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 11/04/2020

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 Complaint Investigation: #2078521/ IL 128144 #2078549/ IL 128172	S 000		
S9999	Final Observations Statement of Licensure Violation: Licensure Findings 300.690a)b) 300.1210b) 300.1210d)6) 300.3240a)c)d) 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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: 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. _____ _ 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) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of	S9999		

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S9999	Continued From page 2 a resident shall also report the matter to the Department. (Section 3-610 of the Act) These requirements are not met as evidence by: Based on observation, interview and record review the facility failed to supervise a resident and failed to ensure the alarm on an emergency exit door was working resulting in a resident ,with dementia, leaving the facility through the unalarmed door on October 25, 2020 without staff knowledge. This applies to 1 of 3 residents (R4) reviewed for safety and supervision in the sample of 12. The findings include: R4's Minimum Data Set of 10/24/20 shows that R4 has Severely Impaired Cognitive Skill for Daily Decision Making and short and long term memory problems. R4's Physician's Order Sheet dated October 2020 shows that R4 has diagnoses including Dementia with Behavioral Disturbance, Major Depressive Disorder, Anxiety Disorder, Alzheimer's Diseases, Cognitive Communication Disorder, Encephalopathy and COVID-19. R4's Elopement Risk Assessment dated 10/15/20 shows that R4 has a history of wandering/elopement and /or verbalizes a strong desire to leave, responds poorly to staff redirection when roaming into areas that are off-limits or unauthorized, and is considered at risk to elope and should be placed on the Elopement Risk Protocol.	S9999		

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S9999	Continued From page 3 R4's Progress Notes dated 10/26/20 at 12:55AM state, "Physician notified of resident being in (Hospital ER)." There is no documentation related to R4's elopement from the facility. On 10/30/20 at 10:40AM V10 (Licensed Practical Nurse- Wound Nurse) stated, "I was on the second floor and I got a call from the police department. They asked if we had a resident by the name of (R4- first name), I said, (R4's full name). They said she was found outside and she had had a fall. I told them I was not the nurse in charge of her. They asked to speak to whoever was in charge but I told them they could just speak to me. They said she was going to the hospital. I ran downstairs to let the V11 (Registered Nurse (RN) Agency Nurse) on the Homeward Bound Unit know. When I found (V11) she did not know that (R4) was not in the building. She said, "It's your building." So I called V2 (Director of Nursing) and V1 (Administrator). The staff on the unit said the last time they saw (R4) was around 8:30PM. Everyone that works on that unit is from an Agency. I got statements from (V11) and V12 (Certified Nursing Assistant- CNA). I was so upset I was kind of on an adrenaline rush- I ran around and tested all the doors. The patio door alarm went off, but the end of the hall door did not alarm when I opened it. I ran around the entire building and tested the doors. I called the hospital to check the status of (R4). We have never had a dementia unit before. That unit was created for our COVID residents." On 10/30/20 at 11:30AM, V11 stated, "I'm not sure how she (R4) got out. It is supposed to be a locked unit. She has dementia and she kept packing her bags and we kept redirecting her to her room. Then we went in to care for 2 other residents. This is supposed to be a locked unit- I	S9999		

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S9999	Continued From page 4 guess she went out the emergency door in the back of the unit. It had to be this door. We saw her last about 8:00-9:00PM. Then (V10) came and told me that (R4) was found outside. I had never worked at the facility before and I have not worked there since." On 10/30/20 at 11:45AM V12 stated, "She (R4) was in the front foyer area. She was ready to leave and had been packing her bags all night. It is a locked unit. Residents shouldn't be able to get out. These are patients with Dementia. We went in to give care to 2 other residents about 8:30PM and we didn't hear any alarms go off. After caring for the other gentlemen, we came out and (R4) wasn't there. I didn't think anything of it. I thought it was a locked unit. They are pretty independent back there. They said she went out the back door, but it never alarmed while I was back there. " On 10/30/20 at 2:00PM V2 stated, "I got a phone call from (V10) that (R4) had gotten out of the building. I asked (V10) to check the doors and V1 (Administrator) called the emergency number to arrange for the repair of the door that did not alarm. I asked (V10) to call the hospital and check on the status of (R4), call the doctor and get statements from (V11 and V12) on the unit. Then I followed up in the AM with the hospital and (V1) told me the door was secure. When (V10) had tested the door that night the door did not alarm. I did not have a part in the investigation. I just kept having (V10) check on (R4's) status in the hospital. The nurses are supposed to document in Risk Management when we have an incident and that is not part of the medical record. (V11) said she called (R4's) family. I don't know if she documented it anywhere."	S9999		

