STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145111	A. Building B. Wing	05/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenora Elmhurst	200 East Lake Street Elmhurst, IL 60126

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide adequate supervision to a resident with impaired upper extremity range of motion. This failure resulted in the resident spilling hot oatmeal on self and acquiring a burn. The facility also failed to follow their policy to ensure that immediate treatment procedures are followed after a burn incident.This applies to 1 of 1 resident (R1) reviewed for accidents and supervision in the sample of 3.The findings include:R1's face sheet showed that he was a [AGE] year old male admitted on [DATE], with multiple diagnoses including acute lymphoblastic leukemia, personal history of non-Hodgkin lymphomas, other pancytopenia, pressure ulcer of sacral region, stage 3, other symptoms and signs involving the musculoskeletal system, other specified disorders of muscle, type 1 diabetes mellitus, adult failure to thrive.R1's 5-day MDS (minimum data set) dated April 26, 2026, showed that R1 was cognitively intact and required set up or clean up assistance for eating. The same MDS also showed that R1 had impairment on both upper extremities (shoulder, elbow, wrist, hand) for functional limitation in range of motion. Facility incident report dated April 26, 2026, included that on April 25, 2026, V5 CNA (Certified Nursing Assistant) stated R1 reported he believed he had spilled some coffee or oatmeal on himself. V3 RN (Registered Nurse) completed an assessment on his abdomen and did not note any burns or open sores.On April 26, 2026, V6 (CNA) stated R1 was scratching his abdomen area and had reported that he accidentally spilled coffee or oatmeal on himself. When V3 checked his abdomen area, she noted a paste/cream on top of an open skin area.On May 8, 2026, at 10:09 AM, V7 (RN) stated that R1 left the facility around 40 minutes ago for chemo treatment and should only be back at around 5:00 PM. At 2:37 PM, and at 5:05 PM, R1 was reached by telephone while still out at his appointment and provided additional information on return to the facility. R1 stated I spilled hot oatmeal on myself. My wife was with me and had just put a new shirt on me and I could not pull it all the way down and my belly was exposed. The oatmeal was hot, and it came like that from the kitchen. First, they brought me the wrong tray and then they had to bring me the right tray. I got two boiled eggs and a bowl of oatmeal. She (V5 CNA) just brought me the tray and set it down on the table and left. My wife handed me the bowl of oatmeal and was doing other things. I may have held it cockeyed, and it must have tipped over. We called the nurse by pushing the button. The CNA came out and she went and got the nurse. When asked if the CNA had positioned the bedside table over his bed, R1 pointed to the bedside table that was on the left side of his bed and stated It was just as it is now. She just dropped the tray there. They usually just do that. R1 was asked whether it would be better if he was seated upright on side of bed with his feet down, R1 stated that he is very weak and unable to move much. R1 stated that he is not used to eating food propped in bed and holding it over his chest. R1 remarked I have never had to eat in bed before. I am used to sitting up and eating at the kitchen table. When asked whether he has spilled food before at the facility, R1 stated that he has occasionally and now he puts a towel over his abdomen to catch spills. R1 was told that the CNA (V5) stated that she was present when he spilled the oatmeal, R1 raised up his right hand and remarked I swear to God she wasn't there. It was my wife that handed me the bowl of oatmeal.On May 8, 2026, at 2:49 PM, V13 (R1's (continued on next page)

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.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	spouse) stated It was about two weeks ago. The oatmeal came down from the kitchen and I noticed it was a little watery than usual and he must have spilled it. I may have stepped out of the room when it happened. The (chemo) treatment has taken a toll on him and has done something to his hands. Sometimes he is not steady, and they have to understand that. After the nurse looked at it (abdomen), I did put some toothpaste around the area as it has helped before.On May 8, 2026, at 2:15 PM, V10 (Occupational Therapist) stated that R1 is weak on both upper extremities. V11 (Therapy Director) was present during the interview and contributed some information. V10 stated He is able to feed self. When he first got here, he was weaker and the family (wife) told me that she was assisting to feed him. He was severely deconditioned and guarded with weakness and his fine motor skills were impaired and the nurse was helping with pills in his mouth instead of grasping them with his fingers. With good positioning, he was able to feed self. It was more challenging when he first got here. He would have benefitted from supervision initially for eating. The wife is often there at breakfast. When I assessed him on April 20, 2026, his grip strength was below average for his age and gender. The grip strength on his right hand was 9, and left hand was 4. The norms for a [AGE] year-old are average grip strength of 91 for the right dominant hand and 76 for the left hand, and he was well below that. I assessed him next on April 22, 2026, and was focusing on grip strategies, sitting balance/staying up in wheelchair and working on [mechanical lift] transfers as he was not safe for transfers. V10 added that when R1 first came in he was totally dependent on staff as he was very deconditioned and could only sit up after about 10 days of admission.Multiple staff were interviewed related to reported incident of April 26, 2026.On May 8, 2026, at 4:14 PM, V5 (CNA) stated that she had brought R1 his breakfast tray on the morning of April 25, 2026. V5 stated I had put a bowl of oatmeal on the