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	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at Hickory Point	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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to investigate grievances of three (R2, R10, R11) residents out of four residents reviewed for grievances in a sample list of twelve residents. Findings include:1.R2's undated Face Sheet documents R2 admitted to the facility on [DATE].R2's Electronic Medical Record (EMR) documents medical diagnoses as Right Radius Fracture, Left Radius Fracture, Fall from roof, Fracture of facial bones, Fracture of Right Medial Orbital Wall, Left Knee Fracture, Left Femur Fracture, Right Quadriceps muscle strain and Aneurysm of the Ascending Aorta without rupture. R2's Minimum Data Set (MDS) dated [DATE] documents R2 as cognitively intact. This same MDS documents R2 is dependent on staff for assistance with eating, oral hygiene, toileting, bathing, dressing and personal hygiene.R2's Concern form dated 12/8/25 documents R2's concern of not getting showers as scheduled. This same concern documents R2's complaint was partially substantiated. This same concern documents 'action taken' as monitoring daily shower sheets and will check in with R2 on shower days. This same concern has a typed in section that documents Follow up with the person that filed the complaint (complainant) that is blank. This same concern is signed by V1 Administrator and V33 Social Service Assistant (SSA). R2's shower sheet dated 1/2/26 documents V28 provided R2 a shower. This same shower sheet documents lotion applied. On 1/9/26 at 3:20 PM R2 was sitting in his room in his wheelchair with a bedside table sitting in front of him. R2's bilateral arms were in hard casts and both raised in a permanent position straight out in front of him. On 1/9/26 at 3:25 PM R2 stated he was involved in a work related accident. R2 stated he was at work and fell off of a roof breaking my whole body. R2 stated he was sent to the hospital and then to this facility to get therapy. R2 stated had not been receiving his showers as they should have been given. R2 stated the staff fill out the shower sheets that look like he had been given a shower but really it wasn't done. R2 stated he filed a grievance and has not heard anything about it since. R2 stated he knows the facility is supposed to help resolve these kinds of issues but has not had anyone from management help him. 2.R10's Minimum Data Set (MDS) dated [DATE] documents R10 as cognitively intact. This same MDS documents R10 requires maximum assistance with toileting, bathing and dressing.R10's Concern form dated 12/2/25 documents R10 has not had a bed bath. This same concern form documents the corrective action as (R10) was given a bath on 12/3/25. This same form section titled Follow up with person that filed the concern (complainant) is blank.On 1/9/26 at 2:40 PM R10 stated she was not given a shower/bed bath for weeks on end. R10 stated the staff tell her that they do not have time and/or they will be back to assist her with a bath but do not return. R10 stated she filed a concern but has not heard from anyone about it. On 1/9/26 at 2:45 PM V19 (R10) friend stated R10 was not given a bath for weeks. V19 stated she would ask the staff about R10 getting a bath and was told they would get to it. On 1/9/26 at 2:47 PM V20 (R10) family stated R10 is of sound mind. V20 stated if R10 reports that she did not get a bath, then R10 (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	did not receive a bath. V20 stated V19 and/or V20 visit daily and can confirm what R10 is saying. 3.R11's Minimum Data Set (MDS) dated [DATE] documents R11 as cognitively intact. This same MDS documents R11 requires maximum assistance for toileting, bathing, dressing and bed mobility. The facility was unable to provide documentation of a concern form for R11's report of not getting showers/bed baths. On 1/9/26 at 2:50 PM R11 stated she was not receiving showers/bed baths for weeks. R11 stated she reported this to V2 Director of Nurses (DON) before Christmas but has not heard anything back. R11 stated she had asked the staff to give her a shower and was told they do not know how to transfer her to the shower chair using the total body mechanical lift. R11 stated she asked another staff member to give her a bed bath and wash her hair in bed and was told that they (staff) don't do that here. R11 stated she feels dirty when she doesn't get a bath and does not want to get another Urinary Tract Infection (UTI). On 1/13/26 at 9:30 AM V3 Assistant Director of Nurses (ADON)/Licensed Practical Nurse (LPN) stated staff should provide showers at least two times per week or more often if the resident requests that. V3 ADON/LPN stated showers should be documented in the Electronic Medical Record (EMR) and/or on paper shower sheets. V3 ADON stated showers were a problem and V2 Director of Nurses (DON) was doing a shower audit. V3 ADON stated V2 and V3 split the duty of addressing the nursing grievances. V3 ADON stated she was not aware R2, R10 nor R11 had specific grievances about showers not being given. On 1/13/26 at 3:00 PM V2 Director of Nurses (DON) stated she did not follow up with R2, R10 nor R11 about