STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145358	A. BUILDING _____ B. WING _____	09/01/2020

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

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 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to respond to resident call light requests for ADL (Activities of Daily Living) services in a timely manner. This applies to 2 of 7 residents (R3, R4) reviewed for call light response to meet ADL needs. The findings include: On August 19, 2020 at 10:15 AM, surveyors activated the call light system in an empty room and went to the nursing station. The call light above that room's door was lit, and a second call light was lit down the hall. A device at the nursing station sounded, and the device had an LED light display and a telephone attachment which indicated the call lights were on. V6 (RN) was asked how the call light system worked. V6 picked up the telephone attachment and set it back in the cradle. The surveyor's test call light went off and the room number LED display disappeared. V6 picked up the phone again, canceling the second call light in the hall, and the sound from the device stopped. R3's July 9, 2020 Minimum Data Set (MDS) showed he is cognitively intact and has a [DIAGNOSES REDACTED]. On August 18, 2020 at 11:50 AM, R3 was in bed. R3 stated he will press the call light and wait anywhere from 15 minutes to 45 minutes for help when he needs something. R3 stated staff disconnect (the call light) at the nursing station. I know they shut it off and I press it again. I can hear the beep. R4's July 15, 2020 MDS showed he is cognitively intact and has [DIAGNOSES REDACTED]. The same MDS showed he requires extensive assistance of two persons for bed mobility, bathing, and personal hygiene, and is dependent on two persons for transfers. On August 14, 2020 at 3:05 PM, R4 was lying in bed. R4 stated he will hit the call light and wait for an hour for the bedpan. R4 stated staff shut off the call light at the nursing station and I have to keep hitting it. The facility's July 29, 2020 Resident Council Meeting minutes showed .Do not get changed overnight. CNAs are getting better at answering the call light but sometimes still turn them off from the nurse's station . The July 29, 2020 Resident Council Meeting Attendance Sheet showed four residents were present for the meeting. The Attendance Sheet does not show that R3 and R4 were present to discuss the concern. The Purpose section of the facility's September 2019 Call Light policy showed to respond to residents' requests and needs in a timely and courteous manner. The Procedure section showed 1. Answer light (signal) promptly. 2. Be courteous when entering room. 3. Turn off call light. 4. Listen to resident's request. Do not make the resident feel you are too busy to help .
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** Based on observation, interview, and record review, the facility failed to identify that a resident's foot board caused pressure to the side of his contracted foot, resulting in a deep tissue injury. This applies to 1 of 4 residents (R29) reviewed for pressure ulcers in the sample. The findings include: On August 25, 2020 at 8:25 AM, R29 was in bed with the head of his bed elevated approximately 60 degrees. V22 CNA (Certified Nursing Assistant) helped R29 to feed himself. The top of R29's head was approximately four inches below the edge of his mattress at the head of his bed. R29's left foot was contracted and turned inward so the outside of his foot pressed against the wooden foot board. While the surveyor checked his foot, V22 stated and we just pulled him up, too. An irregularly-shaped deep purple area was present on the outside of R29's foot. R29's August 9, 2020 Minimum Data Set (MDS) showed he is cognitively intact, and when asked his height, R29 stated he was six feet tall. When asked about pain to the discolored area on his foot, R29 stated I feel it, it's sore . it's sore as h*** . The same MDS showed R29 is at risk for pressure ulcer development, is six feet tall, and requires extensive assistance of two people for bed mobility. On August 25, 2020 at 8:35 AM, V4 Wound LPN (Licensed Practical Nurse) was asked about the area on R29's left foot. V4 stated she was not aware of the area of discoloration on R29's foot. V4 stated she expects facility staff to check residents' skin and let her know about any questionable areas. V4 identified the area as deep tissue injury (DTI), and measured the area as 0.4 cm by 0.8 cm. The facility's February 2020 Pressure Ulcer Recommended Treatment Protocols policy described DTI as purple or maroon localized area of discolored intact skin .due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful Treatments include eliminate the sources of pressure .
