS including showers. On 5/12/25 at 10:10 AM R14 stated he has had 2 showers in 3 weeks and then stated, I just take what I can get. On 5/12/25 the facility provided R14's shower documentation and it documented R14 has only received 1 shower since admission. R14's shower was documented on 5/8/25 on the facility CNA skin attention form. On 5/13/25 at 10:30 V1, Administrator, confirmed the facility only has documentation of R14 receiving 1 shower between the admission date of 4/24/25 through 5/13/25. On 5/7/25 at 10:45 AM V13 CNA stated we don't really have enough staff, it has been overwhelming, residents and their families are complaining a lot about not having enough help, we don't always have time to give all the residents showers as assigned. On 5/12/25 at 9:40 AM V21 CNA stated, I don't know how I am supposed to work the split hall nor have time to do showers. On 5/13/25 at 10:31 AM V1, Administrator, stated the facility policy says residents should receive a shower or bath no less than once a week. Surveyor requested additional shower documentation for R2, R11, and R14. V1 replied I gave you what we have the shower documentation. On 5/13/25 at 2:15 PM V11, day shift CNA stated she was unable to complete her assigned showers today as she did not have time with all the other job duties she had to complete for the residents. On 5/13/25 at 2:52 PM V3, Regional Nurse, stated resident showers are only documented on the CNA skin impairment forms. The facility's Bathing - Shower and Tub Bath policy, dated 10/2024, documented Purpose: To ensure resident's cleanliness to maintain proper hygiene and dignity. Guidelines: A shower, tub bath or bed/sponge bath will be offered according to resident's preference, no less than once per week or according to the resident's preferred frequency and as needed or requested.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to monitor a resident's enteral nutrition needs, monitor a resident's weight, identify severe weight loss of a resident, provide needed interventions to prevent further weight loss, and re-assess a resident's nutritional needs when the resident was not tolerating enteral nutrition for 1 (R11) of 3 residents reviewed for enteral nutrition. This failure resulted in R6 experiencing a 11. 98% weight loss in 6 weeks of being admitted to the facility. Findings Include: R11's clinical census sheet, print date of 5/13/25, documented R11 was admitted to the facility on [DATE]. R11's medical diagnosis form, print date of 5/12/25, documented R11 has diagnoses including laceration of esophagus, history of anaphylaxis, gastrostomy status, hypertension, depression, anxiety, and anemia. R11's MDS (Minimum Data Set), dated 4/9/25, documented R11 is cognitively intact and dependent on staff for all ADLS (activities of daily living). R11's weights and vitals document, print date of 5/12/25, documented R11 was weighed 2 times between admission date of 4/2/25 through 5/8/25. R11's documented weights are 206.9 pounds on 4/2/25 and the next recorded weight is 182.1 pounds on 5/8/25. R11's gastroenterology progress note, dated 3/12/25, documented R11 presented to local hospital with concerns for angioedema (anaphylactic reaction) thought to be related to shellfish and found to have pneumothorax. Patient was intubated in the ED (Emergency Department) after multiple failed attempts in the field, ICU (Intensive Care Unit) concerned for possible traumatic esophageal perforation. CT (computed tomography) scan reveals diffuse accumulation of contrast in the right chest cavity believed to be caused from mid esophageal perforation. Underwent EGD (esophagogastroduodenoscopy) on 3/3/25 which confirmed diagnosis. Then underwent thoracotomy with decertification, repair of esophagus, and intersection of PEG (percutaneous endoscopic) tube on 3/11/25. R11's progress note, dated 4/2/25 at 1:40 PM, documented (local hospital) nurse called with report. Resident is an [AGE] year-old female. Resident had an allergic reaction to shrimp. It continues, IV (intravenous) ABT (antibiotic) for pneumonia. Resident is alert and oriented x4. NPO (nothing by mouth) G-tube with tube feeding 5x/times day. R11's provider progress note, dated 4/4/25, documented dietician to eval and treat free water flushes and tube feeds. R11's progress note, dated 4/5/25 at 12:44 PM, documented resident nauseated and declined feeding at this time. R11's progress note, dated 4/5/25 at 6:54 PM, documented enteral feed order, resident refused due to being nauseated and dizzy. