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	04/30/2026

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 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** Based on observation, interview, and record review, the facility failed to provide adequate supervision and failed to ensure fall precautions were implemented to prevent falls. These failures affected three residents (R12, R91, and R197) in a sample of 67 residents. This failure caused harm to R197, as evidenced by sustaining a right humorous fracture and traumatic hematoma on R197's forehead and contributed to R197's death 2 days after the fall.Findings include: R197's face sheet documents R197 was a [AGE] year-old resident with a prior medical history of chronic obstructive pulmonary disease, dementia without behavioral disturbance, restlessness and agitation, iron deficiency anemia, contusion of the head, and displaced supracondylar fracture of the right humerus. R197's minimum data set (2/4/2026) documents R197 had a brief interview of mental status summary score of 3, indicating R197 had severe cognitive impairment. R197 required substantial/maximal assistance with personal hygiene (including washing/drying face) and required partial/moderate assistance with transferring. Facility final incident report (3/12/2026) to the department documents R197 experienced an unwitnessed fall in her room. At approximately 6:00 AM, (V72- Certified Nursing Assistant) provided ADL and incontinence care and transferred R197 to the wheelchair. R197 wanted to remain in her room. (V72) left R197 in the room unsupervised and continued morning rounds. Staff heard R197's roommate yelling for help and observed R197 on her left side with a hematoma to the head. R197 told staff that R197 was trying to reach down and pick something up off the ground when R197 slid off the wheelchair. R197 was wearing non-skid socks and the environment was dry. R197 was treated at the hospital and diagnosed with a closed fracture of the right humerous. The facility was given instructions to follow up with an orthopedic physician and the plan of care was updated to address the needs of R197. R197's care plan documents R197 is at high risk for falls related to unsteady gait and dementia. R197 had goals of being free from fall related injury. Interventions to address the high fall risk in place included, I prefer to keep all needed items like water pitcher, tissue box, urinal, etc, within reach (2/27/2025), : I would like staff to provide me a safe environment: even floors, free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; Side rails as ordered, handrails on walls (2/27/2025), Remind me to ask for assistance. Reorient me on how to use the call light, if necessary (2/27/2025), Please make sure that my call light is within my reach and encourage me to use it for assistance as needed. I would like staff to address my needs with a prompt response to all requests for assistance. >Fall Mats/Early Riser. R197 also required assistance from staff for hygiene. R197's care plan was not updated to include any new interventions after the fall sustaining injury on 3/5/2026, as indicated in the facility report. There was no care plan developed or revised to address the fracture of the right humerus, splint use, monitoring of (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	neurological decline/injury after R197 sustained head injury. This review directly contradicts the facility's report that The plan of care has been updated to address the needs of (R197). R197's hospital records (3/5/2026) document R197 presented to the emergency department from emergency medical services (EMS) from the nursing home after suffering a fall. Per EMS, R197 was sitting in the wheelchair and reached for an object on a table and subsequently fell and hit head against the ground. R197 was unable to recall what happened. Imaging was completed and R197 was diagnosed with 1) closed supracondylar fracture of right humorous 2) fall 3) traumatic hematoma of forehead. R197 was discharged to the facility and asked to follow up with primary care in 1-2 days. R197's progress notes document on 3/5/2025 at 6:36 AM, (R197) was sitting in wheelchair when she leaned too far forward reaching for something and fell out of wheelchair striking head. Pt noted with hematoma, soft BP, slightly hypoxic requiring o2 application, amd on Asa. Due to culmination of all of this will refer to ED for eval. At 7:56 AM, (Private Ambulance Company) here to transport resident to (hospital) for eval. Resident is leaving in stable condition. At 10:57 PM, Resident returned from (Emergency Department), after a fall. Dx: closed supracondylar fx rt humerus, and traumatic hematoma to her forehead. Right arm is placed in a splint., intact and elevated. Resident is alert and oriented to baseline. Resident placed in bed and made comfortable, call light within reach. Fall precautions in place, plan of care ongoing. There is no progress notes documented in the records until 3/7/2026 at 12:02 PM, LATE ENTRY Note Text : 9:10am While rounding resident observed resting in bed comfortably. 10:30am Resident offered medication and tolerated well writer took vitals BP 119/62, hr 88, r-18, O2-98%. 11:11am CNA was rounding on resident and noted in bed unresponsive to name. CNA alerted writer. Writer assessed resident and resident noted in bed unresponsive to verbal stimuli, painful and tactile stimuli. Writer verified code status, resident is a full code. Writer unable to palpate carotid or radial pulse. 11:12am Code blue initiated, CPR started and 911 called. AED applied with no shock advised. CPR continues with vitals unable to be obtained. CPR ongoing. 11:20am Evergreen Park paramedics and fire department arrive at the facility and took over compressions. 11:30am (Nurse Practitioner) notified of clinical status. 11:40am (V70 - Family Member) notified of change in condition and stated that (V70) was in route to the facility. 11:46am Paramedics CPR efforts cease and was pronounced deceased by (physician) 11:50am (EMS) left facility.12:00pm Postmortem care initiated. R197's death certificate (3/24/2026) documents R197's cause of death was organic cardiovascular disease and significant conditions contributing to death but not resulting in the underlying cause were multiple injuries due to fall(s), and chronic obstructive pulmonary disease. The death certificate indicates the injuries that contributed to R197's death occurred on 3/5/2026 at the nursing home and the injuries occurred from a fall and sustained injury. On 4/28/2026 at 1:01 PM, V71 (Physician, Forensic Pathologist) affirmed V71 is a medical physician and forensic pathologist for the coroner's office. V71 affirmed V71 completed the medical review of R197's death. V71 explained the coroner's office was notified by the police on 3/7/2026 of R197's death and the police believed R197's death was of natural causes. Later, the coroner's office was notified by the funeral home. The funeral home told the coroner's office R197 had hit her head in a fall recently before the fall. The coroner's office requested records from the facility to rule out if an autopsy was needed. V71 explained that a medical review was conducted in lieu of an autopsy. V71 stated, There is a small chance that a (brain) bleed could have developed after the CT was obtained by the hospital. But altered mental status or other neurological symptoms would start to develop. They (the facility) does not have good documentation from when (R197) got home on [DATE]) and then nothing (documented) until (R917) ended up passing. I can't speak to whether they were (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	providing the care or not, but I would have expected if there was a change in condition they would have sent (R197) back to the hospital. V71 reviewed the findings of the medical record review and explained, Yes, we believe the falls did contribute to (R197's) death. We listed the cause of death to be organic cardiovascular disease, which is a blanket diagnosis for things related to hypertension, renal dysfunction, etc. that cause cardiac arrest. We think the falls contributed to the death for multiple reasons. Multiple traumatic injuries, especially with elderly individuals with a natural disease process, we might not normally think of an arm fracture to be super traumatizing, right? But it can put a lot of stress on a body because there will be internal bleeding, blood loss, especially when someone has anemia and being [AGE] years old. I think (R197) had a cardiac event that caused her death, but that the diagnosis of COPD (chronic obstructive pulmonary disease) and multiple falls with fractures contributed to that cardiac event. It's hard to say for sure if (R197) would be alive today if (R917) did not have the falls and fractures, however, it seemed like (R197) was fairly stable prior to the fall. Given the proximity of the fall to the death, we do believe they are related. I feel like with injuries related to falls, it only comes as the cause of death if it is a large fracture like a femur fracture, those put a very large amount of stress on the body that you can't ignore. As for a humorous fracture, I can't say the fracture is the reason for the death, but I do think it contributed. R197's neurochecks initiated after the fall on 3/5/2025 document V73 signed neurochecks as complete on 3/13/2026 and 3/15/2026, V69 signed neurocheck as complete on 3/14/2026, and V75 (Agency Registered Nurse) signed neurochecks as complete on 3/13/2026. R197's post-fall follow up Day 1 2/3 was signed by V69 on 3/14/2026 as complete. Day 2 (1/3, 2/3) were signed by V75 as complete on 3/13/2026. Day 2 (3/3) was signed as complete by V73 on 3/14/2026. There was no post fall charting completed for day 3 after the fall. On 4/28/2026 at 2:02 PM, V18 (House Supervisor/Licensed Practical Nurse/Falls Nurse) affirmed V18 oversees the fall prevention program for the facility and assists with fall investigations. V18 recalled R197 was confused at baseline, alert and oriented to self, and had a history of dementia. R197 had a history of impulsiveness but believed R197's behaviors were more at nighttime. R197 would frequently go to the dining room and self-propel the wheelchair with R197's feet. V18 reviewed R197's electronic health record and affirmed R197's last fall before the fall on 3/5/2026 was on 3/2/2025. The root cause was R197 trying to get up unassisted from bed so R197's care plan was updated to have R197 on an early riser program so R197 would be up and in the dining room in the early morning on 3rd shift. V18 also added fall mats to R197's floor to prevent injury. V18 recalled R197 was gotten up by the nurse aide (V72), put R197 in the wheelchair in R197's room and went to go assist another resident to dialysis. R197 was left unsupervised in the room. (V72) heard the roommate screaming, so (V72) went back to the room and observed R197 on the ground. R197 was laying on her left side on the floor and there was a large hematoma to R197's forehead. R197 said she was reaching for something on the ground. There wasn't anything on the ground in the reports. (V73, Licensed Practical Nurse) was the nurse that assessed R197 and sent her to the hospital. R197 came back in a sling. V18 believed R197 could safely be unsupervised as long as R197 was not in bed and in a wheelchair as all of R197's fall history was related to being in bed and not a wheelchair. V18 reviewed R197's electronic health record and the investigative reports related to the incident. V18 affirmed the floor mats were not in place at the time of the fall. V18 explained the purpose of the floor mats is to prevent injury from falls. V18 stated, I don't know if I would have the fall mats on the ground when (R197) was up in the wheelchair. You couldn't roll the wheelchair on them, so while she is in the wheelchair, I don't know if they would be on the ground. Yes, based on the care plan the fall mats should have been there. V18 affirmed that R197's care plan was not updated after the fall to address the new fracture or head injury. V18 explained the facility completed post-fall charting and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	neurological checks after the fall to check for level of consciousness, neurological decline. V18 affirmed the last neurocheck was due at 10 AM and was not completed by the nurse but all other neurochecks were completed. Observed the neurocheck charting and post fall charting with V18 and noted multiple neurocheck entries and post fall entries were charted on or after 3/13/2026 (6+ days after the resident had passed away). V18 explained the purpose of charting timely is to ensure accuracy of the records and make sure changes in condition were not missed. V18 recalled coming back from a leave and noticed they were completed but not signed out so V18 had to notify the non-compliant nurses and have them complete their charting. V18 confirmed that R197's death was not expected and believed the fall had been reported to the state survey agency by V2 (Director of Nursing). On 4/28/2026 at 3:47 PM, V35 (Licensed Practical Nurse) affirmed V35 was assigned to care for R197 in the past and was familiar with R197. V35 recalled R197 was confused, on a pureed diet, needed assistance feeding herself, and needed medications crushed. R197 was impulsive and frequently had behaviors, such as trying to get up from the wheelchair. V35 stated, We tried to keep her in the dining room as much as possible so we could have better supervision of her. I tried to keep her there as much as I could. I don't think it would be safe to leave her along in the room especially in the middle of the day. Maybe you could in the early morning, but sometimes (R197) was resistive to care on our shift. V35 denied any knowledge of the fall or seeing R197 after the fall before her death. On 4/28/2026 at 3:51 PM, V69 (Licensed Practical Nurse) affirmed V69 was assigned to care for R197 in the past and was familiar with R197. V69 described R197 a small, little woman who was confused, emotionally labile, and could be easily agitated. V69 expressed V69 would not feel comfortable leaving R197 in the room unsupervised unless maybe if R197 was sleeping in bed. R197 was impulsive and frequently tried to get up from her wheelchair unassisted. V69 affirmed V69 was assigned to care for R197 when she came back from the hospital and completed neurochecks. V69 didn't recall anything abnormal with R197's neurological status. V69 did not recall completing the neurochecks or the fall follow up at a later date, but affirmed V69 did them while caring for R197. On 4/28/2026 at 4:29 PM, V74 (CNA Supervisor) affirmed V74 was familiar with R197 and cared for R197 in the past. V74 recalled R197 was a night shift get up (Early Riser) program, was often restless, and confused. V74 denied V74 was present for R197's fall or death. V74 explained, I wouldn't feel comfortable leaving (R197) in a room alone, (R197) would think that (R197) could do things on her own, like stand up without assistance. On 4/29/2026 at 11:01 AM, V29 (Social Worker) affirmed V29 was assigned to R197's unit as the social worker. V29 affirmed R197 heard from staff reports that R197 would frequently try to get up unassisted. V29 denied V29 saw R197 after the fall or before she had passed. V29 affirmed based on R197's BIMS score, R197 has severe cognitive impairment. V29 stated, Yeah, based on (R197's) cognition, I don't know if I think it is safe that (R197) was left in a room unsupervised. On 4/29/2026 at 12:21 PM, V70 (Family Member) recalled R197's care at the facility. V70 explained, (R197) always thought she could walk. She thought she could get up. This isn't the first time this has happened, (R197) had multiple falls at other nursing homes too. (R197) had broken hips and elbows before from falling. A few days before (R197 passed), (R197) had a fall and (R197) broke her arm and hit her head. I saw (R197) after she passed, there was a lump on her head from when she fell the other day. I was told she hit her head from the fall. I told that to the funeral home when they were asking and they said they wanted to call the coroner to make sure they didn't want to do an autopsy. They said a lot of times when head injury is involved, they want to complete an investigation. I did (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	talk to the coroner, and they said her cause of death was organic cardiovascular disease and multiple injury from falls, I have the death certificate here. (R197) was not on oxygen, we weren't really expecting it. At baseline (R197) was very confused. I don't think (R197) necessarily should have been left in the room because of her dementia. She can think she can walk. it's obvious now she can't. They (staff) treated (R197) good, but it was a Saturday. The regular people that took care of her probably weren't there. (R197) probably had newer caregivers that didn't know her that well. Maybe they didn't know she was at risk (for falling). On 4/29/2026 at 12:58 PM, V54 (Certified Nursing Assistant) recalled being assigned to R197 the day R197 had expired. V54 recalled, (R197) was pretty confused. I didn't really have a lot of behaviors with her on my shift, but I know she had behaviors on second shift. On the day (R197) passed, I was assigned to care for her in the morning. That morning, (R197) didn't eat much for breakfast. She was like holding food in her mouth. She didn't really want to eat. She was so tired, it was like she didn't sleep at all that night. I wouldn't say she had any unexpected weakness, she was probably weak from being that tired though. I reported it to the nurse. A little bit later, I went back on my next rounds and she was unresponsive. I yelled out for the nurse and they called for the code blue. We all did compressions, there were people everywhere. She was in bed that day and not in the dining room. I heard she tried to get up unassisted before. I don't recall if she had floor mats. On 4/29/2026 at 3:57 PM, V72 (Certified Nursing Assistant) affirmed that V72 was assigned to care for R197 the day R197 fell. V72 explained on the day of the incident V72 got R197 dressed and situated and gave R197 a warm washcloth to wash her face. V72 locked R197's wheelchair and left R197 in her wheelchair unsupervised next to her bed in her room. V72 went to another resident's room to get them ready for dialysis. About 5 minutes after, V72 heard screaming coming from R197's room and could saw R197 on the ground of her room by the wheelchair. V72 recalled R197 telling the nurse (V73) she had arm pain, and R197 had a large hematoma on the right side of her head that was approximately the size of a baseball. V72 recalled (V73) stayed with R197 until the resident was with EMS. V72 denied there were any floor mats in R197's room during the incident. V72 stated, I wasn't aware R197 was supposed to have floor mats. V72 affirmed R197 was a high fall risk and stated, Yes, that's why (R197) is a night shift get up. V72 stated, No, leaving (R197) alone in the room wasn't safe. V72 explained R197 was left unsupervised because another resident needed to go to dialysis. On 4/29/2026 at 4:15 PM, V2 (Director of Nursing) affirmed V2 was familiar with R197 and completed the investigation into the fall. V2 explained R197 needed assistance with ADLs, was alert and oriented to self, forgetful and was impulsive. R197 would try to get things without assistance. V2 affirmed R197 needed increased supervision because of the behaviors. V2 affirmed that V2 completed the investigation and recalled V72 observed R197 on the floor of her room. Was sent to the hospital, subsequently diagnosed with a humorous fracture, contusion to the head, and sent back to the facility. V2 affirmed the facility staff completed neurochecks and V2 had talked to the staff that had cared for R197 prior to her death and they did not report any signs of a change in condition. V2 affirmed R197's death was not expected and that the death was not reported to the state survey agency. V2 stated, If I felt like the fall was related to (R197's) death was related to the fall, I would have reported that. I don't think the fall is related, no personally, she fell and then passed, nothing really stuck out to me. Fractures are a reportable incident, the death is not reportable. V2 accessed R197's electronic health record. V2 affirmed that facility staff should be following the care plan and the care plan was not revised to include the humorous fracture diagnosis or head trauma. V2 affirmed that a plan of care should have been developed. V2 stated, Yes, (R197) should not have been left alone. We have educated V72. V2 reviewed the post-fall charting/neurochecks and affirmed multiple entries were signed as complete on 3/13/2026. V2 stated the facility standard is to be charting as (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	you go, so you don't miss anything. If charting isn't completed timely, it may not be as accurate. Record review of the facility nursing schedule indicates V69 (Licensed Practical Nurse), V73 (Licensed Practical Nurse), V75 (Agency Registered Nurse), and V76 (Agency Licensed Practical Nurse) were assigned to care for R197 after the fall occurred and before R197 expired. On 4/30/2026 at 10:35 AM, V75 (Agency Registered Nurse) affirmed V75 was assigned to work AM and PM shift on 3/6/2026. V75 could not remember any details about the shifts or R197. V75 could not remember if V75 completed neurochecks on any resident while at the facility. V75 denied any knowledge of charting neurochecks or fall follow up documentation after the shifts on 3/13/2026. V75 stated, Yeah, I worked my day there with my agency and haven't been back. I haven't been back to chart anything late, I don't remember doing that. On 4/30/2026 at 12:45 PM, V73 (Licensed Practical Nurse) affirmed V73 was assigned to care for R197 on 3/5/2026 when R197 fell and 3/6/2026 the following night before R196 expired. V73 recalled R197 was confused and impulsive at baseline and incontinent. On night shift, R197 was typically sleeping through the night but was an early riser get up. V73 recalled on 3/5/2026, V73 gave R197 medication between 4-5 AM and R197 was in bed. Around 6:30 AM, V73 was sitting in the nurses station and V72 came to V73 and stated R197 fell. V73 initiated fall protocols and assessed R197 for injury. One arm was moving better than the other and R197 had a large hematoma to her forehead that was about the size of a golf ball. V73 applied an ice pack to R197's head, started neurochecks and notified EMS. V73 denied any abnormal findings during neurological assessment. V73 denied observing floormats on the floor of R197's room. V73 stated, R197 was on the floor on the ground of the room, there was no mat. V73 stated, Hmm . should (R197) be left alone in the room? Well, I don't think any resident should be in a wheelchair while in the room unsupervised. I remember (V72) told me (V72) was getting another resident up when (R197) fell. V73's late charting of the post fall/neurochecks was reviewed with V73. V73 stated, I don't recall doing my charting late, I thought all of it was in there. I did double check my work. All of the neurochecks should be documented prior to the end of shift, that is the standard. I don't recall why it says I completed them after. On 4/30/2026 at 1:27 PM, V76 (Agency Licensed Practical Nurse) affirmed V76 was assigned to care for R197 when R197 passed. V76 explained V76 was working an agency shift at the time. Someone had called in so they had an urgent agency need and V76 picked up the shift, arriving at approximately 9:00 AM and began passing medications. V76 did not get report from the off going nurse V76 recalled seeing R197 during med pass at around 9:45, but did not complete a neurological check. R197 stated, Nothing really seemed off. R76 was in bed, watching the news and we had a typical conversation. I didn't notice any disorientation or confusion or tiredness. Nothing seemed out of the ordinary. I didn't get report from the offgoing nurse so I don't know why (R197) wasn't up in the dining room. I didn't do a neurocheck. When residents need a neurocheck, I usually, come in and ask them questions. I don't want to have them feel like they are being examined. I talk to them about things like what is on television, regular conversations to see if they are alert in general. I did not assess (R197's) orientation but (R197's) speech seemed ok. R197 was able to move her limbs and I didn't recall anything abnormal. I didn't ever use a pen light to assess for pupil reactivity. Around 11, the CNA told me R197 was unresponsive. So, I went and assisted with CPR along with the other staff until EMS took over. There were no floormats that I could remember in her room. The general care policy (revised 6/30/25) states it is the facility's policy to provide care for every resident to meet their needs. Upon admission or readmission, the facility will evaluate the resident for physical and psychosocial needs. Physical needs would include but are not limited to ADL (Activities (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	of Daily Living). The facility will assist the resident to meet these needs. Record review of CMS' Resident Assessment Instrument (RAI) Manual (October 2025) documents in part, Falls result in serious injury, especially hip fractures . DEFINITIONS INJURY RELATED TO A FALL Any documented injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall. INJURY (EXCEPT MAJOR) Includes, but is not limited to, skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the resident to complain of pain. MAJOR INJURY Includes, but is not limited to, traumatic bone fractures, joint dislocations/ subluxations, internal organ injuries, amputations, spinal cord injuries, head injuries, and crush injuries. A fall refers to unintentionally coming to rest on the ground, floor, or other lower level or as a result of an overwhelming external force (e.g., being pushed by another resident). A fall without injury is still a fall. Falls are a leading cause of morbidity and mortality among the elderly, including nursing home residents. Falls may indicate functional decline and/or the development of other serious conditions, such as delirium, adverse medication reactions, dehydration, and infections. A potential fall is an episode in which a resident lost their balance and would have fallen without staff intervention .The information gleaned from the assessment should be used to identify and address the underlying cause(s) of the resident's fall(s), as well as to identify any related possible causes and contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause(s) of the resident's fall(s), as well as the factors that place them at risk for falling . R91 is [AGE] years old and has a history of hemiplegia/hemiparesis following cerebral infarction affecting the left non-dominant side, a history of falling, anemia diabetes, atrial fibrillation, osteoporosis and dizziness. On 3/9/2026 R91's Brief Interview of Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. Minimum Data Set (MDS) dated [DATE] Section GG indicated that R91 had impairment of both upper and lower extremities and required substantial/maximal assistance, in which the helper does more than half of the effort, with toileting hygiene which includes the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. On 04/27/2026 10:28 AM R91 stated R91 called for help on 2/10/2026 because R91 had to have a bowel movement and did not want to have an accident. R91 got to the bathroom, slid off the toilet, tried to catch the wheelchair to prevent a fall, but because the wheelchair was not locked, R91 slid to the floor. On 4/28/2026 at 11:02 V18 (House Supervisor/Licensed Practical Nurse/Fall Prevention Coordinator) stated R91 needs assistance going to the bathroom. On 2/10/2026 R91 was in the dining room and needed to go to the bathroom. Activity staff brought R91 from the dining room to R91's room and left R91 unattended. R91 went to the bathroom, slid off the toilet, and fell. V18 stated activities staff should have stayed with R91. V18's expectation is that the activities staff should have assisted R91 back to the room and handed R91 off to the nurse or CNA, not leave R91 in the room alone knowing that R91 had to go to the bathroom. On 4/29/2026 at 1:58 AM V32 (Certified Nursing Assistant) stated V32 was working when R91 fell. R91 had to go to the bathroom. An activity aide brought R91 back to the room and left R91 unattended. R91 tried to go to the bathroom without assistance and fell. On 4/29/2026 at 2:43 PM V2 (Director of Nursing/DON) stated R91 was at risk of falling based on the (continued on next page)

