STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146112	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at Bradley	650 North Kinzie Ave Bradley, IL 60915

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 46003 Based on observation, interview and record review the facility failed to provide call light access. This applies to 2 of 7 residents (R2, R3) reviewed for call light accessibility in a sample of 8. Findings include: 1.R2 has diagnoses that includes quadriplegia, type 2 diabetes and epilepsy. R2's current care plan interventions include ensure call light is within reach and answer promptly. On 2/19/25 at 4:02 PM, R2 was sitting up in his motorized wheelchair. R2's call light that is activated when he blows into it was located on the left side of his bed near the wall and not in reach of his mouth. R2 stated the call light is never left near him when he is up in his wheelchair. R2 stated he must go out in the hall and look for assistance if he needs anything. On 2/20/25 at 1:17 PM, V7 CNA (Certified Nursing Assistant) stated all residents should have a call light available to them to notify staff if they need assistance. 2. R3 has diagnoses that includes hemiplegia and hemiparesis following cerebral infarction, carcinoma in situ of anus and anal canal, hypertension and dysphagia. R3's current care plan interventions includes ensure call light is within reach and answer promptly. On 2/19/25 at 4:33 PM, R3 was lying in bed and her call light was tied to a purple stuffed duck on her nightstand. R3 stated her call light is always left on her nightstand. R3 stated sometimes she needs help but doesn't have the call light to call for staff. On 2/19/25 at 4:40 PM, V5 RN (Registered Nurse) was called to R3's room to observe her call light that was out of reach. V5 stated R3 was alert and could make her needs known. V5 stated if R3 needs assistance she alerts her roommate (R8) will call for staff assistance for her. When V5 attempted to place R3's call light within her reach, it could not reach due to the string being tied in a knot. On 2/19/25 at 4:43 PM, R8's MDS (Minimum Data Set) dated 12/26/24 shows she is cognitively intact. R8 stated she looks out for R3. R8 stated she puts the call light on for R3 when she does not have access to her call light. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/20/25 at 3:11 PM, V2 DON (Director of Nursing) stated both R2 and R3 are alert and able to make their needs known. Their call lights should be within their reach. V2 added that it is not any residents' responsibility to call for staff assistance for their roommates. The facility policy Call Light dated 10/2024 states all residents that have the ability to use a call light shall have the nurse call light system available at all times and within easy accessibility to the resident at the bedside or other reasonable accessible location.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003 Based on interview and record review, the facility failed to implement pressure ulcer prevention interventions including completing and documenting physician ordered weekly skin assessments and failed to identify and treat a facility-acquired pressure ulcer for one of three residents (R1) reviewed for skin concerns on a sample list of eight. These failures caused R1 to develop a sacral pressure ulcer that was discovered and noted to be unstageable, upon assessment by a wound physician. Findings include: R1's Face Sheet showed his diagnoses included type 2 diabetes, adult failure to thrive, hypertension, blindness in one eye unspecified, left side hemiplegia and hemiparesis, chronic kidney disease, and acquired absence of left leg below the knee. R1's 1/5/2025 MDS (Minimum Data Set) showed he was cognitively intact and he did not have a behavior of rejecting care. R1 was identified as being at risk for developing pressure ulcer / injury. R1 utilized a manual wheelchair for mobility and was occasionally incontinent of urine and stool. R1 did not have any documented MASD (Moisture Associated Skin Damage) or pressure wounds on the 1/5/25 MDS. R1's 2/7/25 nursing progress note from 1:00 PM showed R1 was readmitted to the facility after a hospital stay. The progress note showed no skin breaks were noted and his skin was warm, dry (normal), skin intact. On 2/20/25 at 1:17 PM, V6 CNA (Certified Nursing Assistant) stated R1 was missing half of one of his legs and he was dependent on staff for assistance. V6 stated R1 would inform staff when he was incontinent and needed assistance. V6 stated she was not aware R1 had any rashes or open