

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145607	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024
NAME OF PROVIDER OR SUPPLIER Avantara Palos Heights		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>40001</p> <p>Based on observation, interview and record review, the facility failed to ensure, each resident's dignity was maintained by not placing the urinary catheter inside of his pants leg and securing it for 1 of 3 residents (R128) in a sample of 27 reviewed for dignity.</p> <p>Findings include:</p> <p>On 10/29/2024 at 11:50am R128 was observed with the unit manager, at the dining room table with his urinary catheter exposed and coming out the top of his pants and not secured.</p> <p>On 10/29/2024 at 11:55am V13 (Unit Manager) said R128's urinary catheter should be inside of his pants and secured down his leg into the privacy bag.</p> <p>On 10/30/2024 at 1:00pm V2 (Director of Nursing-DON) said she expects all residents with a urinary catheter to have it properly secured and not exposed.</p> <p>An order summary report indicates R128 has a diagnosis of urinary tract infection, a urinary catheter of 22 French for obstructive uropathy.</p> <p>A care plan dated 10/7/2024 indicated R128 has a potential for infection related to the indwelling catheter, and an intervention of ensure proper placement of the indwelling catheter secure lock device in place, tubing non-kinked, drainage bag below bladder and off the floor.</p> <p>Facility Policy: Facility unable to prevent a policy.</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781</p> <p>Based on observation, interview and record the facility failed to follow their policy and procedures in providing safety during incontinence care by not providing 2 persons assist. The facility also failed to ensure reporting and documentation of the incident immediately in resident medical record. This deficient affects one (R61) of three residents reviewed for Quality of Care.</p> <p>Findings include:</p> <p>On 10/29/24 at 10:35AM, Observed R61 lying in bed with dark blue purple discoloration /bruising and swelling on facial more prominent on forehead, bilateral eyes, cheeks, and right side of neck. R13 can barely open her eyes because of the swelling. R61 said she was pushed out of the bed by CNA during providing care. She has bilateral floor mats on the sides of her bed, but her bed is not in low position. V9 LPN (Licensed Practical Nurse) said R61 is at high risk for falls due to her recent fall. V9 said R61's bed should be in the lowest position. V9 adjusted the bed to the lowest position using the bed control at the foot part of the bed.</p> <p>On 10/29/24 at 10:38AM, Informed V7 Restorative Nurse of above observation made.</p> <p>R61 was readmitted on [DATE] with diagnosis listed, in part but not limited to, Paroxysmal Atrial Fibrillation, Gastrointestinal hemorrhage, Needs assistance with personal care, Disorder of the muscle, Muscle spasm of back, Stage 3 chronic kidney disease, Congestive heart failure, History of falling, Old myocardial infarction, Alzheimer's disease. Re-admission fall assessment dated [DATE] and most recent fall assessment dated [DATE] indicated she is at high risk for fall. MDS section GG Functional abilities and goals: GG0130 Self-Care indicated Personal hygiene, Toileting hygiene and Shower/bathe were coded 01- Dependent, Helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity. Comprehensive care plan indicates: She is at risk for falls related to Current medication use, Poor safety awareness, Unsteady gait, and Generalized weakness. She has ADL self-care performance deficit and impaired mobility. She has impaired cognitive function/dementia or impaired thought processes (forgetful, short term memory impairment) related to diagnosis of dementia as evidenced of BIM (brief interview for mental status) score of 9.</p> <p>R61's progress notes dated 10/26/24 at 6:50AM documented by V21 LPN indicated: V23 Agency CNA reported to her R61 was confused and not following commands when asked to turn on her side while changing her diaper (brief). Upon rounding, observed R61 swaying her legs out of the bed stating, CNA pushes me out of the bed. V21 LPN and V23 Agency CNA together redirected and repositioned R61, reassuring her she did not fall out of bed, safety measures are in place. Endorsed to oncoming nurse and CNA.</p> <p>R61's fall incident report dated 10/26/24 at 8:55AM completed by V12 Unit Manager indicated: When CNA delivered breakfast tray, R61 mentioned she has a headache and pointed to her right forehead. CNA observed some swelling and called for the nurse. R61 stated when the CNA was changing her, she was placed on her right side and slipped off the bed.