

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER Arc at Hickory Point		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to maintain a resident bathroom/shower in clean condition for two residents (R1,R2) of four residents reviewed for environment in a sample list of seven residents. Findings Include:On 9/18/25 at 9:00AM in R1's and R2's room private bath with shower, there was an area above the shower head on the grout line approximately 5 inches by a half inch and an area above the shower where the ceiling meets the drywall approximately 12 inches by 6 inches that were covered by a slimy, fuzzy, black material with the appearance of black mold. On 9/18/25 at 9:05AM, V5, Housekeeper, stated, That black stuff has been in the shower for quite a while. I have turned in a work order and maintenance knows about it. On 9/18/25 at 9:15AM, V1, Administrator, and V7, Corporate Administrator, verified a slimy, fuzzy, black material was present above the shower in R1's and R2's room. V7 stated, This will be taken care of immediately. We will close off the bathroom until it can be fixed. On 9/18/25 at 11:00AM, V1, Administrator, stated, I have looked back for three months and I can't see where there has been a work order for this.</p>

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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