

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 07/31/2026
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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident received timely antibiotic therapy for a wound infection, failed to notify the physician of new wounds and obtain treatment orders, and failed to follow Enhanced Barrier Precautions, complete wound assessments and update wound care plans for two of four (R4 and R6) residents reviewed for pressure sores on the sample list of 20. Failing to ensure R4 received timely antibiotic therapy resulted in R4's pressure sore continuing to deteriorate and R4 experiencing severe pain. Findings Include: The facility's Risk Call Procedure, revised January 2022, documents that the Risk Call process is designed to review facility-acquired pressure ulcers, identify the root cause of the facility-acquired pressure ulcer, determine whether the care plan was updated with new interventions, and determine whether the pressure ulcer was unavoidable. The facility's Physician-Family Notification - Change in Condition Policy, revised November 2018, documents the facility will notify the resident, physician, and resident representative when there is a significant change in the resident's condition, including the development of Stage II pressure ulcers. The facility's Comprehensive Care Plan policy, revised August of 2017, documents the facility will develop and implement a comprehensive person-centered care plan for each resident. The care plan must describe services that are to be furnished to attain the resident's highest practicable physical, mental, and psychosocial well-being. The facility's Skin Condition Assessment & Monitoring - Pressure and Non-Pressure Policy, revised June 2018, documents that its purpose is to establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown and ensuring interventions are implemented. The policy documents that pressure and other ulcers will be assessed and measured weekly by the licensed nurse and documented in the resident's clinical record. The policy further documents that when weekly changes requiring physician or responsible party notification occur, those individuals will be notified and the notification will be documented in the clinical record. These changes include new onset of purulent drainage, new onset of odor, increased wound-related pain, and the onset of new ulcers. The resident's care plan will be revised, as appropriate, to reflect changes in skin integrity, interventions, and goals of care. The facility's Enhanced Barrier Precautions Policy, revised December 2025, documents that Standard Precautions must be followed with all care. Additionally, gown and gloves must be worn when assisting a resident with incontinence care, dressing, and providing hygiene. The facility's Certified Nursing Assistant Policy, revised July 2023, documents Certified Nursing Assistants are to reposition bedridden residents at least every two hours, or more frequently if clinically indicated. 1. R4's admission Assessment, dated 3/25/26, documents excoriation to the coccyx. R4's Nurse Practitioner Note, dated 3/27/26, documents R4 was recently hospitalized following a mechanical fall resulting in a vertebral fracture. R4 had a thoracolumbosacral orthosis (TLSO) brace (back brace) applied and R4's past medical history includes, Dementia, Hypertension, (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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Anxiety, Depression, and Spinal Stenosis.R4's Treatment Administration Record, dated March 2026, documents an order for Miconazole Nitrate Powder 2% to be applied to a rash every 12 hours as needed.R4's Nursing Note, dated 5/5/26, documents a 2 centimeter (cm) length by 2.5 cm width abrasion to R4's left buttock and that the physician was notified.On 7/29/26 at 12:44 PM, V9 Assistant Director of Nursing (ADON), stated the facility was not completing Risk Management Assessments for skin conditions and that these were instead being documented under a Skin-Other Assessment. V9 confirmed there was neither a Risk Management Assessment nor a Skin-Other Assessment completed for R4's left buttock wound identified on 5/5/26. V9 stated a Skin-Other Assessment should have been completed but acknowledged it was not completed because V9 was unaware one was required.R4's Weekly Skin Observation Note, dated 5/26/26, documents an abnormal, discolored area on the right heel measuring 3.0 cm length x 4.2 cm width. The note documents that treatment was initiated, appropriate notifications were completed, and R4's Care Plan was updated.R4's Care Plan, dated 6/10/26, documents skin impairment of the left buttock and right heel related to fragile skin. R4's interventions, all dated 6/10/26, included encouraging adequate nutrition and hydration to promote skin integrity, monitoring the wound