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R61's progress notes dated 10/26/24 at 8:55AM documented by V12 Unit Manager a change of condition form indicated: R61 stated she fell out of bed during ADL care. R61 reporting pain to right hip and headache 6/10. She has light purple bruising and swelling to right forehead. Neuro checks initiated and WNL (within normal limit). She can move all extremities without difficulty. R61 was sent to the hospital for evaluation.</p> <p>R61's concerns/response form dated 10/26/24 completed by V12 Unit Manager indicated: R61 stated, I was pushed out of bed, right before the sun came up, it happened. R61 said, She (V23 Agency CNA) turned me while changing me and before I knew it, I was on the floor. She went to get help and they each took a side, one at my head and one at my feet and lifted me into bed.</p> <p>R61's hospital record dated 10/26/24 indicated: This is a [AGE] year-old female with a history of dementia presents emergency room for fall. Patient was turned onto her side while they were changing her. Patient then apparently went over the rail, landed on her right side. She is anticoagulated. She has bruising on her forehead. She does have a history of dementia, is difficulty to obtain history from. X-rays were done, negative for fractures. CT (computed tomography) scans were done negative for intracranial hemorrhage and traumatic injury. R61 returned to facility.</p> <p>R61's progress notes documented by V12 Unit Manager dated 10/26/24 at 4:06PM indicated: Discussed with R61's daughter fall intervention would be she will be changed with 2 staff now, one on each side of bed, floor mat upon her return, bed to be in low position except during transfers which also be with two staff. R61 agreed.</p> <p>On 10/30/24 at 10:33AM, Observed R61 lying in bed still with dark blue purple discoloration /bruising and swelling on facial more prominent on forehead, bilateral eyes, cheeks, and right side of neck. Observed floor mat on bilateral side of the bed but the bed is not on low position. Called V7 Restorative nurse and showed observation made. V7 lowered the bed to the lowest position using the bed control located at the foot part of the bed.</p> <p>On 10/30/24 at 12:54PM, V21 LPN said she was the nurse for R61 on 10/25/24 11-7 shift. She was not aware R61 fell out of bed when V23 Agency was providing care. She said around 6:00AM, V23 Agency CNA asked her help to pull up R61 from bed. She observed R61 hanging her legs out of bed. R61 said to her, She (CNA) pushed me out of bed. V21 asked V23 what happened but denied allegation of R61. V21 said she did not notice any bruises nor swelling on her face at time. She assumed R61 is confused. She did not complete an incident report and did not notify the supervisor or DON (Director of Nursing). R61's allegation V23 Agency CNA pushed her out of bed. She endorsed it to the next shift. Then when she got home around 10:00AM, she received calls from V2 DON and V1 Administrator regarding the incident. V21 said she should notify them and complete an incident report because it is an allegation of abuse.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/30/24 at 12:29PM, Review R61's medical records with V2 DON. Informed V2 of concerns regarding V23 Agency CNA providing 1 person assist instead of 2 persons assist with R61 during personal hygiene/incontinence care. R61's MDS section GG Functional abilities and goals: GG0130 Self-Care indicated Personal hygiene, coded 01- Dependent, Helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity. Informed V2 of fall intervention was not implemented. R61 was observed for 2 days 10/29 and 10/30/24 with bed not in low position. Informed V2 R61 reported to V21 LPN V23 Agency CNA pushed her out from bed, she did not investigate allegation made. V21 assumed R61 is confused. V12 Unit Manager started investigation when R61 complaint of pain and purplish discoloration/bruise started to occur.</p> <p>On 10/31/24 at 11:10AM, V2 DON said they don't have procedure guidelines in turning resident during incontinence care for dependent resident. V2 said resident should be turned towards the CNA, not away. R61 does not use side rails in bed for bed mobility.</p> <p>On 10/31/24 at 11:57AM, V1 Administrator said she is the abuse coordinator. She said she did not receive a call from V21 LPN about allegation of R61, but V12 Unit Manager did the investigation. Informed V1 R61 reported to V21 LPN V23 pushed her from bed. Allegation was ignored because she assumed R61 is confused. V21 documented allegation made but did not notify the supervisor. No incident report was made, and no investigation was done not until R61 presented sign and symptoms of bruising, swollen, and complaining of pain on forehead. V1 said she expected any allegation of abuse should be reported immediately. She did staff in services for timeliness of reporting and investigation.