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R11's progress note, dated 4/6/25 at 5:46 AM, documented resident expressed clear refusal to receive morning G-tube medications, stating I don't want anything through my tube right now. Reported feeling extremely dizzy and nauseated since yesterday. No emesis or pain reported. Resident requested transfer via ambulance to local ER (Emergency Room) for further evaluation. Resident insisted on the need for a higher level of medical care. Notified POA (Power of Attorney) and charge nurse. EMS (emergency medical services) initiated, transported via gurney to local hospital at 0430 per wishes. R11's local emergency room progress notes, dated 4/6/25, documented reason for visit: vomiting, diagnoses: low sodium levels, dizziness, nausea and vomiting, medications given Antivert (for vertigo), Zofran (for nausea), and sodium chloride 0.9% (for low sodium). R11's progress note, dated 4/8/25 at 1:33 PM, documented resident complained to writer she is having loose stools after every tube feeding. Writer sent an email to the dietician to evaluate resident's tube feeding. R11's dietician recommendation, dated 4/8/25, documented recommend (enteral nutrition supplement) at 35 ml/hour continuous with water flushes every 4 hours to provide adequate nutrition. R11's progress note, dated 4/8/25 at 7:11 PM documented resident refused tube feeding due to having constant diarrhea. R11's progress note, dated 4/10/25 at 11:20 AM, documented resident refuses to have feeding through pump and would like to have feedings administered via bolus as previously ordered, will notify dietician as well. R11's progress note, dated 4/10/25 at 8:51 PM, documented resident states she doesn't want the feeding and would like to talk about other options. R11's progress note, dated 4/12/25 at 4:27 PM, authored by V25, R11's physician, documented patient states that she cannot tolerate tube feeding and frequently refuses continuous tube feedings she prefers boluses not only allows small amount of bolus. It continues, patient is NPO (nothing by mouth) and is getting tube feeding through G-tube not able to tolerate G-tube feeding well. Will ask dietician to see patient continue with fiber to prevent diarrhea, advised patient to do tube feeding as much as possible. R11's progress note, dated 4/12/25 at 8:29 PM, documented resident refused tube feeding. R11's progress note, dated 4/12/25 at 9:16 PM, documented resident refused her feeding this shift, stated it gives her diarrhea. Doctor (V25) aware. R11's physician progress note, dated 4/15/25 at 2:28 PM, documented patient is NPO (nothing by mouth) and is getting tube feeding through G-tube not able to tolerate G-tube feeding well. Will ask dietician to see patient, continue with fiber to prevent diarrhea, advised patient to do tube feeding as much as possible. C-diff (clostridium difficile) negative. R11's progress note, dated 4/16/25 at 10:09 AM, documented continues tube feeding at 35ml/hour, requests bolus feedings. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R11's progress note, dated 4/17/25 at 2:27 PM, documented nurse practitioner in facility to visit resident. Dietician to eval for possible different tube feeding as this once causes her significant diarrhea. R11's provider progress note, dated 4/17/25, documented dietician to eval for possible different tube feeding as this one causes her significant diarrhea. R11's progress note, dated 4/17/25 at 9:28 PM, documented resident refused tube feeding this shift. Resident educated on the importance of her ordered feedings as well as the impact not receiving these feeding can have on her overall health. Resident is aware and acknowledges understanding. MD (Medical Doctor) and NP (Nurse Practitioner) are aware of this as well. Plan of care continues. R11's progress note, dated 4/18/24 at 10:42 PM, documented resident's feeding refused this shift. Resident expressed concerns to writer regarding her feeding order. Resident is currently NPO and has an order for (enteral nutrition) via g-tube however she has expressed to MD and NP (Nurse Practitioner) that the (enteral nutrition brand) gives her diarrhea and she would like order changed to a new type of feeding. As of now dietitian has been contacted and resident is awaiting word from dietitian about this matter. She states to writer that this has gone on for too long and she feels that her concerns are not being taken seriously by her MD at this time. She is asking to be seen by a new doctor. Writer explained that she will make managers aware of this. R11's progress note, dated 4/19/25 at 4:56 AM, documented resident continued to have an order for continuous tube feeding at 35ml/hour 24 hours a day. It continues, resident chose to take 60ml of (nutritional supplement) at this time, she stated that the (nutritional supplement) gives her severe diarrhea and wants to ease into talking the (enteral nutrition brand) feeding supplement. R11's progress note, dated 4/22/25 