

Illinois Department of Public 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 04/16/2026	
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			
	Revisit to Complaint Investigations 25612852/IL2704474 and 2660271/IL2710481						
S9999	Final Observations			S9999			
	Statement of Licensure Violations:						
	1 of 3						
	300.1210b)						
	300.1210c)						
	300.1210d)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:						
	Based on observation, interview, and record review, the facility failed to implement supervision and fall interventions and thoroughly investigate falls to identify root cause and develop appropriate fall						

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 interventions for two of three residents (R202, R206) in the sample list of 15. These failures resulted in R202 falling and sustaining a head laceration that required sutures. Findings include: The facility's Fall Prevention Program dated January 2026 documents safety interventions will be implemented for residents at risk of falling, interventions are identified on the care plan, and nursing staff are responsible for ensuring ongoing precautions are implemented and maintained. This policy documents accident/incident reports will be reviewed by the interdisciplinary team to ensure appropriate care/services were provided and to determine interventions. This policy documents residents will be checked on according to their plan of care and safety monitoring for 15–30-minute periods will be documented to validate observations. On 4/13/26 at 10:03 AM R202 was sitting in his recliner in his room which was near the nurse's station. R202 had bruising below his left eye and a dressing to his left elbow. R202 stated those were injuries from a recent fall but was unable to provide any additional information regarding R202's falls. R202's Minimum Data Set (MDS) dated 3/18/26 documents R202 has moderate cognitive impairment and requires setup/cleanup assistance for toileting hygiene and supervision/touch assistance from staff for toileting transfers and walking. This MDS documents R202 requires setup/clean up assistance from staff when moving from lying to sitting, sitting to standing, and with chair/bed transfers. R202's Care Plan revised 3/12/26 documents R202 is an elopement risk, R202 has impaired safety awareness and wanders aimlessly. This care plan includes an intervention dated 2/8/26 to monitor R202's location every 15 minutes. R202's Care Plan revised 12/23/25 documents R202 is at risk for falls and includes interventions to anticipate and meet R202's needs (12/10/25), low bed (2/3/26), urinary catheter inserted and urology consult (3/29/26), and room change closer to nurse's station (3/30/26). The fall investigation dated 3/28/26 at 1:40 AM documents R202 had an unwitnessed fall while walking in the hallway causing a bump to his left forehead. R202 stated R202 was looking for the bathroom. The staff statements document R202 was last seen in bed at 12:30 AM by V31 Certified Nursing Assistant (CNA.) There is no documentation in this investigation as to when R202 was last			S9999			

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S9999	Continued from page 2 toileted or if R202's bed was in low position. The interdisciplinary team (IDT) note dated 3/30/26 documents the root cause of the fall was poor safety awareness and post fall intervention was increased monitoring and room move closer to the nurse's station. The fall investigation dated 3/29/26 at 2:00 AM documents R202 had an unwitnessed fall and was found lying in bed with a bleeding laceration to the top of his head and forehead and a skin tear to the left elbow. There was a pool of blood near the nightstand and bathroom door. R202 was unable to say how he fell. This investigation does not include when R202 was last toileted or if R202's bed was in low position. The IDT note dated 4/2/26 documents the root cause was urinary retention, and new intervention was urinary catheter insertion in the emergency room and referral to urology. There is no documentation in R202's medical record that a urology appointment had been scheduled. R202's hospital discharge paperwork dated 3/29/26 documents six sutures in the forehead need removed in 5-7 days and includes information on fall prevention, laceration and contusion care. R202's Hospital History & Physical dated 4/1/26 documents R202 was evaluated in the emergency room after sustaining a fall and was discharged back to the facility. The fall investigation dated 3/31/26 at 10:00 PM documents R202 had an unwitnessed fall in his room and was found near the front of his bed on the floor. This investigation documents R202 was last observed in bed 10 minutes prior but does not identify if R202's bed was in low position. R202's active census documents R202 resided in the same room on 3/28/26 and 3/29/26 and was not moved to R202's current room next to the nurse's station until 3/30/26. There is no documentation in R202's medical record that 15-minute checks were completed in March and April 2026. On 4/14/26 at 11:53 AM V22 Registered Nurse (RN) stated R202 had an unwitnessed fall on 3/29/26, R202 hit his head during the fall, R202 was sent to the emergency room and returned with stitches to his forehead laceration. V22 stated R202 was found in bed with his face covered in blood and there was blood found on the floor near the bathroom door and night stand. V22 stated R202's wheeled walker and wheelchair were not near his bed; they were across the room by the table and doorway since R202 tries to get up on his own without assistance.			S9999			

