

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000251	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2022
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NAME OF PROVIDER OR SUPPLIER PEARL OF NAPERVILLE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 MARTIN AVENUE NAPERVILLE, IL 60540
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S 000	Initial Comments	S 000		
S9999	<p>Complaint Investigation #2274045/IL147226</p> <p>Final Observations</p> <p>Statement of Licensure Violations:</p> <p>300.610a) 300.1210b) 300.1210d)1) 300.1230e) 300.1230i)1)2) 300.3240a)</p> <p>Section 300.610 Resident Care Policies a)The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care 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 resident to meet the total nursing and personal</p>	S9999	<p>Attachment A Statement of Licensure Violations</p>	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X8) DATE _____

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S9999	<p>Continued From page 1 care needs of the resident.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.</p> <p>Section 300.1230 Direct Care Staffing e) The facility shall schedule nursing personnel so that the nursing needs of all residents are met.</p> <p>Section 300.1230 Direct Care Staffing i) For the purpose of computing staff to resident ratios, direct care staff shall include the following: 1) Registered professional nurses; 2) Licensed practical nurses;</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These regulations were not met as evidenced by: 1) Based on interviews and record reviews, the facility failed to prevent neglect when the facility was left without a licensed nurse in the building for over four hour. This failure resulted in the potential for serious harm or death when residents did not receive services, monitoring, and medications. 2) Based on interviews and record reviews the</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>facility failed to administer medication at ordered times. This applies to 7 of 8 residents (R1, R3-R8) reviewed for medication in a sample of 8.</p> <p>This failure applies to all residents in the facility. The facility's 5/21/22 Daily Census Sheet showed 67 residents reside in the facility.</p> <p>The findings include:</p> <p>On 6/3/22 at 2:20 PM, V6 (Assistant Administrator) stated there were no licensed nurses working at the facility on 5/21/22 from 8:30 PM to 11:05 PM, and from 12:16 AM to 2:40 AM on 5/22/22. V6 added there was a potential for serious harm to the residents because there were no licensed staff members present.</p> <p>On 5/27/22 at 1:51 PM, V8 (Staffing Scheduler) said that on 5/22/22 around 2:00 AM, she received a text that the Fire Department was in the building, and that there were no nurses working in the facility. V8 stated that a minimum of two nurses are necessary to work the 7 PM-7 AM shift.</p> <p>On 5/27/22 at 12:25 PM, R7 stated he called 911 around 1:00 AM on 5/22/22 because he did not get his blood pressure medications, because there were no nurse working to pass medications. R7's 5/25/22 Minimum Data Set (MDS) showed his cognition is intact. R7's May 2022 Medication Administration Record (MAR) showed that among the scheduled medications R7 missed on 5/21/22, two of them were cardiac medications, and his blood pressure was not taken as ordered.</p> <p>On 5/27/22 at 1:51pm V8 the facility's scheduler said that for the 7pm-7am shift the minimum number of nurses is 2. V8 said that on 5/22/22 around 2am she received a text that the fire department was in the building and that there</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>were no nurses in the building. On 5/25/22 at 2:59 V4 CNA said that on 5/21/22 V9 LPN was a no call no show for the 7p-7a shift, and V5 and V17 came in but did not stay for their shifts, and on 5/22/22 from around 12:30am to 2:30am there were no nurses in the facility until V3 LPN came in.</p> <p>1. On 5/26/22 at 11:05am R1 said that on 5/21/22 he did not get his 9pm medications and there was no nurse from around 7PM to 1:30pm. R1's MAR (Medication Administration Record) for 5/1/2022 - 5/31/22 showed that on 5/21/22 R1 did not get the following 9pm medications: Latanoprost Solution 0.005% 1 drop in both eyes, Melatonin 5mg, Quetiapine fumarate 50mg, Sinemet 25-100 for Parkinson, Carbidopa-Levodopa ER 50-200mg. The MAR record showed that on 5/21/22, R1 was not monitored for adverse reaction to anti-coagulation therapy as ordered.</p> <p>2. On 5/26/22 at 12:50pm R3 said that the weekend of 5/21/22 there were no nurses and that she did not get her 9pm blood sugar checked, her insulin, water pills and her potassium. R3's MAR (Medication Administration Record) for 5/1/2022 - 5/31/22 showed that on 5/21/22 R1 did not get the following 9pm medications: Potassium Chloride ER 10 meq., Sildenafil Citrate 20mg, medroxyprogesterone 5mg, Trazadone 50mg, Melatonin 3mg, Levemir FlexTouch Solution (insulin Detemir) 15 units, and Atorvastatin Calcium 10mg. The MAR record showed that on 5/21/22, R3 did not get her blood sugar taken at 9pm as ordered.</p> <p>On 5/26/22 at 1:19 PM, R4 said he experienced a "medical crisis" on 5/22/22. R4 stated his indwelling urinary catheter was clogged and there</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>was blood in his urine. R4 said that on 5/22/22 when the Fire Department was in the facility, the emergency personnel that were there sent him to the Emergency Room (ER). R4 stated his catheter was changed in the ER, and labs were drawn, an infection was identified, and antibiotics were started. R4's May 2022 MAR also showed he did not have his catheter flushed at 9:00 PM or changed per order, his pain level was not monitored, and an anticoagulant medication was among the medications he was not administered on 5/21/22.