STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145699	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara of Elgin	1950 Larkin Avenue Elgin, IL 60123

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 48308 Based on interview and record review, the facility failed to document and promptly resolve resident's stated concerns. This applies to 5 of 5 residents (R29, R43, R85, R38 and R24) reviewed for grievances in the sample of 26. The findings include: 1.During the resident meeting on July 9, 2024, at 1:00 PM, V11 (Ombudsman) asked the resident group if residents' prior concerns had been resolved. R29 (RCP-Resident Council President) stated the previous concern raised regarding R1(confused peer) wandering into other resident's rooms had not been resolved. R43 (resident who regularly attends resident council) stated R1 continues to wander into other resident's rooms after his visitors leave. R43 stated R1 will cuss at other residents if residents tell R1 to leave their room and some residents will cuss at R1 when he tries to enter their rooms. R85 and R38 (residents who regularly attend resident council meetings) also agreed R1 continues to wander into other resident's rooms remains a concern that has not changed since initially brought up in the May 20, 2024, Resident Council Meeting. The Resident Council Meeting Minutes dated May 20, 2024, showed under New Business, showed Resident requesting another resident does not go into their room and staff asked Ombudsman questions on how to respond if a resident is swearing at staff, other residents in the hallway, and discussed swearing at staff and residents. The scribe listed on the meeting minutes was staff member, V12 (Activity Director). On July 10, 2024, at 9:21 AM, V12 stated she does attend the Resident Council Meeting and takes the meeting minutes and stated the resident who wanders into other residents' room was identified as R1. V12 stated she did not create a concern form for the resident's concern regarding R1. On July 10, 2024, at 9:41 AM, V1 (Administrator) stated she was aware of the resident's concerns regarding R1 wandering into other resident's rooms. V1 stated the expectation for staff is to complete the grievance form when a resident raises a concern or a grievance. V1 stated that R1 was placed on 1:1 monitoring on July 9, 2024, in the afternoon after the surveyor made the facility aware of the continued concerns regarding R1, from the resident meeting. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145699	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER: Avantara of Elgin		STREET ADDRESS, CITY, STATE, ZIP CODE: 1950 Larkin Avenue Elgin, IL 60123	

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.On July 8, 2024, at 10:36 AM, R24 stated she had been complaining about the condition of the shower chairs for the last two and one-half years. R24 stated she had complained about the poor condition of the shower chairs, that they stop abruptly, and the chair jerks forward. R24 stated she reported the shower chair concerns to V18 (CNA- Certified Nursing Assistant), V23 (CNA), V24, (CNA) and V26 (CNA). A review of the facility concern/response/compliment forms, provided by the facility, from January 1, 2024, through July 4, 2024, showed there were no concern forms generated on behalf of R1 and R24 during that time frame. The facility's grievance policy revised June 6, 2024, showed 3. The notification will include the name, address, and phone number, of the grievance official, a reasonable time frame to investigate the grievance, and the resident's right to obtain a written copy of the grievance investigation if requested .5. During the investigation the facility will put in place immediate action to prevent potential violation of resident's rights .7. All written grievance decisions will include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns, a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance and the date the written decision was issued.

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide appropriate treatment and care according to orders, resident’s preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48308

Based on interview and record review, the facility failed to obtain resident weights in accordance with physician orders.

This applies to 5 of 5 residents (R21, R60, R14, R37, R61) reviewed for weight documentation in the sample of 26.

The findings include:

1.R21 was admitted to the facility on [DATE], with multiple diagnoses including, heart failure unspecified, atrial fibrillation, chronic kidney disease stage 3, and type 2 diabetes according to R21's face sheet.

R21's physician order summary showed an order initiated on May 28, 2024, to obtain daily weights (on the same scale)-record weight and scale if weight differences is 2 pounds from prior day, reweigh and document every day shift.

R21's weight record showed R21 was weighed on May 29, 2024, June 10, 2024, June 18, 2024, and June 26, 2024, and July 6, 2024. There were no daily weights documented. The record showed the weights as follows:

May 29, 2024, 262 lbs.(pounds) (Mechanical Lift)

June 10, 2024, 255.2 lbs. (Mechanical Lift)

June 18, 2024, 258 lbs. (Mechanical Lift

June 26, 2024, 254.2 lbs. (Mechanical Lift)

July 06, 2024, 260.2 lbs. (Mechanical Lift)

R21's care plan for fluid retention/overload initiated on May 16, 2024, intervention included weight will be obtained as ordered by the MD and Monitor/record/report to MD PRN (as needed) situations leading to increased food consumption, reasons for weight gain, significant wt changes.