at 4:56 PM, documented received email from dietician regarding feeds. Continue (enteral nutrition brand), however, instead of being ran at 35 ml/hr she is requesting 45 ml/hr. Nursing staff as well as resident made aware; all agreeable to plan. R11's progress notes by V24, Registered Dietitian, dated 4/23/25 at 12:33 PM, documented current weight 206.9, diet: NPO, (enteral nutrition brand) at 45ml/hr x 24 hours. It continues, resident admitted [DATE], NPO with TF's (tube feeding) for nutritional support. TF's meeting low end of calorie needs. Unable to assess weight history as resident was recently admitted . Resident previously on (enteral nutrition supplement) however not tolerating it. Staff states resident tolerates (enteral nutrition brand). No pressure injuries, skin is intact. Plan: Recommend continuing current TF regimen. Will continue to monitor TF tolerance and weight changes. RD is available for consult PRN (as needed). R11's physician progress note authored by V26, thoracic surgeon, dated 4/24/25, documented patient may now start a full liquid diet. All further diet recommendations will come from (local) GI (gastrointestinal) clinic. R11's physician progress note authored by V25, dated 4/26/25 at 3:55 PM, documented based on last esophagogram there was not leak, started on CLD (clear liquid diet), does not do tube feeding any more, continue protein supplement and monitor weight. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R11's provider progress note, dated 4/30/25, documented dietician eval as patient on liquid diet until 5/20/25. On 5/12/25 at 9:27 AM R11 stated she is no longer receiving nutrition through her g-tube and she is now on clear liquids with a protein supplement. R11 stated when she was first admitted she could not tolerate the feeding and feels the lactose was upsetting her stomach resulting in her to experience nausea and diarrhea. R11 stated she has lost over 30 pounds since she was admitted to the facility. On 5/12/25 at 9:38 AM V7 LPN stated R11 is receiving her medications and a protein supplement through her g-tube. V7 stated R11 started refusing her g-tube feeding because it caused her to have diarrhea, so the doctor put her on clear liquids and the protein supplement until she follows up with her surgeon. On 5/12/25 at 2:42 PM V7 LPN stated R11 could not tolerate the supplement, so the NP was notified and discontinued the supplement on 5/6/25 and started her on a protein supplement twice a day. V7 presented the protein supplement to surveyor and stated R11 gets 30ml of this twice a day. The supplement bottle documented 1 - 30ml dose of the protein supplement consists of 100 calories, 15 grams of protein, and 0 fat. On 5/12/25 at 2:46 PM V23 Unit Manager stated it is the facility policy to weigh residents every week for the first 4 weeks of admission, (R11) did get missed, we have no weights for her between 4/2/25 to 5/8/25. V23 then stated there is no documentation that the RD was notified of R11's weight loss nor was RD notified of (brand name) supplement being dcd. On 5/12/25 at 2:52 PM V24, Registered Dietitian, stated there was a miscommunication with the facility staff and her, that the facility was messaging her through a system that she does not have access to, and the facility nurses did not realize she was not receiving the messages. V24 stated she was not aware R11's (brand name) supplement was discontinued, was not notified of R11's 24.8-pound weight loss since admission to the facility until 5/8/25 and was not aware nor notified R11 had been placed on a liquid diet. V24 stated she recommended V24 be started on a fortified juice on 5/8/25 after she learned of her weight loss. V24 then stated, I also recommended they increase the (liquid protein supplement) from BID (twice a day) to TID (three times a day) on 5/9/25, and I see they have not increased it yet. On 5/13/25 at 9:55 AM R11 stated no facility staff including the Registered Dietitian have talked with her about her diet, that all she is receiving is a bowl of broth three times a day at meals. R11 stated she went over a month here at the facility without being weighed, she asked them to weigh her recently, and the has lost about 30 pounds. R11 stated she has not received any speech therapy since she was admitted to the facility. On 5/13/25 at 10:18 AM V25, R11's Medical Doctor, stated R11 had a perforated esophagus, it was repaired then developed a leak, she developed more complications including pneumonia, then inserted g-tube, she was receiving bolus feedings 6 times a day in the beginning of her stay. R11 refused the tube feeding because she said it was causing her to have diarrhea. Stated he personally had conversations with her regarding her weight and need for tube feeding, she was then put on clear liquid diet. Stated he was notified of her weight loss and made referrals to RD. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 5/13/25 at 2:55 PM V3, Regional Nurse, provided an email, dated 4/24/25 at 1:52 PM documenting the facility RD, V24, was notified of R11's new order to change her diet from NPO to clear liquid. V24 replied Thanks for the update on 4/24/25 at 2:07 PM. V3 stated the facility does not have any documentation from the RD, V24, regarding R11's diet change to clear liquid from enteral nutrition on 4/24/25 and she would have expected V24 to complete a new nutritional assessment. V3 stated the facility does not have any weekly weights documented for R11 between her documented weight of 206.9 on 4/2/25 and the next documented weight of 182.1 on 5/8/25. V3 stated R11 should have been weighed every week and V24 RD should have been monitoring R11's nutritional status. Surveyor requested a nutritional calculation of R11's daily caloric and protein needs and V3 stated the facility does not have anything documented. On 5/14/25 at 10:55 AM V3, Regional Nurse, stated the facility does not have any Registered Dietitian documentation for R11's daily nutritional needs other than the 3 dietitian recommendation notes dated 4/7/25, 4/8/25, and 4/22/25. V3 agreed that these 3 documents do not calculate R11's calorie, protein, and nutrient needs based on R11's current health condition. V3 stated the facility does not have any documentation showing the facility RD V24 received and responded to V25's referrals to RD on R11. On 5/14/25 at 12:02 PM V3, Regional Nurse, stated V26, R11's thoracic surgeon, is who ordered R11's clear liquid diet and she has a call out to his office for those progress notes. V3 stated she has no documentation showing the facility RD was notified and intervened of R11's ongoing enteral nutrition intolerance, weight loss, nor of R11 being placed on a liquid diet. V3 then provided surveyor with the progress note by V26 from R11's consultation with him on 4/24/25 and surveyor noted the order documented full liquid diet not clear liquid diet as the facility documented on R11's EMR physician orders. V26 also documented all further diet recommendations will come from (local) GI clinic. On 5/14/25 at 1:42 PM V3, Regional Nurse, agreed V26's order documented liquid diet on 4/24/25 and that the facility put R11 on a clear liquid diet rather than a full liquid. V3 stated there is a difference between those two diets and the facility will call for verification. Surveyor asked if V26 or R11's GI specialists were notified of R11 starting back on the continuous tube feeding yesterday, 5/13/25, and V3 stated there is no documentation noting this but R11's primary physician is aware of R11 being back on the continuous tube feeding. On 5/14/25 at 2:05 PM V7 LPN stated R11 was started back on her continuous tube feeding yesterday. Surveyor asked what physician gave the order and V7 replied you will have to ask the unit manager, V23, because she got the order. On 5/14/25 at 2:07 PM V23, Unit Manager, stated she received the order from the facility's RD, V24, yesterday for R11 to start the continuous tube feeding again. Surveyor asked if R11's primary physician, surgeon, or GI specialist approved that order and V23 stated she has no documentation showing they were notified or approved of the order. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 5/14/25 at 2:10 PM R11 stated she was started back on the continuous tube feeding yesterday, she does not know if a doctor approved it, the nurse just came in and said I was starting back on it. R11 stated the only issue she has had since it was restarted was one loose stool this morning, but the tube feeding has been shut off since 8 AM and not restarted. Surveyor observed the bottle of (enteral nutrition brand) hanging in R11's room, the bottle was labeled as being started on 5/13/25 at 12:30 PM, rate of 35ml/hr, observed 600ml remaining in bottle, not connected, and not running. Surveyor asked R11 if V26 (R11's thoracic surgeon) ordered a clear liquid diet or a liquid diet when she saw him on 4/24/25 and R11 replied I assumed it was clear liquid. On 5/14/25 at 2:17 PM V24, Registered Dietitian, stated she recommended R11 be started back on her continuous tube feeding yesterday, 5/13/25. Surveyor asked if she was aware R11's thoracic surgeon recommended R11 be on a liquid diet when she saw him on 4/24/25 and that all further dietary recommendations needed to come from (local) GI (gastrointestinal) specialist and V24 replied she was not aware of that and does not know if a physician approved for R11 to go back on full enteral nutrition. Surveyor then asked V24 if there is a difference between a full liquid