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 _____	09/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Licensure/change of ownership survey Statement of Licensure Violations	S 000		
S9999	Final Observations 1 of 4 Licensure 300.1210a) 300.1210b) 300.1210d)2)3)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	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 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. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 observation, interview and record review the facility failed to prevent the development of pressure injuries, obtain a doctor's order for treatment of the wounds and to develop and implement a plan of care to promote healing.	S9999		

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S9999	Continued From page 2 This applies to 2 of 4 residents (R2, R5) reviewed for pressure ulcers in a sample of 7 residents. The findings include: 1. On September 18, 2018 at 1:25 PM, R2 was noted sleeping in his wheelchair. R18 (R2's) wife was requesting staff to assist R2 to the bathroom. R18 explained, "He's (R2) been up early today around 6:00 AM, the staff usually put him back to bed after lunch (1:30-2:00 PM)." R2 was noted with dressing on the right toe saturated with brownish (Povidone-iodine an anti -septic solution) color stain. During incontinence care R2 was noted with dressing on the left coccyx. At 1:30 PM, V8 and V9 (Certified Nursing Assistant's) explained that the wounds on R2's feet (blisters on right and left toes) and on R2's left ischium were noted and reported to V12 (Nurse) two weeks ago. At 2:10 PM, V4 (Treatment Nurse) reviewed R2's electronic records and explained that there were no treatment ordered for any of R2's wound (right and left foot and on the left ischium) that was obtained. V4 stated, "R2 does have a moisture associated skin disorder (MASD) on his buttocks that is treated with an ointment, R2 does not have any pressure sore." On September 19, 2018 at 9:40 AM, R2 was noted sleeping on his wheelchair inside the room. R18 (R2's wife) said, "He's supposed to go back to bed after meals but they are short staff." At 10:00 AM, V10 (Nurse) reviewed R2's electronic records anexplained, "I do not see any treatment order anywhere in R2's chart (electronic records).	S9999		

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S9999	Continued From page 3 At 10:30 AM, a skin assessment was conducted with V4 and V11 (Restorative Nurse). R2's left ischium was noted with dressing smeared with feces. V4 and V11 provided incontinence care to R2. During the skin assessment V4 and V11 identified and described the following pressure injuries: 1. Stage 2 on the right ankle measured at 1.5 cm (width) X 1.0 cm (length) x 0.1 cm (depth). 2. Unstageable Pressure Injury on the left ischium with 100% yellow slough measured at 1.0 cm X 1.5 cm. V4 presented R2's current physician order sheets and electronic treatment administration records and stated, "It was my bad, there's no treatment order obtained and I should have ordered a special (low air loss) mattress for him. There was a dressing applied on his left ischium but that was not ordered by the physician." V4 was unable to present any skin assessment that was done for R2. V4 said, "I started a skin assessment for the moisture associated skin disorder (MASD) on September 10, 2018 but I did not finished it." At 2:45 PM, V6 (Minimum Data Set/care plan Coordinator) present R2's care plan and said, "There was no care plan developed for his wounds (existing wounds- blisters on toes and left ischium) and/or the wound on the right ankle. 2. On 9/18/18 at 12:10 PM, V4 (Wound Care Nurse) stated R5 only had a pressure ulcer on the left hip. R5 agreed to view the right hip. Located on R5's right hip was a dressing. V4	S9999		

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stated "I had no idea that was there." R5 stated the facility "has been placing the dressing there for a few days now." Visualization revealed an open wound with 3 spots of yellow slough in the wound bed. V4 measured the wound at 4.8 X 2.0 cm. V4 stated "it is a stage 3. I had no idea it was there. Policy is to document and obtain orders. Policy is to document characteristic, draining, measurements etc."

R5's nursing notes showed no documentation of the wound. There was also no orders for the wound. There was no care plan.

R5's toe nails were dry, thick, crumbling and there was a large amount of blood coming from the right great toe. The blood was on the top sheet and the fitted sheet. V4 stated I did not know R5's toe nails were like that. R5 stated the toe nails were like that for a while. R5's nursing notes showed no documentation for the impairment and there were no treatment orders.