2.R60 was admitted to the facility on [DATE], with multiple diagnoses including chronic venous hypertension with ulcer of bilateral lower extremity, lymphedema, type 2 diabetes, and chronic diastolic congestive heart failure according to R60's face sheet.

R60's physician order summary showed an order for daily weight initiated on June 13, 2024.

R60's weight and vital record showed weights were documented on June 15, 2024, June 18, 2024, July 5, 2024, July 9, 2024, and July 10, 2024. R60's weights were not documented daily as ordered.

(continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R60's care plan for CHF (Congestive Heart Failure), lymphedema, and diuretic use dated June 23, 2023, interventions showed weight will be obtained as ordered by MD. 45303 3. R14's EMR (Electronic Medical Record) showed R14 was admitted to the facility on [DATE], with multiple diagnoses including Parkinson's disease, dysphagia, dementia, and clostridium difficile. R14's nutrition care plan dated May 13, 2024, showed, [R14] is at risk for alteration in nutritional status related to Parkinson's, Urinary Tract Infection, clostridium difficile, atrial fibrillation, hypothyroidism, ulcerative pancolitis, altered mental status, dementia, anxiety, depression, type 2 diabetes mellitus, hyperlipidemia, and hypertension. The care plan continued to show multiple interventions dated May 13, 2024, including Obtain weight as ordered. R14's Order Listing Report dated July 10, 2024, showed an order dated May 8, 2024, for Weight Daily, every day shift for monitoring. R14's May MAR (Medication Administration Record) showed R14 was not weighed or refused to be weighed on seven days. R14's June MAR showed R14 was not weighed or refused to be weighed on 12 days. R14's July MAR showed R14 was not weighed on three days. 4. R37's EMR showed R37 was admitted to the facility on [DATE], with multiple diagnoses including spinal fracture, dysphagia, hypertension, and chronic obstructive pulmonary disease. R37's nutrition care plan dated June 7, 2024, showed, [R37] is at risk for alteration in nutritional status related to: depression, hypertension, type 2 diabetes mellitus, arthritis, chronic obstructive pulmonary disease, recent surgical procedure, recent decrease in appetite, obesity. The care plan continued to show multiple interventions dated June 7, 2024, including Obtain weight as ordered. R37's Order Listing Report dated July 10, 2024, showed, an order dated June 6, 2024, for Weight upon admission/readmission, weekly times four, then monthly, every day shift every seven days for 28 days weekly times four. R37's June 2024 Monitoring Record showed R37 was not weighed or refused to be weighed weekly on June 13, June 20, and June 27, 2024. 5. R61's EMR showed R61 was admitted to the facility on [DATE], with multiple diagnoses including stroke, pneumonia, hypertension, and congestive heart failure. R61's nutrition care plan dated July 1, 2024, showed [R6] is at risk for alteration in nutritional status related to type 2 diabetes mellitus, traumatic brain injury, history of craniectomy, hemiplegia, history of dysphagia, vitamin D deficiency, congestive heart failure, hyperlipidemia, hypertension, anxiety. The care plan continued to show multiple interventions dated October 18, 2023, including Obtain weight as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R61's Order Listing Report dated July 10, 2024, showed an order dated June 27, 2024, for Daily weights, every day shift for congestive heart failure. R61's June 2024 MAR showed R61 was not weighed or refused to be weighed on June 27, June 28, and June 29, 2024. R61's July 2024 MAR showed R61 was not weighed or refused to be weighed on July 2, July 3, and July 6, 2024. On July 10, 2024, at 11:55 AM, V2 (DON/Director of Nursing) said resident weights should be obtained as ordered by the physician. V2 continued to say it is the expectation of facility staff to follow the physician's order and document in the medical record if a resident refused to be weighed. The facility's policy titled Weights revised on June 6, 2024, showed Policy Statement: It is the facility's policy to obtain resident's monthly weight unless otherwise ordered differently by the physician. For a resident who is on dialysis, the resident's dry weight will be also obtained monthly .