sites for signs and symptoms of infection, completing treatments as ordered, and having the wound care provider assess and treat the wounds as needed.On 7/29/26 at 9:19 AM, V9 ADON confirmed no new or individualized care plan interventions were implemented after R4's wounds were identified on 5/5/26 and 5/26/26. V9 stated individualized interventions should have been added to the care plan.R4's Nursing Note, dated 6/9/26, documents the wound care provider debrided R4's left buttock wound. The note further documents the wound had an odor, moderate purulent drainage, and signs and symptoms of infection. A wound culture was obtained.R4's Wound Assessment Details Report, dated 6/9/26, documents the left buttock wound measures 4.5 cm length by 4.0 cm width by 0.6 cm depth.R4's Administration Record, dated June 2026, documents a physician's order for Ciprofloxacin 500 milligrams (mg) to be administered by mouth twice daily for 10 days to treat R4's wound infection. The order was scheduled to begin on 6/12/26 and end on 6/22/26.R4's Nursing Note, dated 6/16/26, documents the left buttock wound had moderate serosanguineous drainage and a slight odor. The note also documents a wound culture was obtained and sent to the laboratory by the wound care provider.R4's Final Results, reported 6/22/26, document the wound culture results, including the identified pathogens and recommended antibiotic susceptibilities.On 7/30/26 at 3:15 PM, V42 Chief Executive Officer of the laboratory company stated R4's wound culture results were collected on 6/16/26 and transmitted to V27 Nurse Practitioner on 6/22/26.R4's Wound Assessment Details Report, dated 6/23/26, documents the left buttock pressure ulcer has moderate purulent drainage and signs of infection. The report documents the wound measures 5.0 cm length by 3.0 cm width by 2.0 cm depth.R4's Visit Report, dated 6/23/26, documents signs and symptoms of infection were present in the left buttock pressure ulcer and antibiotics were prescribed.R4's Nursing Note, dated 6/23/26, documents wound rounds were completed with the wound care provider and no new orders were received.On 7/31/26 at 10:04 AM, V27 Nurse Practitioner stated V27 recalled providing wound care for R4. V27 stated that by R4's third wound care visit, the wound had declined. V27 stated V27 became concerned because, although V27 was performing debridement, ordering treatment, and managing the wound, V27 questioned whether R4 was being repositioned every two hours. V27 stated V27 asked facility staff whether R4 was being repositioned every two hours and was informed that repositioning was being completed.On 7/31/26 at 11:47 AM, V27 stated V27 received R4's wound culture results via email on 6/22/26 but did not recall reviewing the results until 6/29/26, when V27 prescribed a different antibiotic. V27 stated that when V27 evaluated R4 on 6/23/26, V27 believed R4 remained on antibiotic (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	hand hygiene, changed gloves, and cleansed the wound. During cleansing of the left buttock wound, R4 winced and moaned in pain. The wound bed contained approximately 60% red granulation tissue and 40% necrotic tissue. A small amount of serosanguineous drainage was observed on the removed dressing, which was dated 7/27/26. V26 photographed the wound. V27 explained the left buttock wound would be debrided. V27 applied lidocaine spray, debrided the wound, and obtained wound measurements. After additional lidocaine was applied and allowed to take effect for several minutes, the debridement resumed. Minimal bleeding was observed. V9 performed hand hygiene and applied the ordered dressing in accordance with the physician's order. R4's right heel dressing was completed using the same technique. 2. R6's Minimum Data Set, dated [DATE], documents R6 is moderately cognitively impaired. R6's admission Assessment, dated 12/30/25, documents R6 has excoriation and redness to the coccyx. R6's Physician Order, dated 1/1/26, documents a treatment order for a skin tear located on the coccyx. R6's Care Plan, dated 1/2/26, documents R6 is at risk for impaired skin integrity related to diabetes, impaired mobility, incontinence, fragile skin, and aging/disease process with interventions including, assessing and documenting changes in skin status, reporting pertinent changes in skin status to the physician, using a pressure-relieving cushion while R6 is up in a chair, and completing weekly treatment documentation including measurements of each area of skin breakdown, including width, length, depth, type of tissue, exudate, and other notable changes or observations. R6's Nursing Note, dated 1/24/26, documents R6 was sent to the hospital for evaluation of a kidney stone obstruction. R6's Other Progress Notes from the local hospital, dated 1/29/26, document R6 has an unstageable pressure injury to the