</p> <p>Facility's policy on Abuse and Neglect indicates revised 7/12/24 indicates:</p> <p>Policy statement:</p> <p>It is the policy of the policy of the facility to provide professional care and services in an environment is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigation of allegations. These guidelines include compliance with the seven (7) federal components of prevention and investigation.</p> <p>V. Investigation:</p> <p>* Investigate all allegations of abuse, neglect, exploitation, and misappropriation of property.</p> <p>*Identify staff responsible for investigation. All allegations will be investigated by administrator or Designee immediately.</p> <p>*Interview all involved person including victim, perpetrator, witnesses and other who might have knowledge of the allegation.</p> <p>*Focusing on the investigation and determining if abuse, neglect, exploitation, or misappropriation of property has occurred.</p> <p>VII. Reporting/Response:</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*All allegations and or suspicions of abuse must be reported to the Administrator immediately. If the administrator is no present, the report must be made to the administrator's designee.</p> <p>*All allegations of abuse will be reported to IDPH immediately not exceeding 2 hours after the initial allegation is received.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781</p> <p>Based on observation, interview, and record review the facility failed to ensure resident safety by failure to provide 2 persons assist when providing incontinence care. This failure resulted in resident (R61) to fall from bed required visit to emergency hospital for evaluation due to bruising, swelling and pain on forehead. The facility also failed to ensure fall preventive measures were being implemented for residents who are at high risk for falls. This deficiency affects five (R13, R33, R61, R105, R392) residents in the sample of 27 reviewed for Fall prevention program.</p> <p>Findings include:</p> <p>R61</p> <p>On 10/29/24 at 10:35AM, Observed R61 lying in bed with dark blue purple discoloration /bruising and swelling on face which is more prominent on forehead, bilateral eyes, cheeks, and right side of neck. R13 can barely open her eyes because of the swelling. R61 said she was pushed out of the bed by CNA during providing care. She has bilateral floor mats on the sides of her bed, but her bed in not in low position. V9 LPN (Licensed Practical Nurse) said R61 is at high risk for fall due to her recent fall. V9 said R61's bed should be in the lowest position. V9 adjusted the bed to the lowest position using the bed control at the foot part of the bed.</p> <p>On 10/29/24 at 10:38AM, Informed V7 Restorative Nurse of above observation made.</p> <p>R61 was readmitted on [DATE] with diagnosis listed, in part but not limited to, Paroxysmal Atrial Fibrillation, Gastrointestinal hemorrhage, Needs assistance with personal care, Disorder of the muscle, Muscle spasm of back, Stage 3 chronic kidney disease, Congestive heart failure, History of falling, Old myocardial infarction, Alzheimer's disease. Re-admission fall assessment dated [DATE] and most recent fall assessment dated [DATE] indicated R61 is at high risk for fall. MDS section GG Functional abilities and goals: GG0130 Self-Care indicated Personal hygiene, Toileting hygiene and Shower/bathe were coded 01- Dependent, Helper does all the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity. Comprehensive care plan indicates: R61 is at risk for falls related to Current medication use, Poor safety awareness, Unsteady gait, and Generalized weakness. She has ADL self-care performance deficit and impaired mobility. She has impaired cognitive function/dementia or impaired thought processes (forgetful, short term memory impairment) related to diagnosis of dementia as evidenced of BIM (brief interview for mental status) score of 9.</p> <p>R61's progress notes dated 10/26/24 at 6:50AM documented by V21 LPN indicated: V23 Agency CNA reported to V21 R61 was confused and not following commands when asked to turn on her side while changing her diaper (brief). Upon rounding, observed R61 swaying her legs out of the bed stating, CNA pushes me out of the bed. V21 LPN and V23 Agency CNA together redirected and reposition R61, reassuring her she did not fall out of bed, safety measures are in place. Endorsed to oncoming nurse and CNA.