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	03/15/2026

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

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement the comprehensive person-centered care plan for 2 of 3 residents (R2, R3) reviewed for skin and wound care. Specifically, facility staff failed to provide incontinence care and skin monitoring as outlined in the residents' established care plans. This resulted in residents remaining in soiled environments for over four hours, directly contradicting the care plan interventions designed to maintain skin integrity and prevent wound contamination.Findings include:R2 is an [AGE] year-old with diagnoses including but not limited to Chronic Obstructive Pulmonary Disease, Pressure Ulcer to left and right hips, back and sacral areas, and Atrial Fibrillation. R2's Care Plan (last reviewed 2/13/26): Includes an intervention to provide incontinence care every two hours and as needed and maintain clean, dry dressings for pressure ulcers.R3 is a [AGE] year-old with diagnoses including but not limited to Multiple Sclerosis, Pressure Ulcer stage 4 to Sacral Region, Major Depressive disorder, and Paraplegia. R3's Care Plan (last reviewed 2/2/26): Includes an intervention to keep skin clean and dry; check and change every two hours to prevent skin breakdown and wound infection.On 3/13/26, between 7:00 AM and 11:45 AM, facility staff failed to execute the interventions listed above for R2 and R3.During an interview on 3/13/26 at 12:10 PM, V5-CNA confirmed awareness of the residents' care needs but stated she did not perform the required incontinence care because she was waiting for the wound team.By failing to perform the specific check and change and hygiene interventions documented in the residents' comprehensive care plans, the facility failed to meet the requirement to implement care in accordance with the residents' person-centered goals and clinical needs.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that 2 of 3 residents (R2, R3) reviewed for wound care in the sample of 3 received the necessary treatment and services to maintain hygiene and prevent the risk of infection. Specifically, the facility failed to check and change residents for incontinence for over 4 hours, resulting in dried fecal matter remaining on wound dressings prior to treatments. Findings include:R2 is an [AGE] year-old with diagnoses including but not limited to Chronic Obstructive Pulmonary Disease, Pressure Ulcer to left and right hips, back and sacral areas, and Atrial Fibrillation. R3 is a [AGE] year-old with diagnoses including but not limited to Multiple Sclerosis, Pressure Ulcer stage 4 to Sacral Region, Major Depressive disorder, and Paraplegia. On 3/13/26, beginning at 11:40 AM, wound observations were conducted for R2 and R3 by V3 Wound Nurse and V4 Wound CNA. Upon arrival for the scheduled treatments, both residents were observed to have large amounts of dried feces from a previous bowel movement (BM) present on their skin and saturated onto their wound dressings. The fecal matter was noted to be dark and crusty, indicating it had been present for an extended period.On 3/13/26 at 12:10 PM, an interview was conducted with V5-CNA (Certified Nursing Assistant). V5-CNA confirmed she had been assigned to R2 and R3 since the start of her shift at 7:00 AM. V5-CNA stated, I checked in on them, but I didn't change either of them because I knew the wound team was going to see them later. V5-CNA admitted that neither resident had been checked or changed for incontinence since at least 7:00 AM, a duration of approximately 4 hours and 45 minutes.On 3/13/26 at 1:14 PM, the Wound Nurse (V3) confirmed that while R2 and R3 had existing wounds that were showing signs of improvement, the presence of fecal matter on a wound dressing poses a significant risk for bacterial contamination and potential setback in wound healing.A review of the facility's Wound Prevention and Skin Care Policy was conducted. The policy directs staff to provide timely incontinence care to maintain skin integrity and prevent contamination of existing wound sites. The facility failed to follow its own policy and standard nursing practices by withholding basic hygiene care based on the expectation of a later clinical treatment. The facility's failure to provide timely incontinence care for R2 and R3 resulted in a breakdown of standard hygiene protocols. While no immediate deterioration of the wounds was documented, the staff's failure to act created a significant potential for infection and compromised the residents' dignity and quality of care.