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 01/15/2026

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 Complaint investigation 25612852/2704474	S0000		
S9999	Final Observations Statement of Licensure Violations 300.1210 b) 300.1210 c) 300.1210 d)6) 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. 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 regulations were not met as evidenced by: R7's medical record documents medical diagnoses as Encephalopathy, Falls, Vascular Dementia with Behavioral Disturbance, Abnormal findings on diagnostic	S9999		

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

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S9999	Continued from page 1 imaging of other parts of musculoskeletal system, Anemia, Weakness and Pacemaker. R7's Minimum Data Set (MDS) dated 11/14/25 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 1/1/26 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 1/1/26 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	S9999		

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S9999	Continued from page 2 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 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	S9999		

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S9999	Continued from page 3 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. (B)	S9999		