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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 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** 45303 Based on interview and record review, the facility failed to obtain treatment orders for a newly admitted resident with pressure ulcers. This applies to 1 of 3 residents (R256) reviewed for pressure ulcers in the sample of 26. The findings include: R256's EMR (Electronic Medical Record) showed R256 was admitted to the facility on [DATE], with multiple diagnoses including encephalopathy, pressure ulcer of right buttock, pressure ulcer of left buttock, pressure ulcer of right heel, chronic kidney disease, and urinary tract infection. R256's MDS (Minimum Data Set) dated July 4, 2024, showed R256 had moderate cognitive impairment. The MDS continued to show R256 had two stage three pressure ulcers, two unstageable pressure ulcers, and one deep tissue pressure injury present on admission to the facility. On July 8, 2024, at 10:33 AM, R256 said she has wounds on her buttocks. On July 10, 2024, at 9:44 AM, V28 (Wound Care Nurse) said R256 was admitted to the facility on [DATE], with multiple pressure ulcers. V28 continued to say she saw R256 on July 1, 2024, and assessed R256's pressure ulcers and received treatment orders for R256's pressure ulcers. V28 said before July 1, 2024, R256 did not have any orders for treatment for her pressure ulcers and V28 does not see documentation of R256 receiving pressure ulcer treatment from facility staff. V28 said upon admission to the facility, the admitting nurse should notify the physician if the resident has pressure ulcers to receive treatment orders. On July 10, 2024, at 11:08 AM, V2 (DON/Director of Nursing) said when a resident is admitted to the facility, the nurse should assess the residents, specifically for wounds. V2 continued to say as soon as the nurse identifies a pressure ulcer, the nurse should notify the physician for treatment orders and enter the orders into the medical record. V2 said R256's admitting nurse should have entered treatment orders for R256's pressure ulcers. V2 said facility staff are expected to document pressure ulcer treatments. On July 10, 2024, at 11:14 AM, V16 (Regional Nurse Consultant) said the nurse should enter treatment orders for pressure ulcers on admission. V16 continued to say if the treatment order is to leave the wound open to air, the nurse should enter that as an order in the medical record. R256's Order Summary Report dated July 11, 2024, showed the first treatment orders for R256's pressure ulcers was ordered on July 1, 2024. The facility does not have documentation to show R256 received pressure ulcer treatment on June 28, June 29, and June 30, 2024. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled Wound Care Guidelines revised on January 24, 2024, showed, .10. Pressure Injuries Treatment: a. Initiate wound care treatment upon identification of the wound with physician's order .

