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	06/28/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure a resident who is dependent with staff assistance for ADL (Activities of Daily Living) was checked and changed every two hours and as needed in accordance with facility's incontinence policy. This failure affected 1 (R4) of 3 residents reviewed for incontinence care in the sample of 9.The Findings include:On 06/26/2026 at 10:48am with V5 (Assistant Director of Nursing) inside R4's room, there was a strong smell of urine in R4's room. V5 checked R4's incontinence brief. R4 stated the last time the staff came in to check her brief was before breakfast.On 06/26/2026 at 10:51am, R4's incontinence brief was fully soaked with urine. R4 stated she was last changed before breakfast. On 06/26/2026 at 10:55am, V5 checked the incontinence pad and flat sheet underneath R4. V5 turned R4 to her left side; the flat sheet was wet, and the incontinence pad had brownish stain formed at the border between the wet and dry areas of the incontinence pad. V5 stated the flat sheet, incontinence pad, and her (R4) gown are all wet and there's brownish staining on the incontinence pad. On 06/27/2026 at 10:32am, V6 (Certified Nursing Assistant/CNA) stated she has been at the facility for a year. She was assigned to (R4) on 06/26/2026. V6 stated she started at 6:30am and she checked R4 between 6:30am - 6:40am and informed R4 she will get a shower once she's done checking everyone and after she got the linens. V6 stated she tried to take R4 to the shower, but she could not because she was busy attending to other residents. V6 stated she was expected to check and change her assigned residents every two hours and as needed. V6 stated she was not able to check her assigned residents every 2 hours because she was still trying to get up her assigned residents who were mostly dependent residents. On 06/27/2026 at 1:51pm, V2 (Director of Nursing) stated the expectation is for the resident to be checked and changed every two hours and as needed to prevent skin alteration and skin breakdown. The importance of providing ADL (Activities of Daily Living) care timely is for skin integrity and patient dignity. Some residents cannot care for themselves, and they depend on staff to do it. On 06/27/2026 at 3:52pm, V1 (Administrator) stated the expectation is for staff to check and change residents every 2 hours and as needed. The brownish stain formed at the border between the wet and dry areas of the incontinence pad means the checked and changed likely extended beyond 2 hours. R4's admission Record documented that this resident's diagnoses include but are not limited to COPD (Chronic Obstructive Pulmonary Disease), morbid obesity, hypertension. R4's (05/19/2026) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 11. Indicating the resident's mental status as moderately impaired. Section GG. GG0130. Self-Care. B. Oral hygiene. C. Toileting hygiene. E. Shower/Bathe self. F. Upper body dressing. G. Lower Body dressing. I. Personal hygiene. Coded: 1 - Dependent.R4's (01/29/2025) Nursing Admission/readmission documented, in part VII. Call Light Evaluation. 1. Is this resident cognitively able to use the call light. A: Yes. R4's (Target Date: 08/17/2026) care plan documented, in part has for alteration of bowel and bladder functioning related to incontinence. Will remain free from skin breakdown due to incontinence and brief use. Keep call light within reach. Remind, offer and assist with toileting as needed. R4's (target date: 08/17/2026) care plan documented, in part restorative nursing. Has an alteration in normal elimination rt (related to) decreased bladder tonicity. Display occasional bladder and bowel incontinence. Will be able maintain neat/clean/free from smell (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of body odor/urine. Incontinence: I would like the staff to check me for incontinence episode every shift and prn. I would also need assistance to wash, rinse and dry my perineum. I would also need assistance to change clothing PRN after incontinence episodes. The (undated) meal time documented that breakfast was from 7:15am to 8:30am. The (05/20/2022) Certified Nursing Assistant Job Description documented, in part Summary/Objective In keeping with our organization's goal of improving the lives of the Guests we serve, the Certified Nursing Assistant (C.N.A.) plays a critical role in providing superior customer service and nursing care to all Guests. The C.N.A. safeguards the health, safety and welfare of all Guests under their care by following applicable laws, regulations, and established nursing policies and procedures. Essential Functions: 1. Provides quality nursing care to Guests in an environment that promotes their rights, dignity and freedom of choice. 2. Provides individualized attention, which encourages each Guest's ability to maintain or attain the highest practical physical, mental and psychosocial well-being. 3. Carry out assignments required for the Guest's activities of daily living (ADL's) which include but not limited to bathing, dressing, grooming, toileting, and feeding. 4. Attends to individual needs of all Guests in regard to incontinent care, transferring, ambulation, range of motion, communication and other needs. 5. Provides care that maintains each Guest's skin integrity to prevent pressure ulcers, skin tears and other damage by changing incontinent Guests.The (6/30/25) Incontinence and Perineal Care documented, in part Policy Statement: It is the policy of the facility to provide perineal care to ensure cleanliness and comfort to the resident, to prevent infection and skin irritation, and to observe the resident's skin condition. Procedures: Do rounds at least every 2 hours to check for incontinence during shift. The (9/25) Residents' Rights for People in Long-Term Care Facilities Ombudsman Program documented, in part You have the right to Safety and good care. Your facility must provide services to keep your physical and mental health, and sense of satisfaction.