coccyx measuring 2 centimeters (cm) length by 1.5 cm width. The notes further document R6 has an unstageable pressure injury to the left sacrum measuring 3 cm length by 2 cm depth and a deep tissue pressure injury to the right sacrum measuring 1 cm length by 1 cm width. The documentation indicates all wounds were present on admission to the hospital. R6's admission Assessment, dated 2/7/26, documents R6 has open areas to the right and left buttocks. R6's Nursing Note, dated 2/17/26, documents R6's second skin assessment was completed, and redness was noted to R6's right back area with one open area containing eschar and another open area containing slough. R6's Electronic Medical Record does not contain documentation of wound measurements, wound assessments, or physician notification regarding R6's wounds until 2/20/26. R6's Wound Assessment Details Report, dated 2/20/26, documents R6 has an unstageable pressure ulcer to the left buttock, identified on 2/8/26, measuring 1.2 cm length by 1 cm width by 0 cm depth. R6's Wound Assessment Details Report, dated 2/20/26, documents R6 has a Stage III pressure ulcer to the coccyx, identified on 2/8/26, measuring 2 cm length by 1.5 cm width by 0.3 cm depth. R6's Treatment Administration Record, dated February 2026, documents a physician order for treatment to R6's coccyx with a start date of 2/20/26. The record also documents a physician order for treatment to R6's left buttock with a start date of 2/20/26. The record does not document treatment orders for R6's wounds identified upon readmission on [DATE] until 2/20/26. R6's Care Plan, dated 3/15/26, documents R6 has a pressure ulcer located on the coccyx and left buttock with interventions including monitoring the site for signs and symptoms of infection. R6's Care Plan does not include additional individualized interventions for the treatment or prevention of pressure ulcers after the wounds were identified on 2/8/26. R6's Care Plan, dated 4/14/26, documents R6 was placed on Enhanced Barrier Precautions (EBP) due to chronic wounds and documents staff must wear a gown and gloves when providing the following care: dressing, bathing/showering, providing hygiene, changing linens, incontinence care, medical device care, and wound care for R6. R6's Wound Assessment Details Report, dated 7/21/26, documents R6 has a Stage III pressure ulcer to the coccyx measuring 4 cm x 1.8 cm x 0.3 cm depth. On 7/27/26 at 9:46 AM, R6 was seated in a (continued on next page)		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on observation, interview, and record review, the facility failed to designate a Registered Nurse as a full time Director of Nursing. This failure has the potential to affect all fifty-five residents residing in the facility. Findings include: During the survey period on 7/22/26, 7/23/26, 7/27/26, 7/28/26, 7/29/26, and 7/31/26, there was not a designated Director of Nursing working in the facility. On 7/28/26 at 9:40 AM, V15, Registered Nurse, stated the facility did not currently have a Director of Nursing. On 7/28/26 at 9:48 AM, V18, Licensed Practical Nurse, stated the facility did not currently have a Director of Nursing but had a Regional Nurse checking on things. On 7/28/26 at 12:37 PM, V4, Regional Nurse, stated V4 was not at the facility full time due to being responsible for multiple facilities. V4 stated another Regional Nurse, V2, was likewise not at the facility full time due to also being responsible for multiple facilities. On 7/28/26 at 12:55 PM, V9, Assistant Director of Nursing, stated there was not a designated Director of Nursing at the facility and neither V2 nor V4 was at the facility full time. On 7/29/26 at 3:22 PM, R16 stated R16 had missed one dose of an intravenous antibiotic due to the medication being stored in a room on a different hall of the facility from where R16 resided. R16 stated the nursing staff needed to be more organized. R16 stated R16 could not ever speak to a Director of Nursing, only being able to speak with the nurses on duty. R16 stated the nursing staff needed to take their direction from a Director of Nursing. On 7/31/26 at 9:20 AM, V1, Administrator, stated the facility did not have a designated Director of Nursing. V1 stated V1 had worked at the facility approximately forty-five days and there had not been a designated Director of Nursing during his time worked. V1 stated the Regional Nurses were not at the facility full time. The facility's Illinois Department of Public Health License, Permit, Certification, Registration effective 5/27/26, issued as conditional status, expiration date of 11/22/26, documents the facility has a licensed bed capacity of 64 beds, and all 64 beds are categorized as skilled nursing. The facility's Resident Roster dated for 7/22/26 documents fifty-five residents reside in the facility, all of whom require skilled nursing services.		