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/31/24 at 10:40AM, Review R105's medical records with V2 DON. R105 is admitted on [DATE] with diagnosis listed in part but not limited to Acute post hemorrhagic anemia, Anxiety disorder, Need for assistance, Dementia, history of transient ischemic attack and cerebral infarction. Admission falls assessment and most recent assessment indicated she is at high risk for fall. Comprehensive care plan indicates she is at high risk for fall related to impaired mobility, weakness, CHF, Atrial fibrillation, and Dementia. Informed V2 DON of above observation made on 10/29/24 and 10/30/24 to R105 without bed alarm and not bed not in low position.</p> <p>R392</p> <p>On 10/29/24 at 10:47AM, Observed R392 lying in bed is not in low position. V7 adjusted the bed to the lowest position using the bed control located at the foot part of the bed.</p> <p>On 10/31/24 at 10:45AM, Review R392's medical records with V2 DON. R392 is admitted on [DATE] with diagnosis listed, in part but not limited to, Myopathy, Muscle wasting and atrophy, Epilepsy, History of transient ischemic attack and Cerebral infarction. Admission falls assessment and most recent fall assessment indicated she is at high risk for fall. Comprehensive care plan indicated she is at risk for falls related to Cardiac dysrhythmias, Chronic or acute condition resulting instability, Congestive heart failure pulmonary edema, decline in functional status, Use of cardiovascular medications, Use of other medications cause lethargy or confusion. Informed V2 DON of above observation made bed was not in low position.</p> <p>R33</p> <p>On 10/29/24 at 10:54am, Observed R33 lying in bed. V7 Restorative Nurse checked for bed alarm, but no alarm was found. Facility's list of high fall risk indicated R33 is on bed alarm. V7 said R33 should have bed alarm as indicated in the list as fall preventive measures.</p> <p>On 10/31/24 at 10:59AM, Review R33's medical records with V2 DON. R33 is admitted on [DATE] with diagnosis listed, in part but not limited to, Dementia, Cognitive communication deficit, History of falling, Anxiety disorder, Psychosis, Chronic Obstructive Pulmonary Disease, Malignant neoplasm of bladder. Admission falls assessment and most recent fall assessment indicated she is at high risk for fall. Comprehensive care plan indicates R33 is at risk for falls related to Anemia, Anxiety disorder, Arthritis, Cognitive impairment, Dementia, Gait problem, such as unsteady gait, even with mobility aid or personal assistance, slow gait, takes small steps, takes rapid steps, or lurching gait, history of falls, incontinence, pain, poor safety awareness. Informed V2 of above observation made she does not have bed alarm.</p> <p>On 10/31/24 at 11:10AM, V2 DON said resident who was assessed as high risk for falls was placed on fall prevention program list. Surveyor showed the high fall list on 3rd floor given by V7 Restorative Nurse. V2 said the high fall list was updated by the Fall nurse before she left. The interventions placed were individualized and not necessary in care plan. V2 said they don't have procedure guidelines in turning resident during incontinence care for dependent resident. V2 said resident should be turned towards the CNA, not away.</p> <p>Facility's policy on Fall Occurrence revised 7/26/24 indicated:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145607	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/01/2024
NAME OF PROVIDER OR SUPPLIER Avantara Palos Heights		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Policy statement: It is the policy of the facility to ensure residents are assessed for risk for falls interventions are put in place, and interventions are reevaluated and revised as necessary.</p> <p>Facility's policy on High-risk fall identification program indicates:</p> <p>Purpose: This program is intended to aide nursing home staff with easy identification of residents with a heightened risk of falling. A visual identified such as yellow star, is placed close to the resident. This allow staff to be diligent with safety measures, response times and fall prevention measures for these residents.</p> <p>The high-risk fall identification program goes beyond the fall risk evaluation score ad identified residents in the facility with the highest risk for falling. It is important to remember many residents are at risk for falling and should have care plan interventions available accordingly, even if the resident is not on the high-risk identification program.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>40001</p> <p>Based on observation, interview and record review the facility failed to ensure pain was thoroughly assessed and treated before, during and after surgical wound care for 1 of 4 resident's (R127) reviewed for pain management in a sample of 27.