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On 10/30/20 at 12:00PM V1 stated, "The door was fixed by (Repair Company). The panel has a battery and the battery was dead so he changed out the battery so the alarm will go off. The doors are fixed now. There is supposed to be a 15 second egress on the doors." Surveyor and V1 then went to the unit to check the doors. V1 stated,
"We did not use agency until this unit opened. This unit had been closed for 3 years. Then I got a call on a Wednesday night that they were going to admit 15 residents from another facility on Thursday, so we quickly got this unit in order."
Surveyor and V1 checked Foyer/patio door inside unit. Door released and alarmed when pushed open. Then Surveyor and V1 checked the End of hall emergency door (door that was repaired following R4's elopement) V1 pushed on door release and the alarm sounded, however the door would not release. V1 put in the code and door released and did not alarm. V1 stated, "The door is supposed to have a 15 second egress." V1 called (V13- Maintenance) and explained to him what was happening. V1 then stated," (V13) is calling the guy now- this is not good."
This Emergency Exit Door has a Door Guardian System and a Magnet Lock. Therefore, the door has 2 different keypad panels with separate codes, 2 different locks, and 2 different alarms. At 1:50PM, V1 stated, "The service company did not put a 15 second egress on the door so they are coming back on Monday to fix it. If the fire alarm goes off the door will automatically release."

The Facility Incident Report dated 10/25/20 states, "(R4) was reported missing on the evening of 10/25/20". Immediate Action Taken: 1. The resident was found missing by non-facility staff and notified police, 2. Police notified facility

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at approximately 10:15PM, 3.The resident was determined to have been unauthorized to leave the facility at the time the resident went missing, 4.Resident was taken to the ER by emergency personnel, 5. The resident was reported missing to the treatment nurse who immediately notified the Administrator, 6. A count of all residents in the facility was conducted, No other residents were reported missing, 7. Physician notified, 8. The resident's family was notified, 9. All doors and door alarms checked. Facts Determined by Facility: 1. Facility Protocol regarding missing resident followed, 2. Resident was found by police, 3. Resident was taken to the ER and no new injuries immediately noted. Analysis and Conclusion: 1. Resident admitted to facility from another Skilled Nursing Facility on 10/15/20. Resident's diagnoses include but not limited to Dementia, Depression, Anxiety, and Alzheimer's disease. Resident is oriented to self only due to diagnosis, 2. Resident was redirected by staff several times, 3. Resident's care plan will be updated upon readmission, 4. Resident to be monitored upon readmission by facility staff for any behaviors that can trigger a repeat occurrence, 5. Plan discussed between administrator and family and family is happy with plan."
Written statements from V11 and V12 are included with this Incident Report.

V11's written statement dated 10/25/20 reads, "(R4) was last seen by the nurse around 8:30PM. She was confused, kept talking about leaving. Redirected several times before helping (V12) put 2 other residents down for the night."

V12's written statement also dated 10/25/20 reads, "Right before 8:30PM (V11) and myself were collaborating on giving patient {care},

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considering I'm the only CNA on the unit. Patient was last seen down the hall in front of her room. The unit is a locked unit. I'm not aware of how the patient escaped. "

On 11/2/20 at 10:00AM V14 (R4's daughter) stated, "I got a call from the ER at 11:45PM on 10/25/20. I tried to call the facility all night and no one answered the phone. I was told they don't have a receptionist at night, but they are getting one. I called the facility at 7:40AM and spoke with a nurse on the unit but she didn't know anything about the situation. I finally got a call on 10/26/20 at 11:17AM from V1 and V2. They kept apologizing to me over and over and said that the facility had blown a fuse and that is why the alarm did not go off when my (R4) opened the door and that is how she got out. The ER said she was dressed in jeans, a sweatshirt and tennis shoes and she was carrying a garbage bag with her clothes. They said she had 2 black eyes, a cut on her forehead, a cut on her cheek, 2 skin tears on her arm- one was old because it was bandaged, and her knee was swollen. They did a CT because they didn't know if she hit her head and that was negative. They admitted her with a Urinary Tract Infection and she tested positive for COVID-19. They told me her body temperature was low but did not give me a number. They said they had her wrapped up like a burrito and had heat lamps on her. The facility told me that they had a back -up plan so this would not happen again but I never told them I was happy with their plan. They knew I was mad. The facility did not even know she was gone until the police called them."

R4's Emergency Room Report dated 10/25/20 states, "Stated complaint: Fall, Hypothermia. 81 year old woman with a history of Dementia

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S9999	Continued From page 8 brought in by ambulance. She had reportedly eloped from the extended care facility was found outside face down in the cold. Face is bruised, unknown how long she has been there for. Unknown how long she has been missing..." This same report shows that R4 arrived at the Emergency Room at 10:30PM and her rectal temperature was 96.2 degrees Fahrenheit (Equal to 95.2-95.7 degrees Fahrenheit- orally) According to Wunderground.com (Weather Underground) accessed on 11/1/20, the temperature in Naperville, Illinois on 10/25/20 between 8:00PM and 11:00PM ranged from 40-42 degrees Fahrenheit. On 11/3/20 at 11:00AM V1 (Administrator) stated, "I did not notify Public Health of (R4's) elopement. I was told by Corporate because there was no injury and she was found within 2 hours, there was not need to." (A)	S9999		