

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

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 05/21/2026
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)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on interview and record review, the facility failed to ensure the right to a clean environment for 1 of 5 (R25) residents reviewed for clean environment from a total sample of 34. Findings include: On 5/14/26 at 3:40 PM, R25 stated staff assisted him after throwing up, but they did not change his soiled gown or bed linens, left soiled incontinence brief in the bathroom, and soiled clothing in the room on 5/9/26. On 5/15/26 at 1:22 PM, V34, R25's family member, stated on 5/9/26 at 3:00 PM when they arrived to visit R25's bed linens and gowns were soiled, used incontinence brief and soiled clothing were left on the floor. On 5/19/26 at 8:30 AM, V31 Certified Nursing Assistant (CNA) stated on 5/9/26 she went to R25's room after V34 complained about the condition of R25's room. V31 stated the gown and bed linens were soiled and there was a used incontinence brief and soiled clothing left on the floor. R25's progress note dated 5/9/26 at 3:16 PM documents V34 stated she had concerns with the condition of R25's room. The Illinois Long-Term Care Ombudsman Program booklet titled Residents' Rights for People in Long-Term Care Facilities revised 11/2-18 documents Your facility must be safe, clean, comfortable and homelike.		

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 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 interview and record review, the facility failed to assist residents with showers. This applies to 2 of 4 (R17 and R34) residents reviewed for showers. 1. R17's Brief Interview for Mental Status dated 3/5/26 documents R17 is cognitively intact. R17's undated care plan documents R17 is to receive showers on Wednesdays and Saturdays. On 5/15/26 at 10:00 AM, R17 stated they missed my shower on Wednesday (5/13/26). R17's shower/bath log documents R17 did not receive a shower on 5/9/2026 or 5/13/26. R17's concern form dated 3/16/26 documents a concern that R17 did not receive a shower on Saturday 3/14/26. This form documents V3 Assistant Director of Nursing confirmed that R17 did not receive a shower on 3/14/26. 2. R34's undated care plan documents R34 was admitted on [DATE] and has shower days scheduled for Mondays, Thursdays and as needed. R34 BIMS assessment completed on 5/18/26 documents R34 is cognitively intact. On 5/19/26 at 8:45 AM, R34 stated I've had 1 since I've been here. R34's shower log documents R34 received a shower on 5/15/26 but did not document a shower for 5/18/26.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement safety interventions to prevent falls. This applies to 2 of 4 (R7, R32) residents reviewed for falls from a sample of 34. Findings include: 1. R32's Minimum Data Set (MDS) dated [DATE] documents R32 is severely cognitively impaired. R32's medical record dated 2/9/2026 documents R32 has a diagnosis of Altered Mental Status and History of Falling. R32's care plan dated 2/9/2026 documents R32 requires a mechanical lift to transfer between surfaces. R32's care plan dated 4/13/2026 documents R32 is to have fall mat placed next to bed. On 5/15/2026 at 3:20 PM, R32 was lying in bed with call light in reach. R32 demonstrated how to use the call light and was able to activate it. R32 did not have fall mats on the floor next to the bed. On 5/19/2026 at 7:55 AM, R32 was sitting up in the wheelchair. R32 did not have any fall mats at the bedside. R32's medical record dated 4/10/2026 at 8:45 AM, R32 was lowered to the floor during morning care. On 5/15/2026 at 4:35 PM, V26 (LPN) stated R32 was sitting upright on the side of the bed. V26 stated when V40 (CNA) stood R32 up, R32 became weak and was lowered to the floor. V26 (LPN) stated V40 (CNA) was assisting R32 with a gait belt and assist of one. V26 (LPN) stated the fall interventions in place for R32 included a lowered bed, non-slip socks or footwear, and the use of a mechanical lift for transfers. On 5/19/2026 at 7:55 AM, V39 (CNA) stated R32 is supposed to have fall mats but R32 did not have any. V39 said that she assisted R32 from the bed to the wheelchair this morning with a gait belt and stood R32 up with assist of one and did not use a mechanical lift. On 5/19/2026 at 8:00 AM, V6 (LPN) stated R32 requires a mechanical lift for transfers. On 5/19/2026 at 9:20 AM, V3 (ADON) stated R32's fall care plan documents to have non-skid