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	03/19/2026

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

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow requirements by failing to submit an initial and final report, for an injury of unknown origin (of serious bodily injury), to the State Agency in a timely manner. This failure affected one (R1) of three residents reviewed for abuse. R1 sustained a displaced right hip fracture that required an emergency surgical fixation of right basicervical femoral neck with cephalomedullary nail.Findings include:R1 is [AGE] year-old admitted on 1/`9/2026, with diagnosis including, but not limited to End stage renal disease, difficulty walking, not elsewhere classified, cognitive communication deficit, other symbolic dysfunction, other complications of vascular dialysis catheter, adult failure to thrive, pressure ulcer of sacral region stage 2, essential primary hypertension, atypical atrial flutter etc.On 3/17/2026 at 10:28AM, V3 (DON) said that she spoke to R1's daughter (V4) (on 3/6/2026) who said that R1's hip was not looking right. R1 went to therapy but complained of pain to the nurse (agency staff) who reported to the unit manager, the unit manager got an order for X-ray and Tylenol. V4 did not want to wait any longer for the x-ray people to come to the facility, wanted resident to be sent out and they sent R1 out per family request. The facility initiated an investigation once they found out from the hospital that R1 had a fracture.R1's progress notes document on 3/6/2026 at 16:41, family requested for patient to be transferred to hospital for dislocated hip. R1's progress notes document on 3/6/2026 at 22:53, spoke with ER (emergency room staff), patient admitted at this time. R1's progress notes document on 3/6/2026 at 23:34, Resident admitted to (hospital) with Right hip fracture. Incident report dated 3/7/2026 (initial), allegation type: injury of unknown origin. Date and time report was sent to Illinois Department of Public Health (IDPH) 3/7/2026, time 11:00AM. Date and time staff became aware of incident 3/7/2026, 10:00AM. The report states in part: R1 was admitted to facility for therapy and medical management on 1/19/2026. R1 complained of hip pain, the nurse practitioner (NP) ordered X-ray and Tylenol as needed, Tylenol was administered, resident's daughter was in the facility and requested resident to be sent to hospital for further evaluation, resident sent out family request. Upon following up with emergency room staff, R1 is admitted for right hip fracture, there has been no fall or injury at the facility since admission, investigation initiated. Final report for the same incident presented by facility documented 3/17/2026 12:00PM (the same day surveyor requested for the report) as the date report was sent to IDPH.On 3/17/2026 at 3:52 PM, surveyor presented this observation to V1 (Administrator), and she said, I forgot to send it, I forgot that I completed it but did not send it. Abuse and retaliation policy revised 1/29/2026 states in part: It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property exploitation, neglect or mistreatment.Under types of abuse, the policy listed among others involuntary seclusion, exploitation, injury of unknown origin, etc.Injury of unknown origin are injuries that meet all 3 criteria according to the State operational manual (SOM):a. The source of the injury was not observed by any person.b. The source of the injury could not be explained by the residents,c. The injury is suspicious because of the extent of the injury or the location of the injury (e.g. the injury is in an area not generally vulnerable to trauma) or the number of (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	injuries observed at one point in time or the incidence of injuries over time.Under reporting/ response, the policy states in part, all allegations of abuse and retaliation will be reported to IDPH immediately not exceeding 2 hours after the initial allegation is received. A final investigation will be submitted to IDPH within 5 working days.