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 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. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview, and record review the facility failed to ensure appropriate restorative services consistent to resident's functional need is provided to a resident with a limitation of range of motion to both upper extremities. This deficiency affects one (R30) of three residents in the sample of 32 reviewed for Restorative Nursing Program. Findings include: On 5/14/24 at 11:15AM, Reviewed list of residents on Braces /Splint program presented by V5 Unit Manager. V5 said that R30 is on bilateral hand splint to prevent contractures. Surveyor and V5 went to R30's room. Observed R30 lying in bed without bilateral hand splint. R30 has bilateral wrist hand and elbow flexion contractures. Observed 1 hand splint on top of bedside drawer. V5 Unit manager searched for the other hand splint but unable to locate. R30 said that she has only using left hand splint. R30 said that she has cannot move both of her hands/arms without assistance. On 5/14/24 at 11:28AM, V6 Restorative Nurse said that she ensures provision of restorative program to the residents such as Braces and splints. Review list of residents on Braces and Splints with V6. She said that R30 is on Restorative program for bilateral hand splint due to her bilateral contractures. V6 said that the restorative aide is responsible to apply the splint during that day and off at bedtime. They usually apply it around 8am. V6 said that Splint and braces should have physician order and care planned. Review R30's medical records with V6. No order found for bilateral hand splint on active physician notes. No care plan was found for using bilateral hand splint due to limitation of ROM. R30's Restorative assessment done quarterly dated 1/1/24 and 4/1/24 indicated that R30 has limitation of ROM on left shoulder, left elbow and left wrist and hand. She in on splint assistance on left hand. V6 said that she applied bilateral splint because she noticed limitation of movement on her right hand. R30 was discharged from occupational therapy on 1/10/23 and was referred to Restorative nursing for application of left-hand splint (carrot) to prevent further contractures. V6 said that R30 was not re-evaluated by occupational therapy. On 5/15/24 at 10:47AM, V6 Restorative Nurse said they do not have policy or procedure guidelines in splint application. On 5/15/24 at 11:11AM, V25 Therapy Director said that she received order to evaluate R30 for bilateral hand splint, but she has to wait for insurance approval due to Medicaid provider. V25 said that R30 was provided occupation therapy services on 11/16/22 to 1/10/23. R30 was referred to Restorative Nursing program on 1/10/23 for left hand splint /carrot splint and Passive ROM to left upper extremity to prevent further contractures. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R30 is admitted on [DATE] with diagnosis listed in part but not limited to Primary Generalized osteoarthritis, Intervertebral disc degeneration lumbar region, Chronic Respiratory Failure with hypoxia. R30's Restorative program assessment dated [DATE] and 4/1/24 indicated that she has limitation in ROM (range of motion) in the following areas: Left shoulder, left elbow, Left wrist and hand. She is on splint or brace assistance program on left hand. R30's MDS (minimum data set) assessment dated [DATE] did not mark that she is on splint assistance program. R30's Active physician order sheet and comprehensive care plan did not indicate that she is on bilateral hand splint as indicated in facility's monitoring list for residents using Splints/Braces. R30's Occupational Therapy discharge summary for date of service 11/16 22 to 1/10/23 indicated: discharged recommendation: Restorative program for ROM and Splint /brace. ROM program- PROM to left arm for all range. Splint/brace Program- to wear carrot hand splint to left hand 4 hours daily to improve ROM and prevent further contractures. Review R30's active physician orders dated 5/15/24 and 5/16/24 indicated: Bilateral palm guard on in am and off in pm. Occupational therapy evaluation and treatment. Review R30's updated care plan dated 5/15/24 indicated she is on a splint and or brace assistance program musculoskeletal impairment. Interventions: Splint/brace program. Please provide assistance and supportive device as needed bilateral palm guard. On 5/17/24 at 11:30AM, Review R30's Occupational Therapy evaluation dated 5/16/24 with V25 Therapy Director. V25 said that they did occupational evaluation for R30 due to exacerbation of decrease in ROM, decrease coordination, joints stability, limited and painful movement, pain and reduced ADL participation. R30 was referred for orthosis assessment for both hands. R30 has history of arthritis and contractures. Musculoskeletal assessment: She has impaired ROM to both right (RUE) and left upper extremities (LUE). She has impaired ROM on right shoulder, elbow, and forearm. She has impaired ROM on left shoulder, elbow/forearm, wrist, hand, thumb, index finger, middle finger, ring finger, little finger. R30 has functional limitation due to present of contractures. Facility's policy on Restorative Nursing Program revised 7/28/23 indicates: Policy statement: it is the policy of this facility to assess for comprehensive nursing and restorative needs upon admission. Procedures: 2. Appropriate nursing and restorative services consistent to the resident's functional needs must be provided. If the assessment shows the resident needs therapy, then therapy should be provided. 3. Nursing and Restorative Services may include the following: c. Contracture Prevention and Management ii. Splint/Orthotic management 4. Nursing and restorative services shall be reflected in the resident's individualized care plan consistent to the completion of the resident comprehensive assessment. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Restorative program shall be reflected and indicated in the resident's electronic restorative log in order to document the provision of services and the frequency by the nurses, CNAs (certified nursing assistant), and restorative aides. Facility unable to provide policy and procedure for splint application.