V4 stated she will inform the doctor and obtain orders for R5's newly facility acquired pressure ulcer and nail impairment as well as podiatry appointment.

(C)

2 of 4 Licensure

300.1210b)
300.1210b)5)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 5 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 care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. These requirements were not met as evidenced by: Based on observation, record review and interview, the facility failed to follow the plan of care for a resident at high risk for falls. This failure led to R4 falling and sustaining a fractured right elbow. This applies to 1 of 1 resident (R4) reviewed for accidents/supervision in a sample of 7. Findings include: The MDS (Minimum Data Set) dated 4/20/18 reads: R4 has a Brief Interview for Mental Status score of 15/15 indicating no cognitive impairment; and R4 requires staff physical assistance with ambulation inside room, outside room, locomotion on unit, and locomotion off unit.	S9999		

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The facility's report to the state surveying agency reads:
On 5/16/18, R4 was standing by medication cart getting medication from the nurse. Resident turned to return to room, lost balance and fell on buttocks.

The written statement from V13 (Agency Nurse) reads: Resident came up to writer about resident's medication when resident turn back, resident lost balance and fell on buttocks.

On 9/18/18 at 1:50 PM, R4 was lying in bed with oxygen per nasal cannula. The oxygen tubing was long and coiled on the floor. R4 stated R4 could not get up and now requires assistance. R4 stated R4 broke R4's right arm. R4 stated I remember the fall, it was an agency nurse. He was agitated. I don't know if he tripped me. I always walk by myself.

On 9/18/18 at 2:25 PM, V15 (Restorative Aide) stated R4 ambulates without staff assistance. V15 stated "R4 can go alone, if R4 goes past the nursing station, R4 will ask for help. R4 ambulates to the desk alone with the walker and oxygen."

On 9/18/18 at 2:10 PM, V2 (Director of Nursing) stated V13 no longer works at the facility.

On 9/18/18 at 2:34 PM, V14 (Nurse) stated R4 ambulates with the rolling walker. V14 stated R4 can ambulate all the way to the nursing station without staff assistance, and R4 carries the oxygen tank with strap. V14 stated if R4 walks past the nursing station, R4 will ask for help but not all the time, "sometimes R4 can walk all the way to the front."

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S9999	Continued From page 7 On 9/20/18 at 11:41 AM, V6 (MDS, Care Plan, restorative nurse at time R4 fell) stated R4 ambulates with the rolling walker and staff have to use a gait belt. V6 stated R4 requires stand by assist with the rolling walker. V6 stated R4 requires staff physical assistance with ambulation in and out of room and with locomotion on and off unit. V6 stated this care plan was in place in May/2018. On 9/20/18 at 12:06 PM, V11 (Restorative Nurse) stated V6 was the restorative nurse during May/2018. The Care Plan provided by V6 reads: R4 is at risk for decline ambulation due to generalized muscle weakness. Interventions Staff will assure R4 has a gait belt on while ambulating for safety. Staff will assure R4 is being followed by wheelchair when ambulating. The radiology report 5/16/18 for R4 reads: positive for acute fracture of the distal humerus (AW) 3 of 4 Licensure 300.1210d)1) 300.1610a)1) 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. Section 300.1610 Medication Policies and	S9999		

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S9999	Continued From page 8 Procedures a) Development of Medication Policies 1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws. These requirements were not met as evidenced by: Based on observation, record review and interview the facility failed to properly administer medication in accordance with physician's orders. The facility also failed to follow their policy for medication administration. There were a total of 37 opportunities with 8 errors resulting in a 21.6% error rate This applies to 7 residents (R19, R20, R21, R22, R23, R24, R25) in the supplemental sample. Findings include: 1). On 9/18/18 at 4:40PM, V16 (Nurse) administered medication to R20. The Physician's Order Sheet/Medication Administration Record (POS/MAR) documented the following order: Coumadin, give 1.5mg by in the evening related to atrial fibrillation. V16 omitted the Coumadin. V16 looked on the medication cart and stated R20 does not have any Coumadin. V16 charted code 9 (medication	S9999		

