

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000496		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/11/2026	
NAME OF PROVIDER OR SUPPLIER Arc at Sangamon Valley				STREET ADDRESS, CITY, STATE, ZIP CODE 3400 WEST WASHINGTON , SPRINGFIELD, Illinois, 62711			
(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			03/26/2026	
	Complaint Investigations:						
	2641120/2728979						
	2641342/2731404						
S9999	Final Observations		S9999			02/26/2026	
	Statement of Licensure Violations:						
	300.610a)						
	300.1210b)						
	300.1210d)2)5)						
	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.						
	d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be						

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 practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These Regulations are not met as evidenced by: Based on interview and record review the facility failed to prevent pressure ulcers from developing and deteriorating for 1 out of 1 (R164) resident; reviewed for quality of care in a sample of 32. This failure led to R164 developing facility acquired pressure injuries with wound infection, ultimately requiring her to be admitted into the hospital. Findings include: R164's Facesheet documented she was admitted to the facility on 1/6/26 and discharged from the facility on 1/26/26 with diagnoses of, in part, fracture of unspecified part of neck of right femur, encounter for orthopedic aftercare, urinary tract infection, and posterior arch fracture of first cervical vertebra. R164's Minimum Data Set (MDS) dated 1/12/26 documented she was severely cognitively impaired, and completely dependent on staff for toileting hygiene, showering/bathing, and all mobility including rolling from left and right in bed. R164's MDS continued to document she was always incontinent of bowel and bladder. R164's Care Plan dated 1/7/26 documented she has a fractured femur and vertebra related to a fall with an intervention for staff to assist with ADLs (activities of daily living) as needed, on 1/6/26 at risk for a skin impairment related to decreased mobility with interventions, in part, for staff to monitor/document location, size and treatment of skin injury and report abnormalities, failure to heal, signs/symptoms of infection, maceration to doctor. R164's Care Plan continued to document on 1/6/26 she has an actual skin impairment to coccyx with interventions for staff to		S9999				

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S9999	Continued from page 2 provide treatment as ordered, wound doctor to assess and treat as needed, and monitor site for signs/symptoms of infection. R164's skin impairment to coccyx Care Plan was not updated after 1/6/26. R164's Risk Assessments for Braden Scales dated 1/7/26, 1/13/26, and 1/23/26 all documented her being at high risk for pressure injury. R164's Wound Summary for her pressure wound on coccyx/left buttock documented it started out as a stage two with a size of 0.5 cm (centimeters) x(by) 0.5 cm x 0.10 cm on 1/6/26 and was facility acquired. On 1/14/26 the wound size increased to 4 cm x 8 cm x 0.1 cm and remained stage two. On 1/26/26 it was documented to be stage three with a size of 4 cm x 3 cm x 0.1 cm. The report also documented on 1/26/26 that the source was changed from present on admission to facility acquired per wound MD (medical doctor) and wound site was changed from coccyx to coccyx/left buttocks due to two areas on the coccyx now. R164's Wound Summary for her pressure wound to left buttock documented it to be facility acquired with a date identified on as 1/14/26. On 1/21/26 it was stage two with measurements of 3 cm x 4 cm x 0.1 cm. On 1/26/26 it became unstageable with same measurements. Wound Visit Report dated 1/9/26 documented R164's coccyx wound #1 was a stage two pressure injury with measurements of 0.4 cm x 0.3 cm x 0.1 cm with wound care orders to cleanse with normal saline/wound cleanser, dress with collagen particles/powder then apply a foam dressing with border to be completed daily and as needed. Wound Visit Report dated 1/16/26 documented R164's coccyx wound #1 deteriorated to a stage three pressure injury and had measurements of 3 cm x 0.5 cm x 0.3 cm. The report further documented wound care orders were to cleanse with normal saline/wound cleanser, dress with honey then apply foam dressing with border to be completed daily and as needed. Wound Visit Report dated 1/16/26 documented R164's wound #2 developed and was a stage two with measurements of 3.5 cm x 3.5 cm x 0.1 cm. The report further documented wound care orders for R164's wound #2 were to cleanse with normal saline/wound cleanser, dress with honey then apply foam dressing with border to be completed daily and as needed. Wound Visit Report dated 1/23/26 documented R164's wound #1 continued to deteriorate at a stage three with		S9999				