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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.

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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** 39781 Based on observation, interview, and record review the facility failed to ensure ongoing assessment and implementation of catheter care to resident with indwelling urinary catheter. This deficiency affects one (R48) of three residents in the sample of 32 reviewed for Catheter Care Management. Findings include: On 5/15/24 at 10:24AM Observed R48 lying in bed with Low air loss mattress. Observed indwelling catheter with brownish, yellow-colored sediments attached inside the lining of the catheter tubing. The urinary drainage has privacy bag. Called V5 Unit Manager/Infection Coordinator and showed observation made. V5 assessed R48's indwelling catheter tubing. Noted the entire catheter tubing from the urinary catheter connectors down to the urinary drainage bag has brownish, yellow-colored sediments attached inside the lining of the catheter tubing. V5 said that indwelling catheter care is rendered every shift to prevent catheter associated urinary tract infection. Any changes in color of the urine or formulation of sediments should be called to the physician. V5 said she will have the floor nurse change R48's catheter tubing immediately. 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, Sepsis, Bacteremia. Active physician order indicates Indwelling catheter 16FR, 30cc balloon Reason for use: Sacral wound. Change indwelling catheter drainage bag as needed for monitoring. Indwelling catheter care every shift and as needed for monitoring and documenting output. Care plan indicates she is at risk for alteration of bowel and bladder functioning related to decreased mobility. Interventions: Catheter care every shift and as needed. Change catheter catheter per facility protocol or physician order. Monitor urine/catheter output every shift. R48's Medication Administration Record indicates monitor and record catheter catheter output every shift has missing documentation dated 5/5/24 (7-3 shift), 5/6/24 (11-7 shift), 5/14/24 (7-3 and 3-11 shift) On 5/16/24 at 10:58AM, Review R48's indwelling catheter assessment with V2 Director of Nursing (DON). Informed V2 that R48's quarterly assessment dated for 3/11/24 and 5/15/24 are both signed on 5/15/24. No quarterly catheter assessment done prior to 3/11/24. R48 was initially admitted on [DATE]. On 5/16/24 at 1:10PM, V5 Unit Manager/Infection Coordinator said that R48 has history of UTI (urinary tract infection). R48 was on antibiotics for UTI when she was readmitted from hospital on 3/10/24. Review R48's McGeer Criteria for infection dated 3/10/24. On 5/16/24 at 2:28PM, Informed V1 Administrator of above concerns. Facility's policy on Urinary Catheter Care revised 7/28/23 indicates: Purpose: to prevent catheter-associated urinary tract infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Changing Catheters: 1. Changing indwelling catheter or drainage bags at routine, fixed intervals is not recommended. Rather, it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction or when the closed system is comprised. Complications: 1. Observe the resident for complications associated with urinary catheters. b. Check the urine for unusual appearance (i.e., color., blood, etc.) Documentation: 4. Character of urine such as color (straw-colored, dark, or red) clarity) cloudy, solid particles or blood) and odor. Facility's policy on Indwelling catheter revised 7/28/23 indicates: Policy statement: to ensure that no resident will have indwelling catheter, unless condition shows that there is a medical reason to justify the use of indwelling catheter. Procedures: 4. A care plan for the use of catheter will be made per policy 5. The use of indwelling catheter will be assessed at least quarterly to determine if use still justified. 9. An indwelling catheter may be changed as needed (PRN). Urine bag will be changed on PRN (as needed) basis.

