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	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at Sangamon Valley	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to safely transfer a resident to prevent falls in 1 of 4 residents (R2) reviewed for falls in the sample of 4. This failure resulted in R2 falling and receiving a laceration which required suture repair. Findings Include:On 10/16/25 at 9:17 AM, R2 was observed in her bed with an approximately 1 1/2 inch moon shaped scabbed, healing laceration to the right/center of her forehead. R2 is alert to self only.R2's Minimum Data Set (MDS), dated [DATE], documents R2 has a BIMS (Brief Interview for Mental Status Score) of 2, indicating R2 has severe cognitive impairment and is dependent with transfers. R2's Care Plan, dated 8/27/19, documents R2 is at risk for falls related to: Impaired mobility, memory loss/dementia, difficulty standing up, unsteady, fear of falling, history of falls, history of fractured left hip and clavicle with an intervention dated 10/6/25, to remove the floor mat from bedside as resident doesn't attempt to sit on the side of the bed any longer. R2's Care Plan, dated 5/30/23, documents R2 has impaired ability to independently transfer and requires a full mechanical lift with 2 assist to transfer.R2's Progress Note, dated 10/4/25 at 7:19 PM, documents the following: Certified Nursing Assistant (CNA) notified writer that patient had fallen while being transferred in the (full mechanical lift). States that the machine tipped over as she was attempting to put patient into the bed. Patient has laceration to forehead. Writer notified POA (Power of Attorney), and physician and patient transferred to local ER (Emergency Room).R2's Progress Note, dated 10/6/25 at 10:27 AM, documents the following: IDT (Interdisciplinary Team) met to review fall from 10/4/25. Root Cause: Resident injured during transfer. Intervention: Remove fall mat from bedside as resident does not sit on side of bed any longer.R2's Progress Note, dated 10/6/25 at 9:27 PM, documents the following: Resident has a new skin concern. Type of skin concern: Laceration, no new orders will follow up with hospital for further treatment plan. Located to Face - forehead: stitches r/t (related to) fall. Resident does not complain of pain.The Hospital ER Discharge summary, dated [DATE], documents the following: [AGE] year-old female presenting from the nursing home due to a fall. Patient had an unwitnessed fall, staff then tried to lift her from the floor with a (full mechanical lift) and she fell from this. Patient sustained a laceration to her forehead. CT (Computed Tomography) of the head impression: small right frontal scalp hematoma. Superficial laceration approximately 5cm (centimeters) in length, closed with 10 sutures.The Facility's IDPH (Illinois Department of Public Health) Final Report, dated 10/10/25 by V2, Prior DON (Director of Nurses), documents the following: on 10/4/25 at 10:35 PM. R2 was being assisted into bed using a full mechanical lift. While cares were being provided and the lift was being used, the wheel became caught on the fall mat in place and caused the lift to tip resulting in a laceration to R2's forehead. She was assessed and the MD (Medical Doctor) and POA were notified. R2 was transported to the ER for evaluation. R2 returned from the ER with sutures. An investigation was conducted, and it was determined that the mechanical lift tipped due to a fall mat being in place while the lift was being used. The resident was being cared for at time of injury and is care planned to be transferred with an assist of 2 utilizing a mechanical lift. The IDT team reviewed the incident, and the care plan was reviewed and updated. Resident is being monitored for pain. Staff were educated on using the mechanical lifts as well as room preparation prior to using the lifts. Maintenance inspected the machine to ensure good working order. MD and POA were notified of plan of care and agreeable. On 10/1625 at 12:40 PM, V7, LPN (Licensed Practical Nurse), stated she was working when R2 fell from the Hoyer lift, but she was not in the room when it happened. V7 stated the aide came to her and stated they were putting R2 to bed and the full mechanical lift tilted over. V7 stated there was a floor (fall) mat in place next to R2's bed but it had been moved when she entered the room, so she isn't sure if it was by the bed when R2 was being transferred. V7 stated R2 was sent to the hospital for evaluation. V7 stated if a resident has a floor mat in place, it should be moved during the transfer. On 10/16/25 at 12:48 PM, V9, CNA, stated on 10/4/25 between 7:00 PM and 7:30 PM, she noticed R2 was in her wheelchair slouching down, so she was going to put her in bed. V9 stated she got R2 hooked up in the full mechanical lift, walked out of the room to get another CNA, she didn't see one, so she did the transfer by herself and has done them by herself several times. V9 stated she had lifted R2 up in the lift, was moving the wheelchair while her other hand was on the full mechanical lift moving it towards the bed and over the floor mat. V9 stated she should've moved the mat but didn't, she tried moving the lift over the mat, the lift caught on the mat and tipped over completely. V9 stated R2 hit her head, and it was busted open. V9 verified there were no other staff in the room during the transfer, and she did not move the floor