footwear, assist of two with a mechanical lift, and mats placed on the floor at bedside. On 5/19/2026 at 4:30 PM, V22 (CNA) stated V22 (CNA) did not know what R32's fall interventions were. On 5/20/2026 at 8:10 AM, V50 (Physical Therapist, PT) stated R32 is a mechanical lift for nursing transfers. V50 (PT) stated transfer status is communicated through a notification sheet passed from therapy to nursing. On 5/20/2026 at 8:20 AM, V51 (PT, Director of Therapy) stated R32 is a mechanical lift for transfers. On 5/20/2026 at 8:30 AM, V3 (ADON) confirmed and stated R32's care plan documents R32 is a mechanical lift for transfers. R32's progress note dated 4/10/2026 at 5:35 PM documents R32 is no weight bearing to left lower leg. R32 was returned to the facility in a wheelchair and was transferred into a facility wheelchair using a gait belt and assist of two to stand and pivot. The facility Fall Prevention Program dated January 1, 2026 documents transfer conveyances shall be used to transfer residents in accordance with the plan of care. The facility Transfer-Manual Gait Belt and Mechanical Lifts policy dated December 2025 documents is the responsibility of the Licensed Nurse, Certified Nursing Assistance (CNA), Restorative, and Therapy that mechanical lift devices shall be used for any resident needing a two person assist, or who cannot be transferred comfortably and/or safely by normal transfer technique. Resident transferring and lifting needs shall be documented in care plans and reviewed via care plan time frame and as needed. 2. R7's medical record dated 12/16/2025 documents R7 has a diagnosis of Obesity, Urinary Tract Infection, Insomnia, and Weakness. R7's care plan dated 12/16/2025 documents as an intervention for R7 to use side rails for turning and repositioning. On 5/13/2026 at 1:10 PM, V15 (Power of Attorney, POA for R7) stated the facility called when R7 fell out of bed. V15 (POA) stated R7 was rolled onto the floor when assisted with one CNA. On 5/13/2026 at 3:06 PM, V17 (Licensed Practical Nurse, LPN) recalled V35 (CNA) reported R7 had rolled out of bed during bed check. V17 stated when R7 was turned for perineal care, R7 continued to roll onto the floor. On 5/19/2026 at 8:20 AM, V35 said she was assisting R7 with perineal care when V35 rolled R7 over and R7 continued to roll onto the floor. V35 said the mattress was slick and there were no bed rails for R7 to hold onto. R7's progress note dated 1/27/2026 at 11:04 PM documents that R7 had rolled out of bed onto the floor.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to prevent potential cross contamination during personal care for 1 of 3 (R16) reviewed for catheter care from a total sample of 34. Findings include: R16's medical record dated 7/17/2025 documents R16 has a diagnosis of Urinary Tract Infection, Bladder Disorders, Urinary Retention, and Neuromuscular Dysfunction of Bladder. R16's Minimum Data Set (MDS) dated [DATE] documents R16 is severely cognitively impaired R16's care plan dated 5/1/2025 documents R16 has an indwelling catheter related to neurogenic bladder. On 5/13/2026 at 12:50 PM, V22 Certified Nursing Assistant (CNA) and V23 (CNA) transported R16 to room the room in a wheelchair. V22 (CNA) retrieved cleaning wipes and wash basin and V22 returned to the room with gloves on. V22 and V23 assisted R16 to bed with a mechanical lift. V22 removed R16's shoes and pants. R16's catheter was no secured with a catheter securement device. V22 opened R16's incontinence brief and performed perineal care to R16's frontal perineal area. R16 rolled to R16's right side with use of grab bar on bed and assist of V22 and V22 performed perineal care to R16's backside. R16's catheter was not cleansed. V22 removed soiled gloves and donned a new pair of clean gloves. V22 applied barrier cream to R16's buttocks. V22 applied a new incontinence brief to R16. V22 removed soiled gloves and donned a new pair of gloves. V22 then retrieved a urinal and drained R16's catheter collection bag. V22 did not perform hand hygiene during this care. On 5/14/2026 at 12:10 PM, V22 said that V22 did not have any hand sanitizer when performing perineal care. V22 confirmed that hand hygiene is needed during personal care. V22 also confirmed that the catheter should be cleaned during care and this was not completed. V22 also said that the catheter needed a securement device, but she did not have one. V22 also said she is aware the catheter should be cleansed but did not perform catheter cleaning. The facility policy for Urinary Catheter Care dated December 2025 documents to perform hand hygiene before and after touching any part of the urinary catheter. The policy documents indwelling catheters may be secured to prevent trauma and tension. The facility policy for Incontinence Care dated January 2026 documents to perform hand hygiene before perineal care. The policy documents after perineal care to change gloves and perform hand hygiene. Record review of R16's physician order dated 5/26/2025 documents to provide catheter care and securement device every shift and as necessary.