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review the facility failed to ensure eye drops were available for administration as ordered, failed to administer medications timely in accordance with prescriber orders, and failed to ensure the prescriber was notified when medication was not available for administration. This failure affected 5 of 5 (R3, R6, R7, R8, R9) residents reviewed for medication administration in the sample of 9. The Findings include:1. On 06/26/2026 at 12:05pm, R3 stated sometime in May 2026, the nurses would tell her they did not have her eye drops in the med cart. R3 stated she did not know their names. R3 stated she had cataract surgery, and she has glaucoma. R3 stated she was supposed to get eye drops with green cap on both eyes in the morning and purple cap in the evening, but the nurse said they could not find her eye drops.R3's (05/2026) MAR (Medication Administration Record) documented that R3 had missed medication doses from 05/26/2026 through 05/31/2026 which also documented that V7 (Licensed Practice Nurse/LPN) and V8 (Registered Nurse/RN) were assigned to R3 when R3 missed doses of her medication. On 06/26/2026 at 1:42pm, V7 (LPN) stated she did not see her medication in the med cart; she needed a refill, and she reordered the medication in the electronic health record platform. V7 stated that when she identified it was missing, she reordered the medication right away.On 06/26/2026 at 2:15pm, V7 stated she informed the nurse supervisor, but she did not document she informed the supervisor. V7 stated she did not notify R3's Health Care Provider.On 06/26/2026 at 1:55pm, V8 (RN) stated when she found that the medication was not available she informed the unit manager that the med is unavailable, and she called the pharmacy. V8 stated she sent the order and the medication arrived that day she reordered it after her shift.On 06/26/2026 at 2:18pm, V8 stated the Nurse Practitioner (NP) was in the room with her (R3) and she (R3) reported to the NP that the facility was missing the eye drops. V8 stated she did not document in the chart that the Nurse Practitioner was aware R3's medication was missing.R3's (Date Range: 05/25/2026 - 06/01/2026) Progress notes were reviewed with no documentation of notification of Provider for missed medications on 05/26/2026 - 05/31/2026. 2. On 06/26/2026 at 10:30am, during the medication administration task with V4 (Agency LPN), V4 opened the EHR/electronic health record; some residents are still on red. V4 stated the residents are still in the red because the morning medications are not administered yet. V4 stated the residents who have not received their morning meds are (R6, R7, and R8) and she just administered R9's medications.R9's Medication Audit report dated 6/26/2026, showed R9 was prescribed Aricept 5 mg (milligrams) scheduled to be administered at 8:30 am, multiple vitamin and ascorbic acid 500 mg scheduled to be given at 09:00 am. These medications were documented as administered at 10:38 am. R9 also had ketotifen fumarate ophthalmic 0.035% solution, 2 drops to be instilled in both eyes, scheduled to be administered at 6:00am and 6:00 pm. The documentation showed R9's eye drops were administered at 7:10 am and 8:05 pm on 6/26/2026. 3.R6's medication audit report dated 6/26/2026, showed R6 had gabapentin 100 mg prescribed to be given three times per day, metformin 500 mg, 2 tabs, to be given twice per day, baclofen 10 mg to be given three times per day and senna 8.6 mg, 2 tablets, to be given every 12 hours.R6's medication audit report showed gabapentin was scheduled to be given at 8:30 am, 1:30 pm and 5:30 pm, and was administered at 11:21 am, 12:43 pm and 5:57 pm on 6/26/2026.R6's medication audit report showed metformin 200 mg, 2 tablets was scheduled to be administered at 8:30 am and 5:30 pm and was administered at 11:21 am and 5:57 pm on 6/26/2026.R6's medication audit report showed baclofen 10 mg was scheduled to be given at 8:30 am, 1:30 pm, and 5:30 pm, and was administered at 11:21 am, 12:34 pm and 5:57 pm on 6/26/2026.R6's medication audit report showed senna 8.6 mg, 2 tablets was scheduled to be administered at 9:00 am and 9:00 pm and was administered at 11:18 am and 8:26 pm on 6/26/2026. 4. R7's medication audit report showed R7 was prescribed docusate sodium 100 mg twice a day, and was scheduled to be given at 08:30 am 8:00 pm, lidocaine cream 4% external apply topically to both knees and right ankle, every 12 hours for pain, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	scheduled for 9:00 am and 9:00 pm and Tylenol oral tablet 325, 2 tablets, every 12 hours for pain and was scheduled for 9:00 am and 9:00 pm. R7's medication audit report documentation showed R7 was administered docusate sodium scheduled 8:30 am dose was administered at 11:16 am. R7's documentation showed the 9:00 am dose for both lidocaine topical and Tylenol 650 mg were administered at 11:17 am. The next dose of Lidocaine topical was administered at 8:27 pm and the next dose of Tylenol 650 mg was given at 8:28 pm, both administered less than 12 hours apart as scheduled. 