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	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at Hickory Point	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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview, and record review, the facility failed to identify one (R4) resident's Sacral Deep Tissue Injury, failed to obtain and provide treatment orders, failed to updat careplan timely, and failed to implement pressure reducing interventions out of three residents reviewed for pressure ulcers in a sample list of eight residents. As a result of these failures, R4 had pain from her Stage 3 Sacral pressure ulcer which was acquired and worsened under the care of the facility. Findings include: R4's undated Face Sheet documents R4 admitted to the facility on [DATE]. This same face sheet documents R4 has medical diagnoses of Pressure Ulcers, Paraplegia, Urinary Tract Infection (UTI), and Osteomyelitis. R4's Electronic Medical Record (EMR) documents R4 admitted to the facility with a Stage Four Pressure Ulcer to her Right Ischium and Stage Four Pressure Ulcer to her Left Knee. R4's Minimum Data Set (MDS), dated [DATE], documents R4 as cognitively intact. This same MDS documents R4 is dependent on staff for bed mobility, toileting, dressing, and requires maximum assistance with bathing and personal hygiene. R4's Physician Order Sheet (POS), dated May 2025, documents a physician order starting 4/11/25 and ending 5/7/25 to cleanse R4's Sacrum Pressure Ulcer, apply Calcium Alginate and cover with bordered foam daily. R4's POS does not include any orders for the treatment of R4's Sacral Stage Four Pressure Ulcer prior to 4/11/25. R4's Careplan, initiated 4/11/25, does not document R4's Stage Four Sacral Pressure Ulcer. R4's Pressure Ulcer Risk Assessment, completed 4/21/25, documents R4 as being high risk for obtaining a pressure ulcer. R4's initial facility Wound Summary report, dated 4/7/25, documents R4's Sacral Stage Two Pressure Ulcer as facility acquired, with dated identified as 4/7/25 measuring 5.0 centimeters (cm) long by 3.0 cm wide by undetermined depth. R4's Initial Wound Evaluation and Management Summary dated: (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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	-4/9/25 documents R4's Sacral Pressure Ulcer as an Unstageable pressure ulcer measuring 12.0 centimeters (cm) long by 6.0 cm wide with undetermined depth. This same summary documents R4 should have her Left Lateral Stage Four pressure ulcer off-loaded with two pillows above the wound. This same summary documents a physician order starting 4/9/25 for 30 days to apply Calcium Alginate and foam daily to R4's Sacral pressure ulcer. -4/17/25 documents R4's Sacral pressure ulcer as an open Unstageable pressure ulcer due to necrosis, full thickness wound with moderate serous drainage. -4/23/25 documents R4's Sacral pressure ulcer as a Stage Four with 80% thick adherent devitalized necrotic tissue measuring 9.0 cm long by 6.0 cm wide by undetermined depth. This same summary documents R4's Stage Four Pressure Ulcer is not at goal. -4/30/25 documents R4's Sacral pressure ulcer as a Stage Four with 80% thick adherent devitalized necrotic tissue measuring 9.0 cm long by 6.0 cm wide by 1.5 cm deep. This same summary documents R4's Stage Four Pressure Ulcer is not at goal. -5/5/25 documents R4's Sacral pressure ulcer as a Stage Four with 85% muscle, fascia and subcutaneous tissue measuring 9.0 cm long by 6.0 cm wide by 1.5 cm deep. This same summary documents R4's Stage Four Pressure Ulcer is not at goal. On 5/7/25 at 11:30 AM-2:00 PM, R4 was laying on her back in her bed, with no pillows/blankets used for off loading pressure areas. On 5/8/25 at 11:40 AM, V4, Licensed Practical Nurse (LPN)/Wound Nurse, completed wound care for R4's Left Knee Stage Four Pressure Ulcer. After V4 completed R4's Left Knee dressing change, R4 declined to have her Sacral pressure ulcer dressing changed, due to R4 having pain in her Sacral area. R4 was laying on her back in her bed with no pillow/blankets for support. There were two extra pillows sitting in the chair in the corner. V4 stated R4 should have the pillows placed under her back and knee to off -load the pressure to her current pressure areas. R4 was grimacing with her dressing change to her Left Knee. R4 stated after the dressing change, she is a Paraplegic and has little feeling in her legs. R4 stated, I can feel my butt though. And it hurts a lot most of the time, especially when they (staff) change that dressing. On 5/7/25 at 11:35 AM, V6, Agency Licensed Practical Nurse (LPN), stated residents are having to wait to be turned and positioned for more than the two hours, due staff being busy. V6, LPN, stated R4 requires the staff assistance for turning and positioning. