STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146148	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Point Christian Village	565 West Marion Avenue Forsyth, IL 62535

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on interview and record review, the facility failed to notify the physician and resident's Power of Attorney (POA) of pressure sores/worsening pressure sores for two of three residents (R1, R4) reviewed for notifications in the sample list of seven residents. Findings include: 1. R1's undated Face Sheet documents R1's medical diagnoses as Alzheimer's Disease, Parkinson's Disease, Dementia, Tremors, Presence of Left Artificial Shoulder Joint, Iron Deficiency Anemia, Vitamin D Deficiency, Osteoporosis, and history of Urinary Tract Infections. R1's Minimum Data Set (MDS), dated [DATE], documents R1 as severely cognitively impaired. This same MDS documents R1 as requiring maximum assistance with eating and was dependent on staff for toileting, bathing, dressing, personal hygiene, bed mobility, and transfers. R1's Skin Evaluation, dated 8/13/24, documents R1's Left Elbow has an open wound. This same evaluation documents V14, Physician, and V5, R1's Power of Attorney (POA), were not notified. On 9/4/24 at 8:00 AM, V5, R1's Power of Attorney (POA), stated, I saw (R1's) left Elbow wound for the first time on 8/24/24 and it was horrible. I could see (R1's) bone. It was just awful. It had a bad odor and yellow/green drainage. I was never informed of (R1's) left Elbow wound getting so bad. On 9/5/24 at 1:00 PM, V1, Administrator, stated the facility should have notified V14, Physician, on 8/13/24 of R1's new Left Elbow Pressure Ulcer. On 9/6/24 at 9:30 AM, V14, Medical Director, stated R1 admitted to the facility with a known medical history of having a left elbow hardware placed [AGE] years prior to admission. V14, Medical Director, stated the facility should have contacted him on 8/13/24 when R1's left elbow pressure ulcer was first noted as open with drainage. V14 stated R1's infection in her left elbow pressure ulcer could have been prevented from getting so bad if it would have been treated earlier. 2. R4's undated Face Sheet documents R4 admitted to the facility on [DATE]. This same Face Sheet documents R4's medical diagnoses of Intertrochanteric fracture of Right Femur, Falls, UTI's, COPD, Iron Deficiency Anemia, Disorders of Bone Density and Structure, and neuromuscular dysfunction of bladder. (continued on next page)

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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's Admission assessment, dated 8/13/24, does not include any pressure areas. This same assessment documents R4's skin as intact. R4's Minimum Data Set (MDS), dated [DATE], documents R4 as severely cognitively impaired. R4's Nurse Progress Note, dated 8/24/24 at 10:46 PM, documents (R4's) right heel discoloration with discomfort noted. Foam dressing applied to protect the area and heel lifted to reduce pressure, which provided relief. (R4's)Power of Attorney (POA) and on-call manager were informed. Ongoing monitoring will continue and (V25) Registered Nurse (RN) dayshift nurse will follow up with the (V23) wound Physician for further evaluation and treatment. R4's Skin Evaluation, dated 8/25/24, documents R4's new facility acquired Deep Tissue Injury (DTI) to R4's right heel. This same evaluation documented R4 had discoloration and discomfort noted and measures 1.2 centimeters (cm) long by 1.9 cm wide by immeasurable depth. This same evaluation does not document V14, Physician, as being notified. On 9/10/24 at 12:00 PM, V4, Regional Director of Operations, stated the facility identified R4's right heel Deep Tissue Injury (DTI) on 8/24/24 during a whole house skin sweep. V4 stated R4's the facility nurse should have notified the Physician on 8/24/24 when the new facility acquired right heel pressure ulcer was identified. On 9/11/24 at 2:00 PM, V25, Registered Nurse (RN), stated V25 was the dayshift nurse for R4 on 8/25/25. V25 RN stated, I am so sorry. I was endorsed that information and must have forgotten to notify (V14, Physician). I should have called (V14, Physician) to obtain orders for the treatment of (R4's) right heel pressure ulcer. On 9/11/24 at 2:45 PM, V14, Physician, stated the facility should have notified the on-call system about R4's new facility acquired right heel pressure ulcer on 8/24/24. V14 stated, This is the second time in the recent past that this has happened. The nurses need to notify the Physician so that an order can be obtained. If they (facility) are unable to contact the Physician on call system, then they need to reach out to me as the Medical Director. V14, Physician, stated V14 was