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S9999	Continued From page 9 not available). 2). On 9/19/18 at 8:00 AM, V17 (Nurse) administered medication to R21 via feeding tube. The POS/MAR documented the following orders: Vitamin C 500mg via feeding tube one time a day; Zinc 220mg via feeding tube one time a day; Docusate Sodium Tablet 100mg by mouth two times a day; Baclofen 10mg by mouth three times a day V17 obtained a docusate Sodium liquid capsule instead of tablet. V17 then crushed the capsule once leaving it mostly intact and placed it in the same cup with all the medication. V17 then administered the medication leaving the capsule in the cup and through it in the garbage. V17 did not flush the feeding tube pre or post medication administration. The medication cart revealed Docusate Sodium tablets. 3). On 9/19/18 at 8:32 AM, V2 (Director of Nursing) administered medication to R22. The POS/MAR documented the following order: Calcium-Vitamin D 600-200, oral two times a day. V2 omitted the Calcium. V2 stated the medication was not available. V2 charted (code 9-not available) 4). On 9/19/18 at 9:05 AM, V2 administered medication to R23. The POS/MAR read Budesonide Suspension 0.5mg/2ml, 1 vial inhale orally every 12 hours for shortness of breath. V2 stated the Budesonide is not available after looking on the cart. V2 omitted the Budesonide documenting code 9. 5). On 9/19/18 at 3:50 PM, V18 administered medication to R19. The POS/MAR reads the	S9999		

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following order: Tamsulosin 0.4mg, give one capsule orally one time a day related to benign prostatic hyperplasia.

V18 omitted the Tamsulosin. V18 stated "R19 is supposed to get Tamsulosin, I don't see it." V18 did not locate the medication on the cart after searching. V18 did not offer or administer the Tamsulosin to R19. V18 then signed the MAR as if the medication was administered.

6). On 9/19/18 at 3:57 PM, V18 administered medication to R24. The POS/MAR read the following orders: Betagan Solution, instill 1 drop in both eyes two times a day related to glaucoma; Timolol Maleate Gel, instill 1 drop in both eyes two times a day

V18 omitted both eye drops for R24. V18 stated to R24 "your sister is supposed to bring your eye drops." V18 stated "you guys have my eye drops, you took them from me when I got here and I have not received them." V18 looked and did not locate the eye drops. V18 documented code 9 for Betagan even though she did not administer either eye drop.

7). On 9/19/18 at 4:47 PM, V19 administered medication to R25. The POS/MAR read the following order: Ferrous Sulfate 220/5ml, give 6.8ml enterally two times a day. V19 looked on the medication cart and stated there is no Ferrous Sulfate. V19 then looked in the medication room but did not locate the medication. The Ferrous Sulfate was omitted by V19.

The Policy for Administration of Oral Medications read:
Medications will be administered by

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licensed/certified staff in a safe manner per physician order.
-Medication administration (MAR) should contain specific direction for administration of an oral drug.
-It is not acceptable to document "Drug Not Available".

The Policy for Administering Medication tube feeding reads: Administer medications separately with 5-10 cc of water.
-Insert syringe without plunger and flush tube with 30cc water
-Administer medication by gravity flow

(C)

4 of 4 Licensure
300.2220a)a)

Housekeeping.
300.2220 a) 1) Keep the building in a clean, safe and orderly condition. This includes all rooms, corridors, attics, basements and storage areas.

These requirements were not met as evidenced by:

Based on observation and interview the facility failed to keep the basement corridor leading to the fire exit clear of clutter.

findings include:

This applies to 2 of 7 residents (R1 and R4) in the sample and 11 residents (R8, R9, R10, R11, R12, R13, R14, R15, R16, R17 and R18) in the supplemental sample reviewed for using the basement beauty shop, computer room and

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S9999	Continued From page 12 vending machines. Findings include; On 9/18/2018 and 9/19/2018 The basement corridor by the kitchen delivery door leading to the exit stairwell was cluttered on both sides of the corridor with wooden pallets, wheel chair, two wheeled cart, clothing and decorations. There was not a clear path to the fire exit. V7 (maintenance) said, "They know they are supposed to put everything on one side of the hallway." (AW)	S9999		