STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016687	A. BUILDING: _____ B. WING _____	C 02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC AT HICKORY POINT	565 WEST MARION AVENUE FORSYTH, IL 62535

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Facility Reported Incident of January 6, 2025 IL186745	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999		

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S9999	Continued From page 1	S9999		

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to ensure two staff members completed a mechanical lift transfer for one of three (R1) residents reviewed for accidents in a sample list of three residents. This failure resulted in R1 injuring R1's leg during a transfer and suffering a femur fracture requiring hospitalization and retrograde nailing.

Findings include:

The Facility's Mechanical Lift Policy, dated 5/26/2009, documents when using a mechanical lift for transfers two staff members need to be present.

R1's Minimum Data Set (MDS), dated 11/20/24, documents R1 is severely cognitively impaired.

R1's care plan, dated 11/27/24, documents R1 transfers with a mechanical lift and assistance of two people.

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R1's Nurse Progress Note, dated 1/6/25 at 2:30 AM, documents R1 began yelling to "get up" around 12:15 AM, V6, Certified Nursing Assistant, assisted R1 out of the bed with a mechanical lift and transferred R1 to her wheelchair. The Note documents R1 was brought out to the nurses' station around 1:00 AM and R1 began yelling and screaming that her leg hurt. V7, Licensed Practical Nurse, documented R1 was unable to move her right lower extremity independently and it appeared displaced. The Note documents when given medications around 7:00 PM, R1 was in normal mood without pain. There was no trauma or injury to affected area, no recent fall, and no popping sounds within the shift. V7 further documented 911 was called around 1:30 AM, and R1 was sent to the emergency room.

R1's x-ray report, dated 1/6/25, documents "oblique displaced fracture of the distal right femur."

The Hospital Discharge Summary, dated 1/8/25, documents R1 underwent a retrograde nailing on 1/6/25 to repair R1's fractured femur.

On 2/26/25 at 10:35 AM, V6, Certified Nursing Assistant, stated on 1/6/25, R1 was yelling out that she needed to go to the bathroom. Using the mechanical lift (sit to stand lift), V6 assisted R1 up out of the bed and transferred her to her wheelchair. V6 stated R1 was complaining of pain once she got in the wheelchair. V6 stated she took R1 to the nurse's station where the nurse assessed R1 and sent her to the emergency room because her right leg "did not look right."

On 2/26/25 at 12:50 PM, V7, licensed Practical Nurse, stated she came into work at 6:00 PM on

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1/6/25. V7 stated she gave R1 her evening medications between 7:00-8:00 PM. R1 was sitting up in her chair and went to bed like normal. V7 stated R1 woke up around 1:00 AM, yelling to get out of bed, V6, Certified Nursing Assistant, went to R1's room and assisted R1 out of bed using the mechanical lift, and brought her out to the nurse's station in R1's wheelchair. R1 was screaming and yelling that her leg was hurting. V7 stated she assessed R1, and her right leg looked like it was "dangling", and V7 could tell with R1 sitting in the chair that her leg looked displaced. V7 stated, "I can't say that (R1) was transferred incorrectly because I was not in the room during the transfer. We placed (R1) in her bed to get her ready before the ambulance arrived, and (R1's) leg was clearly displaced and paramedics gave (R1) pain medications prior to leaving for the emergency room."

R1's Incident Report, dated 1/10/25, documents R1 had not had any recent falls or injuries in the facility.

On 2/26/25 at 11:45 AM, V8, Family Member, stated he never received answers as to what happened to R1 on 1/6/25 from the facility. V8 stated his concern was R1 went to bed fine, and then at 1:00 AM, R1 was screaming and in pain stating her leg hurt. V8 stated he spoke with V9, Orthopedic surgeon, at the hospital, and he stated R1 had a spiral fracture of her right femur and felt like it may have been caused during R1's transfer at the facility.

On 2/26/25 at 1:25 PM, V9, Orthopedic Surgeon, stated he may have told R1's son the facility transferred R1 incorrectly, but he doesn't like to put information or opinions out there that can be used against a facility.

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