diet (as noted by V26) and a clear liquid diet. V24 replied yes, and that a liquid diet would provide more nutrients and calories than a clear liquid diet. Surveyor asked if V24 was aware V26 ordered a liquid diet for R11 and not a clear liquid diet on 4/24/25 and V24 replied she was not aware. The facility's Significant Weight Gain or Loss Policy, dated 2/2024, documented Purpose: to ensure that insidious/significant weight gain or loss will be identified so that nutritional needs can be evaluated, and appropriate intervention provided. Guidelines: 1. Dietary/Nursing team will obtain weights from nursing, 2. Dietician/Nursing will determine significant weight changes: a. Gain or loss of 5% in the last month, b. Gain or loss of 7.5% in the last three months, c. Gain or loss of 10% in the last six months. 3. Dietician will review these clients and document the change. 4. If recommendations are indicated will be communicated to nursing to notify the provider of the significant weight changes and recommendation. The facility's Dietitian Referrals and Recommendations policy, dated 2/2024, documented Purpose: To ensure high risk resident's nutritional needs/goals are met or maintained within acceptable parameter for resident. Responsibility: Dietitian/Licensed Nursing/Dietary Manager. Guidelines: Director of Nursing or designee will determine high risk residents and send referral to Dietitian. Dietitian will complete referrals in a timely manner. Dietitian will complete a nutritional assessment and document in the resident's EMR. Dietitian recommendations will be communicated to the medical provider on a timely basis to provide appropriate intervention if necessary. It continues, Dietitian will complete nutritional assessments on residents according to annual MDS or significant changes. Dietitian will complete assessment on all referrals and document in resident's EMR. High risk criteria examples but not limited to unintentional weight loss of more than 5% in one month, more than 7.5% in three months, and more than 10% in six months, and enteral feeding dependent residents.

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	05/15/2025

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide enough nursing staff to adequately meet the needs for 4 of 4 (R2, R4, R7, and R11) residents reviewed for staffing in the sample of 16. These failures have the potential to affect all residents residing at the facility. Findings Include: 1.R2's diagnosis sheet, print date of 5/12/25, documented R2 has diagnoses including acute hematogenous osteomyelitis of left ankle and foot, type 2 diabetes mellitus, chronic kidney disease, hypertension, and heart disease. R2's MDS (Minimum Data Set), dated 4/18/25, documented R2 is cognitively intact and requires partial to moderate assistance with transfers to and from wheelchair. R2's care plan, undated, documented R2 has an ADL (activities of daily living) self-care performance deficit related to generalized weakness and requires assistance with all ADLS including bathing and toileting. On 5/7/25 at 9:15 AM V6, (husband of R2), step out of R2's room with a full bag of soiled laundry in a yellow isolation bag and placed the bag on the floor outside of R2's room. V6 then stated to V5, CNA, this is the 3rd day I have asked for this dirty laundry to be removed from my wife's room, I am tired of asking. Surveyor then interviewed R2 and V6. V6 stated oh my god they are very short staffed, (R2) called me at home one day because she couldn't get any employees to answer her call light, so I got ready and came to the facility, she waited 40 minutes to get help. R2 stated her initial stay at the facility was very difficult because she could not transfer herself after being in ICU (Intensive Care Unit) for 21 days and had a partial foot amputation during the hospital stay so there was no way for her to transfer herself to the bathroom and she had to wait for an average of 20 to 30 minutes to get her call light answered. R2 stated she was told by her doctors to drink lots of water to improve her kidney function so she was which resulted in her needing to go to the restroom frequently and she would have to wait for extended periods of time to get assistance. V6 stated R2 quit calling for assistance and now she just takes herself to the bathroom. V6 stated we have talked to the DON, (Director of Nursing), 3 times about it taking so long to get her call light answered. I am glad you are here because I was planning on calling state about the lack of staff, now I don't have to. On 5/13/25 at 10:12 AM R2 stated she has not been receiving showers on a regular basis since she was admitted to the facility on [DATE]. R2 stated she would like to get at least 2 showers per week, but she has only received 1 a week and sometimes none. R2 stated the facility does not have enough CNAs to get everything done. R2's CNA Skin Attention Forms documented R2 received showers on 4/17/25, 4/24/25, and 5/1/25. R2's Skin Attention Form, dated 5/8/25, documented R2 refused her shower. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/13/25 at 10:14 AM R2 stated she refused the shower on 5/8/25 because the CNA offered it to her late in the evening and that she was supposed to get a shower the following day on 5/9/25 but no staff ever came to give her one. 2.R7's diagnosis sheet, print date of 5/7/25, documented R7 has diagnoses including recent left artificial shoulder joint replacement, fibromyalgia, hypothyroidism, sleep apnea, atrial fibrillation, morbid obesity, hypertension, depression, anxiety disorder, and spinal stenosis. R7's MDS (Minimum Data Set), dated 5/6/25, documented R7 is cognitively intact and is dependent on staff for her toileting needs. R7's care plan, undated, documented R10 has an ADL (activities of daily living) deficit related to left shoulder replacement. On 5/7/25 at 10:28 AM R7 stated it takes a while to get my call light answered, sometimes 15-30 minutes, I wet the bed once because they didn't come in time to put me on the bedpan. They are so understaffed. On 5/7/25 Surveyor observed R7's call light on from 12:04 PM until it was answered by V16, transportation CNA (Certified Nurse Assistant), at 12:32 PM. The daily nursing department schedule dated 5/7/25 documented 1 nurse (V10) and 1 CNA (V9) CNA were assigned to R7's unit (300) on the day shift. V10 and V9 were not observed on the 300 unit during this observation. On 5/7/25 at 12:35 PM V9 CNA (assigned to 300 unit) stated she passes the 4 room trays on the 300 unit and then she goes to the dining room. V9 stated she does not know how she is supposed to pass trays in the dining room and answer call lights on the 300 unit. V9 stated no specific staff are assigned to answer hall lights while the CNAs are in the dining room including on 300 unit where she is the only CNA. On 5/7/25 at 12:43 PM V16, transportation CNA, stated she answered R7's call light and that she took R7 off the bed pan. On 5/8/25 at 7:45 AM R7 stated she was left on the bedpan for over 20 minutes yesterday afternoon because her call light was not getting answered. R7 stated it was not comfortable being on the bed pan for so long. 3.R4's diagnoses sheet, print date of 5/8/25, documented R4 has diagnoses including multiple sclerosis, quadriplegia, depression, osteoporosis, hypertension, and urgency of urination. R4's MDS, dated [DATE], documented R4 is cognitively intact. R4's care plan, undated, documented R4 needs total care with ADLS, is totally dependent on staff for bed mobility, dressing, eating, personal hygiene, transfers with assistance of 2 via a full body mechanical lift, and is incontinent of both bowel and bladder. On 5/7/25 at 9:52 AM R4 stated the facility does not have enough staff, the average length of time to get her call light answered is 30 minutes, it is especially bad in the evenings, and the staff rush in and out because they are so short staffed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/8/25 R4's call light on at 7:26 AM and it was answered at 7:38 AM. On 5/8/25 at 2:40 PM R4 stated I cannot move anything, so it takes about 45 minutes to complete all my tasks when getting up and going to bed. There have been times when it has taken 2 hours to get my call light answered, it was at shift change from days to evenings. There have been days when 1 CNA had to transfer me in the lift because she didn't have any help. I have lived here for about 2 years and have always been on the 300 unit, we had 2 CNAs on this unit until the last month and then the company cut the second one. My quality of care has declined, it has caused me more anxiety from having to wait longer for help, I am totally dependent since I can't move anything. I have been desperate a few times because no staff answered my call light, so I asked my (hands free smart speaker) to call the front desk and my husband to get help. The CNA must cut corners now since there is only one, I could tell my CNA was stressed yesterday because she said oh, I have all these call lights on so I felt like I asked for too many tasks and I needed to cut out some tasks so she could get out and help the other residents. We need 2 CNAs on this unit, I feel bad because I take so much time to get ready for the day and bedtime. 