their grievances. V2 DON stated she and V3 ADON/LPN share the responsibility of following up with nursing related grievances. V2 DON stated she thought V3 was 'handling' R2 and V3 thought V2 was 'handling' R2. On 1/15/26 at 3:00 PM V1 Administrator stated the facility did not have a grievance official until 1/15/26. V1 Administrator stated V2 DON and V3 ADON should have been following up with the residents for their nursing concerns. V1 Administrator stated going forward all concern forms will be discussed in the morning meeting and V1 will review each one individually as well as follow up with each resident. The facility policy titled Grievances reviewed March 2024 documents every effort shall be made to resolve grievances in a timely manner, usually within five business days. An appointed Grievance Official is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusion, leading any necessary investigations and maintaining the confidentiality of all information associated with grievances.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to document an open wound for one (R2) resident out of three residents reviewed for wounds in a sample list of twelve residents.Findings include:R2's undated Face Sheet documents R2 admitted to the facility on [DATE].R2's Electronic Medical Record (EMR) documents medical diagnoses as Right Radius Fracture, Left Radius Fracture, Fall from roof, Fracture of facial bones, Fracture of Right Medial Orbital Wall, Left Knee Fracture, Left Femur Fracture, Right Quadriceps muscle strain and Aneurysm of the Ascending Aorta without rupture. R2's Minimum Data Set (MDS) dated [DATE] documents R2 as cognitively intact. This same MDS documents R2 is dependent on staff for assistance with eating, oral hygiene, toileting, bathing, dressing and personal hygiene.The facility wound log dated 1/9/26 did not include R2's intergluteal cleft open wound. R2's shower sheet dated 1/2/26 documents V28 provided R2 a shower. This same shower sheet documents lotion applied. On 1/9/26 at 3:20 PM R2 was sitting in his room in his wheelchair with a bedside table sitting in front of him. R2's bilateral arms were in hard casts and both raised in a permanent position straight out in front of him. On 1/9/26 at 3:25 PM R2 stated he was at work and fell off of a roof breaking my whole body. R2 stated he was sent to the hospital and then to this facility to get therapy. R2 stated he can't wipe himself due to both of his arms are broken. R2 stated it is embarrassing for staff to have to wipe R2 but there is no other way until his arms are healed. R2 stated there have been two times when a staff member provided incontinence care and found old s***' (expletive) when he hadn't used the bathroom for several hours or even the day before. R2 stated on 1/2/26 V28 Certified Nurse Aide (CNA) had to apply cream because R2's perineal area was red, open and bleeding. R2 stated it hurt like h*** (expletive). R2 stated Do you know how embarrassing that is to have to have some young girl wipe your a** (expletive) and find a bunch of s*** (expletive) there. Then you find out that you have a big sore because the other staff aren't wiping my a*** (expletive) right?! Don't they teach these things in CNA school? On 1/13/26 at 9:30 AM V3 Assistant Director of Nurses (ADON)/Licensed Practical Nurse (LPN) stated she was not aware R2 had any skin alterations other than those caused by his fall prior to admission. V3 stated after talking with R2, V3 found that R2 did have an open area on his intergluteal cleft that was never reported to V3, assessed and/or treated. V3 ADON stated the staff should have documented R2's open bleeding wound, notified the physician and V3 ADON. V3 stated V3 oversees the facility wound program. V3 stated if she had known, she would have been able to ensure the appropriate treatment was obtained, assessed and notified all the appropriate parties. V3 stated R2's wound is now healed but we are lucky. It could have been much worse.On 1/13/26 at 11:15 AM V28 Certified Nurse Aide (CNA) stated she gave R2 a shower in his room on 1/2/26. V28 CNA stated R2's crease in between his buttocks was open, bleeding and red. V28 CNA stated R2 had some kind of cream (unknown type) in his room so she applied the cream to R2's open wound. V28 CNA stated R2 has large buttocks and has found 'old stool' in between R2's buttocks when cleansing him. V28 CNA stated she let V29 Licensed Practical Nurse (LPN) know about R2's open wound. On 1/13/26 at 3:00 PM V2 Director of Nurses (DON) stated the staff should have documented R2's open area, notified the physician and V3 ADON since V3 is over the wound program. The facility policy titled Skin Condition Assessment and Monitoring-Pressure and Non-Pressure dated December 2025 documents Non-pressure skin conditions (bruises/contusions, abrasions, lacerations, rashes, skin tears, surgical wounds, etc.) will be assessed for healing progress and signs of complications or infection weekly.A wound assessment will be initiated and documented in the resident chart when pressure and/or other non-pressure skin conditions are identified by licensed nurse.Each resident will be observed for skin breakdown daily (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment. If the resident receives a shower, it will be necessary to have the resident stand or be returned to bed to visualize the buttock area and groin.Care givers are responsible for promptly notifying the charge nurse of skin breakdown.At the earliest sign of a pressure injury or other skin problem, the resident, legal representative, and attending physician will be notified. The initial observation of the ulcer or skin breakdown will also be described in the nursing progress notes.