

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Arc at Bradley		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48526</b></p> <p>Based on interview and record review, the facility failed to ensure a resident was able to get into bed to use his urinal.</p> <p>This applies to 1 of 4 residents (R3) reviewed for incontinence care.</p> <p>Findings include:</p> <p>On 03/04/25 at 1:20 PM, R3 stated on Friday 02/28/25 he had been sitting up in his wheelchair since 11:00 AM. R3 stated at 2:30 PM he was still in the wheelchair in his room. He stated his bed was not working. R3 stated the staff knew his bed was not working before he got out of bed. He stated the staff told him a work order was in place to repair his bed. R3 stated at 2:30 PM he pressed his call light to let his CNA (Certified Nursing Assistant) know that he needed to urinate. His bed still was not working. He stated maintenance came in and tried to repair the bed, but it still did not work. R3 stated the facility called the other maintenance person who was at home. R3 stated he still needed to urinate. R3 stated he was wearing and incontinence brief, but he urinates a lot. R3 stated he wanted to use the urinal and he must lay flat when urinating. R3 stated he can't urinate while in the wheelchair. R3 stated between 5:00-6:00 PM, he urinated on himself. R3 stated the urine was on top of sheets that he placed on the floor, the pad in the wheelchair and his shorts. R3 stated he ate dinner with the urine-soaked clothes on. R3 stated he transfers via mechanical lift. R3 stated he got in the bed between 7:00-7:30 PM.</p> <p>On 03/04/25 at 2:00 PM, V6 (CNA) stated last Friday 02/28/25 around 4:15 PM the housekeeper asked him to help assist with fixing R3's bed. V6 stated It took us about 15 minutes to realize that we could not fix the bed. I told the housekeeper we need maintenance because this an electrical issue with the bed.</p> <p>On 03/05/25 at 9:25 AM, V7 (Maintenance Director) stated on 02/28/25, he received a call after 5:00 PM stating that R3's bed was not working, and he needed to come in. V7 stated the call came after he had already left the building for the day. V7 stated he did not know that R3's bed was not working prior to him leaving for the day. V7 stated a work order was not put in for R3's bed. V7 stated he fixed another bed and brought it to R3's room. V7 stated the whole process took about an hour from the time he came in on call until he was done.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Arc at Bradley		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/05/25 at 11:50 AM, V8 (CNA) stated she was the CNA for R3 on 02/28/25 from 6 AM-2:00 PM. V8 stated she got R3 out of bed that morning and his bed remote was malfunctioning. V8 stated if you pressed the remote the regular way, it did not work. V8 stated they had to push the remote different ways than normal for it to work. V8 stated she got him out of bed, but did not report that the remote to the bed was not working. V8 stated R3 was up for the rest of the shift. V8 stated I should have reported that the bed was not working when I got him up.</p> <p>On 03/05/25 at 3:18 PM, V12 (CNA) stated she was the CNA for R3 Friday 02/28/25 from 2:00 PM-10 PM. V12 stated that at 2:15 PM, she found out that R3's bed was not working when he told me he needed to use the bathroom. V12 stated that R3 told her that the bed was broken. V12 stated she went to the receptionist and had them to page maintenance. V12 stated R3 really needed to go to the bathroom. He told me two more times that he really needed to use the bathroom. V12 stated R3 was still in his wheelchair for dinner, and he was wet. V12 stated R3 has to urinate while in the bed with the urinal and must be flat. The staff hold the urinal for him. It is impossible for him to urinate in the urinal while he is sitting up. V12 stated the bed was stuck in a very high position and the mechanical lift was not able to go high enough to get R3 on the bed.</p> <p>On 03/05/25 at 3:43 PM V1 (Administrator) stated when equipment is malfunctioning, the staff reports to maintenance. They can go to the front desk and have maintenance paged. V1 stated her expectations are that the staff report broken or malfunctioning equipment immediately.</p> <p>R3 was admitted to the facility on [DATE] with multiple diagnoses, including acute and chronic respiratory failure, need for assistance with personal care, lack of coordination, reduced mobility, morbid obesity with alveolar hypoventilation, diabetes, chronic obstructive pulmonary R3's MDS (Minimum Data Set) dated 01/08/25 showed R3 was cognitively intact. The same MDS showed R3 had impairments to both his lower extremities, required substantial/maximal assistance with toileting hygiene, and was dependent upon staff for transfers. R3's ADL (Activities of Daily Living) care plan revised on 05/31/24 showed Interventions: Chair/bed to chair transfer, my usual performance is dependent-mechanical lift with assist of two between surfaces. Toilet hygiene: my usual performance is substantial/maximal assistance. Toilet transfer: my usual performance is dependent.</p> <p>The facility's Fall Prevention Program policy last approved date 10/2024 showed Standards: Malfunctioning equipment will be immediately reported to maintenance for repair</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Arc at Bradley		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48526</b></p> <p>Based on interview and record review, the facility failed to transfer a dependent resident safely by failing to use a mechanical lift with two staff assistance for one of four residents (R1) reviewed for accidents. This failure resulted in R1 sustaining an acute nondisplaced proximal tib (tibia)-fib (fibula) fracture.