STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145734	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Evergreen Park	10124 South Kedzie Evergreen Park, IL 60805

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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45316 Based on interview, and record review, the facility failed to exercise the right of the resident representative to choose a Long-Term Care Facility of their choice in one of four (R329) residents reviewed for residents right in a sample of 32. Finding includes: On 5/17/2024 at 09:52 AM, V37 (R329's daughter) said that V37 is the surrogate decision maker for her mother. V37 said that her mother was admitted to the facility for physical therapy only after a hospitalization . V37 said that her mother needed a permanent long term care facility when discharged . V37 said that V37 requested for her mother to be transferred to an assisted living Facility. V37 said that her mother was transferred to another long term care facility without her permission. V37 said that her mother was not happy at that facility and she followed up with having V44 (representative from the assisted living facility) to come to the long term care facility to assess her mother through the assistance of someone she knew. V37 said that the assisted living facility representative came to long term care facility, evaluated her mother, and her mother was accepted. V37 said that her mother has been residing at the assisted living facility 5/1/2024. On 5/15/2024 at 10:34 AM, V7 (Social Service Director) said that V7 reached out to the assisted living facility per V37 request. V7 said that V44 (Representative from assisted living facility) came to the facility to evaluate R329 and after assessing R329, R44 told V7 that R329 is inappropriate and thus, will not be accepted. 05/16/24 12:12 PM V1(Administrator), said that the referral was sent to the assisted living facility by V7 (Social Service Director), on 4/16/24 at 4:30 PM. V1 said that assisted living facility clinical reviewed R329 referral on 4/17. V1 said that assisted living came to the facility to assess R329 on 4/19, but R329 was already transferred to the long term care facility, and the daughter was aware. V1 said that the representative was informed that R329 has been transferred to the long term care facility. V1 said that V1 called the assisted living facility representative today (5/16/2024) who informed V1 that he (representative) went out to the long term care facility and assess R329. V1 said that assisted living facility informed V1 that R329 was accepted and was transferred on 5/1/2024. V1 said that she spoke with representative who confirmed that R329 is at assisted living. mother was accepted. V37 said that her mother has been residing at the assisted living since 5/1/2024. On 5/17/2024, V1 said that expectation is for V7 to follow -up in a week with the request of the family in a week. (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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R329 is a [AGE] year-old female admitted on [DATE] with diagnosis not limited to type 2 diabetes, depression, dementia, and chronic kidney disease. Policy: RESIDENTS' RIGHTS for People in Long-Term Care Facilities As a long-term care resident in Illinois, you are guaranteed certain rights, protections and privileges according to state and federal laws As an individual living in a long-term care facility, you retain the same rights as every citizen of Illinois and of the United States. The following regulations provide clarity on specific rights granted to residents living in long-term care facilities. Your rights to dignity and respect You have a right to make your own choices.