wounds. On 2/20/25 at 2:07 PM, V3 ADON (Assistant Director of Nursing) stated resident skin observations are done biweekly on shower days. V3 stated if the physician ordered skin observations, they would be documented on the TAR (Treatment Administration Record) by the nurse. V3 stated there was an order on 2/9/25 documenting R1's scrotal irritation, but no note or any other nursing assessment. V3 stated she had been informed by R1's family member of his scrotal bleeding. V3 stated the Wound Physician (V4) was seeing R1 on 2/11/25 for the scrotal MASD and V4 discovered the unstageable sacral pressure wound. V3 stated towards the last week R1 was in the facility, he was receiving showers every night per family request. V3 stated staff should have completed the scheduled documentation of R1's showers and documented any skin issues. V3 stated staff should have discovered the skin issues before the family did and documented the findings. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	On 2/20/25 at 3:11 PM, V2 DON (Director of Nursing) stated she was informed of R1's MASD by a night shift nurse. V2 stated she was not informed of any other skin issues, and she was not informed of a sacral wound. V2 stated R1 was dependent on staff for a one person assist with cares. V2 stated nurses were required to document the physician-ordered skin assessment on the TAR every Tuesday. V2 stated a few of R1's assessments had been missed during his stay. V2 stated if staff were doing daily showers, they should have been documented, and when staff perform incontinence care, they should assess the resident's skin. V2 stated R1 had a leg amputation and required the assistance of staff and he was not independent. V2 stated the staff should have seen the sacral wound during his cares and acknowledged the wound was acquired in the facility. V2 stated R1 was not on hospice and she does not know how R1 developed a sacral wound if staff were attending to him. V2 stated pressure wounds can develop from sitting in one spot or not moving, and MASD is from moisture and barrier cream would help prevent that. The wound noted completed by V4 (Wound Physician) on 2/11/25 documented two wounds: Site 1 an unstageable wound (due to necrosis) full thickness of the sacrum. Etiology (cause) documented as pressure, measuring 2 cm x 2cm x 0.1 cm (centimeters). V4 completed a surgical excisional debridement of the sacral wound. Site 2 non pressure wound partial thickness of the scrotum measuring 2.5 cm x 1.5cm x 0.1 cm. Etiology documented as Moisture Associated Skin Damage. On 2/20/25 at 4:17 PM, V4 (Wound Physician) stated in general, MASD occurs from urine, stool or sweat, and barrier cream could possibly have prevented that. V4 stated a pressure wound and MASD could have developed between 2/7/25 and 2/11/25 and stated pressure ulcers develop as result of skin breaking down over a bony prominence and are related to pressure. V4 stated he could not say if staff should have seen the wounds during their cares or if they were even really doing the skin assessments. On 2/20/25 at 5:11 PM, V8 CNA stated she gave R1 a shower on 2/11/25 (the same day R1 was seen by the Wound Physician and the unstageable pressure ulcer was identified). V8 stated R1 had irritation on scrotum. V8 stated she had R1 stand and pivot, she did not note any other skin issues. V8 stated R1 was a daily shower. The shower sheet completed on 2/11/25 by V8 CNA and signed off by V7 RN does not show any documentation of skin issues for R1. On 2/20/25 at 5:16 PM, V7 RN confirmed her signature on R1's shower sheet. V7 stated she did a head-to-toe assessment on 2/11/25 for R1 and did not note any open areas or wounds on R1. V7 also stated that V8 did not report any skin issues for R1. R1's physician orders included weekly skin assessment every Tuesday. Review of R1 TAR (Treatment Administration Record) shows no documentation that physician-ordered skin assessments were done on 12/3/24, 12/20/24, 12/31/24, 1/14/25, and 1/28/25. R1's orders showed MD (Medical Doctor) to be notified of new impairments. Moisture barrier cream to buttocks as needed as preventative; may keep at bedside CNA (Certified Nursing Assistant) may apply. The facility policy Pressure Injury and Skin Condition assessment dated ,d+[DATE] states, residents identified will have a weekly skin assessment by a licensed nurse. Each resident will be observed for skin breakdown daily during care and on assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment. Caregivers are responsible for promptly notifying the charge nurse of skin breakdown .