notified of R4's right heel pressure ulcer on 9/10/24, per the nurse progress note documented in R4's Electronic Medical Record (EMR). The undated facility policy titled Change in Condition documents it is the policy of the facility that a licensed staff member will notify the attending physician and responsible party of change in the resident's condition. The physician/responsible party will be notified when there is a marked changed in relations to usual signs and symptoms and/or the signs and symptoms are unrelieved by measures already prescribed. The physician/responsible party notification is to include but is not limited to onset of pressure ulcers. If the physician cannot be reached the Medical Director will be contacted to report the change in condition until the attending physician can be contacted. Calls will be made to the family/responsible party until they are reached. A message may be left on an answering machine that does not give specifics but leaves a request for the community to be called. The nurse will document in the clinical record. Documentation and assessment will be ongoing until condition has stabilized.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on interview and record review, the facility failed to implement pressure relieving interventions, assess, monitor, and treat a pressure sore, notify the physician of a reopened pressure sore/worsening pressure sore, and notify the physician of a facility acquired deep tissue injury for two of seven residents (R1, R4) reviewed for pressure sores in the sample list of seven residents. These failures resulted in R1's left elbow pressure sore progressing to an infected stage 4 pressure sore requiring hospitalization , surgery, a wound vacuum, and intravenous antibiotic theray and R4's right heel deep tissue injury deteriorating to an open unstageable pressure sore. The Immediate Jeopardy began on 8/13/24, when R1 obtained an open wound to her left elbow that was not reported to V14 (R1's) Physician/Medical Director. R1's left elbow wound progressed to an infected stage 4 pressure sore requiring hospitalization , intravenous antibiotics, surgical removal of R1's left elbow hardware and wound vacuum post surgery. The Administrator was notified of the Immediate Jeopardy on 9/6/24 at 3:03 PM. The surveyor confirmed by observation, interview, and record review, the Immediate Jeopardy was removed on 9/10/24, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training through ongoing Quality Assurance Performance Improvement (QAPI) review. Findings include: 1.R1's undated Face Sheet documents R1's medical diagnoses as Alzheimer's Disease, Parkinson's Disease, Dementia, Tremors, Presence of Left Artificial Shoulder Joint, Iron Deficiency Anemia, Vitamin D Deficiency, Osteoporosis, and history of Urinary Tract Infections. R1's Minimum Data Set (MDS), dated [DATE], documents R1 as severely cognitively impaired. This same MDS documents R1 as requiring maximum assistance with eating and dependent on staff for toileting, bathing, dressing, personal hygiene, bed mobility and transfers. R1's Care plan intervention, dated 4/27/22, documents R1 transfers with one person assist, roller walker, and gait belt. This same careplan documents a focus area of R1's left elbow pressure sore, dated 8/15/24. R1's Careplan did not include goal and interventions for R1's left elbow pressure sore until 8/21/24. R1's Pressure Ulcer Risk Assessment, dated 8/1/24, documents R1 as moderate risk for skin breakdown. R1's Physician Order Sheet (POS), dated August 2024, documents physician orders: -starting 4/26/24 and ending on 8/8/24 to monitor left elbow for redness, swelling, pain and warmth every shift. -starting 4/27/24 and ending 8/29/24 to ensure left elbow protection is in place at all times every shift. -starting 7/3/24 and ending 8/8/24 to apply border gauze daily to left elbow. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Skin Evaluation, dated 8/13/24, documents an open wound on R1's left elbow. This same evaluation documents V14, Physician, nor V5, R1's Power of Attorney (POA), were notified. R1's Electronic Medical Record (EMR) does not document an assessment of R1's new left elbow wound noted on 8/13/24. R1's Skin Evaluation, dated 8/15/24, documents R1 has a new facility acquired unstageable pressure ulcer on her left elbow that shows slough and eschar measuring 1.6 centimeter (cm) long by 1.3 cm deep with no measurable depth. This same evaluation does not document R1's Physician (V14) nor Power of Attorney (POA) (V5) being notified of R1's new pressure ulcer. The facility provided documentation, dated 8/16/24, documents V14, Medical Director, was faxed notification of R1's left elbow pressure sore. R1's