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to complete thorough fall investigations, failed to implement fall interventions and failed to supervise high fall risk residents for one (R7) resident out of three residents reviewed for Accidents in a sample list of twelve residents. Failing to provide supervision and implement fall interventions resulted in R7 falling and experiencing pain due to injury from an unwitnessed fall that required emergency services. Findings include:R7's medical record documents medical diagnoses as Encephalopathy, Falls, Vascular Dementia with Behavioral Disturbance, Abnormal findings on diagnostic imaging of other parts of musculoskeletal system, Anemia, Weakness and Pacemaker.R7's Minimum Data Set (MDS) dated [DATE] documents R7 as moderately cognitively impaired. This same MDS documents R7 requires supervision with toileting, bathing, dressing, bed mobility and transfers.R7's Fall Care Plan initiated on 11/10/25 documents R7 as being at risk for falls.R7's Incident Fall assessment dated [DATE] documents R7 has had 1-2 previous falls in the past three months and has intermittent confusion.R7's Care Plan intervention dated 11/17/25 documents R7 requires gait belt and assist to transfer between surfaces. This same care plan documents an intervention dated 11/10/25 for staff to ensure that the R7 is wearing appropriate footwear and to anticipate and meet the resident's needs.R7's Nurse Progress Note dated 1/1/26 at 8:34 AM documents R7 was found by V10 CNA on his bathroom floor at 5:56 AM. This same note documents R7 was ambulating without assistance, call light was not used, barefoot using walker and fall was unwitnessed. This same note documents R7 obtained a laceration to his Right Forehead, abrasion to Right Knee and abrasion to his Left Foot. This same note documents R7 who is on blood thinners was walking to his toilet as he lost his balance. R7's Fall Incident assessment dated [DATE] documents R7 had a unwitnessed fall in his bathroom. This same assessment documents R7 has intermittent confusion and was barefoot using his walker when he lost balance and fell resulting in a Forehead laceration and Right Knee and Left Foot abrasion. This same assessment documents R7 was sent to the emergency room for evaluation. R7's Hospital Record dated 1/1/26 documents R7 was seen in the emergency room following a fall at the facility resulting in Left Ankle swelling, foreign body of Left Fifth finger and a closed head injury of Hematoma to R7's Right Forehead. This same record documents R7 has Dementia and is a poor historian. This same hospital record documents R7's Left fifth finger was diffusely swollen with a laceration on the pad of the distal finger tip. R7's Radiology Report dated 1/1/26 documents Impression: Small radiopaque foreign body within the palmar aspect of the distal fifth finger. This same report documents R7's fifth finger injury was Post trip and ground level fall. On 1/13/26 at 2:00 PM R7 was sitting in his chair in his room. R7's urinal was sitting in his bathroom, not within his reach. R7's left fifth finger at the proximal joint showed a black line across the entire width. R7 showed his left fifth finger saying I got that when I fell. It did hurt but not now.On 1/13/26 at 2:05 pm R7 stated he did not know where his urinal was located. R7 stated if he needed to use the bathroom, he would just get up and go. R7's call light was laying across his bed not within reach of R7.On 1/14/26 at 3:00 PM R7 was sitting in his chair in his room. R7's urinal was sitting in his bathroom, not within his reach. On 1/15/26 at 10:45 AM R7 was sitting in his chair in his room. R7's urinal was sitting in his bathroom, not within his reach. On 1/14/26 at 1:50 PM V10 Certified Nurse Aide (CNA) stated she was in the room next door to R7's when she heard him fall. V10 CNA stated she was not assigned to R7 that day but went to his room to check on R7 after hearing the thud noise. V10 CNA stated R7 was laying on his right side on the floor, barefooted with his walker laying on its side next to R7. V10 CNA stated there was blood on the floor due to R7's finger was bleeding.On 1/14/26 at (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1:55 PM V6 Certified Nurse Aide (CNA) stated she was instructed by other staff that R7 does not need any assistance walking. V6 CNA stated R7 walks independently with his walker all the time to his bathroom. V6 CNA stated she does not try to assist R7 when he is walking independently. V6 CNA stated R7 is not a fall risk. V6 CNA searched R7's room and confirmed R7's urinal was in his bathroom, out of his reach. On 1/14/26 at 4:30 PM V32 CNA stated she was assigned to R7 the morning of his fall on 1/1/26. V32 CNA stated she was assisting the nurse with