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	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Actual harm Residents Affected - Few	12/2025 Minimum Data Set (MDS) Section GG. V2 stated that V45 (Restorative Nurse/Licensed Practical Nurse) completed the MDS. If V45 felt that R91 needed assistance, V45 should have communicated the concern about R91's fall risk. V2 stated, This fall could have been prevented. Better communication could have prevented this fall. R91's Minimum Data Set (MDS) Section GG dated completed 12/18/2025 at 10:59 AM by V45 (Restorative Nurse/LPN) documented that for Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment, R91 needed substantial/maximal assistance. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear, R91 required substantial/maximal assistance. Toilet transfer: The ability to get on and off a toilet or commode., R91 required partial/moderate assistance. R91's care plan originally dated 10/23/2025 and revised 12/18/2025 stated: R91 is at high risk for falls. Goal is that R91 will be free of falls through next period. Interventions included: a working and reachable call light and encourage R91 to use it for assistance as needed, staff to address needs with a prompt response to all requests for assistance, and prompt toileting. R91's Resident Interview Notes dated 2/10/2026 and provided by the V18 (Fall Prevention Coordinator) documented: Is resident able to transfer independently? Answer: no. Transfer device used by resident regularly? Answer: gait belt. R12 is [AGE] years old and has a history of atrial fibrillation, hypertensive urgency, myocardial infarction, history of fall with facial bone fractures 12/22/2025, difficulty walking, anemia, diabetes, dementia and abnormalities of gait and movement. On 4/9/2026 R12's BIMS score was 11 indicating moderate cognitive impairment. Minimum Data Set (MDS) dated [DATE] Section GG indicated that R12 required partial/moderate assistance, in which the helper does less than half of the effort, with toileting hygiene which includes the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. On 4/28/2026 at 10:47 AM V18 (House Supervisor/LPN/Fall Prevention Coordinator) stated R12 had a fall in December 2025. R12 had a heart attack which was thought to cause the fall. On 2/7/2026 R12 slipped trying to get on the toilet and fell after the wheelchair moved. Prompt toileting, closer observation of R12 and making sure R12 locks the wheelchair may have prevented the fall. R12's Resident interview note dated 2/7/2026 documented: Is the resident able to transfer independently? Answer: no. What was the resident doing that resulted in the fall? Answer: Trying to put self on toilet. Transfer device used by resident (regularly). Answer: Gait belt. Fall occurrence policy dated 6/30/2025: It is the policy of the facility to ensure that residents are assessed for risk for falls, that interventions are put in place, and interventions are reevaluated and revised as necessary.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, interview, and record review the facility failed to provide evening snacks to residents. This failure affected four (R91, R101, R102, 125) out of four residents reviewed for evening snacks. This failure has the potential to affect all residents residing in the facility. Findings:Facility census (4/27/2026) documents 164 residents reside in the facility.On 04/27/2026 at 10:28 AM R91 stated I've been losing weight, but I don't eat a lot. I eat snacks in between meals. We don't always get snacks at night for a variety of reasons. Mainly, the staff says we didn't get them (snacks) tonight. Other residents say that the staff eat the snacks. R91's electronic health record (EHR) documentation of R91's weight on 10/1/2025 was 147.4 pounds. On 04/06/2026, R91 weighed 136.2 pounds. R91 experienced a 7.6% weight loss in six months.On 04/27/2026 at 10:38 AM R102 stated the facility quite often does not have snacks in the evening. Staff say they don't have snacks at night, so you just have to go to sleep and wait until breakfast the next day. On 4/28/2026 at 8:43 AM R101 stated staff say they don't have any snacks sometimes. It happened two nights ago. R101 wanted a snack, but staff said they did not have any snacks to give R101.On 4/7/2026 at 1:30 PM Resident Council members stated that residents do not get enough snacks. The facility provides snacks on a tray in the evening, but there are not enough for every resident who wants a snack. R125 asked for a snack every day for three months and got a snack only once in those three months. Resident Council stated diabetic residents are supposed to get snacks, but they don't always get a snack in the evening. Some residents are fortunate enough to have a family or friends who bring snacks. For the residents who do not have family or friends to bring snacks, they go without. The Certified Nursing Assistants (CNAs) sometimes eat the snacks.On 04/28/2026 at 3:15 PM V7 (Dietary Manager) stated snacks are sent to the units between 6 PM and 7 PM. On each cart is a snack for residents who are on a list to receive snacks. The resident's name is on the snack. V7 stated when Illinois Department of Public Health was at the facility about three weeks ago, V7 started to put extra snacks on the cart because V7 heard that residents who wanted a snack weren't getting one. V7 heard yesterday at the stand-up meeting, the facility's daily morning meeting, that residents were saying they are not getting snacks, but they were not on the list to get a snack. Nurses distribute snacks. V7 was not sure if staff are eating the snacks instead of providing them to residents. V7 stated It is possible.On 4/29/2026 at 11:01 AM V7 (Dietary Manager) stated breakfast leaves the kitchen at 7:30 AM and service begins at 7:45 AM. The last breakfast tray is served around 8:35 AM daily. Dinner is served at 4:25 PM (over 14 hours between dinner and breakfast). If a resident is on the snack list, they should get a snack. If a resident is not on the snack list, V7 sends snack crackers, You know, whatever we've got as extra snacks.On 4/29/2026 at 11:36 AM V55 (Regional Clinical Nutrition Manager) stated snacks are delivered in the evening to each unit. Snacks are delivered to the nurses station and passed by nursing. It is a resident's right to get a snack.Review of facility task for the last 30 days, to the question Did Resident Take a Snack , the electronic health records reflects that R91 had no response on 4/11/2026, 4/14/2026, 4/25/2026, 4/26/2026 or 4/28/2026. R101 had no response on 4/25/2026 or 4/28/2026. R102 had no documentation on 4/14/2026, 4/19/2026, 4/25/2026 or 4/28/2026. R135 had no documentation on 4/2/2026, 4/4/2026, 4/5/2026, 4/7/2026 through 4/15/2026, 4/17/2026, or 4/22/2026 through 4/26/2026. None of the residents were documented as being on hospital leave on the dates that no snacks were documented as received or declined by the resident.Review Minimum Data Set (MDS) Section F to the question How important is it to you to have snacks available between meals?, R91 answered very important on 9/24/2025. R101 answered very important on 10/20/2025. R102 answered somewhat important on 11/12/2025. R125 answered very important on 2/26/2026.Facility policy titled Bedtime Snacks reviewed 6/26/2026 stated the facility must offer snacks at bedtime daily.