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S9999	Continued from page 3 measurements (pre and post debridement) of 4 cm x 1.5 cm x 1.3 cm. The report continued to document R164's wound care orders for wound #1 remained the same. Wound Visit Report dated 1/23/26 documented R164's wound #2 developed into an unstageable pressure injury with measurements of 4 cm x 5 cm x 0 cm. The report continued to document R164's wound care orders were to cleanse with normal saline/wound cleanser, apply betadine and cover with a bordered foam dressing daily and as needed. The facility's Wound Assessment Details report dated 1/26/26 at 9:50 PM, documented R164's left buttock pressure ulcer became facility acquired and was unstageable with measurements of 3 cm x 4 cm x 0.1 cm. The report comments documented left pressure injury unstageable pressure injury obscured full thickness and tissue loss. The facility's Wound Assessment Details report dated 1/26/26 at documented R164's coccyx/left buttocks pressure ulcer was facility acquired at a stage three with measurements of 4 cm x 3 cm x 0.1 cm. The report comments documented coccyx pressure injury noted to have progressed from stage two to stage three and was a late entry for assessment performed on 1/23/26. R164's Treatment Administration Record (TAR) documented an order for "coccyx cleanse with wound wash or normal saline apply collagen to wound bed cover with hydrocolloid daily and PRN one time a day every 3 day(s) for wound, skin integrity" with a start date of 1/7/26 and an end date of 1/14/26. R164's TAR documented that she missed treatment on 1/10/26, which left her without documented wound care to her coccyx for 5 days in a row from 1/7/26 until 1/13/26. R164's Treatment Administration Record (TAR) documented R164 did not have wound care to her coccyx pressure injuries for a total of 6 days during her 20 day stay at the facility on the following dates 1/8/26, 1/9/26, 1/10/26, 1/11/26, 1/12/26, and 1/19/26. R164's Weekly Skin Observation note dated 1/6/26 documented treatments include coccyx wound to cleanse with wound wash or normal saline, apply collagen to wound bed, cover with hydrocolloid daily and as needed. R164's Physician Order Sheet (POS) documented no order for daily dressings to be completed on her coccyx pressure injury until 1/14/26. Emergency Medical Services report dated 1/26/26		S9999				

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S9999	Continued from page 4 documented R146's first set of vital signs to be 129/68 (blood pressure), 70 (heart rate), 25 (respirations), 89 (oxygen saturation), 119 (blood glucose), 101.1 (temperature); signs and symptoms for call included pressure ulcer to buttocks was primary and altered mental status. Emergency Department nursing notes dated 1/26/26 at 5:52 PM, documented R164 had two sacral ulcers noted, approximately 2-3 cm each, one with eschar and the other wound open with purulent discharge. R164's CT (commuted tomography) of Abdomen and Pelvis dated 1/26/26 documented cellulitis of sacral region for impression and plan. R164's Hospital History and Physical (H&P) dated 1/26/26 documented under assessment infected sacral decubitus ulcer with abscess and surrounding cellulitis with acute encephalopathy likely secondary. The H&P further documented to start antibiotics with blood and wound cultures pending. Hospital Infectious Disease Consultation dated 1/28/26 documented R164's wound culture demonstrated Proteus mirabilis. On 2/2/26 at 1:02 PM, V9 (R164 Family Member) stated R164 would have a bowel movement and soil the wound she has on her buttocks. V9 stated the aide would let the nurse know to reapply a wound dressing on R164 but the nurse sometimes never did. V9 stated one time she left in the evening after the nurse was notified and returned the next morning with it still not covered. V9 stated R164 was sent to the hospital last Monday after she was responding differently, and her oxygen was down to 69%. V9 stated they applied R164's oxygen again, but it wouldn't go above 88% so they sent her out. V9 stated the EMT (emergency medical technician) took one look at R164's wound and stated she needed to go. V9 stated R164 was admitted to the hospital and is still there being treated for a wound infection and on IV (intravenous) antibiotics (seven days). V9 stated R164 was only at the facility for rehab after breaking her hip and the wound started out to be very small and worsened, they weren't doing wound care as ordered. V9 stated tearfully, now R164 must endure painful wound care to heal up at the hospital, it's horrible. On 2/10/26 at 9:20 AM, V1 (Administrator) stated R164's daughter would make multiple allegations, and we would discuss her daily. V1 stated V36 was our previous wound nurse but she does not work at the facility any longer and she didn't have any concerns on her care, but she		S9999				

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S9999	Continued from page 5 would enter charting a little late. V1 stated she wasn't sure on the details surrounding R164's wounds worsening and having facility acquired pressure injuries. On 2/10/26 at 9:25 AM, V26 (Mobile Director of Nursing/DON) stated she was not sure of details for why R164's pressure wounds deteriorated or developed, she started her position after R164 was discharged. V26 stated that she wasn't sure where V2 (DON) was or when she would be in, it's her last day and V36 resigned who would know more. On 2/10/26 at 9:30 AM, V37 (ADON) stated she was not sure of details for why R164's pressure wounds deteriorated or developed and V36 is no longer working with them who managed the wounds. On 2/10/26 at 9:33 AM, V26 stated their goal is to prevent pressure ulcers. On 2/10/26 at 12:24 PM V26 stated she would expect wound care orders to be followed as written by the provider unless something is not available and they are waiting on it; then she would expect to continue current until it came in, unless told otherwise. On 2/10/26 at 12:51 PM, V35 (Medical Director) stated wound care orders should be followed as written by the wound care provider and could have had the potential to cause the wound to deteriorate or become infected if not. The facility's Skin Condition Assessment and Monitoring Pressure and Non-Pressure policy last revised on 6/2018 documented each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA (certified nursing assistant). Changes will be promptly reported to the charge nurse who will perform the detailed assessment. The policy continued to document dressings will be checked daily for placement, cleanliness, and signs and symptoms of infection. The policy documented the licensed nurse will document the observation in the treatment administration record and initial the dressing to verify the treatment was performed. The policy also documented the resident's care plan will be revised as appropriate, to reflect the alteration of skin integrity, approaches and goals for care. (A)		S9999				