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S9999	Continued from page 3 V22 stated R202 would have tried to use the wheelchair or walker if they were near him. On 4/15/26 at 11:35 AM V15 CNA confirmed R202's unwitnessed fall as documented on 3/29/26. V15 stated R202 had hit his head where it was bruised from the prior fall, and it was open and bleeding and R202 had to get stitches. V15 stated R202 was in a room near the end of the 200 hall which was not near the nurse's station. V15 stated a room change could have prevented the fall as he keeps his door open, and staff could have seen him more. V15 stated R202's wheelchair and walker and not kept at the bedside since R202 is a fall risk, but R202 has self-transferred into the wheelchair and has used an overbed table to walk to the bathroom. On 4/14/26 at 12:35 PM V2 Director of Nursing (DON) stated R202 has a history of forgetting his limits and self transfers; staff should keep his wheelchair and walker near him as it would be safer. V2 confirmed R202's care plan includes an intervention to anticipate R202's needs. On 4/16/26 at 11:12 AM V2 confirmed all of R202's fall investigation documentation was provided and confirmed lack of documented fall interventions, including low bed, and when R202 was last checked on or toileted prior to the falls. V2 stated staff are expected to follow care planned interventions. V2 confirmed the urology referral was a fall intervention and there was no documentation that attempts had been made to schedule this appointment. V2 stated R202's 3/28/26 fall intervention was a room move closer to the nurse's station, and the room change was completed on 3/30/26, the date of the IDT note. On 4/16/26 at 11:43 AM V2 stated V2 had no documentation of 15-minute checks for March and April for R202. V2 confirmed R202's care plan includes an intervention for 15-minute checks, and this care plan section was recently updated on 4/13/26. On 4/16/26 at 9:10 AM V23 Nurse Practitioner stated V23 was notified the night of R202's head laceration and hospital transfer. V23 stated the facility should have fall precautions in place and V23 leaves that up to the facility to determine and the facility should follow their policy. On 4/13/26 at 11:17 AM R206 was lying in bed. There was dried blood and faint bruising to R206's right forehead/eyebrow. R206 stated R206 was sitting on the side of his bed and fell forward hitting his head while attempting to pull his pants up. R206 stated R206 went to the emergency room and had to get stitches. R206 stated R206 had another fall after that due to sliding off the bed while reaching for a			S9999			

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S9999	Continued from page 4 remote control. There were no nonskid strips on either side of R206's bed. On 4/16/26 at 9:58 AM R206 stated nonskid strips weren't on the floor during his last fall, which likely would have prevented the fall since he was wearing socks, and it would have helped provide grip and prevented his feet from sliding. R206's MDS dated 3/19/26 documents R206 as cognitively intact. R206's Care Plan revised 3/27/26 documents R206 is at risk for falls related to deconditioning, gait/balance problems, and a history of falls. This care plan includes interventions call don't fall signs (3/30/26), nonskid strips on each side of bed (3/30/26), and R206 prefers not to wear nonskid socks (3/29/26). R206's Fall Investigation documents R206 had an unwitnessed fall on 3/29/26 at 3:00 PM. R206 was found face down on the floor next to his bed with blood around his head. R206 had on regular socks and reported he was trying to stand up to pull his pants up. R206 had a deep facial laceration and was transferred to the emergency room. The IDT note dated 3/30/26 documents root cause of fall was dressing without assistance and post fall intervention for call don't fall signs and nonskid strips on both sides of the bed. R206's Fall Investigation documents R206 had an unwitnessed fall on 4/11/26 at 4:15 AM. R206 was found sitting on the floor near the foot of his bed. R206 denied needing to use the bathroom and reported that he was sitting at the edge of the bed and tried to pick up the bed remote control. V22 RN staff interview documents R206 was found on the floor near his bed, and call light and bed remote control were on the floor near R206. This investigation and staff interviews do not document if there were nonskid strips on the floor near R206's bed. On 4/13/26 at 12:59 PM there were nonskid strips on the floor on each side of R206's bed. R206 stated maintenance staff just applied the strips approximately 20 minutes ago. On 4/13/26 at 1:04 PM V6 CNA stated maintenance staff was just in R206's room and applied the nonskid strips, as those weren't in place earlier. V6 stated R206 did not have nonskid strips prior to today. On 4/13/26 at 1:07 PM V32 Maintenance Director confirmed V33 Maintenance Assistant applied R206's nonskid strips today. On 4/14/26 at 11:53 AM V22 RN stated R206 was			S9999			