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

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50469 Based on observation, interview and record review, the facility failed to label foods being thawed inside the refrigerator. This failure has the potential to affect all 159 residents currently residing in the facility. Findings include: On 05/14/2024 at 10:15AM during initial kitchen tour with V4 (Dietary Manager), the refrigerator was observed with unlabeled food thawing. V4 verified and identified the food as chicken breast, ham, turkey, ground beef, and a pitcher of orange juice. On 05/14/2024 at 10:20AM V4 said that the food thawing should all be labeled. On 05/15/2024 at 10:19AM Informed V1 (Administrator) of above observation made. V1 said that the expectations of food being thawed referred to facility policy. Review of facility policy with section entitled Food Safety/ Thawing and Food Handling Standards and Procedures on Labeling Processes developed on 05/08/2023 indicated the following: Policy: Thawing Ensure food is only thawed using one of these four approved methods: 1. In refrigerators operating at <40F (<4C) 2. Under cold running water that's <70F (<21C) ensuring product is completely sealed to prevent cross-contamination and fully submerge under water line. 3. In a microwave, if food is fully cooked immediately after 4. As part of the cooking process 5. Ensure all foods are labeled correctly during thawing. Policy: The facility will follow 8. Labeling Processes Standards and Procedures 8.1.1. Prepared Foods Definition Inclusive of any ingredients or foods that have been washed, prepped, sliced, cooked, assembled, opened, thawed, or otherwise processed within Aramark food service establishments. 8.1.2. TCS Refrigerated Food Label Requirements- - These food labels intended for storage must include this information: (continued on next page)

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	145734	A. Building B. Wing	05/17/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Item Name - Preparation Date - Use-by Date (within 7days of preparation or opening commercially-prepared TCS foods) - Employee Initials Procedure: Labeling Requirements By Food Type, Preparation/Process, and Packing TCS foods will be stored, dated and labeled in the refrigerator held at 41F for a maximum of 7 days. The count begins on the day thawing starts.

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	145734	A. Building B. Wing	05/17/2024

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49871 Based on observation, interview, and record review, the facility failed to implement appropriate use of Personal Protective Equipment (PPE) during high contact care activities on a resident with urinary catheter and on Enhanced Barrier Precaution (EBP). This facility also failed to perform hand hygiene before donning new pair of gloves after incontinence care. These failures affect 2 of 5 residents (R137, R140) reviewed for infection control in a sample of 32. Findings include: 1. On 5/15/2024 at 01:44 PM observed V30 (Certified Nursing Assistant/CNA) without gloves on while emptying R140's urinary catheter bag. R140 on Enhanced Barrier Precaution (EBP) On 5/15/2024 at 01:45 PM V30 stated he should used gloves while emptying the catheter bag. On 5/15/2024 at 02:03 PM V5 (Infection Control Nurse) said staff should use gown and gloves when emptying the catheter bag and must do handwashing after the task. On 5/15/2024 at 02:25 PM V2 (Director of Nursing/DON) said gown and gloves must be worn while emptying the urinary catheter bag. Order Summary Report: Diagnoses include malignant neoplasm of prostate, Pseudomonas aeruginosa, pressure ulcer of sacral region. 4/4/2024: Suprapubic catheter, catheter size: 16FR (french), 30ml (milliliter) balloon, Reason for use: pressure ulcer of sacral region, stage 3 Care Plan Focus: R140 is on Enhanced Barrier Precaution to prevent further infection due to Dialysis, urinary catheter and wounds. Interventions: Ensure that gown and gloves are used during high-contact resident care activities Policy Name: Enhanced Barrier Precaution, Revised 10/23/23 Policy: The facility will use Enhanced Barrier Precautions (EBP) to reduce transmission of multi-drug resistant organisms in the nursing homes. EBP involves the use of gowns and gloves to reduce transmission of resistant organisms during high-contact resident care activities for residents known to be colonized or infected with MDROs as well as residents with wounds and/or indwelling medical devices. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procedure: 1. EBP will be used for any resident in the facility: Has indwelling medical devices (e.g. central line, urinary catheter, feeding tube, tracheostomy/ventilator) 3. The EBP requires the use of gown and gloves during high-contact resident care activities Examples of high-contact resident care activities requiring gown and glove use among residents that trigger EBP use include: g. Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. 39781 2. On 5/14/24 at 12:25PM, Observed V20 CNA (Certified Nurse Assistant) provided incontinence and changed bed sheets/linens to R137. Observed V20 removed gloves and donned new pair of gloves without performing hand hygiene. Informed V20 of observation made that she did not perform hand hygiene after removing her gloves. V20 said she just forgot it. V20 said she should perform hand hygiene after removing gloves, before putting new pair of gloves. On 5/14/24 at 12:40PM, Informed V3 Assistant Director of Nursing (ADON) of above observation made. V3 said that they are expected to perform hand hygiene after removing of gloves and before donning new pair of gloves. R137 is admitted on [DATE] with diagnosis listed in part but not limited to Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, Mixed receptive expressive language disorder, Dementia, Muscle wasting and atrophy. Facility's policy on Hand hygiene revised 7/28/24 indicates: Policy statement: Hand hygiene is important in controlling infections. Hand hygiene consists of either hand washing or the use of alcohol gel. The facility will comply with the CDC. Guidelines in regard to hand hygiene. Procedures: 1. Hand hygiene using alcohol based is recommended during the following situations: i. After removing gloves