table, and I told him that it was hot. He pulled the table and the bowl toppled over and some of it dropped on his belly. He can feed himself. I usually just set it up for him. His wife was not present. I did not see her. I called the nurse and the nurse put something on it. I did not see the area red. The nurse did not see oatmeal on the resident, as I wiped it with a paper towel.On May 8, 2026, at 10:12 AM, V6 (CNA) stated He was coming back from an appointment around 5:00 PM (on April 26, 2026), and when I was transferring him back to bed, I noticed like a burn mark with an open area at the top left side of his stomach with a white paste over it. I had worked a double and stayed over for night shift. I did not see the burn mark earlier as I had not changed him in the morning as his wife had got his top half of him dressed and I had only put his pants on before he went out to his appointment. I asked him what happened and when did it happened, and he had told me that he had spilled oatmeal on his stomach a day or two before I saw the burn mark. He does not drink coffee. He said that he had told the nurse about it when it happened and she had applied some type of ointment on it. Anytime, I see an open area, they (nurse) always apply a dressing over it. So, I asked him if the nurse was aware of the open area. The wife told me that she herself had applied toothpaste over the burn mark after the nurse applied a cream as she did not like that. I came and told the nurse who was here for the morning and also the on-coming nurse about it. The second shift nurse was V3 (RN). She told me that she had applied cream on the bottom of his stomach area as that's what the resident and the wife told her where he had spilled the oatmeal. I told her that I saw the burn mark on top area. When he comes back from the hospital, he likes to eat in bed. He eats breakfast in bed as well. He can feed himself. I just set everything up for him at meals and open everything and sit him upright for his meals. He can express his needs.On May 8, 2026, at 10:54 AM and 2:10 PM, V3 (RN) stated It was a Saturday (April 25, 2026), the CNA (V5) told me that he (R1) spilled the coffee or oatmeal on his abdomen and told me to go and check. It was around after breakfast. I checked his whole abdomen and there was nothing there, no redness or anything and his skin was intact. I just cleaned it with normal saline around his abdomen. His skin was dry, and I put some barrier cream on his abdomen area and his hands. I endorsed the next shift nurse to monitor any changes. I worked from 7:00 AM to 3:30 PM. I put my progress notes in the risk management, and I did not call the doctor as there was no redness or skin tear, his clothes were not wet or anything. He (R1) did not mention anything to me after that on my (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	shift and neither to night shift. I endorsed the next shift to monitor and call the doctor with any changes. I came on Sunday (April 26, 2026) as I worked on 3:00-11:00 PM shift and after getting report, the CNA V6 came and said that there was something on his (R1) belly to check his abdomen and I saw an open area on left upper abdomen. I called the wound nurse as she was working on 2nd floor. We both checked the area, and we saw a whitish (color) paste on the abdomen and the resident said that his wife or daughter put some toothpaste on the area. We measured the area and informed the wound doctor and got the treatment orders. I put everything on my (incident) report. The resident can feed himself. We sit him upright. He prefers to eat in his room while watching television. He is alert and oriented and does not need supervision. The wife comes in majority of the time for breakfast.On May 8, 2026, at 4:03 PM, V4 (Wound Nurse) stated I was working on the building on April 26, 2026, Sunday at around 3:00 PM and the nurse (V3) reported to check the abdomen site. He said that he spilled some coffee or oatmeal accidentally on the abdomen. On the left upper abdomen, I saw a full thickness wound with an open superficial area. There was toothpaste on the abdomen but not in the wound. I called his (primary care) doctor and she gave me treatment orders. I called the wound doctor, and he agreed with the treatment and he follows him (R1) every Wednesday. He had no pain or signs of infection. I did not know about this earlier. I am not there all the time. I usually work on Wednesdays for wounds and some days on the floor.On May 8, 2026, at 1:54 PM, V2 (DON) stated This incident was reported to me the same day it happened. I told them to notify the doctor and keep an eye on it for any changes. If someone spilled a hot liquid, I would exam the site and look for redness, blistering, and oozing of fluid. I would call the doctor on whatever the appearance is and get recommendations. I would call the doctor first for directions before any further treatment.On May 8, 2026, at 3:45 PM, V14 (Wound Doctor) stated that he saw R1 related to a burn on his abdomen. V14 stated that only pressure sores are staged and not burns. V14 stated that R1 had a full thickness wound that was superficially open to less than one ml (milliliter). V14 stated that the facility should follow their policy protocols for any injury with burns in order that the area is covered and safe until they get orders. V14 stated that V4 (wound nurse) had texted him about getting orders for the burn after she became aware of it.Wound Evaluation and Management Summary dated April 29, 2026, showed as follows:Focused wound exam (site 2): Burn Wound Abdomen Full Thickness.Etiology-Burn, Further etiology detail-Hot liquid, Duration- greater than 2 days, Estimated time to heal-1-4 weeks, Wound size (length/width/depth) 3.1 x 4.9 x 0.1 cm (centimeter), Surface area-15.9 cm2, Exudate-light serrous.Policy and Procedure for Burns (effective date January 4, 2025) included:First Aide for Burns: A. Relieve pain. B. Prevent contaminationB. Treatment: 1. Apply a thick, dry, sterile dressing or bandage to keep the air out.