STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145593	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Libertyville	1500 South Milwaukee Avenue Libertyville, IL 60048

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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide a resident with the Physician prescribed diet, failed to have a policy in place regarding changes in dietary orders, and failed to implement a physician diet order change. This failure resulted in R1 choking on her food and expiring at the hospital. This applied to one of three residents (R1) reviewed for diets in the sample of three.The Immediate Jeopardy began on 5/17/26 when R1 received physician orders for a downgrade in diet to pureed and the next morning was served a mechanical soft diet rather than the Physician prescribed puree diet. R1 choked and expired at the hospital. V1 (Administrator) was notified of the Immediate Jeopardy on 5/22/26 at 9:58 AM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed, and the deficient practice corrected, on 5/18/26, prior to the start of the survey and was therefore Past Noncompliance. This past noncompliance occurred from 5/17/2026 to 5/18/2026. Findings include:The facility face sheet for R1 shows she was admitted to the facility with diagnoses to include metabolic encephalopathy, osteoarthritis, and dysphagia. The facility assessment dated [DATE] shows R1 had moderate cognitive impairment and required a set up for meals. A nursing note dated 5/17/26 shows that R1 was observed eating her physician ordered diet of mechanical soft in her room. R1 was observed coughing and gagging while eating her breakfast. R1 then appeared not to be able to cough to clear her airway. The nurse documented that she performed the Heimlich maneuver, and an expulsion of food was achieved. The same note shows the nurse contacted the on-call provider and was given orders to downgrade the diet for R1 to puree. The Physician Order Sheet for R1 shows a new order dated 5/17/26 for a pureed texture diet. A nursing noted dated 5/18/26 for R1 shows at approximately 7:30 AM, staff became aware of R1 coughing while eating her breakfast in bed. The nurse was called to the room and encouraged the resident to cough up the food but R1 was unable to do this. The staff assisted her to a standing position and began performing abdominal thrusts. The nurse documented a mouth sweep was performed and no food was observed. The note goes on to show that at approximately 7:40 AM 911 was called and the crash cart was brought to the resident's room. A pulse was unobtainable and R1 was lowered to the floor and Cardiopulmonary Resuscitation (CPR) was initiated. At approximately 7:45 AM, the paramedics arrived and took over the situation. R1 was transported to the local emergency room.On 5/21/26 at 10:09 AM, V3 LPN (Licensed Practical Nurse) said she was the nurse that responded to R1 choking on 5/18/26. V3 said she was called to the room by the CNA (V7) and found R1 coughing on her breakfast. V3 said R1 then required abdominal thrusts which was attempted numerous times, R1 then went limp and was lowered to the floor where abdominal thrusts were attempted. R1 lost her pulse and CPR was started. R1 was transferred to the hospital by EMS but later died at the hospital. V3 said she noticed cut up pancakes on R1's breakfast tray. V3 said she was aware that R1 had choked the day before and her diet was to be downgraded. On 5/21/26 at 10:25 AM, V4 CNA (Certified Nursing Assistant) said he had served R1 her breakfast on the morning of 5/18/26. V4 said her diet slip on the breakfast tray said for a mechanical soft diet and the tray contained a mechanical soft diet which included regular pancakes. V4 said he set up R1 with her tray (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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and continued with passing trays. V4 said he was not aware that R1 had choked the day before and that her diet had been downgraded to a pureed diet. On 5/21/26 at 10:52 AM, V7 CNA said she was monitoring the residents who were eating in their rooms on 5/18/26 and she noticed R1 coughing and holding her neck. V7 said she yelled for the nurse who was near R1's room. On 5/21/26 at 12:34 PM, V15 [NAME] said he was the cook on 5/18/26 and was the staff plating the food for breakfast. V15 said he was not aware that R1 had choked the day before and that her diet was downgraded to pureed foods. V15 said R1's diet slip showed she was on a mechanical soft diet and that was the diet he served to R1. On 5/21/26 at 11:44 AM, V10 LPN said she was working with R1 on Sunday 5/17/26. V10 said R1 was eating her breakfast in bed as she usually does. V10 said she heard a noise from R1's room and saw R1 holding her throat and could not speak. V10 said she stood R1 up and began abdominal thrusts and was able to help R1 expel food from her airway. V10 said she called V11 Nurse Practitioner on call and explained what had happened and a chest x-ray was ordered and R1's diet was downgraded to puree. V10 said she called the kitchen before lunch and told the person who answered the phone (V16 Dietary Aide) that R1 would need a puree diet due to a choking incident. V10 said at lunch, R1 was served a puree diet so she assumed the kitchen was aware of the new diet order downgrade and did not feel she needed to do anything else. V10 said she had never had to change a resident diet order and felt what she had done was enough. On 5/21/26 at 10:40 AM, V5 [NAME] said he was the cook on 5/17/26 and was the person plating the food for the residents. V5 said at lunch a nurse (V10), called the kitchen and spoke with one of the dietary aides (V16) and requested a puree tray for lunch, so that is what I served R1 that day. V5 said no written