STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000501	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC AT HICKORY POINT	565 WEST MARION AVENUE , FORSYTH, Illinois, 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) COMPLETION DATE
S0000	Initial Comments Facility Reported Incident of July 9, 2025 / 2595356	S0000		09/16/2025
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)6) 300.1220 b)3) 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		09/16/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to ensure fall interventions were in place for one (R1) of three residents reviewed for falls on a sample list of seven. This failure resulted in R1 falling and sustaining multiple left-sided rib fractures, a collection of blood in the chest cavity, and a left sided collapsed lung. Findings include: The facility's "Fall Prevention Program" policy provided by V1, Administrator, does not contain a date. This documents the purpose of this policy is to assure	S9999		

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S9999	Continued from page 2 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. Quality Assurance Programs will monitor the program to assure ongoing effectiveness. Guidelines for the Fall Prevention Program included the following components: methods to identify risk factors, methods to identify residents at risk, educate resident and resident representative to fall prevention program at time of admission, throughout residents stay, and when changes occur, assessment time frames, use and implementation of professional standards of practice, immediate change in interventions that were successful, notification of physician, family/legal representative, communication with direct care staff members, documentation requirements, adherence to manufacturer's recommendation in us of alarm and medical devices and special care equipment. The policy documents the resident's Care Plan will incorporate the following: identification of all risk/issue, addresses each fall, interventions are changed with each fall, as appropriate, and preventative measures. This policy documents the following standards: a Fall Risk Assessment will be performed by a licensed nurse at the time of admission. The assessment tool will incorporate current clinical practice guidelines, safety interventions will be implemented for each resident identified at risk, the admitting nurse and assigned CNA are responsible for initiating safety precautions at the time of admission, all assigned nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained, and the Director of Nursing or Designee is responsible for monitoring the Fall Prevention Program, including further staff educations programs, purchase of additional equipment, or other appropriate environmental alterations. R1's profile sheet, dated 6/30/25, documents a medical diagnosis of repeated falls. R1's Fall Risk Assessment, dated 06/29/25, documents R1's assessment score was 13.0 on a scale of zero (low risk) to fourteen (high risk). R1's Care Plan, dated 7/01/25, documents R1 is at risk for falls related to weakness and partial paralysis on one side of R1's body following a stroke that affected R1's left non-dominant side. R1's MDS (Minimum Data Set) Admission Assessment, dated	S9999		

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S9999	Continued from page 3 7/08/25, documents R1 requires partial to moderate assistance with toileting hygiene including the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. R1's Nursing Note, dated 7/09/25, documents a Certified Nursing Assistant (CNA) found R1 on the bathroom floor while doing rounds at 8:35 PM. This note documents the nurse assessed R1 and found there to be a red mark on her left upper back (by the rib cage) and found there to be a displacement or a deformity in her rib cage. Computed Tomography (CT) scan of R1's chest, dated 7/10/25, documents R1 had multiple left-sided rib fractures, a collection of blood in the chest cavity, and a left sided collapsed lung. A follow-up X-ray of R1's chest, dated 7/10/25, documents R1's left-sided collapsed lung had worsened, was moderate in size, and had an increase in bleeding and bruising. This x-ray also documents "multiple rib fractures." On 9/03/25 at 9:45 AM, V10, Licensed Practical Nurse, stated she was the nurse caring for R1 at the time of R1's fall. V10 stated R1 was a known fall risk and R1 didn't have any fall interventions in place. On 9/03/25 at 12:48 PM, V11, CNA, stated R1 was a known fall risk, and the only intervention she knew of was to put R1's bed in the low position. On 9/3/25 at 1:35 PM, V14, MDS/Care Plan Coordinator, stated she did a Baseline Care Plan for R1 on admission, and it included falls as a problem. V14 stated the only intervention that was marked on the Care Plan was for staff to ensure R1 was wearing appropriate footwear. V14 stated other fall interventions should have been on the R1's Care Plan for the prevention of falls. On 9/03/25 at 2:27 PM, V15, CNA, stated she knew R1 was a fall risk and there were no fall interventions in place that she was aware of. On 9/03/25 at 2:38 PM, V16, CNA, stated she didn't know R1 was a fall risk, but some of the CNA's would put R1's bed in the low position. V16 stated there were no other fall interventions. On 9/03/25 at 1:40 PM, V13, Assistant Director of Nursing/LPN, confirmed R1's fall risk assessment was completed on 6/29/25, and R1's score was 13, indicating she was at a high risk for falls. V13 stated fall risk	S9999		

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S9999	Continued from page 4 assessments are completed to determine a resident's risk for falls and to develop appropriate interventions according to the resident's risk. On 9/03/25 at 2:54 PM, V12, Regional Nurse Consultant, stated they have an "IT" (Information Technology) issue with Care Plans, and fall interventions should have been in place. On 9/03/25 at 1:35 PM, V2, Director of Nursing, stated R1 was pleasantly confused and easily redirected. V2 stated R1 was a fall risk, and that having fall interventions in place could have changed R1's outcome. On 9/03/25 at 3:47 PM, V17, Physician (former Medical Director), stated if there had been proper fall protocols and precautions in place for R1 it might have changed R1's outcome. (A)	S9999		