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	09/03/2025

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 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

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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	Based on interview and record review, the facility failed to ensure fall interventions were in place for one (R1) of three residents reviewed for falls on a sample list of seven. This failure resulted in R1 falling and sustaining multiple left-sided rib fractures, a collection of blood in the chest cavity, and a left sided collapsed lung. Findings include: The facility's Fall Prevention Program policy provided by V1, Administrator, does not contain a date. This documents the purpose of this policy is to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Quality Assurance Programs will monitor the program to assure ongoing effectiveness. Guidelines for the Fall Prevention Program included the following components: methods to identify risk factors, methods to identify residents at risk, educate resident and resident representative to fall prevention program at time of admission, throughout residents stay, and when changes occur, assessment time frames, use and implementation of professional standards of practice, immediate change in interventions that were successful, notification of physician, family/legal representative, communication with direct care staff members, documentation requirements, adherence to manufacturer's recommendation in us of alarm and medical devices and special care equipment. The policy documents the resident's Care Plan will incorporate the following: identification of all risk/issue, addresses each fall, interventions are changed with each fall, as appropriate, and preventative measures. This policy documents the following standards: a Fall Risk Assessment will be performed by a licensed nurse at the time of admission. The assessment tool will incorporate current clinical practice guidelines, safety interventions will be implemented for each resident identified at risk, the admitting nurse and assigned CNA are responsible for initiating safety precautions at the time of admission, all assigned nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained, and the Director of Nursing or Designee is responsible for monitoring the Fall Prevention Program, including further staff educations programs, purchase of additional equipment, or other appropriate environmental alterations.R1's profile sheet, dated 6/30/25, documents a medical diagnosis of repeated falls.R1's Fall Risk Assessment, dated 06/29/25, documents R1's assessment score was 13.0 on a scale of zero (low risk) to fourteen (high risk). R1's Care Plan, dated 7/01/25, documents R1 is at risk for falls related to weakness and partial paralysis on one side of R1's body following a stroke that affected R1's left non-dominant side.R1's MDS (Minimum Data Set) admission Assessment, dated 7/08/25, documents R1 requires partial to moderate assistance with toileting hygiene including the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement.R1's Nursing Note, dated 7/09/25, documents a Certified Nursing Assistant (CNA) found R1 on the bathroom floor while doing rounds at 8:35 PM. This note documents the nurse assessed R1 and found there to be a red mark on her left upper back (by the rib cage) and found there to be a displacement or a deformity in her rib cage. Computed Tomography (CT) scan of R1's chest, dated 7/10/25, documents R1 had multiple left-sided rib fractures, a collection of blood in the chest cavity, and a left sided collapsed lung. A follow-up X-ray of R1's chest, dated 7/10/25, documents R1's left-sided collapsed lung had worsened, was moderate in size, and had an increase in bleeding and bruising. This x-ray also documents multiple rib fractures.On 9/03/25 at 9:45 AM, V10, Licensed Practical Nurse, stated she was the nurse caring for R1 at the time of R1's fall. V10 stated R1 was a known fall risk and R1 didn't have any fall interventions in place. On 9/03/25 at 12:48 PM, V11, CNA, stated R1 was a known fall risk, and the only intervention she knew of was to put R1's bed in the low position.On 9/3/25 at 1:35 PM, V14, MDS/Care Plan Coordinator, stated she did a Baseline Care Plan for R1 on admission, and it included falls as a problem. V14 stated the only intervention that was marked on the Care Plan was for staff to ensure R1 was wearing appropriate footwear. V14 stated other fall interventions should have been on the R1's Care Plan for the prevention of falls.On 9/03/25 at 2:27 PM, V15, CNA, stated she knew R1 was a fall risk and there were no fall interventions in place that she was aware of.On 9/03/25 at 2:38 PM, V16, CNA, stated she didn't know R1 was a fall risk, but some of the CNA's would put R1's bed in the low position. V16 stated there were no other fall interventions.On 9/03/25 at 1:40 PM, V13, Assistant Director of Nursing/LPN, confirmed R1's fall risk assessment was completed on 6/29/25, and R1's score was 13, indicating she was at a high risk for falls. V13 stated fall risk assessments are completed to determine a resident's risk for falls and to develop appropriate interventions according to the resident's risk.On 9/03/25 at 2:54 PM, V12, Regional Nurse