STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145607	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Palos Heights	7850 West College Drive Palos Heights, IL 60463

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(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 - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 41758 Based on observation, interview and record review, the facility failed to provide incontinence care with 2 hours for residents who were identified as dependent for staff assist for toileting/incontinence care. This affected four of four (R2, R5, R6 and R7) residents reviewed for incontinence care. This failure resulted in R2 being left soiled in urine for over fifteen hours and feeling drenched and disgusted. R5 being left soiled in urine for over eight hours feeling wet and cold with chills. R6 being left soiled in urine for sixteen hours and R7 being left soiled and saturated in urine with a strong ammonia smell for over eighteen hours. Findings Include: 1.) R2 was diagnosis with need assistance with personal care. Minimal data set section C (cognitive pattern) brief interview for mental status dated 7/25/24 documents a score of fifteen which indicates cognitively intact. Section H (bladder and bowel) dated 8/3/24 documents: urinary/bowel- always incontinent. Care plan dated 8/18/24 documents: R2 displays bowel and bladder incontinence. Intervention document: R2 would like the staff to check her for incontinence episode as scheduled and as needed. Point of care response history (system staff used to document care to residents) dated 9/11/24 documents: incontinent 18:51 (6:51pm). On 9/12/24 at 10:11 AM, R2 who was assessed to be alert and oriented to person, place and time when interviewed, said CNA changed her yesterday on the evening shift. R2 said, she was not provided incontinence care on the overnight shift or day shift. R2 said, she only saw the overnight nurse. R2 said, the night shift staff comes in around 1100PM to check on her and then will change her around 5:30/6:00AM and give medications. R2 said she was drenched and felt disgusted. R2 said her gown was wet. R2 was observed in bed with bilateral position wedges cushion on each side. V6 (treatment nurse) and V5 (CNA) assisted R2 with incontinence care. V5 said she was not R2's assigned aide, had not provided care to R2 and the amount of urine in R2's adult brief, on the wedge cushion and bed sheets took more than two hours to occur. V5 said, the wedges cushions were wet, R2's bed sheets were wet with yellow-brown rings where R2's laid. V6 said R2 should have been checked and changed every two hours or as needed. V6 said R2 has a strong smell urine with multiple dried and wet urine rings on R2's bed sheets. R2's gown, sheets and mattress were observed saturated with urine. A bordered gauze dressing was observed on R2's right inner thigh. V6 said he was unaware of any open area and R2 does not have any treatments in place. R2 was observed with two small pink circular opened areas on her inner right upper thigh and right posterior thigh. V6 said someone is aware of R2's skin alteration because there was a dressing in place. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/12/24 at 1:57pm, V6 said R2's skin alteration was caused by moisture from body fluids, friction and sheering forces when she was turned and repositioned. On 9/12/24 at 4:17pm, R2 said she did not refuse incontinence care. R2 said the facility will report that she refused care when she did not as an excuse not to provide care. On 9/12/24 at 4:28pm, V2 (DON) said if R2 refused care it should have been charted by the certified nursing assistance. V2 said she does not think R2 has any reason to lie about not being provided care. R2 said she does not recall, R2 making false allegations against staff. Incontinence and perineal care policy dated 12/3/15 documents: It is the policy of the facility to provide perineal care to ensure cleanliness and comfort to the resident, to prevent infection and skin irritation and to observe the resident's skin condition. 2.) R5 was diagnosed with hemiplegia and hemiparesis following a cerebral infraction affection left non-dominate side. Minimal data set section C (cognitive pattern) brief interview for mental status dated 7/17/24 documents a score of thirteen which indicates cognitively intact. Section H (bladder and bowel) dated 8/2/24 documents: urinary/bowel- always incontinent. Care plan dated 4/13/23 documents: Resident (R5) is at risk for complications related to alteration of bowel and bladder functioning. Remind, offer and assist with toileting as needed. On 9/12/24 at 10:35am, R5 who was assessed to be alert to person, place and time said, she was last provided incontinence at 2:00am. R5 said she knew what time it was because she has a digital clock on the wall near the foot of her bed. A large numbered digital clock was located on the wall directly in front of R5 displaying the correct time which could been seen from the head of R5's bed. R5 said, she felt wet and cold. R5 said, she has been having chills. R5 said, it could because she was wet. V7 (restorative nurse) provided incontinence care with another staff member. V7 said, R5 comforter and sheet was wet. V7 said R5 had brown urine rings on her bed sheet. V7 asked, R5 if she spilled coffee on herself/sheets. R5 replied, no. R5's adult brief was observed full and expanded with liquid consistent with urine. R5 also had a strong odor of urine smelled emitted with care. R5's comforter and bed sheets were observed wet. V7 said he was not sure if it would have taken more than two hours to produce urine saturate R5's comforter, brief and sheets but there should not be a brown ring on R5's sheet. [NAME] rings indicated multiple urine voids that have dried. Incontinence and perineal care policy dated 12/3/15 documents: It is the policy of the facility to provide perineal care to ensure cleanliness and comfort to the resident, to prevent infection and skin irritation and to observe the resident's skin condition. 