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	145734	A. Building B. Wing	04/30/2026

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, facility failed to dispose of garbage and refuse appropriately, failed to ensure dumpster lids were covered, failed to ensure garbage, including food/drink waste and medical waste were properly contained. This failure affected all 164 residents that reside within the facility.Findings include:Facility census (4/27/2026) documents 164 residents reside in the facility.On 4/27/2026 at 11:17 AM, observed facility dumpsters with scattered garbage on the ground including, but not limited to, PPE (gloves), cans, food wrappers, and soiled boxes. One dumpster lid was fully open and another could not fully close due to large boxes filling the dumpster and trash bags. Directly adjacent to the garbage area, observed piles of refuse including dead leaves, cigarette butts, food wrappers, drink containers, that covered approximately 15% of the smoking area. Approximately 60% of the area had cigarette butts on the ground. V7 (Dietary Manager) observed the areas and confirmed these findings. V7 was unsure the reason why the dumpster lids were supposed to be closed. V7 reported that the garbage/refuse disposal responsibility lies with housekeeping/maintenance.On at 7/27/2026 at 11:45 AM, observed the dumpster area and the vicinity with V8 (Maintenance Director). The garbage/refuse was still observed on the ground around the dumpsters and in the direct vicinity, and the dumpster lids were still open and contained the same refuse. V8 confirmed these observations. V8 affirmed there was garbage, cigarette butts, and other refuse on the ground and that the dumpster lids were open. V8 stated, Yes, the dumpster lids should be closed and garbage should be in the dumpster. The lids need to be closed because otherwise the wind will pick up the trash inside and it will go everywhere. It also attracts pests like raccoons and can cause a pest control problem. On 4/28/2026 at 6:59 PM, V1 (Administrator) stated via email communication that the facility does not have a garbage/refuse/dumpster policy.The manual Residents' Rights for People in Long-Term Care Facilities (Revised 11/18) documents in part .Your facility must be clean, safe, comfortable, and homelike.

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	145734	A. Building B. Wing	04/30/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow policy and procedure; failed to ensure staff appropriately doff appropriate personal protective equipment (PPE) after performing high contact care on one resident; failed to ensure staff don appropriate PPE when performing high contact resident care for one resident; failed to ensure the EBP (enhanced barrier precaution) sign was posted on one resident's door; and failed to implement appropriate measures for the transport and containment of clean linen throughout the facility. These failures affected three residents (R17, R65, and R165) residents reviewed for infection control and have the potential to affect all 164 residents residing at the facility. Findings include: On 4/27/26 at 9:32AM, V1 (Administrator) stated the facility census is 164 residents residing at the facility. On 04/27/2026 at 10:36am in R65's room, R65 was lying on bed. There was a dressing on his left forearm. Inquiring about the dressing on his left forearm, R65 stated he is on dialysis and staff applied dressing after dialysis. Surveyor checked R65's door, there was no EBP sign posted. On 04/27/2026 at 10:43am, V23 (Clinical Care Coordinator) stated he (R65) should be placed on EBP and there should be an EBP sign posted if he really is on dialysis so staff know they should wear gown and gloves prior to rendering ADL care to resident. On 04/27/2026 at 11:12am, V3 (Assistant Director of Nursing) checked R65's dressing on his left forearm and stated residents getting dialysis via an AV (Arteriovenous) fistula access do not need to be placed on EBP but since he still has the dressing, he should be on EBP and should have an EBP sign posted to let the staff, family, and visitor know he is at risk of getting infection; to prevent bringing infection to the resident. On 04/28/2026 at 10:47am, there was a clean linen cart outside of R165's room and an EBP (Enhanced Barrier Precautions) sign posted by his door. V42 (Certified Nursing Assistant) stated she was doing Patient Care to R165. Inside R165's room, there was a basin on the sink with water and towels; V42 was touching R165's sheets and gown; V42 was wearing gloves, with no isolation gown on. On 04/28/2026 at 10:52am, outside of R165's room with V43 (Licensed Practical Nurse). Inquiring about the use of gloves and gown when providing care to a resident on EBP, V43 stated staff should wear gown and gloves when providing adl (activities of daily) care to residents to prevent cross contamination, to prevent infection. This surveyor requested V43 to do an observation of V42. V43 knocked on R165's door, opened the door, and saw V42 rendering care to R165. V43 entered the room and told V42 you should wear a gown. V43 stated she is not wearing a gown, and she should have when performing high contact care to a resident for infection control. On 04/28/2026 at 2:07pm, V2 (Director Of Nursing) stated if residents have dressing, it should be classified as EBP because they don't know what is in the dressing. The purpose of placing a resident on EBP is to prevent any type of infection and there should be an EBP sign posted. If a resident has any opening, that is an entry point for infection. (continued on next page)

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	145734	A. Building B. Wing	04/30/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/28/2026 at 2:14pm, V2 (Director Of Nursing) stated staff are expected to don isolation gown and gloves when rendering high contact care to residents, if the staff anticipate touching a resident then the staff should don appropriate PPE like gown and gloves. The purpose is for infection control. R65's (Active Order As Of: 04/27/2026) Order Summary Report documented, in part Diagnoses: (include but are not limited to) dependence on renal dialysis, heart failure, and fluid overload. Order Summary: AV Fistula, location: Left Arm. Hemodialysis 3 times per week every day shift every Mon, Wed, Fri. Active. Order Date: 04/19/2026. R65's (04/27/2026) care plan documented, in part Focus: is on Enhanced Barrier Precaution is at risk for infection. Dialysis – AV Fistula. Goal: Potential spread of infection will not occur. Ensure that gown and gloves are used during high-contact resident care activities (like dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, Device care or use for those with central line, urinary catheter, feeding tube, tracheostomy/ventilator, and Wound care for any skin opening requiring a dressing) that provide opportunities for transfer of MDROs to staff hands and clothing. R165's admission Record documented that R165's diagnoses include but are not limited to hemiplegia (paralysis) and hemiparesis (muscle weakness), muscle wasting and atrophy of right and left shoulder, and multi focal osteomyelitis, hypertension. R165's (04/18/2026) Minimum Data Set documented, in part Section C. – Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 10. Indicating the resident's mental status as moderately impaired. R165's (Active Order As Of: 04/28/2026) Order Summary Report documented, in part Order Summary. Left foot cleanse with normal saline solution, apply betadine soaked gauze every day shift Tuesday, Thursday, and Saturday and as needed for wound care. Active. 04/27/2026. Right great toe: cleanse with normal saline solution, pat dry, paint betadine, lota (leave open to air) everyday shift Tuesday, Thursday, and Saturday and as needed. On 4/27/26 at 10:25 AM, V49 (contract phlebotomy staff) was observed doffing personal protective equipment (PPE) in the hallway, outside of R17's room. V49 stated she knows the procedure to doff PPE is inside the room but did not see the garbage can in the R17's room. R17's garbage can was observed inside the room under the alcohol hand rub. V49 then stated she just saw it the garbage can. R17's face sheet documents diagnoses that include but are not limited to osteomyelitis of vertebra, sacral and sacrococcygeal region, local infection of the skin and subcutaneous tissue, and diabetes mellitus due to underlying condition with diabetic neuropathy. R17's Nursing Care Plan dated 4/7/26 documents, in part, is on Enhanced Barrier Precaution and at risk for infection. R17 has wounds, and foley with a history of Candida auris of the urine & PICC/Midline. and interventions that documents, in part, Ensure that gown and gloves are used during high-contact resident care activities(like dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, Device care or use for those with central line, urinary catheter, feeding tube, tracheostomy/ventilator, and Wound care for any skin opening requiring a dressing) that provide opportunities for transfer of MDROs to staff hands and clothing. On 4/27/26 at 11:48am, accompanied by V52 (Laundry Manager/Accounting Manager), a tour of the (continued on next page)

