

Illinois State Department of Health

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 02/17/2026	
NAME OF PROVIDER OR SUPPLIER ARC AT HICKORY POINT				STREET ADDRESS, CITY, STATE, ZIP CODE 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		S0000				
	Complaint Investigation 2661718/IL2738430						
S9999	Final Observations		S9999				
	Statement of Licensure Violations:						
	300.610 a)						
	300.1210 b)						
	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.						
	These regulations were not met as evidenced by:						
	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						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 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. Findings include: R1's face sheet documents R1 is 99-years old and admitted to the facility on 2/2/2026. 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 2/2/26 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		S9999				

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S9999	Continued from page 2 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. 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.			S9999			

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S9999	Continued from page 3 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.			S9999			

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S9999	Continued from page 4 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 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		S9999				

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S9999	Continued from page 5 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. (A)			S9999			