Nurse Progress Notes dated: -8/13/24-8/19/24 there were no nurse progress notes addressing R1's left elbow pressure sore during this time period. -8/20/24 at 3:07 PM, documents, On 8/16/24 a facsimile was sent to (V14, Physician) to inform of (R1's) left elbow wound. (V14) responded asking if wound physician was following (R1). Response sent to inform (V14) that wound physician no longer follows (R1) due to left elbow wound healing in the past. Awaiting response. -8/21/24 at 7:26 PM, documents, (V23, Wound Physician) to follow up on Monday (9/2/24). (R1's) Left Elbow wound is open and pin in elbow is exposed. Wet to dry applied, management notified of worsening of wound. -8/24/24 at 12:05 PM, documents, Noted that (R1's) left elbow wound is worsening. Wound is red and warm to the touch. Wound is open and has exposed bone and internal hardware present and visible. (R1) sent to the emergency room . R1's Hospital Record, dated 8/24/24, documents R1 was admitted to the hospital with Cellulitis of the Left Elbow and Altered Mental Status secondary to Left Elbow prosthetic joint infection. This same record documents R1 underwent Left Prosthetic hardware removal and Incision and Drainage (I and D) of Left Elbow followed by a Wound Vacuum placement on R1's left elbow on 8/27/24. This same record documents, Discussed wet to dry dressings and applying support to avoid putting any pressure on the wound as this occurred from chronic pressure on the left elbow most likely. R1's Final Report to the State Agency, dated 8/29/24, documents, (R1) had an area to her left elbow that is a result of an Olecranon fracture with surgical repair with hardware placement prior to her admission to the facility on [DATE]. From the time of admission, (R1) had a chronic area to her left elbow that will frequently open and resolve. The area to the left elbow most recently resolved as of 7/29/24. This same report documents V21, Registered Nurse (RN), visualized (R1's) Left elbow and it appeared to be the same as usual, the area was linear and there was a small amount of dried drainage on the dressing, no changes from usual for (R1). This same report documents R1 had a left elbow wound that required monitoring and dressing changes. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's X-Ray report, dated 8/24/24, documents, Findings: Post surgical change to the Olecranon noted with a pin and wire construct. There is separation of the hardware from the native bone posterior with protrusion through the skin surface. No significant lucency is noted at the hardware/bone interface. The fracture is healed. The radiocapitellar and ulnar trochlear joints are anatomic in alignment. On 9/4/24 at 8:00 AM, V5, R1's Power of Attorney (POA), stated, I saw (R1's) left elbow wound for the first time on 8/24/24 and it was horrible. I could see (R1's) bone. It was just awful. It had a bad odor and yellow/green drainage. I was never informed of (R1's) left elbow wound getting so bad. Now (R1) is on Intravenous (IV) antibiotics for the next four to six weeks. (R1) is in terrible shape now because of this facility. On 9/5/24 at 10:20 AM, V19, Certified Nurse Aide (CNA), stated R1 had an open wound on her left elbow that was being treated by the nursing staff. V19 stated, The long-term area where (R1) lived was using agency nurses. Those (agency) nurses did not attend to (R1's) left elbow wound like they should have. The dressing was never on. (R1) like to lean on her Left side when she sat up in her wheelchair. (R1's) left elbow would sit directly on her arm of her wheelchair when it wasn't dressed or padded with anything. That was about half of the time. I told the agency nurses about this, but they didn't do anything. On 9/5/24 at 11:00 AM, V15, Orthopedic Surgeon, stated R1 had hardware placed in R1's left elbow [AGE] years ago. V15 stated V15 took over R1's care on 8/24/24. V15 stated R1's hardware removal could have been caused by her pressure ulcer or her infection. V15 stated, It is difficult to tell if (R1's) pressure ulcer or her infection caused the removal of the hardware, but the hardware itself did not cause the infection. V15 stated the facility nursing staff should have notified the Physician (V14) on 8/13/24 when noting R1's left elbow had an open wound. V15 stated R1's infection could have addressed at that time and was not. On 9/5/24 at 11:30 AM, V1, Administrator, stated the facility staff should have obtained a treatment order and made notifications to R1's Physician and Power of Attorney (POA) on 8/13/24 when R1's open wound on her left elbow had re-opened. V1 stated an open wound would cause an infection. V1 stated the nursing staff treated R1's open wound off and on for the entire length of R1's stay. V1 stated the nursing staff did not obtain orders for treatment due to This was a common problem for (R1). The nursing staff would apply an absorbent pad when her wound would drain off and on. It was the general thought from the nurses that the order to apply elbow protectors meant to provide treatment. (R1's) open left elbow pressure ulcer should have had a separate physician order for treatment. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/6/24 at 9:30 AM, V14, Medical Director, stated R1 admitted to the facility with a known medical history of having a left elbow hardware placed [AGE] years prior to admission. V14 stated after reviewing R1's hospital records from her 8/24/24 admission, R1 did not have a deep infection due to her C-Reactive Protein (CRP) level not being extremely high. V14 stated R1's infection was in her left elbow pressure ulcer. V14 stated, The facility nurses should have been more aggressive in contacting me due to (R1's) wound was open and draining. I would have provided orders until the wound Physician could take over her care. Apparently, the facility sent a fax to my office after hours on a Friday (8/16/24) which was not received until 8/19/24. They (facility) should have called me to get the necessary orders. They (facility) did not give proper care for (R1). V14, Medical Director, stated the facility should have contacted him on 8/13/24 when R1's left elbow pressure ulcer was first noted as open with drainage. V14 stated, (R1's) infection in her left elbow pressure ulcer could have been prevented from getting so bad if it would have been treated earlier. The undated facility policy titled Change in Condition documents it is the policy of the facility that a licensed staff member will notify the attending physician and responsible party of change in the resident's condition. The physician/responsible party will be notified when there is a marked changed in relations to usual signs and symptoms and/or the signs and symptoms are unrelieved by measures already prescribed. The physician/responsible party notification is to include but is not limited to onset of pressure ulcers. If the physician cannot be reached the Medical Director will be contacted to report the change in condition until the attending physician can be contacted. Calls will be made to the family/responsible party until they are reached. A message may be left on an answering machine that does not give specifics but leaves a request for the community to be called. The nurse will document in the clinical record. Documentation and assessment will be ongoing until condition has stabilized. The Immediate Jeopardy that began on 8/13/24 and was removed on 9/10/24 when the facility took the following actions to remove the immediacy: 1. The facility completed skin audits of 100% of the residents on 8/24/24, 8/30/24, and an audit of the skin audits on 9/5/24. These audits were completed by V2, Interim Director of Nurses (DON), V3, Senior [NAME] President of Operations, V4, Regional Director of Operations, V17, V31, Minimum Data Set (MDS)/Registered Nurse (RN), and V6, former Assistant Director of Nurses (ADON)/wound nurse. The skin audit on 8/24/24 showed R4 had a previously unidentified facility acquired deep tissue injury (DTI) to her right heel. R4's right heel pressure sore was not reported to V14, Physician, until 9/10/24. R4's careplan intervention to apply heel protectors was initiated on 9/10/24. R4's Electronic Medical Record (EMR) was updated with a treatment order on 8/27/24. 2. V1, Administrator, and the Interdisciplinary Nursing Team inserviced licensed nursing staff starting 9/2/24 on Wound Protocols, Change of Condition, Skin Evaluations, Pressure Ulcer Risk Evaluations, Wound assessment and management and Skin Check Policy. On 9/10/24, V31, Agency Registered Nurse (RN,) was observed actively working with her assigned residents, passing medications, managing staff, and providing direct care to residents. On 9/10/24, V31, Agency RN, stated she had already completed R5's Moisture Associated Skin Damage (MASD) treatment. V31 stated she did not know what R5's skin interventions were, due to she had not received any training and was not able to find R5's careplan. On 9/10/24, V22, Clinical Documentation Specialist/Licensed Practical Nurse (LPN), showed V31, Agency RN, how to find a resident's careplan and abatement inservicing was provided to V31. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. V1, Administrator, and the Interdisciplinary Team inserviced Certified Nurse Aides (CNA) starting on 9/2/24 and ending on 9/5/24 on Skin Checks and following the resident careplan. 