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 5/8/25 at 12:00 PM, V4, LPN/Wound Nurse, stated R4 should be propped on pillows to help alleviate pressure. V4, LPN, stated R4's Left Knee Stage Four Pressure Ulcer showed slough, Fascia, Tendon, and bone, with yellow serous drainage. V4, LPN/wound nurse, stated she did have to soak off the previous dressing because it had adhered to the wound due to the excess drainage. V4 stated R4's Stage Four Sacral Pressure Ulcer started at the facility. V4, LPN, stated she was made aware on 4/7/25, but forgot to obtain and implement the dressing orders. V4, LPN, stated V23, Wound Physician, saw R4's Sacral Stage Four Pressure Ulcer on 4/9/25, and documented it as an Unstageable pressure ulcer. V4, LPN, stated V23, Wound Physician, ordered Calcium Alginate with an absorbent pad and wrapped in gauze on 4/9/22, but those orders were not entered into the EMR until 4/11/25. V4, LPN/Wound Nurse, stated R4's Sacral wound deteriorated in that time, because no one was treating it, due to there were no updates to the careplan and no physician orders were entered. V4, LPN/Wound Nurse, stated the floor nurses were dressing R4's Right Ischium Stage Four Pressure Ulcer twice daily prior to 4/7/25, and should have known to tell V4, LPN/Wound Nurse, about R4's Sacral area. V4, LPN/Wound Nurse, stated the floor nurses failed to communicate to V4 that R4 had a new Sacral wound until 4/7/25. V4 stated the facility is unable to provide any documentation that R4's Sacral pressure ulcer was provided any kind of treatment prior to 4/11/25. The facility policy titled Pressure Ulcer Prevention, effective April 2025, documents dependent residents should be turned approximately every two hours or as needed. Position dependent residents with pillow or pads protecting bony prominences as needed. Use positioning devices or pillows, rolled blankets etc. to reduce pressure and/or friction/shearing as indicated.

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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** 41970 Based on observation, interview, and record review, the facility failed to provide a safe transfer for two (R3, R7) residents out of three residents reviewed for transfers in a sample list of eight residents. Findings include: 1. R3's undated Face Sheet documents R3 admitted to the facility on [DATE]. This same face sheet documents R3's medical diagnoses as Hemiplegia and Hemiparesis affecting Left non-dominant side, Frontal Lobe and Executive function deficit following non-traumatic Intracerebral Hemorrhage, Left Foot Drop, Left side Sciatica, Syncope, and Collapse. R3's Electronic Medical Record (EMR) documents R3 as cognitively intact. R3's Physician Order Sheet (POS), dated May 2025, documents a physician order starting 4/24/25, with no end date to monitor skin tears on bilateral lower extremities for signs of infection and healing three times per day. This same POS documents a physician order starting 4/16/25, with no end date, to complete a weekly skin assessment. R3's Nurse Progress Note, dated 4/20/25, does not document any skin injury, notifications of injury, nor assessment of bilateral lower leg skin tears. R3's Careplan, initiated 4/11/25, does not include a focus area, goal, nor interventions for R3's bilateral lower extremity skin tears. On 5/7/25 at 12:05 PM, R3 was sitting in her wheelchair in her room. R3 stated V22, Certified Nurse Aide (CNA), came into her room on 4/20/25, and assisted her from her bed to her wheelchair without using a gait belt. R3 stated V22 was by herself when transferring R3. R3 stated V22 was talking on her cellular phone through earbuds when V22, CNA, was transferring her. R3 stated R3 yelled out and told V22 to stop because R3 had obtained a skin tear to her Left Lower Leg, but V22 couldn't hear her because V22 had her earbuds in talking to someone else. R3 stated V22 caused her skin tear on her Left Lower Leg. On 5/8/25 at 2:05 PM, V22, Certified Nurse Aide (CNA), stated she transferred R3 by herself on the morning of 4/20/25. V22, CNA, stated she does not like to wear her gait belt because it is uncomfortable. V22, CNA, stated she was told by the