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	145734	A. Building B. Wing	04/30/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	facility's laundry room was conducted. Four clean linen carts were observed. V52 said that the four clean linen carts are used for transporting the clean linen throughout the facility to replenish the stock. V52 stated that the clean linen carts are covered during transport but was not sure if the bottom shelves of the clean linen cart were required to be solid (barrier-type shelf) for infection control purposes. V52 said, This is what we (facility) always have used. On 4/28/26 at 1:45pm, upon observation of the clean linen carts near the laundry area, with V3 (ADON/Assistant Director of Nursing) and V4 (Infection Preventionist/IP), six clean linen carts, prepared in the laundry area for transport and distribution throughout the facility to replenish point-of-use supplies, were observed to be covered; however, they lacked protective measures (solid bottom shelves) to prevent potential contamination and the spread of infection. The six metal carts were equipped with open, grated bottom shelves, which did not ensure cleanliness or adequately protect the linens from potential contamination by microbes, dust, dirt, debris, spills, or moisture during transport from the facility's clean laundry area to points of use throughout the facility. V3 (ADON) and V4 (IP) confirmed that the open, grated bottom shelves on the linen carts do not prevent environmental contamination of clean linens. V4 (IP) said, The bottom open shelving exposes the linen to dirt and debris that can pop up from the floor. Facility census dated 4/27/26, documents 30 residents residing on Unit 400 at the facility. On 4/27/26 at 10:15 a.m. one clean linen cart at point of use on unit 400 (between rooms 413-416) was not covered and contained. Two corners of the mesh cover on the left side and right sides of the cart cover were ripped and hanging off the corners of the clean linen cart, exposing the clean linen. On 4/29/26 at 11:00 a.m. One clean linen cart (same cart observed on 4/27/26 at 10:15 a.m.) at point of use on unit 400 (between rooms 408-412) was not covered and contained. Two corners of the mesh cover on the left side and right sides of the cart cover were ripped and hanging off the corners of the clean linen cart, exposing the clean linen. On 4/29/26 11:00 AM V50 (Certified Nursing Assistant/CNA) affirmed the clean linen cart next to room [ROOM NUMBER] had tears on two sides and the cart was not covered and contained. On 4/29/26 11:10 AM V54 (Certified Nursing Assistant/CNA) affirmed the clean linen cart next to room [ROOM NUMBER] had rips on two corners and the cart was not covered and contained. Record review of facility's policy titled, Linen Handling by Laundry Staff, dated 6/30/25, documents, in part, It is the policy of this facility to wash linens and clothes to produce hygienically clean laundry. Procedures: All laundry staff will be trained upon hire how to handle regular soiled linens and isolation linens and clothing properly, to avoid cross-contamination. Clean linens will be brought to the floor in a cart that prevents contamination from the environment. Clean linens may be placed in a clean linen room or left in the cart that is protected from the environment. The (9/16/25) Enhanced Barrier Precaution documented, in part 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. PROCEDURE: EBP will be used for any resident in the facility: With Open wound/s (pressure ulcer, diabetic ulcer, venous ulcer, arterial ulcer, unhealed surgical wounds, etc) whose drainage can be contained by dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	This generally includes residents with chronic wounds, and not those with only shorter-lasting wounds, such as skin breaks or skin tears covered with a Band-aid or similar dressing. 3. The EBP requires the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of XDROs to staff hands and clothing. Use of eye protection may be necessary when splash or spray may occur. Examples of high-contact resident care activities requiring gown and glove use among residents that trigger EBP use include: b) Bathing/showering. 7. An EBP sign should be posted on the doors of each resident on EBP. The (6/30/25) Infection Prevention and Control documented, in part Policy Statement: The facility has established a policy to Identify, Record, Investigate, Control, Test, and Prevent infections in the facility. The facility will also maintain a record of incidents and corrective actions implemented for the identified infection. 8. A sign will be provided outside the room for residents on transmission-based precaution indicating the type of the precaution (Contact, Droplet, or EBP). Record review of Pamphlet titled, Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities, revised date 11/18, documents, in part, Your facility must provide services to keep your physical and mental health, at their highest practical levels. Your facility must be safe, clean, comfortable, and homelike.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview and record review, the facility failed to ensure dryer lint traps were clean and without damage to provide a safe environment for the residents. These failures affect all 164 residents residing at the facility.Findings include:On 4/27/26 at 9:32AM, V1 (Administrator) stated the facility census is 164 residents residing at the facility.On 4/27/26 at 11:48am, accompanied by V52 (Laundry Manager/Accounting Manager), a tour of the facility's laundry room was conducted. V52 opened the lint compartment for dryer #4 and the lint compartment floor had loose lint on the floor, and the lint screen was fully covered with lint. V52 said, There shouldn't be that much lint. V52 said that the dryer lint compartments are cleaned every hour and the staff document when the lint screens are cleaned. V52 opened the lint compartment for dryer #2 and the lint screen was observed damaged with a large amount of lint. V52 said, Yeah, it (lint screen) needs to be replaced. It's (lint screen) not capturing the lint like it (lint screen) should be. V52 opened the lint compartment for dryer #1 and the lint compartment floor had loose lint on the floor, and the lint screen was fully covered with lint. V52 said, We (facility staff) clean the lint compartments to prevent a fire.V1's (Administrator) e-mail, dated 4/28/26 at 11:57am, documents, in part, No Dryer Maintenance policy.Record review of facility job description titled, Maintenance Director, dated 12/01/19, documents, in part, In keeping with our organization's goal of improving the lives of the Guests we serve, the Director of Maintenance plays a critical role in maintaining all physical plant assets on the property. The Director of Maintenance manages the day-to-day operations of the maintenance department. Operates the maintenance department in a safe manner by ensuring compliance with Federal, State, and local regulations and following established policies and procedures. Ensures the physical building meets all safety and building codes. Ensure that regular equipment and systems maintenance schedules are monitored and followed at all times. Works with department heads to ensure routine maintenance in Guest care areas does not interfere with the care or safety of Guests. Follow established safety precautions when performing tasks and using equipment and supplies. Reports all hazardous conditions, damaged equipment, accidents/incidents and supply issues to the supervisor. Maintains the comfort, privacy and dignity of Guests and interacts with them in a manner that displays warmth, respect and promotes a caring environment. Ensure each Guest receives person centered care.Record review of facility job description titled, Housekeeper, dated 12/01/19, documents, in part, In keeping with our organization's goal of improving the lives of the Guests we serve, the Housekeeper plays a critical role in providing superior customer service and housekeeping services to all Guests in the facility. The Housekeeper is responsible maintaining environmental and infection control standards by performing a variety of general cleaning tasks. Cleans and sanitizes Guest rooms, offices, hallways and other areas inside the facility as well as outside and the entire property. Reports all hazardous conditions, damaged equipment, accidents/incidents and supply issues to the supervisor. Maintains the comfort, privacy and dignity of Guests/guests and interacts with them in a manner that displays warmth, respect and promotes a caring environment. Ensure each Guest receives person centered care.Record review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, in part, Your facility must be safe, clean, comfortable, and homelike. You should receive the services and/or items included in the plan of care.

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	04/30/2026

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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based up observation, interview, and record review the facility failed to follow policy procedures, failed to provide (R85) required feeding assistance and failed to ensure that call lights were within reach for five of 43 residents (R1, R26, R85, R99, R177) in the sample reviewed for accommodation of needs.Findings include: R85's (4/7/26) BIMS (Brief Interview Mental Status) determined a score of 8 (moderate impairment). R85's (4/7/26) functional assessment affirms resident requires substantial/maximal assistance for rolling left/right and is dependent on staff for sit to stand and transfers. R85's (7/16/25) care plan states resident requires assistance with ADL's (Activities of Daily Living), interventions: keep call light within reach when in bedroom. On 4/27/26 at 9:51am, R85 was lying in bed, however the call light was on the floor - out of reach. R85's call light cord was tied to the side rail, and the clip was near the floor - not the push button. Surveyor inquired if R85 could reach the call light R85 nodded her head no. On 4/27/26 at 9:52am, surveyor inquired if R85's call light was within reach V9 (CNA/Certified Nursing Assistant) subsequently entered the room and stated No, it's on the floor. Surveyor inquired where the call light should be placed, V9 responded Across her (R85). V9 then exited the room without providing R85 the call light. On 4/27/26 at 9:53am, surveyor inquired about the location of R85's call light V10 (CNA) subsequently entered the room and stated Oh, my goodness. Probably when they (staff) let her (R85) head up it probably fell off. V10 placed the call light on R85's chest however failed to secure it with the clip. Surveyor inquired if there was a clip on R85's call light V10 inspected the cord and stated, It's a clip on there; it was just too far back to clip it. R177's BIMS determined a score of 3 (severely impaired). R177's (2/9/26) functional assessment affirms resident is dependent on staff for rolling left/right. R177's (1/30/26) care plan states resident requires assistance with ADL's, interventions: keep call light within reach when in bedroom. On 4/27/26 at 9:57am, R177 was lying in bed however the call light was between the side rail and the mattress- out of reach. Surveyor inquired if R177 could reach the call light R177 responded No. On 4/27/26 at 10:01am, surveyor inquired about the location of R177's call light V11 (LPN/Licensed Practical Nurse) entered the room and stated, It's on the side of the bed, it should be on top of him (R177). R1's (2/5/26) BIMS determined a score of 4 (severe impairment). R1's (2/5/26) functional assessment affirms resident is dependent on staff for rolling left/right. R1's (7/27/26) care plan states resident requires assistance with ADL's, interventions: keep call light (continued on next page)

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	145734	A. Building B. Wing	04/30/2026