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S9999	Continued from page 5 found sitting on the floor next to his bed and R206 reported he was reaching for his bed control that had fallen on the floor causing R206 to slide out of bed. V22 stated there were no nonskid strips on the floor near R206's bed. On 4/14/26 at 12:39 PM V2 stated the root cause of R206's 3/29/26 fall was self-transfer/ambulating. V2 confirmed call don't fall signs and nonskid strips on the floor next to the bed were the post fall interventions for this fall. V2 stated R206's 4/11/26 fall was caused from attempting to self-transfer and self-toilet during the night and the post fall intervention was to offer toileting during the night. V2 confirmed this would not be an appropriate intervention if R206 was reaching for a remote control during the fall. V2 confirmed nonskid strips should have been in place for this fall. (B) 2 of 3 300.1210d)6) Section 300.1210 General Requirements for Nursing and Personal Care 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: Based on observation and interview, the facility failed to safely secure an oxygen cylinder for one of four residents (R212) reviewed for oxygen in the sample list of 15. Findings include: On 4/15/26 at 12:58 PM V11 Physical Therapy Assistant left R212's room leaving an oxygen cylinder free standing and unsecured in R212's room. This was confirmed with V21 Certified Nursing Assistant. V21 stated the facility had recently provided training regarding oxygen cylinder storage and the cylinder should be stored in a cart and not			S9999			

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S9999	Continued from page 6 left free standing in a room. On 4/15/26 at 1:18 PM V2 Director of Nursing confirmed oxygen cylinders should be secured and not left free standing. V2 stated therapy staff should use a tripod cart to store an oxygen cylinder. (C) 3 of 3 300.610a) 300.1210a) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) These regulations were not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide supervision and implement care-planned interventions for a resident			S9999			

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S9999	Continued from page 7 at risk for elopement. This failure affected one of three (R202) residents reviewed for elopement on a sample list of 15 residents. Findings include: The facility's "Code Pink – Missing Resident/Elopement" Policy, revised April 2023, states that the facility strives to promote resident safety and protect resident rights and dignity. The policy requires a process to assess all residents for elopement risk, implement risk-reduction strategies for those identified as at risk, and ensure resident identification measures are in place at the time of admission. The policy defines elopement as the ability of a cognitively impaired resident, who is not capable of protecting himself or herself from harm, to leave the facility unsupervised and unnoticed, potentially placing themselves in harm's way. Wandering is defined as a cognitively impaired resident's movement within the facility that is aimless or without clear purpose, often without regard for personal safety. Interventions that may be used for residents identified as high risk for elopement include frequent monitoring of the residents' whereabouts to ensure the resident remains in the facility (e.g., 15-minute checks or 1:1 monitoring). On 4/15/26 at 9:10 a.m., R202 was observed sitting in a recliner in his room watching television. At that time, the resident was noted to be wearing a wander bracelet on his left ankle. R202's Minimum Data Set (MDS) dated 3/5/26 documented that R202 has severe cognitive impairment. R202's Care Plan, dated 2/8/26, documented that R202 is an elopement risk due to disorientation to place, a history of attempting to leave the facility unattended, impaired safety awareness, and aimless wandering behavior. Interventions initiated on 2/8/26 direct staff to monitor R202's location every 15 minutes and to document wandering behaviors, as well as attempted diversionary interventions, in the behavior log. R202's Electronic Health Record (EHR) contains a nursing note dated 2/8/26 that documented R202's medical doctor gave an order to initiate 15-minute checks due to wandering.			S9999			

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S9999	Continued from page 8 R202's EHR contains an elopement/unauthorized leave risk assessment dated 04/13/2026 documenting that R202 has dementia, a prior history of elopement, and reported and/or documented episodes of elopement and attempts to elope. On 4/15/26 at 9:17 a.m., V10, Certified Nurse Assistant (CNA), stated she is not directly assigned to care for R202; however, she stated that she has heard from other staff that the R202 is frequently up and down, is at risk for elopement, and requires close monitoring. On 4/16/26 at 12:02 a.m., V24, Licensed Practical Nurse (LPN), stated R202 frequently wanders in his wheelchair, moves around within his room but also exits into the hallway and continues wandering down the hallway. On 04/16/2026 at 12:06 p.m., V25, CNA, stated that R202 is confused and wanders in his wheelchair within his room and the hallways and requires close monitoring. V25 further stated that 15-minute checks are no longer in place as R202 is now wearing a wander guard. On 04/16/2026 at 12:10 p.m., V26, CNA, stated R202 is very confused, frequently wanders out of his room, and propels his wheelchair up and down the hallways and within his room. On 04/16/2026 at 12:12 p.m., V27, CNA, stated she is very familiar with R202 and that R202 is confused and constantly attempts to roam the hallways. On 04/16/2026 at 2:32 p.m., V31, CNA, stated R202 wanders "a lot" and takes off down the hall by himself. On 4/16/26 at 11:43 a.m., V2 Director of Nursing (DON) stated V2 had no documentation of 15-minute checks for March and April for R202. V2 confirmed R202's care plan includes an intervention for 15-minute checks, and this care plan section was recently updated on 4/13/26. V2 stated R202 is an elopement risk and uses (an electronic monitoring device), and 15-minute checks should have been discontinued. When asked what prompted this intervention to be added and why it should be resolved, V2 did not give a response. (B)			S9999			