</p> <p>R6's progress notes for 5/21/22 from 5:05 PM showed an order to send R6 to the ER because of abnormal laboratory results. R6's note showed transportation was arranged to pick her up in two hours. R6's 5/22/22 7:20 AM progress note from the next day showed R6 was transferred to the hospital ER on 5/22/22 at 4:15am, eight hours and 45 minutes later than arranged. R6's May 2022 showed an anticoagulant was among the scheduled medications she missed on 5/21/22.</p> <p>4. On 5/26/22 at 1:03pm, R5 said that on the weekend of 5/21/22 there were no nurses, and she didn't get her medications that night. R5's MAR (Medication Administration Record) for 5/1/2022 - 5/31/22 showed that on 5/21/22 R1 did not get the following 9pm medications: Olanzapine 15mg, Risperidone 4mg, Alprazolam 0.5mg, Aripiprazole 15mg, Atorvastatin Calcium 40mg, and Mirtazapine 45mg.</p> <p>5. R6's MAR (Medication Administration Record) for 5/1/2022 - 5/31/22 showed that on 5/21/22 R1 did not get the following 9pm medications: Xarelto 2.5mg, Gabapentin 300mg, Ammonium lactate cream 12%, Atorvastatin Calcium 20mg, and Ketoconazole cream 2%. The MAR record showed that on 5/21/22, R6 was not monitored</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>for pain every 6 hours as ordered.</p> <p>6. R7's MAR (Medication Administration Record) for 5/1/2022 - 5/31/22 showed that on 5/21/22 R1 did not get the following 9pm medications: Atorvastatin Calcium 80mg, Meloxicam 7.5mg, Tamsulosin HCL 50mg, Trazodone HCL 75mg, Lactulose solution 30 grams, Metoprolol Tartrate 12.5mg, Mucinex ER 600mg, Senna-Docusate 8.6-50mg, and Hydralazine HCL 25mg. The MAR record showed that on 5/21/22, R7 was not monitored for pain and his blood pressure was not taken as ordered.</p> <p>7. On 5/27/22 at 1:24pm R8 said that on 5/21/22 only two nurses came in for the 7pm-7am shift and they both walked out. She said she had been asking for her medication from 9pm to 10pm and a CNA told her that there were no nurses in the building. R8 said she didn't get her medications for pain, sleep, and her antibiotic. R8 said she also missed her 5am medication on 5/22/22 for her hypothyroidism. R8's MAR (Medication Administration Record) for 5/1/2022 - 5/31/22 showed that on 5/21/22 R1 did not get the following 9pm medications: Ciprofloxacin HCL 125mg, Atorvastatin 20mg, Melatonin 3mg, Ropinirole HCL 0.5mg, Cranberry tablet, Heparin Sodium Solutions 5000 unit/ml 1 vial, Gabapentin 300mg, Nystatin powder 100000 unit/GM, and Carboxymethylcellulose Sodium 2 drops in both eyes. The MAR record showed that on 5/21/22, R8 did not get her supplement of Ensure plus 1 carton as ordered, and R8 was not monitored for pain or vital signs taken as ordered.</p> <p>R3's May 2022 MAR showed she did not receive her scheduled insulin injection on 5/21/22 and did not have her blood glucose value checked. The MAR also showed R3 missed scheduled doses of</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>a vasodilator and potassium.</p> <p>R1's May 2022 MAR showed R1 was not monitored on 5/21/22 for adverse reactions to anti-coagulation, and R1 missed doses of Parkinson's medications and a dose of a psychotropic medication.</p> <p>R5's May 2022 MAR showed R5 missed doses of three psychotropic medications on 5/21/22 and was not monitored for pain every four hours as ordered.</p> <p>R8's 3/24/22 MDS showed her cognition is intact. On 5/27/22 at 1:24 PM, R8 stated only two nurses came in for the 7 PM-7 AM shift on 5/21/22, and they both walked out. R8 stated she had been asking for her medications from 9 PM to 10 PM, and a CNA (Certified Nursing Assistant) even told her that there were no nurses in the building. R8's May 2022 MAR showed she missed a dose of her antibiotic and a heparin injection.</p> <p>Three "General Incident Reports" (each revised 6/1/22) sent to three physicians all showed "Incident: Medication and treatment not administered per orders, approximately bedtime on 5/21/22 until morning of 5/22/22." The three Reports together listed names of 56 residents where "medication and treatment" was not administered.</p> <p>On 6/2/22 at 1:50 PM, V18 (Physician, Facility Medical Director) said that the facility should have licensed nurses always working because there is potential for a medical crisis needing a licensed nurse to perform lifesaving interventions. V18 said with the residents' medical conditions, there is potential for hypoglycemia, fluid overload, infection from not getting antibiotics, labile sugar for those who are insulin dependent and do not get their insulin, exacerbations of congestive heart failure or chronic obstructive pulmonary diseases, or heart attacks and strokes.</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>The facility's "Subject: Abuse Neglect Exploitation Mistreatment and Misappropriation of Property Prevention" policy/procedure (reviewed 2/8/22) defined Neglect as " ...the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect occurs when the facility staff fails to monitor and or supervise the delivery of patient slash resident care and services to assure care is provided as required." The policy further showed under "3. Prevention 1. The deployment of staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs ..."</p> <p>The facility's Assignment Sheets for 4/28/22 through 5/26/22 were reviewed and the assignment sheet for May 21, 2022, 7pm to 7am shift showed that 3 nurses were scheduled, V9 LPN (Licensed Practical Nurse) was a no call no show, V17 LPN (agency nurse) walked off the job, and V5 RN (Registered Nurse) walked off the job, leaving the facility with no licensed nurses on 5/21/22 from 8:30pm to 11:05pm and on 5/22/22 from 12:16am to 2:40am.</p> <p>The facility' General Incident Report for 5/21/22 at approximately 9pm until 5/22/22 morning, medications were not administered as ordered.</p> <p>(A)</p>	S9999		