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 02/17/2026
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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 identify a newly admitted resident as a potential elopement risk and failed to provide supervision and interventions to prevent elopement for one of four (R1) residents reviewed for elopement on a sample list of four. These failures resulted in R1, a severely cognitively impaired resident at risk for falls with impaired safety awareness, leaving the facility unsupervised on foot with no coat or shoes on with outside temperatures below freezing. R1 was found by family members six tenths of a mile from the facility in a restaurant parking lot near two interstates/highways eight hours after the resident was last observed in the facility. R1 suffered frostbite to bilateral feet great toes due to environmental exposure, hypothermia, a fracture to the proximal phalanx of left great toe, and a hematoma with laceration to the right frontal forehead requiring hospitalization.The immediate jeopardy began on 2/7/26 at approximately 11:00 pm when R1 was last seen in the facility. R1 left the facility unnoticed and traveled six tenths of a mile away from the facility on foot with no coat or shoes on with outside temperatures below freezing. V1, Administrator, was notified of the Immediate Jeopardy on 2/11/26 at 3:55 p.m. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 2/8/26, but non-compliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.R1's face sheet documents R1 is 99-years old and admitted to the facility on [DATE].R1's Minimum Data Sheet (MDS) section C with print date of 2/10/26 documents R1 has severe cognitive impairment.R1's initial elopement evaluation assessment dated [DATE] was not completed in full before V12 Social Service Director (SSD) locked assessment as completed which then indicated R1 was not an elopement risk.R1's Care Plan, undated, documents R1's diagnoses as Gastrointestinal Hemorrhage, Hypertensive Urgency, Anemia, Atherosclerotic Heart Disease, Presence of Aortocoronary Bypass Graft, Abdominal Aortic Aneurysm, Chronic Obstructive Pulmonary Disease, Dementia, Psychotic Disturbance, Mood Disturbance, Anxiety, Delirium, Gout, Benign Prostatic Hyperplasia Without Lower Urinary Tract Symptoms, and Personal History of Malignant Neoplasm of Prostate.R1's Care Plan, undated, documents current skin impairment, increased risk for falls related to gait imbalance requiring walker and gait belt, impaired cognitive function, impaired communication, impaired hearing requiring hearing aids, and impaired visual function requiring the use of glasses.R1's community survival skills assessment completed on 2/8/26 by V12 Social Service Director (SSD), documents R1 has no safety awareness and survival skills if outside the facility on R1's own and recommends R1 not be unsupervised outside. R1's Undated Care Plan documents a new intervention dated 2/8/26 for increased risk of elopement.Progress Notes dated 2/2/26 at 7:56PM document R1 had an unwitnessed fall in his room with neuro checks to be completed through 2/5/26.The Facility Investigation Notes dated 2/7 to 2/8/2026 document on 2/8/26 at 6:09AM, V8 Nurse Supervisor Licensed Practical Nurse (LPN) notified V9 Director of Nursing (DON), that R1 was missing from the facility. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At 6:11 AM V9 DON notified V1 Administrator of the incident. At 7:06AM, V14 Certified Nurse Assistant (CNA) located R1 in a restaurant parking lot and at 7:07AM, V14 CNA called 911. On 2/8/26 at 7:16AM, EMS arrived on scene and transported R1 to the local hospital for evaluation.R1's Hospital Records dated 2/10/26 document R1 arrived at the Emergency Department at 7:23AM on 2/8/26. The Hospital Records document R1 was hypothermic with a temperature of 94.8 degrees Fahrenheit (F), with frostbite to bilateral great toes and additional digits related to environmental exposure, discoloration of bilateral hands, abrasions to bilateral knees, a hematoma to the forehead, a comminuted fracture through the distal neck and head of the proximal phalanx of the left great toe extending to the articular surface, and that R1 was disoriented and complaining of back pain. The Records document R1 was found with no coat and no shoes on.V14 Certified Nurses Aide's (CNA) statement dated 2/8/26 documents on 2/8/26 at 5:40AM V14 entered through the front entrance of the facility for her shift and noticed a bedside table sitting by the door. While completing morning vital signs, V14 noted that R1 was not in his room and alerted V8 Licensed Practical Nurse at that time. V14 found R1 at a local restaurant and placed her coat over his shoulders and called 911. The statement documents that R1's family arrived around the same time as V14 at the restaurant parking lot.The Facility Investigation File documents on 2/8/26, time unknown, V8 Licensed Practical Nurse (LPN) stated she last saw R1 at 11:00PM in his room in bed. The File documents V8 denied hearing any door alarms throughout the night and stated she was alerted to a missing resident around 5:30AM.R1's Progress Notes dated 2/9/26 document the Interdisciplinary Team (IDT) met following R1's unauthorized leave and the root cause was determined to be confusion/wandering behavior.The Facility Final Report dated 2/13/26 documents R1 was hospitalized with frostbite to toes and bilateral feet, hypothermia, Urinary Tract Infection (UTI), and fracture to the left great toe. The Report documents R1 was reassessed for risk of elopement and community survival skills and R1's Plan of Care was updated to reflect current risk of elopement and associated behavioral needs.The Google Map Application dated 2/17/26 documents the distance from the facility to the location R1 was found is 0.6 miles.The World Weather Forecast Temperature Charts dated 2/7/26 and 2/8/26 for the facility location document the temperature at 11:00PM on 2/7/26 was 25 degrees F with a real feel of 16 degrees F and the temperature at 7:00AM on 2/8/26 was 27 degrees F with a real feel of 15 degrees F.The Facility Daily Assignment