Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006175	A. BUILDING: _____ B. WING _____	C 07/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTA HEALTHCARE	1136 NORTH MILL STREET NAPERVILLE, IL 60563

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S 000	Initial Comments Complaint Investigation # 2074692/IL123927 300.3240a)b)d)f) and 300.1230a)2)d)1)2)f)1)2)i).	S 000		
S9999	Final Observations Statement of Licensure Violation: Section 300.1230 Direct Care Staffing a) For the purposes of this Section, the following definitions shall apply: 2) Skilled care is skilled nursing care, continuous skilled nursing observations, restorative nursing, and other services under professional direction with frequent medical supervision. d) Each facility shall provide minimum direct care staff by: 1) Determining the amount of direct care staffing needed to meet the needs of its residents; and 2) Meeting the minimum direct care staffing ratios set forth in this Section. f) For the purpose of computing staff to resident ratios, direct care staff shall include the following, as long as the person is assigned to duties consistent with the identified job title and documented in employee time schedules as required by Section 300.650(i): 1) registered nurses;	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 2) licensed practical nurses; i) The facility shall schedule nursing personnel so that the nursing needs of all residents are met. Based on observation, interview and record review the facility failed to staff the night shift with adequate nursing personnel to meet the needs of the residents. This applies to 2(R1 and R2) of 3 residents reviewed for staffing requirements. As evidenced by: On 6/26/2020 at 10:40AM, R2 and R3 were both in bed in the room. R2 and R3 were asked many questions about life in the facility. R2 said, yes there is a problem with staffing, just last night I had to wait almost 2 and 1/2 hours for pain medicine. I was told there was only one nurse on duty last night. When V6(Nurse) came in this morning she gave me the pain medicine. I can not get restorative services because they have had to pull the restorative aide and have them work as certified nursing assistants. R2 said we have complained to the administrator. R2's Face Sheet says she was admitted on 2/26/2020 with the following pertinent diagnosis': status post surgical amputation, absence of left knee, phantom limb syndrome, osteoarthritis and neuralgia/neuritis. R2 has a Care Plan for Pain dated 2/26/2020 that says to anticipate and provide relief from pain. Nurse Practitioner Note dated 6/26/2020 at 3:06PM states, R2 has left foot gangrene and is status post left below knee amputation. Seen as requested by the staff to evaluate	S9999		

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her pain after getting her Tramadol and Gabapentin late this morning. Seen sitting at the bedside, alert and oriented X3... She reports that she suppose to take her Tramadol and Gabapentin at 0600 but received the medications at 0900. Pain worsened before receiving the pain medication. Current pain level is 5 out of 10.

On 6/30/2020 at 9:25 AM R1 was in her room in an adult recliner. R1 said a few days ago there was only one nurse on duty, this happened a few other times, recently. R1 said it is hard to get the things you need.

Minimum Date Sets dated June 2020 were reviewed for both R1 and R2. Brief Interview for mental status scores of 15 were recorded for both indicating R1 and R2 have intact cognition.

On 6/26/2020 at 11:32AM, V6(Nurse) said when she got on duty today she gave R2 pain medicine after 7 am. V6 said there was only one nurse in the building on the night shift, should have been more than one. " Sometimes we are a little challenged with staffing." V6 said R12 is the scheduler and should know more about what happened last night.

On 6/26/2020 at 11:36AM, R12(Scheduler) said she was recently hired about a week ago. R12 said two nurses were scheduled to work last night. R12 said the requirement is two nurses for the night shift. Upon requesting time cards for nurses that worked last night, R12 then said there was only one nurse on for a few hours last night, that should not have occurred.

On 6/26/2020 at 11:44AM, Z1(Administrator) and V2(Director of Nursing) were present in a

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meeting, V2 said for about 3 hours there was only one nurse on duty last night. V1 said if there was a problem I expect management to come in. There should always be a minimum of 2 nurses on the night shift.

The schedule was reviewed for 6/25/2020, it said V16(Nurse) was scheduled to work until 3 am and V17(Nurse) worked from 11 pm to 7 am. Time cards for V16 and V17 reflected the same. The facility had one nurse on duty from 3 am to 7 am on 6/25/2020 to 6/26/2020. The Facility Data Sheet dated 6/26/2020 says the census is 72 residents.

On 6/30/2020 at 9:10AM, V1(Administrator) and V2(Director of Nursing) were present in the meeting. V2 said V16(Nurse) was not sick and did not have an emergency, just decided to go home without notifying management. V1 said V16 should know the procedures for leaving work. V2 said, V16 should have notified management prior to leaving and I could have come in to cover the shift, I only live 5 minutes away.

