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	10/14/2025

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	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to identify and report an alteration in skin integrity to prevent a pressure ulcer for one (R1) of four residents reviewed for quality of care. This failure resulted in R1 developing a Stage 2 pressure ulcer to the middle of R1's tailbone.Findings include:The facility's Skin Condition Assessment & Monitoring - Pressure and Non-Pressure Policy, dated 04/2025, documents that the purpose of the policy is to establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown, pressure injuries, and other non-pressure skin conditions, and ensuring interventions are implemented.R1's Care Plan, initiated on 05/22/2019, documents that R1 is at risk for developing pressure ulcers and other impairments to skin integrity related to decreased mobility, pain, and weakness. This Care Plan includes an intervention dated 05/23/2019 for monitoring, reminding, and assisting to turn/reposition R1 at least every two hours, more often as needed or requested, and to notify R1's nurse immediately of any new areas of skin breakdown noted during bathing or daily care.R1's CNA (Certified Nurse Assistant) Skin Attention Form (completed by CNA during resident bath) from 09/01/2025 through 10/01/2025 does not document any skin issues.R1's Comprehensive Incident Fall assessment dated [DATE] documents a skin tear on R1's tailbone measuring 4.2 centimeters (cm) by 3.1 cm.R1's Hospice Plan of Care Update Report dated 10/04/2025 documents that R1 had a pressure ulcer/pressure injury to the tailbone area.On 10/09/2025 at 9:52 AM, V14, Assistant Director of Nursing (ADON), stated she was not aware that R1 had a sore on her tailbone until it was found the morning of R1's fall on 09/27/2025, and that the area on R1's tailbone did not have the appearance of a skin tear.On 10/09/2025 at 12:36 PM, V5, Licensed Practical Nurse (LPN), stated the CNAs are responsible for checking on residents every two hours and repositioning them. She stated R1 preferred to be up in her geriatric chair and that she sits in it most of the day. She also stated that she did not know how one would be expected to reposition a resident who sits in a geriatric chair. On 10/09/2025 at 1:51 PM, V23, Registered Nurse (RN - Hospice), stated that during R1's initial Hospice assessment on 10/04/2025, she discovered a pressure ulcer on R1's tailbone area that was the size of an egg, 0.1 cm in depth, deeper than skin, and pale in color.R1's Wound Care visit report dated 10/07/2025 documents that R1 had a Stage 2 pressure ulcer in the middle of R1's tailbone measuring 6.5 cm by 5.5 cm by 0.1 cm in depth.On 10/09/2025 at 2:39 PM, V24, Doctor of Nursing Practice (DNP - Wound Care), stated he saw R1 on 10/07/2025 and that the area on R1's tailbone was a pressure ulcer, not a skin tear. By the appearance of the wound, it had developed three to four weeks prior and was not caused by R1's fall on 09/27/2025.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review the facility failed to ensure adequate supervision was provided to prevent a fall for two (R1, R4) of four residents reviewed for accidents. This failure resulted in localized swelling of clotted blood on R1's forehead and a displaced break to R4's left collarbone and localized swelling of clotted blood on R4's forehead.Findings include: The facility's Fall Prevention Program Policy dated 10/2024 documents that 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. This policy documents that residents will be observed approximately every two hours to ensure the resident is safely positioned in the bed or chair and provided care as assigned in accordance with the plan of care.On 10/09/2025 at 5:30 AM, R1 was lying bed and noted to have a yellowish-purple discoloration to R1's entire forehead.On 10/09/2025 at 5:33 AM, R4 was lying in bed and noted to have a yellowish-purple discoloration on R4's forehead. On 10/09/2025 at 7:00 AM, R4 was sleeping in a geriatric chair in Hall 1B with a sling supporting her left arm. R1's Care Plan initiated on 5/22/2019 documents that R1 has a history of falls as evidenced by physical limitations, weakness, and cognition. R1's electronic medical record contains a nursing note dated 9/29/2025 that documents the interdisciplinary team met to review R1's recent fall and R1 sustained a fall with injury of skin tear to tailbone and noted swelling to forehead. R4's Care Plan initiated on 12/13/2024 documents that R4 is at risk for falls related to Parkinson's. R4's incident investigation report documents that R4 was observed on the floor on 9/27/25 at 4:30 AM with redness to left shoulder, a cut to forehead and complaints of head pain. On 10/08/2025 at 1:28 PM, V4 Licensed Practical Nurse (LPN) stated V11 Certified Nurse Assistant (CNA) was the CNA assigned to Hall 1B the night of R1 and R4 had unwitnessed falls. V4 LPN stated that twice between 10:00 PM and 4:30 AM she found V11 CNA asleep in a chair. V4 LPN stated she found V11 CNA also lying on the couch in the nook with the lights off, and several other times throughout that night V4 LPN stated she could not locate V11 CNA anywhere on Hall 1B. V4 LPN stated she found R4 at 4:30 AM on 9/27/25 lying on the floor in a puddle of urine next to R4's bed with a cut and dried blood on her forehead. V4 LPN stated V11 CNA was nowhere to be found. V4 LPN stated she never saw V11 CNA doing rounds on Hall 1B on the night R1 and R4 had unwitnessed falls.On 10/08/2025 at 1:21 PM, V11 CNA stated she is no longer an employee at the (Facility Name). V11 CNA stated she gave the facility a statement regarding the incident with R1 and R4. V11 CNA declined to answer any further questions.On 10/08/2025 at 12:39 PM, V9 CNA stated V10 CNA called V9 CNA into the room because V10 CNA had found R1 on the floor next to R1's bed. V9 CNA stated R1's incontinence underwear was saturated with urine and R1 had a lump on the right side of her forehead.On 10/08/2025 at 12:53 PM, V10 CNA stated she found R1 lying on her stomach with a large lump noted on the right side of R1's forehead. V10 CNA stated R1's incontinence underwear was fully saturated so much that there was a wet mark left on the floor. V10 CNA stated R1's bed was four feet off the ground and should have been in the low position. On 10/14/2025 at 9:40 AM, V28 Human Resources Manager stated that V11 CNA was terminated for failure to follow (Facility Name) conduct of standards policy. V28 HR stated V4 LPN was working with V11 CNA the night R1 and R4 fell, and V4 LPN reported that V11 CNA could not be located several times throughout the night, and that V4 LPN reported that V11 CNA was found with her eyes shut. V28 stated it was the expectation of the company that staff remain on the hall they are assigned to, and that V11 CNA should have remained on the Hall 1B. X-Ray results of R1's head dated 9/27/2025 documents that R1 sustained localized swelling of clotted blood to R1's left forehead. X-Ray results of R4's head and arms dated 9/27/2025 documents that R4 sustained localized swelling of clotted blood to R4's right forehead and a displaced break to R4's collarbone.