</p> <p>Findings include:</p> <p>The facility's 2/24/2025 Report to the State Survey Agency showed R1 .was observed on his right side Stat Xray done .Upon investigation that included review of clinical records, assessment, hospital documentation, and statements of staff on duty; it was found that resident is a 2 transfer assist This serves as final report.</p> <p>On 03/02/25 at 9:42 AM, R1 stated her fall occurred when the CNA (Certified Nursing Assistant) was trying to put her in the shower chair. R1 stated there was only one CNA assisting her to transfer. R1 stated she fell , and her left leg was hurting. R1 stated the CNA told her Your leg is fine. R1 stated her left leg is broken in two places.</p> <p>On 03/02/25 at 1:33 PM, V2 (Director of Nursing) stated An investigation was done; V13 (CNA) used the wrong transfer technique. V2 stated V13 lifted R1 for the transfer by herself and did not use a mechanical lift. V2 stated the correct transfer technique for R1 is a mechanical lift with two assistance. V2 stated the x-ray came back in the afternoon, and it showed an acute nondisplaced proximal tib-fib fracture. V2 stated V13 knew very well that she should have transferred R1 with a mechanical lift and two assist. V2 stated when residents are not transferred appropriately, they could have a fall with injury to both the patient and the staff, adding in this case, the resident had a fall with an injury.</p> <p>On 03/05/25 at 3:10 PM, V13 stated she was the CNA taking care of R1 when she fell and got injured. V13 stated she was trying to lift R1 without a mechanical lift and with no assistance from another staff member. V13 stated R1 became too heavy, and she lowered her onto the floor. V13 stated R1 was complaining of pain to her legs. V13 stated she had worked with R1 before and knew R1 transferred with a mechanical lift.</p> <p>On 03/04/25 at 9:41 AM, V4 (Nurse Practitioner) stated R1 has a non-displaced fracture to the lower left leg. V4 stated the CNA was transferring R1 into her chair, and she slid and fell . V4 stated R1 is supposed to be transferred by a mechanical lift, with two staff members due to her contractures. V4 stated the fracture was the result of the CNA transferring the resident inappropriately and the fracture could have been prevented if the resident was transferred with a mechanical lift and two staff instead on one staff.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Arc at Bradley		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R1 was admitted to the facility on [DATE] with diagnoses including multiple sclerosis, lack of coordination, abnormal posture, dysarthria, reduced mobility, chronic obstructive pulmonary disease, major depressive disorder. R1's MDS (Minimum Data Set) dated 02/19/25 showed R1 had moderate cognitive impairment. R1's MDS dated [DATE] showed R1 had impairments to both upper and lower extremities. The same MDS showed R1 was dependent upon staff for chair/bed-to-chair transfers.</p> <p>R1's progress notes dated 02/20/25 at 11:45 AM showed received resident laying in bed, alert and oriented x4. Resident complains of left lower leg pain. NP (Nurse Practitioner) notified and ordered left lower leg and ankle and foot. Progress notes dated 02/20/25 at 6:11 PM Notified NP regarding x-ray result. NP ordered to send out to ED (Emergency Department) for evaluation. POA (Power of Attorney) made aware. Progress notes dated 02/20/25 at 6:49 PM Resident was sent out at (Hospital) ER (emergency room ) via (Ambulance) for further evaluation and treatment. Management and POA made aware. Progress notes dated 02/20/25 at 9:37 PM Resident came back from (Hospital). (Hospital) ER called and informed this nurse that they did an x-ray, and it was positive for tib-fib fracture and no hip fracture and needs to have an appointment to orthopedics.</p> <p>R1's Radiology Results Report date 02/20/25 at 3:32 PM showed Procedure- left tibia and fibula, two views. Findings- 4 view left tib-fib. No prior study for comparison. Acute nondisplaced proximal tib-fib fracture. Mineralization is decreased with degenerative changes. No radiopaque foreign body. No convincing plain film evidence osteomyelitis. Impression- acute nondisplaced proximal tib-fib fracture.</p> <p>R1's Kardex Report dated 03/02/25 showed Transferring: Transfer- The resident is totally dependent on 2 staff for transferring. R1's ADL self-care/mobility care plan dated 01/26/24 showed interventions: Chair/bed to chair transfer: My usual performance is dependent. I use a mechanical lift for transfer assist.</p> <p>The facility's Transfers- Manual Gait Belt and Mechanical Lifts Policy (last approved 10/2024) showed Purpose: In order to protect the safety and well-being of the Staff and Residents, and to promote quality care, this facility will use Mechanical lifting devices for the lifting and movement of Residents. Guidelines: 1. Mechanical lifting devices shall be used for any resident needing a two person assist, or who cannot be transferred comfortably and/or safely by normal transfer technique. The facility's Fall Prevention Program policy last approved date 10/2024 showed Purpose: To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Guidelines: Transfer conveyances shall be used to transfer residents in accordance with the plan of care.</p>		