4. A Quality Assurance Performance Improvement (QAPI) Ad hoc meeting was held on 9/3/24 for QAPI team to discuss concerns and plan of action. 5. On 9/3/24, V3, Senior [NAME] President of Operations, who is wound care certified, provided training to V16, current Wound Nurse/Licensed Practical Nurse (LPN). 6. Weekly assessments of all skin conditions and pressure injuries were completed, started on 8/24/24. V23, Wound Physician, completed weekly wound assessments/treatments, started on 8/19/24. 7. V22, Clinical Documentation Specialist, confirmed daily clinical meetings have occurred and will continue. V22 stated V1, Administrator, V2, Interim DON, V17, V31, Minimum Data Set/MDS RN, all attend daily meetings. V22 stated resident Treatment Administration Records (TAR), Physician Order Set (POS), Nurse Progress Notes and 24-hour reports are all reviewed. V2, Interim DON, stated she has reviewed all residents with skin alterations and V23, Wound Physician, will review all residents with any kind of skin alteration i.e., skin tear, abrasion, pressure ulcer, surgical wound, diabetic wounds, etc. on an ongoing basis. 8. V2, Interim DON, stated R4's right heel wound should have been provided a treatment, and V14, Physician, should have been notified. V2, Interim DON, stated R4 has had Interdisciplinary Team meetings twice after R4's wound was identified on 8/24/24 and prior to V14, Physician, being notified. V2, Interim DON, stated, This should have been caught and it wasn't. We (facility) are looking closely at everyone now who has a risk for skin alterations. 9. V1, Administrator, stated daily and weekly clinical meetings have been completed and will be ongoing. 10. Audits of five residents per week for pressure interventions have been completed and will be ongoing. Audits of three residents per week for any skin conditions have been completed and will be ongoing. Monthly skin audits were initiated on 8/24/24 and will be ongoing. All resident audits were completed by V2, Interim DON, V17, V31 Minimum Data Set (MDS) nurses, V16, Wound Nurse, V8, Infection Preventionist, and V22, Clinical Documentation Specialist. V4, Regional Director of Operations, stated she has been reviewing all audits and will continue to review future audits. V4 stated V4 is not aware of any new skin conditions, other than R4 that had been identified through the auditing process. 11. All new agency and/or new hire nursing staff were to be provided training. On 9/10/24, V31, Agency Registered Nurse (RN), was assigned a group of patients to provide nursing care for, and stated she had not been trained prior to starting her shift. 12. Annual and as needed training conducted by V16, Wound Nurse, and/or V2, Interim DON, will be ongoing. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility presented an abatement plan to remove the immediacy on 9/6/24. The survey team reviewed the abatement plan and was unable to accept the plan to remove the immediacy. The abatement plan was returned to the facility three separate times on 9/10/24 for revisions. The facility presented revised abatement plans on 9/10/24 and the survey team accepted the abatement plan on 9/10/24. 2. R4's undated Face Sheet documents R4 admitted to the facility on [DATE]. This same Face Sheet documents R4's medical diagnoses of Intertrochanteric fracture of Right Femur, Falls, UTI's, COPD, Iron Deficiency Anemia, Disorders of Bone Density and Structure, and neuromuscular dysfunction of bladder. R4's Admission assessment, dated 8/13/24, does not include any pressure areas. This same assessment documents R4's skin as intact. R4's Minimum Data Set (MDS), dated [DATE], documents R4 as severely cognitively impaired. This same MDS documents R4 requires maximum assistance with bed mobility, bathing, dressing, personal hygiene and is dependent on staff assistance for toileting. R4's Pressure Ulcer Risk Evaluation, dated 8/20/24, documents R4 is a high risk for obtaining a pressure ulcer. R4's Nurse Progress Note, dated 8/24/24 at 10:46 PM, documents, (R4's) Right Heel discoloration with discomfort noted. Foam dressing applied to protect the area and heel lifted to reduce pressure, which provided relief. Power of Attorney (POA) and on-call manager were informed. Ongoing monitoring will continue and (V25, Registered Nurse/RN) dayshift nurse will follow up with the (V23) wound Physician for further evaluation and treatment. R4's Skin Evaluation, dated 8/25/24, documents R4's new facility acquired deep tissue injury (DTI) to R4's right heel. This same evaluation documents R4 had discoloration and discomfort noted and measures 1.2 centimeters (cm) long by 1.9 cm wide by immeasurable depth. R4's Physician Order Sheet (POS), dated September 2024, documents a physician order starting 8/27/24 to apply skin prep and