wound care at the time of R7's fall. V32 CNA stated she had not checked on R7 for a few hours. V32 CNA stated the last time she saw R7, he was in bed sleeping. V32 CNA stated R7 gets up independently and does not need staff assistance for toileting. On 1/16/26 at 1:15 PM V2 Director of Nurses (DON) stated R7 should have had on the appropriate footwear to help prevent his fall. V2 DON stated the intervention for R7's fall was to place a urinal at his bedside. V2 DON stated R7's urinal should always be within his reach. V2 DON stated she reviewed the hospital record and read where R7 had a foreign body in his left fifth finger but is unaware of what that might be. V2 DON stated R7 does not have a medical history of any procedure in which hardware might have been placed. V2 DON stated during her investigation of R7's fall, she read the nurses progress note but did not interview staff. V2 DON stated she did not ask if R7's call light was within reach or where R7's footwear might have been. V2 DON confirmed R7's fall investigation could have been more thorough.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to prevent cross contamination during incontinence care for two (R11, R12) residents out of three residents reviewed for incontinence care in a sample list of twelve residents. Findings include:1.R11's medical record documents R11's medical diagnoses as Facial weakness following Cerebral Infarction, Spinal Stenosis, Obesity, Urinary Retention, History of Falling, Embolism and Thrombosis of Right Popliteal vein, Occlusion and stenosis of Right Middle Cerebral Artery, Discitis, fusion of spine and history of Urinary Tract Infection (UTI). R11's Minimum Data Set (MDS) dated [DATE] documents R11 as cognitively intact. This same MDS documents R11 requires maximum assistance for toileting, bathing, dressing, bed mobility and is dependent on staff for transfers. On 1/12/26 at 2:45 PM R11 stated she recently had a UTI and is afraid of getting another one. R11 stated the staff are very nice to her but don't always 'clean me up' as often as they should.On 1/15/26 at 11:35 AM V31 Certified Nurse Aide (CNA) completed catheter care/perineal care for R11. V31 assisted R11 with front perineal care, then proceeded to walk to the other side of R11's bed to complete perianal care. V31 CNA did not cleanse R11's catheter tubing with perineal care. V31 CNA left the garbage can on the side of the bed where V31 was standing to complete catheter care. V31 CNA wore the same pair of gloves to walk over, reach down and pick up the garbage can with the same gloves, then proceeded to complete perianal care without changing her gloves and/or preforming hand hygiene. On 1/15/26 at 11:50 AM V31 Certified Nurse Aide (CNA) stated she cross contaminated R11's perianal area by not changing her gloves. V31 CNA stated she should have cleansed the catheter tubing also to the junction of the drainage bag tubing. V31 CNA stated not cleansing the catheter tubing and cross contaminating could cause an infection.2.R12's Minimum Data Set (MDS) dated [DATE] documents R12 as cognitively intact. This same MDS documents R12 as requiring moderate assistance with toileting, bathing and dressing.R12's medical record documents R12's medical diagnoses as Weakness, Congestive Heart Failure, Diabetes Mellitus Type II, Urinary Tract Infection (UTI), Cervical Disc Degeneration, Wedge compression Fracture of T11-T12 Vertebra and Polyneuropa.On 1/15/26 at 11:10 AM V10 Certified Nurse Aide (CNA) completed catheter care/perineal care for R12. V10 CNA arranged the supplies on R12's bedside table, including a box of gloves that had several gloves protruding out of the top of the box. V10 CNA bumped the box of gloves which landed on its top side facing the floor. V10 CNA picked up the box of gloves that fell onto the floor, washed her hands and then obtained a pair of gloves from the top of the box to wear. V10 CNA wore the contaminated gloves to provide catheter care/perineal care. V10 CNA stated '(R12) is very red, swollen and looks sore' when cleansing R12's perineal area. R12's penis showed red, raw areas that encompassed the girth of R12's penis. R12 stated 'oh. That is sore.' When V10 CNA was providing perineal care. On 1/15/26 at 11:25 AM V10 CNA stated she should have gotten a new box of gloves instead of using the contaminated gloves to wear to provide catheter care/perineal care for R12.On 1/15/26 at 1:15 PM V2 Director of Nurses (DON) stated the staff should not cross contaminate during perineal care. V2 DON stated V31 CNA should have changed her gloves prior to completing perianal care. V2 DON stated this could cause an infection. V2 DON stated once an item touches the floor it is considered contaminated and should not be used. V2 DON stated V10 CNA accidently knocked the gloves off of the table but should have thrown them away, washed her hands and applied new gloves prior to completing catheter care for R12. V2 DON stated the facility does have policies for incontinence care/catheter care/perineal care but the policies do not address these specific concerns. V2 DON stated the expectation is for staff to not cross contaminate residents perineal (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	areas while performing cares.