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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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 43389 Based on observation, interview and record review, the facility failed to ensure safe transport of resident to the shower room when a shower chair was utilized for the transfer in place of a wheelchair. This failure resulted in R24 falling from the chair and fracturing both of her legs. This applies to 1 of 4 residents (R24) reviewed for accidents in the sample of 26. The findings include: R24 is a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that include Multiple Sclerosis, Chronic pain, and Polyneuropathy. R24's MDS (Minimum Data Set) assessment dated [DATE], documents that resident requires substantial to maximal assistance with lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed and with no back support. R24 was also assessed to be cognitively intact as evidenced by a BIMS (Brief Interview of Mental Status) score of 15/15. The Facility Reported Incident dated June 13, 2024, stated that at approximately 6:30 AM Certified Nursing Assistant (CNA) was transporting R24 to the shower room via shower chair. The report documents the chair suddenly stopped at the metal transition strip on the floor. This caused the chair to become unstable and the resident to lose balance and fall to the floor. Resident complained of pain to bilateral legs and knees. The resident was sent to the hospital and sustained a fracture of the right femur and fracture of the left tibia and fibula. On July 8, 2024, at 10:36 AM, R24, stated that on June 13, 2024, at about 6:20 AM, V10 (CNA) helped her into a Polyvinyl Chloride pipe (PVC) shower chair via a full body mechanical lift and wheeled her towards the shower room. R24 stated the shower chair was made of PVC pipe and had a footrest board. R24 stated the shower room closet to her room was occupied so he started to wheel her to the next closet shower room. R24 stated that when they got to the metal strip on the floor, the wheels locked, and the chair stopped abruptly, and she kept going and landed on her legs and knees. R24 stated when the staff is pushing you in the shower chairs the wheels lock and the shower chair jerk you forward then you see black marks on the floor behind you. R24 stated she has been complaining the shower chairs were not in good repair for 2.5 years. R24 stated she has told CNA's V18, V23, V24, and V26 that the shower chairs are in poor repair, stop abruptly, and the chairs jerks you forward. On July 9, 2024, at 9:02 AM, V9 (CNA) stated she has been working at the facility for 3 years. V9 stated the shower chairs are hard to move. They lock on their own while you are pushing them. V9 stated it is hard to get over the metal strips with the residents in the shower chairs. V9 stated when you go over the strips, with residents in the shower chair, the chairs tilt. V9 stated You have to push slowly so they don't tilt over. Observed 3 shower chairs 2 with PVC pipe and one gray metal one to be hard to push and pull with the locks on or off. They were very stiff with brown substance around the wheels. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On July 9, 2024, at 2:12 PM, V10 (CNA) stated, the day of the incident, he lifted R24 into a shower chair with a whole-body mechanical lift, then proceeded to wheel R24 to the shower room. V10 stated when the chair reached the metal transition strip on the floor, the chair abruptly stopped and tipped forward. V10 stated he is not sure if it was the wheels that locked, the shower chair got caught on something, or her feet were dangling that caused the shower chair to stop and tip forward. V10 stated the transitions where higher at the time of the accident. V10 stated the chair he used to transport R24, is no longer in the facility. V10 stated, the shower chair was made of PVC pipe with a gray seat and a foot stand that was not movable but part of the chair. V10 stated some of the chairs stop abruptly and are hard to push. V9 stated there were no straps on the chair to hold the resident. On July 9, 2024, at 2:49 PM, V2 (Director of Nursing, DON) stated it could be multiple factors that caused R24 accident. V2 stated that it could have been that the resident's feet could have stopped the chair, the chair could have locked, and there may have been a problem with transition strip on the floor. V2 stated they ordered new chairs, pounded the metal strips down, and took the particular chair out of circulation and trashed it. V2 stated that the best practice for transporting residents to the shower room is to transfer them from bed to wheelchair, use the wheelchair to wheel the resident to the shower room, and then transfer the resident back to wheelchair before transporting the resident back to their room. On July 11, 2024, at 8:53 AM, V22 (Occupational Therapist) stated transporting residents in a shower chair would not be safe if the chair abruptly stopped or tilted while resident is in it. R24's Hospital imaging report dated June 13, 2024, showed fractures to her left tibia and fibula and her right femur. The facility's provided manufacture's owner's manual for the shower chairs and it shows the following: Do not use device if it appears wobbly or unstable, the casters are rusted or fail to move easily, the fabric appears torn or weak, cracks are observed in the fittings, or the device appears to be compromised in anyway. If you suspect a device is not functioning as intended, do not use device, and contact your distributor for assistance. Do not abruptly turn or stop the device. Do not abruptly turn or stop the device.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15845 Based on observation, interview, and record review the facility failed to provide indwelling catheter care in a manner that would prevent infection. The facility also failed to ensure indwelling urinary catheter is kept secured to prevent from pulling and tugging and prevent catheter related skin trauma. This applies to 3 of 5 residents (R1, R70 and R86) reviewed for indwelling catheter care in the sample of 26. The Findings include: 1. R1, a [AGE] year-old with diagnoses of hemiplegia and hemiparesis; lack of coordination; flexion deformity, UTI (urinary tract infection), presence of urogenital implant and epilepsy. R1 was admitted to the facility on [DATE]. On July 08, 2024, at 10:00 A.M, R1 was sitting in his wheelchair by the hallway next to the shower room R1 was with V18 (CNA-Certified Nursing Assistant). V18 was observed placing R1's indwelling catheter tubing and drainage bag to the other side of R1's wheelchair arm rest. R1 was indwelling catheter tubing was cloudy with yellowish sediments and the tubing and drainage bag was discolored with bluish color. On July 08, 2024 at 2:24 P.M. R1 was sitting in his wheelchair by the 300 nurse's station. R1's still with same condition regarding his indwelling catheter with urine being cloudy and with yellow sediments. On July 09, 2024, at 1:30 P.M., R1 was sitting in his wheelchair by the lounge area. R1's indwelling catheter still with cloudy sediments in the tubing. On July 10,2024 at 9:35 A.M., R1 was sitting in his wheelchair in his room. V15 (CNA) was providing a 1:1 supervision to R1. V15 was repositioning R1. The indwelling catheter was still with cloudy urine and with sediments in the tubing. The care plan dated June 6,2024 showed interventions for the indwelling catheter to prevent infection and catheter-related skin trauma. The intervention included but not limited to catheter care every shift and as needed, change indwelling catheter drainage bag as needed, change the indwelling catheter per facility's protocol or physician order. 2. R70, a [AGE] year-old with diagnoses of Parkinson's' disease, urine retention, UTI, obstructive and reflux uropathy. R70 was admitted to the facility on [DATE]. On July 8, 2024, at 11:53 A.M., R70 was lying in bed. R70 was observed with an indwelling catheter. The urine in the indwelling catheter tubing was cloudy and noted with yellowish sediments. (continued on next page)