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	within reach when in bedroom. On 4/27/26 at 10:20am, R1 was lying in bed, however the call light was dangling below the mattress - out of reach. R1's right upper extremity was noted to be severely contracted, and the call light cord was tied to the bed rail (on R1's impaired side). Surveyor inquired if R1 could reach the call light R1 nodded her head no. On 4/27/26 at 10:22am, surveyor inquired about the location of R1's call light V11 (LPN) stated It was on the side of the rail, side of the bed and affirmed it was out of reach. On 4/27/26 at 12:24pm, R85 was (alone) in the room and feeding herself, however R85's dietary card states 1:1 feeding assistance required. R85's (4/7/26) functional assessment affirms the resident requires supervision or touching assistance with eating. On 4/27/26 at 12:38pm, R85 remained in the room alone - without feeding assistance. R85 was able to feed herself a cheeseburger however all the other food items (requiring utensils) remained untouched. The general care policy (revised 6/30/25) states it is the facility's policy to provide care for every resident to meet their needs. Upon admission or readmission, the facility will evaluate the resident for physical and psychosocial needs. Physical needs would include but are not limited to ADL (Activities of Daily Living). The facility will assist the resident to meet these needs. R99's face sheet documents in part the following diagnoses: cerebral infarction, muscle wasting and atrophy, type 2 diabetes mellitus, right sided hemiplegia and hemiparesis, hyperlipidemia, and history of falling. R99's minimum data set (2/21/2026) documents R99 has a brief interview of mental status (BIMS) summary score of 10, indicating R99 is cognitively impaired. Additionally, R99 requires assistance from staff with activities of daily living, including wheeling a wheelchair, transferring, and toileting. R99's care plan (2/18/2026) identifies R99 is at risk for falls related to a history of falling, reports of dizziness, right sided hemiplegia and hemiparesis and impaired balance. R99's goal related to the risk of falls is (R99) will request assistance prior to mobility attempts). Interventions to address this risk include, Remind me to ask for assistance. Reorient me on how to use the call light, if necessary (02/18/2026), and Please make sure that my call light is within my reach and encourage me to use it for assistance as needed. I would like staff to address my needs with a prompt response to all requests for assistance. (2/18/2026) On 4/27/2026 at 10:40 AM, observed R99 in a wheelchair next to the window right of R99's bed. R99's call light was observed on the left side of the bed near the left side of the mattress. R99 could not reach the call light from R99's position in the room. Observation was confirmed with V77 (Licensed Practical Nurse). V77 stated R99 is able to use the call light and the call light should be within reach of R99 to allow R99 to call for assistance. R99 pulled the call light from the side of the bed and clipped it to the side of R99's wheelchair. The cord of the call light was taut from the wall to the wheelchair with no slack in the call light. V77 was unable to place the call light near R99's lap or any closer to V77 as the cord was not long enough. This was confirmed with V77. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R26's face sheet documents diagnoses that include but are not limited to secondary chronic gout, multiple sites, without tophus, muscle wasting and atrophy, not elsewhere classified, right and left shoulders, morbid (severe) obesity due to excess calories, type 2 diabetes mellitus with diabetic chronic kidney disease, difficulty in walking, and recurrent depressive disorders. R26's BIMS (brief interview for mental status) score, dated 2/2/26 is 14 which indicates R26 is cognitively intact. R26's nursing care plan, dated 4/27/26, documents, in part, Focus: R26 is at risk for falls r/t recent history of falls, incontinence, requires ADL assistance, Gout, DM. with interventions that documents, in part, Please make sure that my call light is within my reach and encourage me to use it for assistance as needed. I would like staff to address my needs with a prompt response to all requests for assistance. On 04/28/2026 11:15 AM, observed R26 sitting in wheelchair at the end of the bed. R26 stated she needs to have a bowel movement. R26 said that she cannot push herself in her wheelchair because she has pain in both her shoulders. R26 pointed to the call light and stated that she could not call for the CNA as the call light was attached to left upper bed rail. On 4/28/26 at 11:17 AM, V22 (Registered Nurse/RN) affirmed R26's call light was out of R26's reach and moved R26 close to the bed to access the call light. On 4/29/26 at 2:48pm, V3 (Assistant Director of Nursing/ADON) said, Call lights should be placed within reach, either clipped to the shirt, blanket, depending on resident's preference; But should be within reach so they (residents) can call for help, assistance to restroom, ice water, make needs known, and thing like that. The call light policy (revised 6/30/25) states be sure call lights are placed within reach of residents who are able to use it at all times.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that staff provide grooming (nail care and shaving) for residents who were dependent on staff for Activities of Daily Living (ADL). This failure affected five (R16, R59, R69, 165 and R176) of six residents reviewed for ADL care.Findings include:R16 is [AGE] years old and have resided at the facility since 2025, face sheet listed the following past medical history in part: nontraumatic intracerebral hemorrhage, iron deficiency anemia, gastrostomy status, adult failure to thrive, hear failure, diabetes mellitus, etc.Minimum Data Set (MDS) assessment dated [DATE], section c (cognitive patterns) scored R16 with a brief interview for mental status (BIMS) score of 6, section gg (functional) of the same assessment indicated that R16 is dependent on staff for all activities of daily living (ADL) care needs.On 04/27/2026 11:00AM, R16 was observed in bed, awake but could not respond to questions, noted with long dirty fingernails on both hands. 04/28/2026 11:10AM, R16 was observed again still with long dirty fingernails on both hands, with crusty dry skin all over, him. ADL care plan initiated 4/3/2026 documented the following: Resident requires assistance with ADL's (bed mobility, transfers, dressing, walking, personal hygiene, eating and toileting). R59 is 72 years and has resided at the facility since 2022, face sheet listed the following past medical history in part: hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, unspecified protein calorie malnutrition, depression, acute ischemic heart disease, other seizures, hyperlipidemia, essential primary hypertension, dysphasia, etc.MDS assessment dated [DATE], section c (cognitive patterns) scored R59 with a BIMS score of 3, section gg (functional) of the same assessment indicated that R59 is dependent on staff for all activities of daily living (ADL) care needs.ADL care plan initiated 10/12/2024 documented that R59 has an ADL Self Care Performance Deficit and Impaired Mobility.On 04/27/2026 at 11:00AM, R59 was observed sleeping in bed, contracture noted to the left side, fingernails noted to be long and dirty with the left fingernails digging into resident's hands. On 04/28/2026 at11:10AM, R59 was observed again in bed, awake and alert and stated that he needed to be turned. Resident still noted with long dirty fingernailsOn 4/28/2026 at 11:50AM V44 (C.N.A) was presented with resident's long dirty fingernails and she acknowledged that they are long and need to be trimmed. V44 said that fingernails are supposed to be clipped during activities of daily living (ADL) care. R69 is 71 years, admitted to the facility on [DATE], past medical history includes, but not limited to hemiplegia and hemiparesis following non traumatic intracerebral hemorrhage affecting left non-dominant side, dysphagia oral phase, hyperlipidemia, other lack of coordination, anemia, etc.On 04/27/2026 10:37AM, R69 was observed up in chair, awake and alert, stated he is doing okay. R69 was observed with long fingernails with brownish substances on both hands, Resident said he would like them trimmed. 04/28/2026 10:31AM, R69 was observed in bed again, still noted with long dirty nails.MDS assessment dated [DATE], section c (cognitive patterns) scored R69 with a BIMS score of 14 section gg (functional) of the same assessment indicated that R69 is dependent on staff for all activities of daily living (ADL) care needs.Care plan initiated 3/20/2026 documented that (Interim) R69 requires assistance with ADL's (bed mobility, transfers, dressing, walking, personal hygiene, eating and toileting).R165 is 87 years admitted to the facility on [DATE], past medical history includes, but not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia oral phase, difficulty walking, hyperlipidemia, essential primary hypertension, unspecified osteoarthritis, etc.On 04/27/2026 at 10:07AM, R165 was observed sleeping in bed and noted with lots of facial hair and long fingernails with brownish substances on both hands. On 04/28/2026 at 12:00 PM, R165 was again observed in bed, still with long dirty nails and lots of facial hair. R165 said that he will like a shave, does not remember the last time his nails were trimmed.MDS assessment dated 4/182026, section c (cognitive patterns) scored R165 with a BIMS score of 10 section gg (functional) of the same assessment indicated that R165 I requires partial to moderate assistance with eating, and dependent (continued on next page)

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	145734	A. Building B. Wing	04/30/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on staff for all other activities of daily living (ADL) care needs.Care plan initiated 4/22/2026 documented that resident has an ADL Self Care Performance and Impaired Mobility Deficit related to limited mobility to right hand.R176 is 95 years admitted to the facility on [DATE], past medical history includes, but not limited to other abnormalities of gait and mobility, muscle wasting and atrophy left shoulder, hyperlipidemia, generalized anxiety disorder, hypotension, etc.On 04/27/2026 at 10:45AM, R176 was observed in bed awake and alert and stated that he would like to have a shave, does not recall the last time he was shaved. R176 also has long fingernails on both hands with brownish substances underneath. 04/28/2026 11:00AM, observed R176 again in bed, still with lots of facial hair and long dirty fingernails.MDS assessment dated [DATE], section c (cognitive patterns) scored R176 with a BIMS score of 13 section gg (functional) of the same assessment indicated that R176 requires substantial/maximal assistance to partial/ moderate for all other activities of daily living (ADL) care needs.Care plan initiated 4/22/2026 stated that residents have an ADL Self Care Performance and Impaired Mobility Deficit related to limited mobility to right hand. On 4/29/2026 at 2:52PM, V3 (ADON) said that residents' nails are supposed to be free of debris, clean and at acceptable length. Nail care should be provided by CNAs during Activities of daily Living (ADL) care. Some residents do like their nails long so staff will ask them if they want them to be clipped. V3 said that residents' shaving should also be done during ADL care by the CNAs, residents will be asked if they need their face shaved.General care policy revised 6/20/2025 documented in part: Policy Statement - It is the facility's policy to provide care for every resident to meet their needs.Procedures:1. Upon admission or readmission, the facility will evaluate the resident for physicaland psychosocial needs. Physical needs would include, but are not limited to ADL,wound care, medical needs, etc. Psychosocial needs would include but are notlimited to areas of mental and psychosocial well-being.Nail care policy revised 7/2/2025 stated in part: policy statement: The purpose of this procedure is to clean the nail bed, to keep nails trimmed, and to prevent infections.General guidelines: 1. Nursing staff shall check the residents for nail care which includes cleaning and regular trimming.2. proper nail care can aid in the prevention of skin problems around the nail bed.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to follow the medication pass policy and failed to administer medications within regulatory requirements (within 1 hour before and 1 hour after the scheduled time) therefore failed to maintain a medication error rate below 5%. There were 6 medication errors out of 27 opportunities resulting in a 22.22% medication error rate. Two of four residents (R89, R144) in the medication administration sample were affected.Findings include:R89's Physician Orders include Sevelamer Carbonate 800mg (milligrams) with meals, Amlodipine Besylate 10mg daily, Aspirin chewable 81mg daily, Renal Capsule 1mg daily, and Hydralazine HCL 50mg three times daily.On 4/28/26 at 9:30am, V34 (Licensed Practical Nurse) dispensed R89's Selevamir Carbonate (scheduled for 8am administration per EMAR-Electronic Medication Administration Record), Amlodipine Besylate (scheduled for 7:30am administration per EMAR), Aspirin (scheduled for 7:30am administration per EMAR), Renal Capsule (scheduled for 7:30am administration per EMAR), and Hydralazine (scheduled for 7:30am administration per EMAR) in a medication cup then affirmed she (V34) was prepared to administer the medication. Surveyor inquired about the regulatory requirement for medication administration V34 stated One hour before and 1 hour after. Surveyor inquired why R89's medications were not administered within regulatory requirements V34 responded This is the end of my (V34) med pass, I (V34) had other things I had to prioritize. R144's Physician Orders include Magnesium Oxide 400mg daily and Metoprolol Succinate ER (Extended Release) 25mg (2 tablets) daily.On 4/28/26 at 9:51am, V22 (Registered Nurse) dispensed R144's Metoprolol Succinate ER (scheduled for 7:30am administration per EMAR), and Magnesium Oxide (scheduled for 7:30am administration per EMAR) in a medication cup then affirmed she (V22) was prepared to administer the medication. Surveyor inquired about the regulatory requirement for medication administration V22 stated A hour before or a hour after. Surveyor inquired why R144's medications were not administered within regulatory requirements V22 responded We (staff) try to wrap it up, but it does get busy because we got people going to dialysis and everything. R144 subsequently refused the Metoprolol - which was therefore excluded from the medication error rate. The Medication pass policy (revised 7/25/25) states it is the policy of the facility to adhere to all Federal and State regulations with medication pass procedures.

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	145734	A. Building B. Wing	04/30/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to follow policy procedures, failed to ensure that (R1, R17, R49, R74, R105, R136) medications were labeled appropriately, failed to ensure multidose medication were dated when opened, failed to ensure medication carts were lock, failed to ensure medications were stored in locked storage areas, failed to ensure narcotic medications were double locked, and failed to ensure (R25, R133) refrigerated medications and six (6) emergency box insulins were stored within the required temperature range. These failures have the potential to affect 164 residents.Findings include:The 4/26/26 census includes 164 residents.On 4/28/26 at 9:02am, surveyor inspected the (100 - front) medication cart with V35 (LPN/Licensed Practical Nurse). R105's Humalog pen was not in a bag and did not have a pharmacy sticker attached. R105's name was handwritten (in smeared marker) on the Humalog pen and barely legible. Surveyor inquired if medications are supposed to be labeled V35 stated Absolutely and it should be bagged because the bag also has a label on it. On 4/28/26 at 9:04am, V36 (LPN) left the (100 - back) medication cart unlocked and unattended in the hallway. At 9:08am, (5 minutes later) V36 returned to the medication cart. Surveyor inquired if the medication cart was locked (while unattended) V36 proceeded to press the medication cart handle downward and opened the drawer (without touching the electronic lock keypad). Surveyor inquired why the cart wasn't locked V36 stated It was something with the battery, but I (V36) already reported it I wanna say a couple days ago. Narcotic medication was single locked. On 4/28/25 at approximately 9:20am, V34 (LPN) approached the (200 - front) medication cart and opened the drawer (without touching the electronic lock keypad). Surveyor inquired if the medication cart was locked, V34 stated The keypad is not locking. Surveyor inquired if the issue was reported V34 responded It's been reported. Surveyor inquired how long ago the issue was reported V34 replied Maybe a week. Narcotic medication was single locked.On 4/28/26 at 9:53am, the (400 - back) medication cart was inspected with V22 (Registered Nurse) R17's Lispro was opened and undated. V22 inspected R17's Lispro and stated, This one don't have a expiration date. On 4/28/26 at 10:03am, surveyor inspected the (200- back) medication cart with V37 (LPN). V37 affirmed that the Geri-Tussin container was opened and undated. Surveyor inquired about the requirement for multidose medications V37 stated We (staff) put the date that you open it. R1's Lantus pen, R74's Novolog pen, R49's Novolog pen, R136's Lispro pen were opened, unbagged, did not have a pharmacy sticker attached and handwritten names were on each pen. Surveyor inquired about concerns with the opened/unlabeled insulin pens V37 responded If they don't have the bag they supposed to be labeled.On 4/29/26 at 12:13pm, the medication room was inspected with V43 (LPN). The medication refrigerator thermometer was noted to 48F (Fahrenheit) therefore not within the required range. Surveyor inquired about the temperature in the medication refrigerator V43 stated its 48. Surveyor inquired what the medication refrigerator temperature range should be V43 responded 38 and 41. The following contents were in the medication refrigerator at this time: an emergency box containing six (6) insulin pens, R133's Prevnar 20 vaccine, R133's Abrysvo vaccine, and R25's Trulicity insulin. The (April 2026) refrigerator temperature log states temperature range for all refrigerators are to be between 38-41 degrees at all times. The medication storage, labeling and disposal policy (revised 7/2/25) states it is the facility's policy to comply with federal regulations in storage, labeling, and disposal of medications. Medications from the pharmacy will be labelled by the pharmacy to include the name of the resident, route of administration, instruction, medication name, strength, and expiration date when applicable. Medications will be stored safely under appropriate environmental controls. Medications will be secured in locked storage areas. Schedule 2 medications will be double locked (placed in a locked medication cart inside a locked controlled medication box).