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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** 39781 Based on observation, interview, and record review the facility failed to ensure implementation of pressure ulcer prevention interventions and manufacturer recommendation for using low air loss mattress for resident with Stage 4 pressure ulcers. This deficiency affects one (R48) of three residents in the sample of 32 reviewed for Pressure Ulcer Prevention and Treatment Management. Findings include: On 5/15/24 at 10:24AM, Observed R48 lying in bed with LAL (low air loss) mattress. R48 has flat sheet and thick bath blanket folded in quarters over the LAL mattress. Called V5 Unit Manager and showed observation made. V5 said that R48 has pressure ulcers on sacral and bilateral heels. V5 said that R48 should only be on flat sheet over the mattress. Surveyor asked V5 to see the bilateral feet of R48. Observed bilateral heels with dressing but no heel protectors to off load heels. Bilateral heels on pillows, not elevated off from bed. R48 is admitted on [DATE] with admitting diagnosis listed in part but not limited to Osteomyelitis of vertebra, sacra and sacrococcygeal region, Stage 4 pressure ulcer of sacral region, Pressure ulcer induced deep tissue damage, Stage 2 pressure ulcer, Unstageable pressure ulcer of right ankle, Sepsis, Metabolic encephalopathy. Active physician order sheet indicates Off load heels in bed (use heel protectors to offload) every shift. Pressure relieving device. Care plan indicates she has an actual skin impairment to skin integrity due to medical history. Interventions: Low air loss mattress. Off load heels as ordered. Most recent Braden scale/skin risk assessment dated [DATE] indicated that R48 is at high risk for developing skin impairment/pressure ulcer. R48's most recent wound assessment/report from Wound care Physician dated 5/9/24 indicated: 1. Stage 4 Pressure Ulcer Sacrum measures 10cm x 10cm x 5.5cm (centimeter). Wound base 50-74% epithelial, 25-49% granulation, 1-24% slough. Wound edges attached. Peri wound intact. Exudate moderate amount of serosanguineous. 2. Left heel Pressure ulcer measures 2cm x 1.5 x 0.2cm. Wound base 100% slough. Wound edges attached. Peri wound intact, fragile. Exudate none. 3. Right heel Pressure ulcer Unstageable. Measures 3cm x 4cm x 0.1cm. Wound base 75-99% epithelial, 0% granulation, 1-24% slough, 0% eschar. Wound edges attached. 4. Left lateral foot Pressure ulcer. Measures 1.3cm x 1cm x 0cm. Wound base 100% epithelial. Wound edges attached. Exudate none. 5. Right ankle Pressure ulcer. Measures 1.5cm x 0.7cm x 0.1cm. Wound base 100% epithelial. Wound edges attached. Exudate none. On 5/15/24 at 1:38PM, V2 Director of nursing said that they are expected to implement physician orders, wound care plan interventions, and follow manufacturers recommendation in using low air loss mattress for resident with multiple pressure ulcers. On 5/15/24 at 1:51PM, V8 Wound Care Director said that they are expected to implement physician orders, wound care plan interventions, and follow manufacturers recommendation in using low air loss mattress. V8 said that resident (R48) on low air loss mattress should have flat sheet and incontinence pad over the low air loss mattress. On 5/15/24 at 2:48PM, Informed V1 Administrator of above concerns. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's policy on Wound care Guidelines Revised 1/24/24 indicates: Overview of the program: This facility adheres to the federal and State regulatory requirements for wound care management and the care guidelines for wound care established by the National Pressure Injury Advisory Panel. The goal of this guidelines is to achieve compliance to regulatory requirements and provide evidence-based recommendations for the prevention and treatment of pressure injuries that can be used by the health professionals in the facility. The purpose of the prevention recommendations is to guide evidence-based care to prevent development of pressure injuries and the purpose of the treatment focused recommendations is to provide evidence-based guidance on the most effective strategies to promote pressure injury/ulcer healing. Procedures: Timely identification of residents assessed to be risk for skin breakdown. d. Facility shall develop a plan of care and implement intervention according to the resident's Braden Scale and Clinical Evaluation or identified individual risk factors. 4. Activity, Mobility and Positioning i. Evaluate and utilize appropriate pressure redistribution surface modalities while in bed and or up in wheelchair. *Low air loss mattress: alternating or static J. Off load elbows and heels as needed. k. Elevate resident heels off the bed as indicated (e.g., place pillows under calf (not under ankles or use heel protector that offloads the heel from the bed surface) to raise heels off the bed, unless contraindicated due to medical condition. Facility's policy on Skin Care Regimen and Treatment formulary revised 1/24/24 indicates: Policy statement: to ensure prompt identification, documentation and to obtain appropriate treatment for resident with skin breakdown. Procedures: 9. Residents with stage 3 and or 4 pressure injuries will be placed in specialized air mattresses like air loss mattress with an incontinence brief if they are incontinent only, incontinence pad which will act as repositioning aid, and a flat/fitted sheet which are all necessary to prevent infection control issue. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's policy on Specialized Mattress and Appropriate layers of padding Revised 7/28/23 indicates: Policy statement: it is the policy of this facility to use the NPIAP guidelines on the use of layers on top of specialized mattress appropriately in accordance with the need of the resident. Procedures: 1. Limit the amount of layers on top of specialized air mattress such as low air loss (LAL) mattress according to the resident's needs and individual's condition in order to manage comfort, positioning and moisture. For LAL mattresses, consider 1 fitted or flat sheet on top of the bed for dignity, 1 cloth incontinence pad and or 1 absorbent brief to absorb fecal and or urinary incontinence and help with repositioning and prevent fecal and urinary soiling of the entire bed and resident's skin if the resident is incontinent.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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** 39781 Based on observation, interview, and record review the facility failed to implement fall prevention intervention to R53 who has history of fall. The facility also failed to ensure individualized fall prevention care plan interventions are in place upon admission for a resident who has history fall and fracture of left femur. This deficiency affects two (R53 and R229) of three residents in the sample of 32 reviewed for Fall Prevention Management. This failure resulted in R229 having an unwitnessed fall and sustained acute comminuted left ischial pubic and tuberosity fractures that required hospitalization . Findings include: 1. On 5/14/24 at 11:28AM, V6 Restorative nurse stated R229 admitted on [DATE] with history of falls from home and fracture of left femur. R229 was admitted to the facility for rehabilitation. R229 is non ambulatory and dependent with activities of daily living. She is alert but confused with poor safety awareness. V6 said that on 1/13/24, R229 attempted to get out from bed to go to the bathroom without assistance. She has unwitnessed fall and was sent out to the hospital for evaluation. V6 said that it is was protocol of the facility that resident with unwitnessed fall and currently on anticoagulant was sent to the hospital for evaluation. V6 said she does not know what happened with R229 after. V6 denied V22 Family member presented concern regarding R229 fall incident. On 5/15/24 at 10:47AM, Review R229's medical records with V6 Restorative Nurse. R229 admitted on [DATE] with diagnosis listed in part but not limited to Repeated falls, Alzheimer's disease, Displaced fracture of greater trochanter of right femur, Fracture of left pubis, Displaced transverse fracture of shaft of left femur, History of falling, Muscle wasting and atrophy, Poly arthritis. Admission fall assessment done on 1/9/24 indicated R229 is at high risk for fall. R229 has history of falls with injury. Interim care plan dated 1/9/24 indicated that R229 is at risk for falls related to current medication use, poor safety awareness, unsteady gait, and disease process. Interventions: Restorative program to prevent further falls. Skilled rehabilitation therapy evaluation. Informed V6 that R229 did not formulate individualized care plan based on admission fall assessment done on 1/9/24 indicating that she is at high risk for falls due to history of falls with injury. Fall care plan was not updated until 1/15/24 after R229 had unwitnessed fall with injury dated 1/13/24. R229's hospital record dated 1/13/24 indicated a [AGE] year-old female with past medical history of Hyperlipidemia, Hypertension, Gastro Esophageal Reflex Disease, Depression, Anxiety, Thyroid, Coronary Artery Disease, Dementia presenting with chief complaint of fall from nursing home on left side present with pelvic pain found to have pelvic fracture. She had right femur intermedullary nail fixation right femur in [DATE]. She complaint of pain 10/10. Ortho consult. Diagnosis: Acute traumatic left pelvic fracture. Imaging: Acute left ischial pubic ramus and tuberosity fractures, minimally displaced. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review Post fall investigation completed by V6 Restorative Nurse dated 1/15/24 indicated: Unwitnessed fall with injury: fracture of left pubis. 