(No violation Issued)

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)

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S9999	Continued From page 4 d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) f) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) Based on observation, interview and record review the facility failed investigate an allegation of neglect and failed to notify the state agency. This applies to 1(R3) of 3 residents reviewed for call light response. As evidenced by: On 6/26/2020 at 10:40AM, R2 and R3 were both in bed in the room. R2 has double lower limb amputations. R3 was in bed watching television. R2 said she is related to R3. R2 said about 4 to 5 weeks ago a certified nursing assistant put R3 on the bed pan, neither R2 or R3 were sure of who the certified nursing assistant was that put R3 on the bed pan. R2 said I put the call light on when R3 needed to be removed from the bed pan and V14(CNA) entered the room to answer the call light. R2 said they (R2 and R3) told V14(CNA) that R3 needed to be removed from the bed pan. Both R2 and R3 said, V14(CNA) said I did not put R3 on the bed pan and am not going to take R3 off. R2 and R3 said, V14(CNA) turned off the call light and went out of the room without providing	S9999		

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care. R3 said, " I felt just horrible with what V14(CNA) said and I tried to get my self off the bed pan but I could not, I have this pressure sore on my butt." R2 said she got up and went out of the room to get help and V13(Social Service Director) came into the room and was told about what V14 said and did . R2 and R3 said V13(Social Service Director) asked V14(CNA) to take R3 off the bed pan and V14(CNA) refused again. It took awhile but V14 did remove R3 from the bed pan, V13(Social Service Director) made her do it. Both R2 and R3 said that V14(CNA) should have been written up, but we do not know what happened. Both R2 and R3 said V14 is the worst CNA and has not worked with them since the bed pan issue.

The Face Sheet says R3 was admitted on 2/26/20 with the following pertinent diagnosis: Stage 4 sacral pressure ulcer, asthma, liver transplant, diabetes type 2, anxiety, morbid obesity, heart disease, irritable bowel syndrome and scoliosis. R3's Fall Care Plan dated 6/16/2020 has an intervention of place call light within reach and staff to respond and provide assistance upon use. Other Pertinent Care Plans reviewed include: Alteration in Skin Integrity, stage 4 sacral pressure ulcer dated 3/11/2020 and Impaired visual function dated 3/11/2020. The Minimum Data Set dated 6/5/2020 was reviewed; R3 has a Brief Mental Status Score of 15 indicating R3 is cognitively intact and R3 requires total dependence with one staff assistance for toilet use. The Wound Care Report dated 6/22/2020 says R3 has a sacral wound measuring .6 cm in length by .5 cm in width by .4 cm in depth and is improving.

On 6/26/2020 V14(CNA)'s Personnel File was reviewed it contained no discipline. Allegations of

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Abuse Log was reviewed from March 1, 2020 to June 26, 2020, there was no documentation or investigation concerning the incident with R2, R3 and V14.

On 6/30/2020 at 9:40AM, V13(Social Service Director) was interviewed. V13 said she remembers one day about 4- 5 weeks ago when she was working the evening shift as the night manager on duty. V13 said she was alerted by R2 that V14(CNA) would not take R3 off the bed pan. V13 said she talked to V14(CNA) and V14 told V13 that R3 was not on her assignment, was not her resident and she was not going to take her off the bedpan. V13(Social Service Director) said V14 continued to say" the nurse did not ask her," V13 said 'I am asking you, better yet, the resident has asked you." After much conversation, she took R3 off the bed pan. V14 said "I did say that V13(CNA) should be written up , so I informed the Director of Nursing, V4. V4 is now the wound care nurse. V13 was unsure of the date or the nurse on duty of this incident.

On 6/30/2020 at 10:02AM, V4(Wound Care Nurse) said she was the Director of Nursing about 4-5 weeks ago. V4 said she remembers one evening when V13(Social Service Director) was upset and told her that staff need to listen to evening managers. V4 said she was not made aware that V14(CNA) refused to take R3 off the bed pan, V14 should have received a write-up. V4 said V13(Social Service Director) could have written that incident up. V4 said R3 does have a sacral sore that measures .6 cm in length by .5 cm in width by .4 cm in depth. V4 said R3 was admitted with the sacral sore and it is improving.

On 6/30/2020 at 10:21AM, V2(Director of Nursing) and V3(Assistant Director of Nursing)

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S9999	Continued From page 7 were made aware of the call light response of V14(CNA) regarding R3. V2 said she has been providing education for staff on answering call lights even if the resident is not on your assignment. V2 and V3 said they were not employed at the facility when the event occurred. On 6/30/2020 V1(Administrator) was also made aware of this concern. On 7/1/2020 at 7:36PM, V1(Administrator) said he started an investigation and has suspended V13(CNA), even though he was not the administrator at the time. (B)	S9999		