foam every shift and as needed to R4's right heel. R4's Careplan intervention, dated 8/29/24, documents R4's facility acquired deep tissue injury (DTI). This same careplan, dated 9/11/24, instructs staff to apply heel protectors. R4's Initial Wound Evaluation and Management Report, dated 9/9/24, documents R4's Unstageable Full Thickness Right Heel Pressure Ulcer measuring 2.0 centimeters (cm) long by 3.0 cm wide by immeasurable depth due to necrosis. This same evaluation documents R4's Right Heel Unstageable Pressure Ulcer as an open ulceration. R4's Nurse Progress Note, dated 9/10/24 at 9:45 AM, documents, (V14, Physician) states to follow up with (V23, wound Physician/(V16), wound nurse) to evaluate and treat coccyx in addition to the (right) heel. On 9/10/24 at 11:30 AM, R4 was sitting in wheelchair in her room. R4 was wearing non-skid socks with her feet directly on foot pedals. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/12/24 at 12:15 PM, R4 sitting up in her wheelchair with her feet on the foot pedals by her bed in her room. R4's heel protectors were laying on the opposite side of R4's bed on the floor. On 9/12/24 at 12:20 PM, V10, Certified Nurse Aide (CNA), stated R4 should have her heel protectors on at all times. V10, CNA, confirmed R4 did not have her heels floated, and was not wearing her heel protectors. V10, CNA, stated, They (facility) just got those heel protectors for (R4) two days ago. (R4) didn't have them before. On 9/10/24 at 12:00 PM, V4, Regional Director of Operations, stated the facility identified R4's right heel deep tissue injury (DTI) on 8/24/24, during a whole house skin sweep. V4 stated R4's facility nurse should have notified the Physician on 8/24/24 when the new facility acquired right heel pressure sore was identified. V4 stated, There should have been a skin assessment completed, order obtained, and the Physician should have been notified. We (facility) are working through training our nursing staff on all of these things. There was a delay in treatment for (R4) for three days. That should have never happened. V4 stated the delay in treatment for R4's right heel may have contributed to its deterioration. On 9/11/24 at 2:00 PM, V25, Registered Nurse (RN), stated V25 was the dayshift nurse for R4 on 8/25/25. V25 RN stated, I am so sorry. I was endorsed that information and must have forgotten to notify (V14, Physician). I should have called (V14, Physician) to obtain orders for the treatment of (R4's) right heel pressure ulcer. On 9/11/24 at 2:45 PM, V14, Physician, stated the facility should have notified the on-call system about R4's new facility acquired right heel pressure sore on 8/24/24. V14 stated, This is the second time in the recent past that this has happened. The nurses need to notify the Physician so that an order can be obtained. (R4's) right heel is now open which could have been prevented. If they (facility) are unable to contact the Physician on call system, then they need to reach out to me as the Medical Director. V14, Physician, stated V14 was notified of R4's right heel pressure sore on 9/10/24, per the nurse progress note documented in R4's Electronic Medical Record (EMR). The facility policy titled Wound Assessment, revised 7/1/2019, documents new wounds and/or other skin impairments/abnormalities will be assessed and documented using the skin and wound program in the electronic medical record upon being observed. The designated wound nurse will ensure that all wounds have a weekly assessment completed and monitor all wounds for improvement, deterioration or healing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146148	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Point Christian Village	565 West Marion Avenue Forsyth, IL 62535

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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 41970 Based on interview and record review, the facility failed to implement a staff training program to ensure Certified Nurse Aides completed required training on Communication, Resident Rights, Abuse, Quality Assurance Performance Improvement (QAPI), Infection Control, Compliance and Ethics, and Behavioral Health. This failure has the potential to effect all 55 residents residing in the facility. Findings include: The facility daily midnight roster, dated 9/4/24, documents 55 residents residing in facility. The facility Course Completion History, dated 9/11/24, does not document the required trainings in Communication, Resident Rights, Abuse, Quality Assurance Performance Improvement (QAPI), Infection Control, Compliance and Ethics, and/or Behavioral Health as being completed for five Certified Nurse Aides (CNA) (V26, V27, V28, V29, V30). The facility