5.R8's medication audit report showed R8 was prescribed Procardia XL 60 mg. extended-release tablet, 1 tablet scheduled to be given every 12 hours scheduled for 9:00 am and 9:00 pm. The medication audit documentation showed that R8 was administered Procardia medication at 10:38 am and 8:39 pm on 6/26/2026. On 06/26/2026 at 10:34am, V5 (Assistant Director of Nursing) stated the expectation with medication administration is to administer the medication within one hour before and one hour after the schedule. V5 stated the importance of administering the medication within that timeframe is because these medications are vital for the residents' health; if it is a blood pressure medication, the facility did not want to administer it late to prevent blood pressure elevation and cause further damage to the resident. V5 stated the expectation is for the nurse to call the doctor that the medication was given late and to follow the order of the doctor if an order is given.On 06/27/2026 at 1:35pm, V2 (Director of Nursing/DON) stated the expectation if a resident missed a dose of medication is to notify the resident's provider, to ask if they need to give an alternative medication or to get an order to administer once delivered. V2 added it is important to notify the doctor to communicate what is going on to the resident.On 06/27/2026 at 1:38pm, V2 (DON) stated the rights of medication of administration include the right person, right dose, right time, medication, and route. Medication should be administered one hour before and after the schedule. If the medication was given late, the expectation is for the nurse to call the provider, to communicate that the medication was given late and to get an order to monitor the resident; it is also expected to document that the provider was notified. The Facility's policy title Medication Pass, dated 7/2/2025, showed it was the policy of the facility to follow all applicable laws and both stated and federal regulations regarding all medication pass procedures.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review, the facility failed to ensure a resident who is dependent on staff assistance with ADL (Activities of Daily Living) care had a functioning call device. This failure affected 1 (R4) of 1 resident reviewed for call device in the sample of 9 residents. The Findings Include: On 06/26/2026 at 10:39am, R4's call device cord was wrapped on the right-side rail. R4 stated she had been calling but nobody seemed to notice. When R4 to activated the call device; no light illuminated on the call device box attached to the wall or on the overhead indicator box outside of R4's room.On 06/26/2026 at 10:47am, V5 (Assistant Director of Nursing) pushed R4's call device. V5 stated there was no light that was lit on the call device box and on the overhead light indicator outside of R4's room. On 06/26/2026 at 11:00am, V20 (Maintenance Director) tested R4's call device, no light was lit on the call device box. V20 unwound the call device cord from the side rail and stated they should not have tied the cord on the side rail because when they raised the head of the bed up, it pulled the cord off the call device box. V20 stated they should have just clipped the call device to the resident's gown or sheet. V20 showed this surveyor the clip from the old called device. V20 stated all call devices have clips. V20 stated he checked her (R4) call device and it did not turn on. He replaced it with a new call device. V20 stated he told them all the time that they are not supposed to tie the cord of the call device on the siderail because it could break. V20 stated the facility should provide a working call device to the resident so they could tell the nursing staff they need help.On 06/27/2026 at 1:48pm, V2 (Director of Nursing) stated call device should be within reach and functioning. The purpose of giving a functioning call device so the resident can notify staff when they need assistance. If the call device is not functioning then the resident will not be able to get assistance in a timely manner. V2 stated the call device should not be wrapped on the siderail and it should clipped be within the resident's reach. If the cord is wrapped in the siderail, it could get frayed and malfunction.On 06/27/2026 at 3:50pm, V1 (Administrator) stated the call device should be functioning so the resident could call the staff for assistance outside of the regular rounding of every 2 hours and as needed.R4's admission Record documented that this resident's diagnoses include but are not limited to COPD (Chronic Obstructive Pulmonary Disease), morbid obesity, hypertension.R4's (05/19/2026) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 11. Indicating the resident's mental status as moderately impaired. Section GG. GG0130. Self-Care. B. Oral hygiene. C. Toileting hygiene. E. Shower/Bathe self. F. Upper body dressing. G. Lower Body dressing. I. Personal hygiene. Coded: 1 - Dependent.R4's (01/29/2025) Nursing Admission/readmission documented, in part VII. Call Light Evaluation. 1. Is this resident cognitively able to use the call light. A: Yes.R4's (Target Date: 08/17/2026) care plan documented, in part has for alteration of bowel and bladder functioning related to incontinence. Will remain free from skin breakdown due to incontinence and brief use. Keep call light within reach. Remind, offer and assist with toileting as needed.R4's (target date: 08/17/2026) care plan documented, in part Restorative nursing. Has an alteration in normal elimination rt (related to) decreased bladder tonicity. Display occasional bladder and bowel incontinence. Will be able maintain neat/clean/free from smell of body odor/urine. Incontinence: I would like the staff to check me for incontinence episode every shift and prn. I would also need assistance to wash, rinse and dry my perineum. I would also need assistance to change clothing PRN after incontinence episodes.The (6/30/25) Call Light Policy documented, in part Policy Statement: It is the policy of this facility to ensure that there is prompt response to the resident's call for assistance. The facility also ensures that the call system is in proper working order.The (9/25) Residents' Rights for People in Long-Term Care Facilities Ombudsman Program documented, in part You have the right to Safety and good care. Your facility must provide services to keep your physical and mental health, and sense of satisfaction.