</p> <p>Findings include:</p> <p>On 10/30/2024 at 10:40 am R127 was observed flinching during sacral wound care treatment. R127 said she had pain medication about 15 minutes ago and it was okay V14 (Wound Care Nurse) could continue.</p> <p>On 10/30/2024 at 11:15am V14 was asked did he apply R127 lidocaine gel to the sacral wound before starting the wound care treatment? V14 said He does not apply the lidocaine gel and he was not aware if the nurse had applied the gel.</p> <p>On 10/30/2024 at 12:00 noon V15 (Unit Nurse) said she did not apply the lidocaine gel to R127 surgical wound because it is for the treatment nurse and the lidocaine gel was given to V14 when it arrived from the pharmacy.</p> <p>On 10/30/2024 at 12:00 noon V2 (Director of Nursing) said, I expect the wound care nurses and the staff nurses to assure all residents are medicated before, during and after treatment as ordered by the physician.</p> <p>An order summary sheet dated 10/30/2024 indicated R127 has a diagnosis of encounter for surgical aftercare following surgery to the skin and subcutaneous tissue, an order dated 10/2/2024 for lidocaine external gel 4% apply to sacrum topically every day shift for wound care apply 15 minutes before dressing change. A care plan dated 9/18/2024 indicates R127 has a focus of risk for pain related to sacral wound, rheumatoid arthritis and osteoarthritis, and intervention to evaluate efficacy of pain management, medicate prior to therapy and treatment, observe for non-verbal signs of pain.</p> <p>Facility Policy: Pain management revised 8/16/2024. Policy statement:</p> <p>It is the policy of the facility to ensure all residents are assessed for pain in every situation where there is a potential for pain. For pain complaints and for situations incidents might result to pain (example wound care).</p> <p>Procedure:</p> <p>2. During treatment procedure the resident will be assessed for pain. It is important pain medication will be administered to residents prior to wound.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>39781</p> <p>Based on observation, interview, and record review the facility failed to post an up-to-date and current daily nurse staffing information that readily accessible to the residents and visitors. This deficiency affects the entire residents in the facility.</p> <p>Findings include:</p> <p>On 10/29/24 at 9:40AM, Observed 24-hour daily staffing posting at the front desk dated 10/25/24. V13 said that today is 10/29/24. Informed V13 Receptionist of observation made that the staffing posted was not updated. V13 said she will inform who is responsible for updating the staffing posting.</p> <p>On 10/29/24 at 9:44am V1 Administrator said V8 Scheduler is responsible for posting the daily 24-hour staffing at the front desk. Showed V1 observation made that posting at the front desk still dated 10/25/24. Current date is 10/29/24, they did not update the posting for 4 days. V1 said it should be updated daily.</p> <p>On 10/31/24 at 10:58AM, V8 Scheduler said she does the daily 24-hour staff posting at the front desk except on weekends. The Manager on Duty should be the one updating on weekends when she is off. V8 said she forgot to update the posting on 10/28/24 (Monday) when she comes to work.</p> <p>Facility unable to provide policy.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>39781</p> <p>Based on observation, interview, and record review the facility failed to ensure appropriate infection control practices were followed when handling soiled linens/gown. This deficiency affects one (R60) of three residents in the sample of 27 reviewed for Infection control during ADL (Activity of Daily Living) care.</p> <p>Findings include:</p> <p>On 10/29/24 at 10:50AM, Observed V10 Hospice CNA (Certified Nurse Assistant) providing morning care/personal hygiene to R60. Observed all soiled linen and gown were on the floor. Surveyor asked V10, why the soiled linens are on the floor. V10 said that it is okay for her to placed it on the floor because the linens are soiled. V7 Restorative Nurse corrected V10 Hospice CNA and informed her that it is not right to place the soiled linens on the floor. It should be placed in plastic bag for infection control.</p> <p>On 10/29/24 at 12:53PM, Informed V5 Infection Preventionist Nurse of above observation. She said V10 Hospice CNA should not place the soiled linens/gown on the floor. She should use soiled hamper linen or placed the soiled linens in plastic bag. Requested for policy.</p> <p>On 10/31/24 at 2:05PM, Informed V1 Administrator and V2 DON (Director of Nursing) of above concern.</p> <p>Facility unable to provide policy.</p>