provided documentation of employee hire dates and inservices for the following: -V26 Certified Nurse Aide (CNA) was hired on 11/1/2018. V26, CNA, was not documented as completing training in Resident Rights, Abuse, Quality Assurance Performance Improvement (QAPI), Infection Control, and Behavioral Health in the past twelve months. -V27, CNA, was hired on 8/30/2022. V27, CNA, was not documented as completing training Communication, Resident Rights, Abuse, Quality Assurance Performance Improvement (QAPI), Compliance and Ethics and Behavioral Health in the past twelve months. -V28, CNA, was hired on 10/31/2017. V28, CNA, was not documented as completing training in Communication, Resident Rights, Abuse, Quality Assurance Performance Improvement (QAPI), Infection Control, and Behavioral Health in the past twelve months. -V29, CNA, was hired on 6/13/2016. V29, CNA, was not documented as completing training in Communication, Resident Rights, Abuse, Quality Assurance Performance Improvement (QAPI), Infection Control, Compliance and Ethics and Behavioral Health in the past twelve months. -V30, CNA, was hired on 6/14/2022. V30, CNA, was not documented as completing training in Communication, Resident Rights, Abuse, Quality Assurance Performance Improvement (QAPI), Infection Control, Compliance and Ethics and Behavioral Health in the past twelve months. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146148	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Point Christian Village	565 West Marion Avenue Forsyth, IL 62535

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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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/11/24 at 3:05 PM, V1, Administrator, stated the facility is unable to provide documentation of V26, V27, V28, V29, V30, Certified Nurse Aides (CNA), required trainings. V1 stated V26, CNA, V27, CNA and V30, CNA have all recently worked at the facility providing direct cares for residents. V1 stated V28, CNA, and V29, CNA, had not worked for two months, but prior to that were working at the facility regularly providing direct care for residents. V1, Administrator, stated V26, CNA-V30, CNA all had access to all of the residents. V1, Administrator, confirmed the staff trainings are important for the staff to know to take better care of the residents. V1, Administrator, stated the facility does not have a specific policy for this training, but expects the staff to be trained to better understand the resident care model.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146148	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Point Christian Village	565 West Marion Avenue Forsyth, IL 62535

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 41970 Based on interview and record review, the facility failed to ensure five Certified Nurse Aides (CNA) had a minimum of twelve hours of required education annually. This failure has the potential to affect all 55 residents residing in facility. Findings include: The Daily Midnight Census report, dated 9/4/24, documents 55 residents residing in facility. The Facility Assessment, reviewed 8/23/24, documents, Required in-service training for nurse aides must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year, include Dementia training, abuse prevention. The facility provided documentation of employee hire dates and inservices for the following: -V26, Certified Nurse Aide (CNA), was hired on 11/1/2018 and has completed five hours of required inservices in the past twelve months. -V27, CNA, was hired on 8/30/2022 and has completed four hours of required inservices in the past twelve months. -V28, CNA, was hired on 10/31/2017 and has completed four hours of required inservices in the past twelve months. -V29, CNA, was hired on 6/13/2016 and has completed zero hours of required inservices in the past twelve months. -V30, CNA, was hired on 6/14/22 and has completed zero hours of required inservices in the past twelve months. On 9/11/24 at 3:00 PM, V1, Administrator, stated the facility is unable to provide documentation of V26, V27, V28, V29, V30, Certified Nurse Aides (CNA), required twelve hours of educational trainings. V1, Administrator, stated the CNA trainings are monitored by the Human Resources (HR) role. V1 stated there was a change in the HR position that caused a lapse of monitoring the CNA trainings. V1, Administrator, stated, We (facility) now have a new HR person and are trying to get all the staff caught up on their trainings. I know they (staff) are behind, but now we are working towards getting the problem fixed. V1, Administrator, confirmed the staff trainings are important for the staff to know to take better care of the residents.