3.) R6 was diagnosed with Dementia and hemiplegia and hemiparesis following a cerebral infraction affection left non-dominate side. Minimal data set section C (cognitive pattern) brief interview for mental status dated 8/16/24 documents a score of five which indicates severe impairment. Section H (bladder and bowel) dated 8/23/24 documents: urinary/bowel- always incontinent. Care plan dated 11/22/21 documents: Resident (R6) has alteration in urine continence. Intervention: Provide incontinent care as needed. (11/25/23) R2 has frequent bladder incontinence and is at risk for complications. Intervention: keep clean and comfortable. Provide assistance with her toileting needs as needed. Point of care response history dated 9/11/24 documents: incontinent 17:38 (5:38pm). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/12/24 at 10:54AM, R6 was provided incontinence care by V5 (CNA). R6 was observed in bed alert to self. V5 (CNA) said she had not provided any care to R6 that morning. R6 had two incontinence briefs on. The first incontinence brief was saturated with urine, brown in color, with the brief lining forming clumps. R6 emitted a strong smell of urine with care. The second brief was clean and dry. V5 said R6 is saturated with urine. R6 should have been checked and changed every two hours or as needed. Incontinence and perineal care policy dated 12/3/15 documents: It is the policy of the facility to provide perineal care to ensure cleanliness and comfort to the resident, to prevent infection and skin irritation and to observe the resident's skin condition. 4.) R7's minimal data set section C (cognitive pattern) brief interview for mental status dated 7/19/24 documents a score of twelve which indicates moderate impairment. Section H (bladder and bowel) dated 8/1/24 documents: urinary/bowel- always incontinent. Care plan dated 11/06/21 documents: Resident (R7) has alteration in urine continence. Intervention Provide assistance with toileting. Provide incontinence care as needed. Point of care response history dated 9/11/24 documents: incontinent 17:40 (5:40pm). On 9/12/24 at 11:04AM, R7 was provided incontinence care by V5 (CNA). R7 was observed in bed alert to self. V5 (CNA) said, she had not provided any care to R7 that morning. R7 had two incontinence briefs on. The first incontinence brief was soiled, saturated, full and expanded with yellow liquid consistent with urine that had a strong ammonia smell. V5 (CNA) said R7 is saturated with urine. V5 said resident should be checked and changed every two hours. On 9/12/24 at 140pm, V6 (wound care) said residents should be provided with incontinence care every two hours to prevent skin breakdown. V6 said residents should not be double diapered because it creates additional moisture which can lead to skin breakdown. Incontinence and perineal care policy dated 12/3/15 documents: It is the policy of the facility to provide perineal care to ensure cleanliness and comfort to the resident, to prevent infection and skin irritation and to observe the resident's skin condition.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 41758 Based on observation, interview and record review, the facility failed to follow their skin care regimen and treatment formulary by not documenting and obtaining a physician order for a resident who was identified as high risk for skin breakdown. This affected one of three residents (R2) reviewed for non-pressure wound care. This failure resulted in R2 have two small pink opened circular areas on the inner right upper thigh and right posterior thigh. Findings Include: R2's Braden scale dated 9/5/24 documents: a score of sixteen which indicates at high risk for skin breakdown. Moisture: very moist skin is often, but not always moist. Linen must be changed at least once a shift. Friction and shear: Potential Problem: Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down. Scoring: 20 and Below = High Risk On 9/12/24 at 10:15am, during incontinence care with V6 (treatment nurse) and V5 (CNA), R2 was observed with a small boarder gauze dressing on her right upper inner leg. V6 said R2 does not have a treatment in place. V6 said he was not aware or informed R2 had any skin altercations. V6 said removed R2's dressing, R2 was observed with two small pink circular opened areas on her inner right upper thigh and right posterior thigh. V6 said someone is aware of R2 skin alteration because R2 had a dressing in place. V6 said when a resident has a new skin alterations, an assessment should be completed in the computer by the nurse which will generate an alert that would notify him of any new skin alterations/breakdown. On 9/12/24 at 1:57pm, V6 said R2's skin alteration was caused by moisture from body fluids, friction and sheering forces with she is turned and repositioned. R2 did not have a skin assessment to alert staff of a new skin altercation prior to the evaluation dated on 9/12/24. Skin/wound note dated 9/12/24 documents: Incontinence care provided with CNA. New skin alteration noted to right inner groin distal and right inner groin proximal. Wounds classified as abrasions. Measurements taken. Proximal site 0.4 length x 0.4 width x 0.0 depth cm. Distal site 1.0 x 1.0 x 0.0 cm. New orders given for xeroform dry dressing three (3x) times a week and as needed. Physician order sheet dated 9/12/24 documents: Right Inner Groin (Proximal): Clean with normal saline (NSS), apply xeroform, and cover with dry dressing three times (3x) a week and as needed. Right Inner groin (distal): Clean with NSS, apply xeroform, and cover with dry dressing 3x a week and as needed. Skin Alteration Nursing Evaluation dated 9/12/24 documents: New, right inner groin abrasion and right inner groin distal abrasion. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Skin care regimen and treatment formulary dated 12/3/2015 documents: It is the policy of this facility to ensure prompt identification, documentation and to obtain appropriate treatment for residents with skin breakdown. Charge nurses must document in the electronic health record any skin breakdown upon assessment and identification. Furthermore, treatment must be obtained from the patient's physician.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340 Based on observation, interview and record review, the facility failed to follow one resident plan of care, who was identified as high risk for skin breakdown with a stage four and stage three pressure wounds by not following the wound practitioner's treatment orders and ensuring an air loss mattress was in place. This affected one of three residents (R3) reviewed for pressure sore prevention interventions. Findings include: R3 was admitted to the facility on [DATE] with a diagnosis of pressure ulcer stage four, anemia, peripheral vascular disease, depression, psychotic disorder with delusions, unspecified dementia, and surgical amputation. R3's Braden score dated 9/5/24 documents a score of 13 which indicates high risk for skin breakdown. On 9/12/24 at 9:30AM, R3 wound care observations with V6 (wound care nurse) was conducted. R3 right buttocks (facility refers to right ischium) wound dressing removed. Area cleaned with normal saline. Silver alginate packed into the area and covered with bordered gauze. R3's wound assessment report dated 9/4/24 documents: right ischium stage four pressure sore measuring 3. 0 cm length x 6.0cm width x 6 cm depth under treatment documents: cleanse with normal saline, medical grade honey. Silver alginate and bordered foam. R3's wound assessment report dated 9/11/24 documents: right ischium stage four pressure sore under treatment documents: cleanse with normal saline, medical grade honey. Silver alginate and bordered foam. On 9/12/24 at 1:24PM, V10 (Wound NP) said she would expect her treatment orders to be followed. V10 said she will put her treatment orders in her notes and verbally tell the wound care team as well. V10 confirmed that she did order Medihoney for R3's right ischium wound site to aide with cleaning the wound due to its location and R3's refusal of care. On 9/12/24 at 140pm, V6 (Wound care nurse) said V10 will send wound notes over same day that will include the orders to be placed. V6 said he will input orders in electronic medical record. V6 was shown V10 notes dated 9/4/24 and 9/11/24 that document Medi honey to ischium site. V6 said he is unsure of that order and that there is separate spreadsheet that V10 will send with orders. Surveyor requested to see this document and was never received. R3's treatment record documents for September documents for right ischium dated 9/4/24 documents: clean with normal sterile saline, pack with silver alginate and cover with dry dressing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's plan of care dated 7/19/24 documents: Resident has an actual impairment to skin integrity Right above the knee amputation (AKA) dehisced surgical wound stage 4 pressure injury to right ischium Deep Tissue Injury to left heel and potential for further skin breakdown related to impaired mobility, weakness, Peripheral Vascular Disease, Cerebral Vascular Accident, dementia, and recent surgery. Interventions include the following: Apply wound treatment as ordered by the physician Date Initiated: 07/19/2024. Facility policy Physician orders revised 8/16/24 documents: It is the facility policy to ensure that all residents medications, treatment and plan of care must be in accordance with the licensed physician orders. On 9/12/24 at 9:30AM, R3 was observed in room on a pressure relieving mattress. V6 confirmed that R3 was not on an air loss mattress because R3 wounds were arterial and surgical wounds. On 9/12/24 at 1:24PM, V10 (Wound NP) said R3 wounds on left heel and right ischium are pressure sores and R3 should be on an air loss mattress. On 9/12/24 at 140pm, V6 (Wound care nurse) said R3 wounds are surgical and vascular wounds. V6 was shown R3's wound notes which document areas as pressure sore to heel and ischium. V6 said he most of mixed it up. V6 said R3 should have a low air loss mattress and he had one prior and unclear why he does not have one currently. R3's plan of care dated 7/19/24 documents: Resident has an actual impairment to skin integrity right above the knee amputation (AKA) dehisced surgical wound stage 4 pressure injury to right ischium Deep Tissue Injury to left heel and potential for further skin breakdown related to impaired mobility, weakness, Peripheral Vascular Disease, Cerebral Vascular Accident, dementia, and recent surgery. Interventions include the following: Low Air Loss Mattress Date Initiated: 07/19/2024. Facility policy Skin Care Regimen and Treatment Formulary revised 1/24/24 documents: Residents with stage three and/or stage four pressure injuries will be placed on specialized air mattress like low air loss mattress with an incontinent brief if they are incontinent only.