STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001085	A. BUILDING: _____ B. WING _____	C 02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC AT BRADLEY	650 NORTH KINZIE AVE BRADLEY, IL 60915

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S 000	Initial Comments Complaint Investigation 2571221/IL186358	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210a) 300.1210b) 300.1210d)2)5) 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) 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	S9999		

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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 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 requirements were not met as evidenced by:

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:

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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 re-admitted 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

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(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.

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)

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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

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S9999	Continued From page 5 (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 10/2024 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... (B)	S9999		