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On July 9,2024 at 12:45 P.M., R70 was lying in bed. R70 noted with same condition of the indwelling catheter that had the cloudy urine with sediments. On July 10, 2024 at 9:23 A.M, R70, was in bed. R70's cloudy urine with sediments was pointed to V14 (RN/Registered Nurse). V14 said that she would have to call the physician to either change the entire catheter or just change the tubing or irrigate the tubing first, but something needs to be done due to the cloudiness of the urine and clumps of sediments. The care plan dated July 2,2024 showed interventions for R70's indwelling catheter that included but not limited to R70's potential for infection related to indwelling catheter and that assessment for signs and symptoms of infection and catheter care every shift and as needed were to be implemented. 3. R86, an [AGE] year-old with diagnoses that included ventricular tachycardia, protein-calorie malnutrition, dementia, obstructive and reflux neuropathy, diabetes mellitus type 2, chronic kidney disease, and benign prostatic hyperplasia. On July 8, 2024, at 2:08 P.M., R86 was lying in bed. R86 was noted with an indwelling catheter. The urine in the catheter tubing was cloudy and full of sediments. On July 10,2024 at 9:25 A.M., together with V14 (RN/Registered Nurse), R86's indwelling catheter was checked. R86 was noted to try playing/pulling the catheter tubing. There was no device to secure the tubing in place. V14 said she will apply an anchor device to ensure that indwelling catheter will be secured and not be pulled or tugged and prevent catheter related trauma. R86 was also noted with cloudy urine full of sediments. V14 said that she will call the physician and the catheter need to be irrigated or change the indwelling catheter. The care plan October 18,2023 showed interventions for R86's indwelling catheter that included but not limited to R86's potential for infection related to indwelling catheter and that assessment for signs and symptoms of infection and catheter care every shift and as needed were to be implemented. On July 10, 2024 at 11:30 A.M., V2 (DON/Director of Nursing) said that if the indwelling catheter tubing was cloudy with sediments, then an irrigation of the tubing was indicated and calling the physician for further interventions. V2 also said that irrigation was indicated to ensure patency of urine flow and prevent UTI. V2 said that the indwelling catheter tubing should be secured with an anchor device to prevent the indwelling catheter from being pulled or tugged and prevent catheter related trauma. On July 10, 2024, at 11:50 A.M., V16 (Nurse Consultant) said that she will discuss with corporate to revise policy to ensure there was a secured device for the indwelling catheter to prevent pulling and tugging. The facility's policy and procedure dated June 6, 2024, and titled Urinary Catheter Care showed Catheter irrigation may be ordered to prevent obstruction in residents at risk for obstruction.Secure catheter . The facility's policy for indwelling catheter dated January 5, 2026 showed an indwelling catheter maybe changed as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145699	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER: Avantara of Elgin		STREET ADDRESS, CITY, STATE, ZIP CODE: 1950 Larkin Avenue Elgin, IL 60123	

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 - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 35267 Based on observation, interview and record review, the facility failed to puree foods to a smooth consistency. This applies to 6 of 6 residents (R1, R56, R66, R68, R99 and R406) reviewed for pureed diets. The findings include: On July 8, 2024 at 12:30 PM, R66 was sitting in wheelchair and eating her lunch in her room. R66's meal ticket, dated 7/8/24, showed R66 was to receive a pureed diet including a serving of pureed beef top round roast beef. The pureed beef on R66's meal plate looked very lumpy with solid particles of beef visible in the serving. On July 8, 2024 at 12:34 PM in R66's room during lunch, V21 (Food Service Director) observed R66's pureed beef and stated it appeared to need more thickener. On July 8, 2024 at 12:38 PM in the kitchen after lunch service, V21 tasted the leftover pureed beef from the steam table line that was served to the pureed residents. V21 stated the pureed beef was not completely pureed and should be pureed further. The pureed beef tasted lumpy and had a large amount of small pieces of unpureed beef that required some chewing. On July 10, 2024 at 11:52 AM, V21 stated the pureed foods should be a smooth consistency with no solid particles. Facility Diet Census, dated July 8, 2024, shows R1, R56, R66, R68 and R99 and R406 all receive pureed diets at the facility. Facility policy Kitchen, reviewed June 6, 2024, shows, During pureed preparation, as the consistency of the pureed food changes with how the food is cooked the cook may add thickener to the food items being pureed, until the right consistency (pudding or mashed potato consistency) is reached. Meal Tray ticket, dated July 8, 2024, shows R66 was served pureed beef top round roast beef.