Sheet dated 2/7/26 third shift, documents V8 LPN and V15 LPN were the nurses on shift between the hours of 10:00PM and 6:00AM. The Daily Assignment Sheet documents V16 CNA, V17 CNA, V18 CNA, and V19 CNA were the Certified Nursing Assistants for the third shift on 2/7/26 between the hours of 10:00PM and 6:00AM. The Facility Daily Assignment Sheet dated 2/8/26 first shift, documents V14 CNA worked from 6:00AM to 2:00PM.On 2/11/26 at 12:55 PM V14 CNA confirmed V14's statement dated 2/8/26. V14 stated V14 noted R1 missing the morning of 2/8/26 after arriving for the day shift and V14 alerted V8 LPN that R1 was not in his room.On 2/8/26 at 8:00AM, V15 Licensed Practical Nurse (LPN) stated that he was the overnight nurse for the other wing and stated he was completing wound rounds at end of the shift when he was alerted there was a Code Pink (Missing Resident).Attempts were made during the survey to contact V8 LPN, V16 CNA, V17 CNA, V18 CNA and V19 CNA night shift staff.On 2/10/26 at 1:15PM V10 Hospital Registered Nurse stated that R1 sustained a hematoma with skin tear to the right forehead area, bilateral foot frostbite involving great toes and additional digits due to environmental exposure, and fracture to left proximal phalanx great toes requiring a surgical shoe. V10 stated R1 was currently being treated for a Urinary Tract Infection with Intravenous Antibiotics. On 2/10/26 at 2:05 PM V6, Facility Nurse Practitioner, stated that R1 could have suffered kidney failure, hypothermia, loss of limbs, falls, fractures, heart attack, and ultimately death from being unattended outside of facility. V6 stated R1 has (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	poor cognition, is extremely hard of hearing, has poor vision, and has no safety awareness.At 11:50AM on 2/10/26, V1 Administrator, and V2 Regional Operations Director, stated that the facility does not have cameras and that through interviews and witness statements, R1 was identified as last seen around 11:00PM on 2/7/26 and was not identified as missing until 6:05 AM the following morning on 2/8/26. V1 and V2 stated R1's family was notified and family found R1 at approximately 7:00AM.On 2/10/26 at 9:55AM, V4, R1's Family Member, stated on 2/8/26 at 6:55AM she was notified by facility staff that R1 was missing. V4 stated at 7:00AM, V4 and V4's spouse found R1 crouched down by a wall at a restaurant on the way to the facility wearing a T-shirt, sweatshirt, jeans and socks. V4 stated R1 did not have a coat, hat or shoes on. V4 stated R1, complained he was cold, and the wind was very bad. V4 stated R1 had a visible knot on his forehead and R1's left-hand fingers were blue. R1 stated he had been a bad boy and that he had wandered into the hallway looking for help when he wandered out. V4 stated R1 stated that he fell several times that night. V4 stated that R1 required a walker to walk, but the facility did not have one for R1, so he did not have any walking aid when found at the restaurant that morning. V4 stated upon admission to local emergency room, R1 was found to have frostbite to the left index finger and right and left great toes, and R1's left great toe was broken and at this time, amputation of frostbit extremities is still a possibility. V4 stated R1 was also found to have a urinary tract infection at the hospital that R1 did not have at the time of admission to the facility five days prior. V4 also stated that R1 was found in clothing from the day prior, and R1's hearing aides were in R1's ears but not charged, R1's dentures were in place, and R1 did not have his glasses on. V4 stated V4 believes R1 was never assisted to bed that evening prior. V4 also stated that after admission to facility on 2/2/26, R1 had fallen in the facility. On 2/10/26 at 11:30 AM, V5 Receptionist stated there is an elopement alert binder at the front desk that identifies residents who are at risk of elopement. V5 stated there is always someone at the front desk from 8AM to 8PM seven days a week and prior to leaving shift, the outside front door is locked so no one can enter, and the inside exit door is alarmed a with code.On 2/10/26 at 9:00AM the restaurant parking lot where R1 was found, 0.6miles from the facility, was noted to be located at the intersection of two major highways. The policy titled Code Pink-Missing Resident/ Elopement, dated 11/2017, documents the facility maintains a process to assess all residents for risk for elopement, implement risk reduction strategies for those identified as an elopement risk, and institute measure for resident identification at the time of admission.The Immediate Jeopardy that began on 2/7/26 was removed on 2/8/26 when the facility took the following actions to remove the immediacy:1.) R1 was reassessed for risk of elopement and community survival skills and R1's Plan of Care was updated to include R1's current risk of elopement and associated behavioral needs by V12 SSD on 2/8/2026. The facility has a plan to have R1 on one to one observation when R1 returns.2.) On 2/8/26, V11 Maintenance Director reviewed the incident and confirmed door alarms/system functional status.3.) The elopement binder was reviewed and updated on 2/8/2026, completed by V12 SSD, V13 SSD, V21 MDS, V9 DON and V1 Administrator.4.) Code Pink Education and Rounding Expectations were provided to 100% of staff on 2/8/2026, completed by V22 Human Resource Director, V20 CNA Scheduler, V9 DON, V3 ADON, & V1 Administrator.5.) All residents were assessed for risk of elopement and community survival by V12 SSD, V13 SSD, V21 MDS, and V8 admission Nurse on 2/8/2026.6.) All residents will be reevaluated for elopement risk at admission, readmission, quarterly, annually, and significant change or incidentally if at risk behaviors are identified. This will be on-going. SSDs assigned this responsibility as of 2/8/26. Audit will be reviewed by the administrator or designee for six weeks.7.) On 2/8/2026 100% of staff were in serviced regarding wandering/exit seeking behavior, and when to provide/implement increased supervision to a (continued on next page)

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