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure an antibiotic was given as ordered by the physician for one (R6) of six residents reviewed for medication administration in the sample of 34. Findings include: R6's Skilled Nurse Hospice Visit Note dated 3/27/2026 documented by V21 (Hospice Registered Nurse -RN) shows a new order for Azithromycin (antibiotic) 250 milligrams (mg) give two tabs on day one and one tab for the next four days. R6's Medication Administration Record dated 3/27/26 does not document R6 received the Azithromycin. On 5/14/2026 at 9:49 AM, V21 said she ordered the Azithromycin for R6 on Friday 3/27/2026. V21 stated that she verbally told the facility nurse caring for R6 at that time that there was a new order for an antibiotic to be processed. V21 stated the nurse stated to her that she did not have time to process the order at that time. V21 stated she could not recall the name of the nurse she talked to. V21 stated she then put the handwritten order in the hospice binder and left it face down on the nurse's station so that the nurse would know it still needed to be processed. V21 stated she returned to the facility on Tuesday 3/31/2026 and found the Azithromycin order had not yet been processed by the facility nurse. V21 stated she sat down at that time with V7 RN, R6's nurse at that time, and assisted her with putting the order into the computer system. V21 stated the medication did not arrive until the next day, Wednesday 4/1/2026. V21 stated she returned to the facility a few days later on Friday 4/3/2026 and saw the resident's medication card had the medications still in it, showing that R6 had missed several doses of the Azithromycin. On 5/14/2026 at 12:56 PM, V7 RN stated she recalls on 3/31/2026 R6's Azithromycin had been written by hospice to be ordered the day prior, however this never got done, therefore V7 RN sat down with V21 Hospice RN to put the order into the computer. R6's physician order dated 3/31/2026 shows the initial order for Azithromycin was transcribed five days after V21 Hospice RN had initially notified the facility of the new order. The order is written as Azithromycin 250 mg tablet, give two tablets by mouth in the morning for possible pneumonia until 4/1/2026 11:59 PM and give one tablet by mouth in the morning for possible pneumonia for four administrations. The facility's pharmacy requisition sheet shows that R6's Azithromycin was dispensed to the facility on 4/1/2026. R6's Skilled Nurse Hospice Visit Note dated 3/31/2026 shows New orders received from V41 Advanced Practice Registered Nurse (APRN) on 3/27/2026 was not entered or administered by facility. Spoke with V7 RN, facility nurse, and she entered medication orders during hospice visit. V41 APRN notified of delay. R6's Skilled Nurse Hospice Visit Note dated 4/3/2026 shows (V19), R6's family member, states patient has not been getting medications as prescribed. This nurse discussed with facility nurse and noted antibiotics to have four of the five pills remaining. The pills should have been gone by this time. Educated facility staff on patient's need for antibiotic and reinforced importance of patient receiving this. (V41 APRN) notified of facility not administering antibiotics as prescribed. (V19) states she will discuss with the (V2) Director of Nursing (DON) again, as this is the second medication issue this patient has had. On 5/14/2026 at 10:49 AM, V2 DON stated on 4/3/2026 she received an order R6's Azithromycin to be given for an additional five days because the medication had been delayed, however she cannot remember how many days the medication had been delayed for. On 5/14/2026 at 2:31 PM, V2 DON stated she would expect nurses to process any verbal or written orders given to them by hospice on that same day. On 5/19/2026 at 11:21 AM, V1 Administrator stated the facility does not have a specific policy regarding initiating physician orders immediately after they are received.		