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	05/01/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to supervise a resident's smoking activity and failed to implement interventions to prevent her from sustaining burn injuries. This failure resulted in a resident sustaining blistered (second degree) cigarette burns.This applies to 1 of 4 (R1) residents reviewed for smoking safety in a sample of 5.The findings include:The facility's Reportable Incident form showed that on 4/6/26 at 11:40 AM, R1 was observed with a wound to left side of chest. [R1] was outside on a smoke break and was wearing the smoker's apron. Resident was observed with what appeared to be a cigarette burn on the left side of her chest. Root cause determined to be burn caused by cigarette ash due to windy conditions, smoker's apron flew up while smoking during smoke break.On 04/29/2026 at 1:31 PM, the resident smoking activity was observed. Staff placed a smoking ring (device that holds a cigarette) on R1's left index finger. R1's smoking apron was placed in a manner that left R1's left upper chest exposed, and the neck ties on the apron were left unsecured. R1's previous burn mark was visible on R1's left chest. R1's bilateral upper extremities and fingers were contracted, and she was positioned in a reclining wheelchair. Staff lit R1's cigarette then cigarette ashes were seen dropping down the front of R1. While R1 was smoking, V6 (Activity Aide) walked away from her to assist another resident into the building.On 04/29/2026 at 1:59 PM, V6 stated she was doing the one-on-one observation of R1 but did not realize she walked away from her while her cigarette was still lit. V6 stated the smoking ring that holds R1's cigarette sometimes slips from R1's finger and has caused her fingers to be burned in the past. On 04/29/2026 at 12:29 PM, R2 stated V6 (Activity Aide) and another unknown Activity Aide were working when R1 was burned. R2 stated R1's smoking apron blew up from the wind when R1 was burned. R2 stated she had to go in and get the nurse because no one was outside when it happened. R2 stated the staff lit the cigarettes then left the residents outside unsupervised. R2 stated it was cold and windy, and the staff don't like to be out in the cold.On 04/30/2026 at 1:02 PM, V2 DON (Director of Nursing) she interviewed R2 and V3 RN (Registered Nurse) about how R1 got burned. V2 stated R1 had been burned before she started working in the facility. V2 stated she expects staff and residents to follow the smoking policy and smoking contracts.V2's 4/7/26 written interview of R2 showed R2 said she was outside and sitting by [R1] during smoke break. She said [R1] had smoker's apron on, it was windy, and the apron flew up. She reported to the nurse what happened. On 04/29/2026 at 4:24 PM, V3 RN (Registered Nurse) stated she was informed by the residents and an Activity Aid when R1 was burned. V3 stated R1 had two blisters that formed on her left upper chest near her clavicle. V3 stated she saw R1 after the staff brought her inside and the smoking apron had already been removed. V3's 4/9/26 written statement about the incident showed another resident, [R2], approached this writer to report that resident [R1] had sustained burns to her chest while smoking in the courtyard.Resident was observed with two cigarette burns on the left side of the chest. R1's 4/5/26 progress note (written by V3) showed R1 observed with two cigarette burns on the left side of her chest. Resident reported stinging pain.The facility's Patient Safety insert for the Smoker's apron showed Instructions: B) Seat resident in wheelchair and drape apron over the resident. Secure the apron by engaging the hook and (continued on next page)

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

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