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** Based on observation, interview, and record review, the facility failed to ensure that fire exits on the first floor remained clear, and that one of the exits had a working alarm. This applies to all 34 residents on the first floor (R3, R4, R8, R9, R13-R16, R19-R31, R33-R45). The findings include: The facility's August 14, 2020 Resident List Report showed 34 residents live on the first floor. On August 14, 2020 at 1:50 PM, a table approximately four feet long and two feet deep was placed against the South fire door on the first floor, blocking the exit. At 2:00 PM, two stationary chairs and a headboard were noted blocking the North fire exit on the first floor. Plaques were posted on both fire exit doors, showing FIRE DOOR Do not block or prop open at any time. R8's room is directly across the hall from the first floor South fire door. R8's July 18, 2020 MDS (Minimum Data Set) showed he is cognitively intact. On August 14, 2020 at 1:55 PM, R8 stated the table has been there for around three weeks or a month. R8 stated the door was blocked because residents kept opening the door. When asked which residents, R8 stated (R16) and a woman that's not here anymore. R8 stated R16 thinks his car is outside. At 2:10 PM on August 14, 2020, V1 (Administrator) was asked about the fire doors being blocked. V1 stated there were two residents (R16 and another) in the facility that need a Memory Care Unit, which the facility does not have. V1 stated the fire doors were alarmed but staff is not always quick enough to intervene or available in the middle of the night. V1 stated We weighed the pros and cons. The first floor South fire door was pushed open to test the alarm function. When the door was opened, the alarm did not sound. At 2:20 PM, V1 stated that blocking the fire exits is a tremendous safety hazard if there was a fire and we needed to quickly access the doors. V1 stated Every exit door should have some kind of alarm. V1 added that the first floor fire exits do not have direct access to outside, and instead open to a stairwell and an exit leading to outside. At 2:25 PM, V7 (Maintenance Director) checked the first floor south fire door alarm. V7 stated that the magnet was missing from the door alarm. V7 stated the last time he checked the door, it was working. The facility's 2020 Monthly Preventative Exit Door Checks, Interior & Exterior form showed the last time the alarms were checked for functionality was July 17, 2020, 28 days earlier.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide any feeding tube formula to a resident for five days.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) This applies to 1 of 4 residents (R51) reviewed for tube feedings in the sample. The findings include: R51's Minimum Data Set (MDS) history showed he was admitted to the facility on [DATE], and expired in the facility on [DATE]. The Census section of R51's Electronic Medical Record (EMR) showed he had elected hospice services. R51's [DATE] physician's orders [REDACTED]. On [DATE] at 4:05 PM, V27 (Hospice RN) stated she had ordered his tube feeding formula on [DATE] from their medical provider's website. V27 stated her records showed the formula was delivered to the facility on [DATE]. (The UPS shipping requisition showed the delivery was signed for by V28 (Admissions Director) at 9:23 AM on [DATE].) V27 stated the last time she visited R51 was [DATE] (three days after admission) and there was no tube feeding running. On [DATE], V6 (RN) stated if a resident has a tube feeding ordered and the formula is not available, staff try to borrow some of it from a sister facility. V6 stated if the formula remains unavailable, nurses talk to the Nurse Practitioner and get an order for [REDACTED]. R51's Hospice After Hours Triage note from 12:25 PM on [DATE] showed at 11:07 AM, facility staff had called and explained there was no tube feeding formula available for R51 (five days after R51 was admitted). The note continued and showed that R51's daughter was sobbing because she verbalized that no one knew if the patient had been fed in a week. The note further showed that R51's tube feeding formula and supplies had been delivered to the facility and had been sitting in the Reception office. On [DATE] at 12:20 PM, V29 (Hospice Physician) stated if the order is written .they should do it. I don't understand why they didn't. V29 continued The expectation is the order written should be followed. V29 stated, R51 missing his tube feeding really would not have had any negative outcome and some empirical data has shown that not giving the tube feeding does not cause any discomfort, although it is often a difficult concept for families. R51's [DATE] Medication Administration Record [REDACTED]. On [DATE], V1 (Administrator) stated chart review showed a lack of simple follow through . a phone call . V1 further described the situation as a complete system failure .no escalation or critical thinking . when the nurses assigned to R51 did not have the tube feeding to administer, adding we did not do what we were supposed to do .