4. R11's medical diagnosis form, print date of 5/12/25, documented R11 has diagnoses including laceration of esophagus, history of anaphylaxis, gastrostomy status, hypertension, depression, anxiety, and anemia. R11's MDS, dated [DATE], documented R11 is cognitively intact and dependent on staff for all ADLS. On 5/12/25 at 9:27 AM R11 stated the facility is short staffed and they are not providing her and the other patients the services they need. R11 stated she was ready to get out of bed and dressed at 7:30 this morning but was unable to get any staff to help her dress until 9:15 AM. R11 stated last Thursday, 5/8/25, she was left on the bedpan for over 2 hours, her call light was on, and no one would answer it. R11 stated I was scared because no one would come, my left does not work, so I was trying to figure out how to get myself out of the bed without with out help since no one was coming. R11 stated she has not had a shower in over 2 weeks. On 5/12/25 at 12:56 PM R11 stated she needs to go to the rest room, but she doesn't want to push her call light during lunch because she has to use the sit to stand to transfer onto the toilet and she is afraid she will get left in the bathroom for a long time because the facility does not have enough CNAs. On 5/12/25 at 2:15 PM surveyor requested R11's shower record documentation from 4/1/25 to 5/12/25 and R11's last documented shower was on 4/29/25. On 5/7/25 at 9:12 AM V5 CNA stated the facility is very short staffed, they do not have enough CNAs, and the family members of the residents are complaining. On 5/7/25 at 9:27 AM V7 LPN stated that the new company who recently bought this facility cut staff and now the facility does not have enough CNAs. V7 stated the residents are not getting the care they need since the new owner cut staff, residents are having skin issues, and they are especially not getting the care they need on the night shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/7/25 at 10:02 AM V10 LPN stated the new company who took over the facility cut staff including nurses and CNAs. V10 stated for several weeks there was just 1 nurse assigned to the 300 and 400 units. V10 stated they are still only allowed to have 1 CNA on the 300 unit and 1 CNA is not enough. V10 stated the floor staff have informed management that the 300-unit CNA does not have any CNAs to cover that unit when they go on break if the nurse is unable to and that management stated the 300-unit CNA has to find a CNA to cover their break, so they have to go searching for help when they go to break or lunch. V10 stated residents and family members have been upset about the lack of staff, resident falls have increased, and nursing staff have quit since the new owner took over and started cutting staff. On 5/7/25 at 10:22 AM V11 CNA stated she was normally routinely scheduled on the 300 unit, but she recently requested a break from the 300 unit because they just assign 1 CNA to that unit and there is too much to do for 1 CNA. V11 stated there are usually about 15 residents on the 300 unit, R4 is a quadriplegic, and it takes 45 minutes to get her ready, then you have to search for someone to assist with R4's transfer because she requires a mechanical lift. V11 stated it was really bad when the company cut a nurse, and the 300-unit nurse had to cover 400 also. V11 stated it is scary working by yourself on the 300 unit. On 5/7/25 at 10:45 AM V13 CNA stated, we don't really have enough staff, it has been overwhelming, residents and their families are complaining a lot about not having enough help, and we don't always have time to give all the residents showers as assigned. On 5/7/25 at 10:52 AM V14 LPN stated she has worked at the facility for the last 7 years and she recently stepped down from the wound care nurse position because the new owner of the facility cut staff and wanted her to work the floor in addition to being the wound care nurse. V14 stated CNAs and residents are complaining about the staff cuts, and resident pressure ulcers have increased. On 5/7/25 at 12:02 PM V15 LPN stated she has worked at the facility for the past 20 years, the new company cut nurse and CNAs, and there has been an increase in resident complaints due to the lack of staff. On 5/7/25 at 12:35 PM V9 CNA stated she passes the room trays on the 300 unit and then she has to go to the dining room to pass trays and assist the residents. V9 stated she does not know how she is supposed to pass trays in the dining room and also answer call lights on the 300 unit. V9 stated no specific staff are assigned to answer hall lights while the CNAs are in the dining room. On 5/7/25 at 1:52 PM surveyor informed V2 DON (Director of Nursing) of the observation of R7's call light being on from 12:04 PM until 12:32 PM and V2 stated that is not an acceptable call light response time. On 5/13/25 at 12:40 PM V3, Regional Nurse, stated the facility follows CMS (Centers for Medicare and Medicaid Services) guidelines and does not have a staffing policy.