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview and record review, the facility failed to ensure resident's refrigerators maintained temperature parameters for food safety; failed to properly log residents' refrigerator temperatures; failed to date outside open food items; and failed to ensure residents refrigerators were clean. These failures affect four residents (R17, R50, R78, and R89) reviewed for safety of personal food items, in a total sample of 67 residents.Findings include: On 4/27/26 at 10:25am, observation of R17's personal refrigerator revealed the absence of a temperature monitoring log. Additionally, a large amount of a brown, sticky substance was noted on the bottom shelf. On 4/27/26 at 10:25am, R17 said, Yes, that's my fridge. Just my food in there. The facility got it for me. Housekeeping usually comes and cleans it. No, I'm not sure when the last time they (housekeeping) came and cleaned it. There used to be a paper on top of the fridge that they (staff) were checking and putting down what the temp was. R17's face sheet documents diagnoses that include but are not limited to osteomyelitis of vertebra, diabetes mellitus, and paraplegia. R17's BIMS (brief interview for mental status) score, dated 3/3126, is 15 which indicates R17 is cognitively intact. On 4/27/26 at 10:33am, V27 (Staffing Coordinator/Scheduler) affirmed that R17's refrigerator lacked a temperature monitoring log and acknowledged that the refrigerator was not clean. V27 said, I think housekeeping is responsible for cleaning the fridge. I am not sure who is responsible for checking the temperatures of the fridge. I think the CNAs, but I am not positive. On 4/27/26 at 10:33am, observation of R50's and R78's personal refrigerator revealed an undated Tupperware container with garlic bread and lasagna and undated clear plastic sandwich bag with cheese puffs inside. On 4/27/26 at 10:33am, R50 said, That container (lasagna and garlic bread) is R78's. Yeah, the cheese puffs too. We (R50 and R78) both use it. R78 just uses it more than me I guess. I've seen housekeeping going through the fridge before. Maybe last week was the last time. R50's face sheet documents diagnoses that include but are not limited to Type 2 diabetes and chronic kidney disease. R50's BIMS (brief interview for mental status) score, dated 2/05/26, is 14 which indicates R50 is cognitively intact. R78's face sheet documents diagnoses that include but are not limited to polyneuropathy, need for assistance with personal care, hypertension, and mixed receptive-expressive language disorder. R78's BIMS (brief interview for mental status) score, dated 4/16/26, is 8 which indicates R78's cognition is moderately impaired. R78 unable to be interviewed due to altered mental status. (continued on next page)

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	145734	A. Building B. Wing	04/30/2026

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Avantara Evergreen Park	10124 South Kedzie Evergreen Park, IL 60805

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/27/26 at 10:54am, V51 (Housekeeper) said, We (housekeeping) check the resident's refrigerators. Yeah, clean them and make sure the temperature is good. The CNAs check the food. I won't throw a resident's food out unless I ask them while I'm cleaning. I swear R17 had a temperature log this morning. I'll go check now and clean it (R17's refrigerator). On 4/29/26 at 2:48pm, V3 (Assistant Director of Nursing/ADON) said, Housekeeping makes sure the temperatures are checked, and the refrigerators are clean. Some of refrigerators, I expect open food to be dated and ask resident before discarding. V1's (Administrator) e-mail, dated 4/28/26 at 11:57am, documents, in part, No personal refrigerator policy. On 04/27/2026 at 10:46 AM R89's personal refrigerator had a daily temperature log with no temperature check documentation from 4/23/2026 through 4/27/2026. The thermometer in the refrigerator was observed to be 50 degrees. On 04/27/2026 at 10:49 AM V18 (Nursing Supervisor/Licensed Practical Nurse/LPN) stated the refrigerator should be set at between 38 and 40 degrees. If it is too high, maintenance needs to check it. Refrigerators in residents' rooms are checked and cleaned daily by housekeeping. On 4/27/2026 at 10:51 AM V17 (Housekeeper) stated personal refrigerators in residents' rooms should be between 38 and 41 degrees. If it is below 38 or above 41 degrees, we take the refrigerator downstairs to defrost and clean it. V18 (Nursing Supervisor/LPN) stated R89's refrigerator has not been checked since 4/22/2026. V18 opened the refrigerator and stated to V17 It is 50 degrees inside this refrigerator. It needs to be checked and it should be cleaned. V18 stated We should be concerned. We don't know how long it has been like that since it has not been checked since 4/22/2026. V18 stated the concern is that the food is not properly stored. It could make R89 sick. On 04/27/2026 at 12:33 PM R89 stated staff told R89 they took the refrigerator away because it wasn't working right. Facility policy titled Kitchen revised 6/30/2025 stated if the resident rooms have refrigerators, the facility will ensure that the daily temperature is checked to ensure proper temperature. Record review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, in part, Your facility must provide equal access to quality care regardless of diagnosis. Your facility must be safe, clean, comfortable, and homelike. Record review of facility job description titled, Housekeeper, dated 12/01/19, documents, in part, In keeping with our organization's goal of improving the lives of the Guests we serve, the Housekeeper plays a critical role in providing superior customer service and housekeeping services to all Guests in the facility. The Housekeeper is responsible maintaining environmental and infection control standards by performing a variety of general cleaning tasks. Cleans and sanitizes Guest rooms, offices, hallways and other areas inside the facility as well as outside and the entire property. Reports all hazardous conditions, damaged equipment, accidents/incidents and supply issues to the supervisor. Maintains the comfort, privacy and dignity of Guests/guests and interacts with them in a manner that displays warmth, respect and promotes a caring environment. Ensure each Guest receives person centered care.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record of review, the facility failed to develop a baseline care plan and failed to provide the resident with a copy/summary of the baseline care plan. This failure affected one resident (R202) in a sample of three residents reviewed for baseline care planning. Findings include: R202's face sheet documents R202 is a [AGE] year-old resident that admitted to the facility on [DATE]. R202's diagnoses include, but is not limited to: surgical aftercare following surgery on the skin, muscle wasting and atrophy, anemia, type 2 diabetes mellitus with hyperglycemia, hypertension, acute kidney failure, Fournier Gangrene. R202's progress notes document R202 admitted to the facility on [DATE] and is alert and oriented x 4 (person, place, time, situation). R202 was admitted to the facility following hospitalization for a fall and an infected groin wound. There is no indication in the progress notes that R202's baseline care plan was developed, or a copy of the baseline care plan was given to R202. On 4/27/2026 at 10:44 AM, R202 explained that R202 was a new resident of the facility and had admitted about 5 days ago. R202 denied ever receiving a copy of R202's baseline care plan. R202 stated, No, I don't know anything about a care plan. They told me I have a care plan meeting on the 29th, but I was never provided a copy of any baseline care plan or a summary. Yes, I would have wanted a copy of that. R202 affirmed R202 is at the facility to receive therapy services and wound care after being diagnosed with a groin wound and sepsis. R202's baseline care plan does not indicate R202 is receiving therapy services. There is no documentation on the baseline care plan that the baseline care plan or the summary was provided to R202. On 4/27/2026 at 1:10 PM, V21 (MDS Coordinator, Registered Nurse) affirmed V21 was the RN assessment coordinator for the facility, and oversees the development of the care plans with the interdisciplinary team. V21 explained residents are supposed to get a copy of the baseline care plan within 48-72 hours of admission and that it should be documented in the clinical record. V21 was unsure which staff member provides the baseline care plan or summary between the admission nurse, guest services, and the social services staff. V21 reviewed R202's clinical record and affirmed there was no documentation the baseline care plan or summary was distributed to R202. V21 stated, (R202) should have recieved a copy by (4/25/2026) or (4/26/2026), it should be documented in the chart. There is no documentation. V21 reviewed the baseline care plan in the chart and affirmed the base line care plan did not address R202's therapy goals. V21 accessed the medical record and affirmed V21 was actively being treated by therapy and had orders by R202's physician to treat. V21 affirmed therapy services should have been included on the baseline care plan. V21 explained the purpose of the baseline care plan is to inform/identify the resident/staff of diagnoses, problems, and treatment goals to ensure the residents needs are being met. Facility care plan policy (6/30/2025) documents It is the policy of the facility to ensure that all care plans including base line care plans are in conjunction with the federal regulations . Based on F655 regulation a baseline care plan will be completed within 48 hours of admission. 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 a minimum should include initial goals based on admission orders, physician orders, dietary orders, therapy services, social services, and PASARR recommendations if applicable. 3. The facility will provide the resident/representative a written summary of the baseline care plan by the completion of the comprehensive care plan. This policy does not meet regulatory requirements for baseline care planning, as the facility must provide a copy of the baseline care plan or summary to the resident. By providing a summary of the baseline care plan to the resident upon completion of the comprehensive care plan, a resident would not be allowed to participate in the care planning process until the development of the comprehensive care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that staff revise and update resident's (R197) care plan after a fall to address a newly acquired fracture and head injury and failed to update a resident's (R16) care plan to reflect the correct advance directives. These failures affect two (R16 and R197) of two residents reviewed for care plan revision in a sample of 67 residents.Findings include: R16 is [AGE] years old and have resided at the facility since 2025, face sheet listed the following past medical history in part: nontraumatic intracerebral hemorrhage, iron deficiency anemia, gastrostomy status, adult failure to thrive, hear failure, diabetes mellitus, etc. Per record review, R16 was listed as a do not resuscitate (DNR) and do not hospitalize (DNH) on his face sheet. IDPH uniform Practitioner order for life sustaining treatment (POLST) form dated [DATE] documented that R16 is a DNR and DNH. Care plan initiated [DATE] documented the following: ADVANCE DIRECTIVE STATUS (CODESTATUS: Full Code) Pursuant to resident rights, personal choices, and the individual's desire to retain control and autonomy over his health care decisions, the individual (or representative) has been educated on Advance Health Care (including end of life care) options. The resident's existing Advance Directive will be honored. The EMR chart should identify FULL CODE status On [DATE] at 12:26PM V5 (Social Service Director) was presented with this observation and she said that social service department is responsible for the resident's advance directive, if a resident's code status changes, the care plan should be updated, social service staff are supposed to check weekly for any changes in resident's code status and update accordingly. Surveyor asked V5 what could be the implication of not having the righr code status in resident's care plan and she said that staff will not follow the rifght advance dirctive and resident's wishes in an emergency situation. R197's face sheet documents R197 was a [AGE] year-old resident with a prior medical history of chronic obstructive pulmonary disease, dementia without behavioral disturbance, restlessness and agitation, iron deficiency anemia, contusion of the head, and displaced supracondylar fracture of the right humerus. R197's minimum data set ([DATE]) documents R197 had a brief interview of mental status summary score of 3, indicating R197 had severe cognitive impairment. R197 required substantial/maximal assistance with personal hygiene (including washing/drying face) and required partial/moderate assistance with transferring. R197's hospital records ([DATE]) document R197 presented to the emergency department from emergency medical services (EMS) from the nursing home after suffering a fall. Per EMS, R197 was sitting in the wheelchair and reached for an object on a table and subsequently fell and hit head against the ground. R197 was unable to recall what happened. Imaging was completed and R197 was diagnosed with 1) closed supracondylar fracture of right humorous 2) fall 3) traumatic hematoma of forehead. R197 was discharged to the facility and asked to follow up with primary care in 1-2 days. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R197's progress notes document on [DATE] at 6:36 AM, (R197) was sitting in wheelchair when she leaned too far forward reaching for something and fell out of wheelchair striking head. Pt noted with hematoma, soft BP, slightly hypoxic requiring o2 application, amd on Asa. Due to culmination of all of this will refer to ED for eval. At 7:56 AM, (Private Ambulance Company) here to transport resident to (hospital) for eval. Resident is leaving in stable condition. At 10:57 PM, Resident returned from (Emergency Department), after a fall. Dx: closed supracondylar fx rt humerus, and traumatic hematoma to her forehead. Right arm is placed in a splint., intact and elevated. Resident is alert and oriented to baseline. Resident placed in bed and made comfortable, call light within reach. Fall precautions in place, plan of care ongoing. There is no progress notes documented in the records until [DATE] at 12:02 PM, LATE ENTRY Note Text: 9:10am While rounding resident observed resting in bed comfortably. 10:30am Resident offered medication and tolerated well writer took vitals BP 119/62, hr 88, r-18, O2-98%. 11:11am CNA was rounding on resident and noted in bed unresponsive to name. CNA alerted writer. Writer assessed resident and residentnoted in bed unresponsive to verbal stimuli, painful and tactile stimuli. Writer verified code status, resident is a full code. Writer unable topalpate carotid or radial pulse. 11:12am Code blue initiated, CPR started and 911 called. AED applied with no shock advised. CPR continues with vitals unable to be obtained. CPR ongoing. 11:20am Evergreen Park paramedics and fire department arrive at the facility and took over compressions. 11:30am (Nurse Practitioner) notified of clinical status. 11:40am (V70 - Family Member) notified of change in condition and stated that (V70) was in route to the facility. 11:46am Paramedics CPR efforts cease and was pronounced deceased by (physician) 11:50am (EMS) left facility.12:00pm Postmortem care initiated. Facility final incident report ([DATE]) to the department documents R197 experienced an unwitnessed fall in her room. At approximately 6:00 AM, (V72- Certified Nursing Assistant) provided ADL and incontinence care and transferred R197 to the wheelchair. R197 wanted to remain in her room. (V72) left R197 in the room unsupervised and continued morning rounds. Staff heard R197's roommate yelling for help and observed R197 on her left side with a hematoma to the head. R197 told staff that R197 was trying to reach down and pick something up off the ground when R197 slid off the wheelchair. R197 was wearing non-skid socks and the environment was dry. R197 was treated at the hospital and diagnosed with a closed fracture of the right humerous. The facility was given instructions to follow up with an orthopedic physician and the plan of care was updated to address the needs of R197. R197's care plan documents R197 is at high risk for falls related to unsteady gait and dementia. R197 had goals of being free from fall related injury. Interventions to address the high fall risk in place included, I prefer to keep all needed items like water pitcher, tissue box, urinal, etc, within reach ([DATE]), : I would like staff to provide me a safe environment: even floors, free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; Side rails as ordered, handrails on walls ([DATE]), Remind me to ask for assistance. Reorient me on how to use the call light, if necessary ([DATE]), Please make sure that my call light is within my reach and encourage me to use it for assistance as needed. I would like staff to address my needs with a prompt response to all requests for assistance. >Fall Mats/Early Riser. R197 also required assistance from staff for hygiene. R197's care plan was not updated to include any new interventions after the fall sustaining injury on [DATE], as indicated in the facility report. There was no care plan developed or revised to address the fracture of the right humerus, splint use, monitoring of neurological decline/injury after R197 sustained head injury. This review directly contradicts the facility's report that The plan of care has been updated to address the needs of (R197). On [DATE] at 2:02 PM, V18 (House Supervisor/Licensed Practical Nurse/Falls Nurse) affirmed V18 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oversees the fall prevention program for the facility and assists with fall investigations. V18 reviewed R197's electronic health record and the investigative reports related to the incident. V18 affirmed that R197's care plan was not updated after the fall to address the new fracture or head injury. V18 explained the facility completed post-fall charting and neurological checks after the fall to check for level of consciousness, neurological decline. On [DATE] at 4:15 PM, V2 (Director of Nursing) affirmed V2 was familiar with R197 and completed the investigation into the fall. V2 accessed R197's electronic health record. V2 affirmed that facility staff should be following the care plan and the care plan was not revised to include the humorous fracture diagnosis or head trauma. V2 affirmed that a plan of care should have been developed. Record review of CMS' Resident Assessment Instrument (RAI) Manual ([DATE]) documents in part, Falls result in serious injury, especially hip fractures . DEFINITIONS INJURY RELATED TO A FALL Any documented injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall. INJURY (EXCEPT MAJOR) Includes, but is not limited to, skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the resident to complain of pain. MAJOR INJURY Includes, but is not limited to, traumatic bone fractures, joint dislocations/ subluxations, internal organ injuries, amputations, spinal cord injuries, head injuries, and crush injuries. A fall refers to unintentionally coming to rest on the ground, floor, or other lower level or as a result of an overwhelming external force (e.g., being pushed by another resident). A fall without injury is still a fall. Falls are a leading cause of morbidity and mortality among the elderly, including nursing home residents. Falls may indicate functional decline and/or the development of other serious conditions, such as delirium, adverse medication reactions, dehydration, and infections. A potential fall is an episode in which a resident lost their balance and would have fallen without staff intervention .The information gleaned from the assessment should be used to identify and address the underlying cause(s) of the resident's fall(s), as well as to identify any related possible causes and contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause(s) of the resident's fall(s), as well as the factors that place them at risk for falling .Facility policy titled Care Plan (revised [DATE]) documents in part, It is the policy of the facility to ensure that all care plans including base line care plans are in conjunction with the federal regulations . 5. These will be periodically reviewed and revised by a team of qualified person after each assessment .