diet slip showing a change in diet was ever sent to the kitchen that day, so her diet slip we use in the kitchen was not changed. On 5/21/26 at 10:41 AM, V6 Dietary Manager said no diet change slip was ever given to the kitchen to show us that R1's diet was downgraded to puree on 5/17/26. V6 said a diet change slip was to be filled out by nursing and brought to the kitchen. On 5/22/26 at 12:30 PM, V16 Dietary Aide said she was the staff that took the call from the nurse (V10 LPN) on Sunday 5/17/26 stating that R1 needed a puree tray for lunch. V16 said she told V5 the cook this information. V16 said that night she was assisting with the supper trays and R1's diet slip showed mechanical soft, so a mechanical soft tray was sent to the unit for R1. V16 later said a staff member (she could not remember who) called and stated they needed puree for R1, so a new tray was sent to the unit for R1 containing puree foods. V16 said she never received any paper diet order changes, and she never communicated the information given to her from the nurse (V10) other than a puree tray for lunch on 5/17/26. On 5/21/26 at 12:18 PM, V11 NP (Nurse Practitioner) said he was called when R1 had a choking incident on 5/17/26. V11 said he gave orders for a chest x-ray and to change R1's diet to puree. V11 said he expects the staff to follow that order to avoid R1 choking again. On 5/21/26 at 1:17 PM, V13 Speech Therapist said he had been seeing R1 for her diagnosis of dysphagia and she was doing well on a mechanical soft diet. V13 said he was surprised R1 had choked on 5/17/26 on her mechanical soft diet, and that a new diet order of puree foods was appropriate and should have been provided to R1 to avoid a second choking incident. The hospital emergency room notes dated 5/18/26 for R1 shows she arrived to their facility by paramedics doing CPR. The note shows the paramedics reported large amounts of pancakes were observed in R1's airway and they were unable to intubate in the field. R1 was intubated in the emergency room and CPR continued until her time of death at 8:30 AM. The menu for breakfast on 5/18/26 showed residents on puree diet were to receive puree pancakes, puree oatmeal and puree sausage links. The facility was asked for a policy regarding diet orders, and a Physician Orders policy was provided. The policy does not provide any guidance for diet orders or changes to a diet order. The Immediate jeopardy that began on 5/17/26 was removed and the deficient practice corrected on 5/18/26 after the facility implemented the following actions: 1.) The facility completed an audit of residents' diet orders to ensure that diet orders match the residents' dietary tickets. This audit was completed by DON and Food Service Director on 5/18/2026 prior to lunch meal being served. All residents diet orders and dietary tickets matched correctly. 2.) (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An education was conducted by DON/Admin on 5/18/2026 to Nurse (who received the physician order for change in diet from regular mechanical soft to puree diet) to ensure that any new diet orders are entered in PCC, printed, and hand delivered to the kitchen. Upon receipt, the Diet Change Order Communication Log is completed, notating the date, time, resident initials and room number, nurse's name, name of dietary staff receiving, and name/date of dietary staff creating the new meal ticket, ensuring the correct diet is served to the resident per physician order. A 1:1 education was also completed with Dietary Aide to ensure that any new diet orders received from nursing are communicated appropriately and follow the process of the Diet Change Order Communication Log. 3.) This new Diet Change /Order Communication Protocol was implemented to ensure the new printed diet order will be hand delivered & signed to the kitchen and have dietary supervisor /cook received and signed the new diet order in the Diet Change Order Communication Log to ensure a new meal ticket is generated and a correct diet is served to the resident per physician order. 4.) All Nursing staff and all dietary staff were educated on the new communication protocol on 5/18/2026 by DON/Food Service Director/Designee. All nursing and dietary staff scheduled to work and in the facility on 5/18/2026 signed this Inservice. All nursing and dietary staff who were not scheduled to work were in- serviced via phone by the DON/Food Service Director and or Designee on 5/18/2026. The staff who were in- serviced via phone were/will sign the Inservice sheet on their next scheduled shift in person.5.) A QA audit tool was developed on 5/18/2026 to monitor and ensure that residents'dietary order matches what is written on the resident dietary ticket, and what isserved to residents during meals. This audit will be conducted to 10 residents 3xweek x12 weeks by Food Service Director and or Designee. (Exhibit E) 6.) A QA audit tool was developed on 5/18/2026 to ensure that the Diet Change /OrderCommunication is completed, and a correct diet is served to the resident perphysician order. The QA audit tool is utilized to monitor and ensure that the dietaryteam receive a printed order for any change in diet order by nursing staff, and thatthis new order is hand delivered to the kitchen by nursing, with a new meal ticketgenerated and logged in the Diet Change Order Communication. This audit will becompleted to 10 residents 3x/week x12 weeks by Director of Nursing and orDesignee. (Exhibit F) 7.) A QAPI meeting was held on 5/18/2026 with the facility medical director to discussthe abatement plan. The facility medical director approved the abatement plan.(Exhibit G) 8.) All trends and results from the audit will be discussed in the monthly QualityAssurance Performance Improvement meeting until resolution.