1/13/24 at 15:10. Resident's room. Attempting to stand or transfer. Awake, confused, poor safety awareness. At risk for fall. History of falls 12/21/23 from home. Root cause analysis: She was last noted sitting on the bed. R229 attempted to ambulate to the bathroom without assistance or using the call light. Interventions to address incident: The resident was sent to the hospital for evaluation. Upon return her room was moved closer to nursing station, she was given ultra-low bed. On 5/15/24 at 2:10PM, V9 Fall Coordinator said that interim care plan intervention is formulated within 24 hours after resident admission. Resident who is at risk for fall should have fall preventions interventions in placed based on fall assessment and resident needs upon admission. On 5/15/24 at 2:48PM, Informed V1 Administrator and V2 Director of Nursing (DON) of above concerns. On 5/15/24 at 5:58PM, V27 Registered Nurse (RN) said that she completed the unwitnessed fall incident report of R229, but she did not observe R229 on the floor. The agency nurse who worked on 7a-3p shift 1/13/24 was the one who observed R229 on the floor after she fell and assessed her. V27 said that the incident was endorsed to her, and she sent R229 to the hospital for evaluation. On 5/16/24 at 10:12AM, Surveyor requested V2 DON for the nurse and CNA who worked with R229 to be interviewed. On 5/17/24 at 10:45AM, V38 Agency Nurse said that she worked with R229 the day she (R229) fell on 7a-3p shift. V38 said that R229 fell during shift change. V38 said that R229 is high risk for fall. V39 said R229 had unwitnessed fall in her room. She was found sitting on the floor next to her bed, R229 said that she wanted to go to the bathroom. R229 was assisted with 2 persons assist using mechanical lift back to bed. R229 denied any pain. R229 was sent to the hospital for evaluation. V39 Agency CNA who worked with R229 on the day of the fall was not available for interview. 2. On 5/14/24 at 10:48AM, Observed R53 lying in bed on slanting position (R53's head was on the left side of the bed with her forehead touching the side rail and her feet are on the right side of the foot part of the bed). The bed is on high position (approximately 30 inches from the floor) with bilateral floor mats on the side of bed. Called V17 CNA (Certified Nurse Assistant) and V18 Agency RN (Registered Nurse) who are assigned to R53 and showed observation made. Both said that R53's bed should be on the lowest position. V18 took the bed control on the right side of the bed, away and out of reach from R53. V18 adjusted the bed to the lowest position. V18 said that R53 had breakfast in bed and probably who ever pick up her breakfast tray forgot to put her bed in the lowest position after eating. V17 CNA denied that she picks up R53's breakfast tray after she ate. On 5/14/24 at 12:12PM, V9 Fall Coordinator said that she is responsible for ensuring implementation of fall prevention policy. V9 said that one of their fall prevention interventions is providing low bed. Resident on low bed should be always on the lowest position when in bed. V9 said that R53 is at high risk for fall, had history of falls and on fall prevention monitoring risk. Informed V9 of above observation made with R53. V9 said that R53 is on low bed and should be in the lowest position when in bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/15/24 at 10:12AM, V2 DON said that they are expected to implement fall care plan interventions to prevent falls. On 5/15/24 at 2:48PM, Informed V1 Administrator of above concerns. R53 is admitted on [DATE] with diagnosis listed in part but not limited to Metabolic encephalopathy, Pain in left knee, Dementia. Admission fall assessment dated [DATE] indicated that R53 is at high risk for fall due to history of falls. Care plan indicates that R53 is at risk for falls related to current medication use, poor safety awareness, unsteady gait, and disease process. Intervention: Bed should be in a lowest possible position. R53's most recent fall incident dated 9/11/23 indicated unwitnessed fall without injury from bed in her room. Facility's policy on Fall occurrence revised 7/17/23 indicates: Policy statement: to ensure that residents are assessed for risk for falls, that interventions are put in place and interventions are re-evaluated and revised as necessary. Procedures: 1. A fall risk assessment form will be completed by the nurse or the falls coordinator upon admission, readmission, quarterly, significant change and annually. 2. Those identified as high risk for falls will be provided fall interventions. 3. If resident has fallen, the resident is automatically considered as high risk for falls. Facility's policy on Care Plan Revised 7/27/23 indicates: Policy statement: to ensure all care plans including base line care plans are in conjunction with the federal regulations. Procedures: 1. During admission, the facility may put in place baseline care plans within 48 hours to address resident's care. 2. The baseline care plan at minimum should include initial goals based on admission orders, physician orders, dietary orders, therapy services, social services and PASARR recommendations if applicable.