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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. Based on observation, interview, and record review, the facility failed to follow policy procedures, failed to ensure that multiple linen layers were not on the LALM (Low Air Loss Mattress) while in use, failed to implement preventive interventions, and/or failed to identify skin integrity impairment for one of 43 residents (R174) in the sample reviewed for pressure ulcers. Findings include: R174's progress note, dated 3/10/26, per V48 (Wound Care Nurse Practitioner), documents, in part, Patient (R174) was examined, found to have no active wounds. Continue current preventative measures. Nursing staff to contact wound care with any new open wounds. R174's progress note, dated 4/09/26, per V57 (Wound Care Nurse Practitioner), documents, in part, Patient (R174) being seen today for new skin alteration. New site noted to right bunion, treatment recommendation provided. Wound Assessment: Location: Right bunion; Primary Etiology: Pressure Ulcer/Injury; Stage/Severity: DTI (Deep Tissue Injury); Wound Status: New; Size: 1 cm x 1.1 cm x 0 cm. Calculated area is 1.1 sq cm.; Treatment Recommendations: 1. Cleanse with normal saline. 2. apply Skin Prep to base of the wound. 3. secure with Leave open to air. 4. change 3 times per week, and PRN. R174's progress note, dated 4/16/26, per V48 (Wound Care Nurse Practitioner), documents, in part, Patient (R174) being seen today for new skin alteration. New site noted to right bunion, treatment recommendation provided. 4/16/26: Wound is stable and measuring larger in size since previous assessment, reviewed results of doppler with ABI (ankle brachial index) exam performed 4/16/26 for suspected arterial insufficiencies: Results: No hemodynamically significant arterial stenosis seen bilaterally. Wound Assessment: Location: Right bunion; Primary Etiology: Pressure Ulcer/Injury; Stage/Severity: DTI (deep tissue injury); Wound Status: Present on Admission; Size: 1 cm x 2 cm x 0 cm. Calculated area is 2 sq cm; Continue with current recommendations at this time. Continue to recommend pt (R174) float heels while in bed with use of heel boots. Patient (R174) is at moderate risk for pressure ulcer formation related to incontinence of urine and stool, decreased mobility, and comorbidities. Treatment Recommendations: 1. Cleanse with normal saline. 2. apply Skin Prep to base of the wound. 3. secure with Leave open to air. 4. change 3 times per week, and PRN. (Wound is larger) R174's progress note, dated 4/23/26, per V48 (Wound Care Nurse Practitioner), documents, in part, 4/16/26: Wound is stable and measuring larger in size since previous assessment, reviewed results of doppler with ABI exam performed 4/16/26 for suspected arterial insufficiencies: Results: No hemodynamically significant arterial stenosis seen bilaterally. Wound Assessment: Location: Right bunion; Primary Etiology: Pressure Ulcer/Injury; Stage/Severity: DTI; Wound Status: Stable; Size: 1 cm x 2 cm x 0 cm. Calculated area is 2 sq cm.; Continue with current recommendations at this time. Patient has limited mobility. Please ensure that patient is turned and/or repositioned when in or out of bed as per facility protocol. Continue to recommend pt (R174) float heels while in bed with use of heel boots. Patient is at moderate risk for pressure ulcer formation related to incontinence of urine and stool, decreased mobility, and comorbidities. 4/23/26: DTI to right bunion remains stable, no changes to measurements or tissue quality. On 4/28/26 at 10:25am, R174 was observed lying in bed on a low air loss (LAL) mattress, with both feet/heels resting directly on the mattress (heels not offloaded) and without the use of heel protection devices (heel boots). On 4/16/26, V48 (Wound Care Nurse Practitioner) recommended R174 to float heels while in bed with use of heel boots. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R174's face sheet documents diagnose that include but are not limited to hypertension, history of falling, syncope and collapse, low back pain, and chronic diastolic heart failure. R174's BIMS (brief interview for mental status) score, dated 4/10/26, is 8 which indicates R174's cognition is moderately impaired. R174 unable to be interviewed due to altered mental status. R174's Braden Scale, dated 3/27/26, documents a score of 7 which indicates R174 is at high risk for developing pressure ulcers. R174's Braden Scale and Clinical Evaluation, dated 3/27/26, documents, in part, Does the resident have a history of and/or existing pressure ulcer? Yes; Left heel and sacrum resolved. R174's Order Summary Report, dated 4/29/26, documents, in part, Low Air Loss Mattress. R174's Order Summary Report, dated 4/29/26, documents, in part, right bunion - cleanse with ns (normal saline) and pat dry. apply skin prep and LOTA (leave open to air) every day shift every Tue, Thu, Sat for wound care. R174's care plan, dated 7/18/23, documents, in part, (R174) with difficulty in turning and repositioning every day due to weakness on lower legs and feet limited range of motion due to the contributing medical condition and factors affecting function. R174's care plan, dated 7/18/23, documents, in part, admitted with self-care deficit in ADL (activities of daily living) Dressing Bathing Grooming, with interventions that documents, in part, 'Provide assistance with dressing, bathing, personal hygiene, toileting, transferring, and eating as needed. R174's care plan, dated 7/21/25, documents, in part, Resident (R174) has an actual impairment to skin integrity. Pt is noncompliant with wound care recommendation, with interventions that documents, in part, HIGH RISK -Skin check every shift. Report abnormalities to the nurse; Off load heels; Turn and reposition at least every 2 hours and as needed. R174's progress note, dated 4/16/26, documents, in part, Resident (R174) has been experiencing a decline in ADL (activities of daily living) performance and mobility. Referred to therapy. On 4/29/26 at 9:29am, V48 (Wound Care Nurse Practitioner) said, R174 had bilaterial arterial and venous doppler done of her (R174) legs and it showed no stenosis, was negative. Yes, she (R174) has a pressure ulcer on her (R174) right medial foot that was acquired here (facility). I did the original skin assessment (3/10/26) and there were no skin issues. I was on vacation when the new pressure ulcer developed, this new deep tissue injury (DTI). My colleague was the one that did the first assessment of R174's new ulcer. I am not sure if R174's DTI was avoidable. The arterial and venous doppler were negative, but I still cannot say if the DTI (R174) was avoidable. I am not sure how she (R174) could have gotten it (DTI). DTIs are caused by anything that would subject the area to constant pressure. Record review of R174's POC (PointClickCare)Task: MONITOR - Turn and Reposition: Was resident turned and repositioned? documents, in part, the following: 3/31/26: 3 entries at 3:08am showing R174 was repositioned; 1 entry at 8:00am; 1 entry at 10:00am; 1 (continued on next page)

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	145734	A. Building B. Wing	04/30/2026