previous shift that R3 was considered to be a one assist. V22, CNA, stated she did not have time to review R3's careplan that morning, due to low staffing issues. V22, CNA, stated R3 did receive a skin tear from her wheelchair. V22, CNA, stated she does wear earbuds, but does not remember if she had them in that particular morning. V22, CNA, stated she remembers R3 yelling out about V22 causing her skin tear, so she told the nurse about it. On 5/9/25 at 2:50 PM, V1, Administrator, stated staff should review the resident careplan if they are not sure about a resident's transfer status. V1, Administrator, stated staff are not supposed to be wearing ear buds and should always use a gait belt when transferring a resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/25 at 3:20 PM, V4, Wound Nurse/Licensed Practical Nurse (LPN), stated R3 is supposed to have two staff members assist with her transfers. V4, Wound Nurse, stated she was not aware R3 had received a skin tear, so that skin injury was not updated on the careplan. 2. R7's undated Face Sheet documents R7's medical diagnoses as Emphysema, Chronic Obstructive Pulmonary Disease (COPD), Osteoarthritis, Repeated Falls, Tremors, Muscle Weakness, Abnormal Posture, and Dementia with Psychotic Disturbances. R7's Minimum Data Set (MDS), dated [DATE], documents R7 as severely cognitively impaired. This same MDS documents R7 is dependent on staff for toileting, bathing, dressing, personal hygiene, bed mobility, and transfers. R7's careplan, initiated 3/13/24, documents R7 requires the assistance of two staff and a total body mechanical lift for transfers. R7's Nurse Progress Note, dated 5/8/25 at 10:46 AM, documents R7 complained of painful buttocks. This same note documents R7's reddened areas on bilateral buttocks, groin, and inner thighs that look 'fungal'. On 5/8/25 from 9:45 AM-10:30 AM, R7 was sitting in his room yelling out 'Help me!', 'My butt hurts!', 'Come and help me to bed!' and 'Please help me!' repeatedly. R7 was yelling loud enough he could be heard three rooms down at the nurses station. On 5/8/25 at 10:30 AM, V15, V21, Certified Nurse Aides (CNA), and V4, Wound Nurse/Licensed Practical Nurse (LPN), transferred R7 from his wheelchair to his bed, and then provided perineal care for R7. V15 and V21, CNA's, used the mesh shower sling that R7 was sitting on in his wheelchair to transfer R7. R7's mesh sling had the long ends of the sling at R7's head end, and the short ends of the sling at his buttock/thighs area. When V15 and V21, CNA's, positioned R7 over his bed, R7 was laying in the sling in a flat position, with his head slightly lower than his buttocks. V15 and V21 CNA's lowered R7 onto his bed without incident. R7's Sacrum, bilateral Buttocks, and upper thighs were dark red, with uneven edges with multiple pinpoint open areas. On 5/8/25 at 10:45 AM, V4, LPN/Wound Nurse, stated R7 could have fallen out of his total body mechanical lift during his transfer because V15 and V21, CNA's, used the wrong sling. V4 stated the long end of that sling should be crossed between R7's legs, not around his head. V4, LPN, stated she saw R7's buttocks on 5/5, and he was red and blanchable at that point, but now R7's buttocks looks like he has a yeast infection. V4 stated that could be caused by his incontinence and sitting in urine for long periods of time. V4 stated she was unaware that R7's buttocks had worsened. On 5/8/25 at 3:20 PM, V19, Licensed Practical Nurse (LPN), stated R7 was assisted up for breakfast and was eating in the dining room by 7:45 AM-8:00 AM. V19, LPN, stated V15 and V21, CNA's, have been busy the entire day, but are not able to keep up with resident demand. V19 stated, (R7) yelled and yelled earlier this morning to be laid down after breakfast. By the time he laid down, it was almost time for lunch. (R7) requires two people to transfer him using a mechanical lift, and unfortunately those residents who use a lift sometimes have to wait longer because many times there are not two people available to help those residents. V19, LPN, stated R7 was sitting up in his wheelchair for almost three hours this morning, which could lead to incontinence and skin breakdown. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The undated facility policy titled Transfers-Manual Gait Belt and Mechanical Lifts states the use of a gait belt for all physical transfers is mandatory. This same policy documents staff will use a mechanical lift for any resident needing a two person assist.