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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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	entry at 12:00pm; 1 entry at 2:00pm; 1 entry at 8:36pm; 2 entries at 8:37pm; 1 entry at 10:15pm. 4/01/26: 1 entry at 11:50am; 1 entry at 11:51am; 2 entries at 8:42pm; 1 entry at 8:43pm; 1 entry at 9:06pm 4/02/26: 4 entries at 6:06am; 1 entry at 8:00am; 1 entry at 10:00am; 1 entry at 12:00pm; 1 entry at 2:00pm; 1 entry at 3:20pm; 1 entry at 6:00pm; 1 entry at 8:00pm; and 1 entry at 10:00pm. 4/03/26: 1 entry at 5:42am; 3 entries at 5:43am; 1 entry at 8:00am; 1 entry at 10:00am; 1 entry at 12:00pm; and 1 entry at 2:00pm. 4/04/26: 1 entry at 10:12pm; and 3 entries at 10:13pm. 4/05/26: 4 entries at 5:56am; 1 entry at 8:59am; 1 entry at 12:05pm; 1 entry at 12:06pm; and 1 entry at 1:02pm. 4/06/26: 1 entry at 8:00am; 1 entry at 10:00am; 1 entry at 12:00pm; 1 entry at 2:00pm; 1 entry at 5:00pm; 1 entry at 5:02pm; 1 entry at 7:26pm; and 10:19pm. 4/07/26: 2 entries at 5:32am; 2 entries at 5:33am; 1 entry at 8:00am; 1 entry at 10:00am; 1 entry at 12:00pm; 1 entry at 2:00pm; 1 entry at 9:58pm. 4/08/26: 4 entries at 2:13pm; 1 entry at 4:10pm; 1 entry at 5:37pm; 1 entry at 8:23pm; and 10:17pm. 4/09/26: 1 entry at 4:17pm; 1 entry at 6:43pm; 1 entry at 8:28pm; and 10:02pm. 4/10/26: 1 entry at 8:00am; 1 entry at 10:00am; 1 entry at 12:00pm; 1 entry at 2:00pm; 1 entry at 3:45pm; and 3 entries at 10:25pm. 4/11/26: There was no documentation that R174 was repositioned for this day. 4/12/26: 3 entries at 5:09am; 1 entry at 5:10am; and 1 entry at 4:22pm. 4/13/26: 4 entries at 5:02am; 1 entry at 7:55am; 1 entry at 9:16am; 1 entry at 12:39pm; and 1 entry at 2:01pm. 4/15/26: 1 entry at 1:33pm; 3 entries at 1:34pm; 1 entry at 9:39pm; and 3 entries at 9:41pm. 4/16/26: 1 entry at 8:00am; 1 entry at 10:00am; 1 entry at 12:00pm; 1 entry at 2:00pm; 1 entry at 5:17pm; 1 entry at 7:27pm; 1 entry at 7:14pm; and 1 entry at 9:54pm. 4/18/26: 2 entries at 7:35pm and 2 entries at 9:55pm. 4/19/26: 2 entries at 2:42am; 1 entry at 8:00am; 1 entry at 10:00am; 1 entry at 12:00pm; 1 entry at 2:00pm; and 1 entry at 11:59pm. 4/20/26: 3 entries at 6:27am; 1 entry at 8:00am; 1 entry at 10:00am; 1 entry at 12:00pm; 1 entry at 2:00pm; 1 entry at 4:00pm; 1 entry at 6:00pm; 1 entry at 8:00pm; and 1 entry at 10:00pm. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	heel protection boots. I talked with the staff to put these in place. When used, heel boots are intended to offload and protect the entire foot, with built-in padding to reduce pressure. I can't really give you an exact cause for the ulcer. Given the location, arterial and venous studies were considered negative but R174 does have heart failure, which can contribute to circulatory issues, although no specific arterial or venous abnormalities were identified. These conditions may increase the resident's overall risk for developing additional wounds. The offloading and heel boots I recommended April 16th (4/16/26). The heel boots are to be on at all times while the resident (R174) is in bed. I did see R174 today and cannot confirm whether they (heel boots) were in place at that time. The nurse had prepared the resident (R174) prior to the assessment. I cannot really say if the heel boots, offloading of heels, and repositioning the resident (R174) are not being done is not helping or delaying healing the ulcer (R174's pressure ulcer) but the staff need to be doing these things. V48 affirmed the interventions for R174 in regard to the heel boots, offloading of heels, and repositioning R174 every 2 hours are in place to help improve and prevent worsening of R174's facility acquired pressure ulcer. Facility presented document titled, Wound Specialist's Assessment of Wound/Pressure Injury Avoidability/Unavoidability, dated 4/29/26 at 4:44pm, per V48 (Wound Care Nurse Practitioner) documents that R174's DTI was unavoidable due to comorbidities and interventions in place such as offloading of heels with pillows or other devices and turning and repositioning every 2 hours. Surveyor observed on 2 separate days (4/28/26 and 4/29/26) that R174's heels were not off loaded with pillows or other devices. Record review shows that out 28 days, R174 was repositioned per V48 (Wound Care Nurse Practitioner) recommendations of every 2 hours, only 7 out of 28 days. Surveyor did not receive facility's expectations on charting when repositioning residents. E-mail from V3 (Assistant Director of Nursing/ADON), dated 4/30/26 at 9:34am, documents, in part, we (facility) do not have a policy for turning/repositioning.

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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** Based on observation, interview, and record review the facility failed to follow policy procedures, failed to follow physician orders, failed to ensure that designated times were specified for applying/removing restorative devices, failed to include all required device(s) in Nursing Rehab tasks, and failed to ensure that staff provide and/or document restorative care/devices for two of 43 residents (R1, R59) in the sample reviewed for range of motion/mobility. Findings include: The general care policy (revised 6/30/25) states that upon admission or readmission, the facility will evaluate the resident for physical and psychosocial needs. The facility will assist the residents to meet these needs. R1's diagnoses include hemiplegia and hemiparesis following cerebral infarction- affecting the right side. R1's Physician Orders include (12/22/25) Right knee brace for contracture management 4 hours daily to progress to as tolerated. (1/20/26) Nursing Rehab: right hand resting splint. R1's (4/14/26) care plan affirms the resident is on a splint and/or brace assistance program. Interventions: please provide assistive and supportive device as needed (right) hand resting splint 2-4 hours daily and right knee brace 4 hours daily. R1's (April 2026) documentation survey report (which specifies Nursing Rehab tasks) includes the right-hand resting splint; however specified times to place on and/or remove the device were excluded. R1's prescribed right knee brace was also excluded. On 4/27/26 at 10:17am, R1's right arm was extremely contracted (at the elbow) and appeared to be in a fixed position - roughly 45-degree angle. R1's right hand was also contracted however the hand/arm splint was observed on the dresser - not in use. V12 (Restorative Aide) entered R1's room and inspected the refrigerators (as requested), however then left the room without applying R1's splint. On 4/27/26 at 10:22am, surveyor inquired why R1's splint was not in use V11 (LPN/Licensed Practical Nurse) stated, Restorative will come through and put it on her (R1). Surveyor inquired when R1's splint should be applied. V11 responded, I (V11) don't know it's different times. R49 (Roommate) replied, They (staff) usually put it on in the morning. On 4/27/26 at 10:24am, V11 (LPN) and V13 (CNA/Certified Nursing Assistant) provided R1's incontinence care then left the room however R1's splint was not applied. On 4/27/26 at 10:42am, surveyor inquired why R1's splint was not in use. V13 (CNA) stated, That's restorative, they (restorative) come around and put em on for her (R1) right hand. This is my (V13) first time working with her, I (V13) think it's their (restorative) department. On 4/27/26 at approximately 10:45am, V16 (Family) stated, We (V15/Family, V16) come here (facility) almost every day. She's (R1) supposed to have a splint on her (R1) right arm, it's not on and she's supposed to have on a leg brace, but they (staff) don't put it on. V16 subsequently opened R1's closet and presented R1's knee brace. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/29/26 at 11:57am, surveyor inquired who's responsible for applying and/or removing resident splints. V12 (Restorative Aide) stated, Restorative puts splints on, and on the weekends the CNAS will. I (V12) don't work the weekends. Surveyor inquired where splint application and removal are documented. V12 responded, You (staff) go in the charting (referring to the Electronic Medical Record - Nursing Rehab) where it says you put it on and took it off. Surveyor inquired if the staff name and/or initials are documented when splints are applied and removed. V12 replied, Yes, cause its under my (V12) charting information. Surveyor inquired when R1's splint(s) are supposed to be applied and removed. V12 stated, Anywhere between 2 to 4 hours, it's no designated time when it goes on and when it comes off. Surveyor inquired if it was appropriate to exclude actual times to place and remove resident splints. V12 responded, Yes and no, not necessarily. Surveyor inquired about R1's splints. V12 replied, I put her (R1) splints on today. Surveyor inquired about R1's wound (on the right forearm/antecubital area - identified 2 days prior). V12 stated, I'm (V12) not aware of a wound. On 4/29/26 at 12:05pm, (7 minutes later) R1's right hand splint was on, and a large dressing was observed on the (right) arm with the wound partially exposed. Surveyor inquired when R1's right hand splint was applied. V15 (Family) stated, I (V15) think they (staff) put it on yesterday. [R1's right hand splint is supposed to be on for 2-4 hours daily]. R1's (April 2026) documentation survey report includes Nursing Rehab: assistance with right hand resting splint (off) and assistance with right hand resting splint (on). The response for placing the splint on is Y for Yes or N for No. The response for taking the splint off is 2 for Yes or 1 for No however from 4/1-4/28 the entries are marked X which affirms nothing was documented. On 4/29/26 at 2:55pm, surveyor inquired about R1's (April 2026) right hand splint documentation. V3 (Assistant Director of Nursing) reviewed R1's documentation survey report and stated, It says 6:30am in the morning to 2:30pm but I don't see anything documented it's just X's. If it was applied, a number 1 for No or number 2 for Yes (for off) would be documented. For the (on), it says was the brace/splint applied? a Y for yes and an N for no. All I (V3) see are X's. Surveyor inquired if R1's Nursing Rehab tasks includes a right knee brace. V3 responded, No. The restorative nursing policy (revised 7/3/25) states it is the policy of this facility to assess for comprehensive nursing and restorative needs upon admission. Appropriate nursing and restorative services consistent to the resident's functional needs must be provided. Restorative programs 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, CNA's and/or restorative aides. R59 is 72 years and has resided at the facility since 2022, face sheet listed the following past medical history in part: hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, unspecified protein calorie malnutrition, depression, acute ischemic heart disease, other seizures, hyperlipidemia, essential primary hypertension, dysphasia, etc. Minimum Data Set (MDS) assessment dated [DATE], section c (cognitive patterns) scored R59 with a brief interview for mental status (BIMS) score of 3, section gg (functional) of the same assessment indicated that r59 is dependent on staff for all activities of daily living (ADL) care needs. On 04/27/2026 at 11:00AM, resident was observed in bed sleeping, contracture noted to the left side, resident did not have any brace or splint to his left side, Fingernails noted to be long and dirty with the left fingernails digging into resident's hands. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/28/2026 at11:10AM, R59 was observed again in bed, awake and alert and stated that he needed to be turned. R59 was asked if he had any splint, brace or arm rest that goes to his left side, and he said no. Physician order dated 05/01/2024 documented the following: Nursing Rehab: Assistance with splint or brace (specify) resting hand splint to left upper extremity (LUE) at bedtime. Order for right arm rest comfort ACTA_BACK, order date 8/15/2024. On 4/28/2026 at 11:50AM V44 (CNA) said that she is not assigned to R59 today but has worked with him before and does not recall resident having any splint or brace or arm rest for his left side. V44 asked resident if he had any splint or brace and he said no. On 4/28/2026 at 2:02PM V45 (LPN/ restorative nurse) was presented with this observation, and he could not state whether R59 has any type of splint, brace or arm rest. On 4/28/2026 at 2:13PM, V46 (Restorative aide) said that resident does not have any brace or splint or arm rest, V46 have not seen resident with any since she starred working here. Documentation survey report for April 2026 presented by V3 (ADON) under nursing rehab: assistance with left hand resting splint application and removal was marked with an X for the whole month, except on 4/29/2026, after surveyor brought it to the attention of the restorative nurse and aide.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to follow provider order for continuous oxygen, failed to ensure the nebulizer mask was labeled with the date it was changed, and failed to ensure the respiratory equipment was contained when not in use. These failures affected two (R101 and R129) residents reviewed for respiratory care in the total sample of 67 residents.Findings include: On 04/27/2026 at 10:53am, there was a red and white sign posted on R129's door frame No smoking, No open Flame, Oxygen in use. Inside R129's room, there was a nebulizer mask and tubing by R129's nightstand. On 04/27/2026 11:03am, V22 (Registered Nurse) checked R129's nebulizer mask on R129 nightstand and stated the nebulizer mask and tubing were not labeled with date and were not contained. V22 stated these should be dated and contained in clear plastic bag. V22 took R129 mask and tubing and stated she would provide her (R129) with a new nebulizer mask and tubing. On 04/28/2026 at 2:02pm, V2 (Director of Nursing) stated the nebulizer mask should be contained in clear plastic bag when not in used to prevent cross contamination and to prevent infection. Changing of nebulizer mask is weekly on Sunday night and as needed. The staff who changed the mask should label it with the date it was changed for the same reason; to prevent cross contamination and to prevent infection. R129's (Active Order As Of: 04/27/2026) Order Summary Report documented, in part Diagnoses: (include but are not limited to) chronic obstructive pulmonary disease, hypertension, respiratory failure with hypoxia, and sepsis. Order Summary: Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-. Albuterol) 1 vial inhale orally every 6 hours as needed for SOB (shortness of breath)/Congestion. Active 04/09/2026. R129's (04/12/2026) Minimum Data Set documented, in part Section C. – Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 15. Indicating the resident's mental status as cognitively intact. Section I. Active Diagnoses. I8000. Acute respiratory failure, muscle wasting, and sepsis. R129's (04/10/2026) careplan documented, in part Focus: is at risk for alteration in respiratory functioning related to: COPD, acute respiratory failure with hypoxia. Goal: Resident will not have respiratory distress and that their respiratory functioning will improve or maintain. Interventions: Administer oxygen and other medications and respiratory treatments as ordered. The (04/28/2026) email correspondence with V2 (Director of Nursing) documented, in part It is the expectation of this facility that respiratory equipment (when not in use) be bagged. The (7/3/25) Respiratory Therapy Equipment Use documented, in part Policy Statement: It is the facility's policy to ensure that oxygen and nebulizer equipment use is compliant with the acceptable standards of practice. Procedures: 1. All oxygen equipment including nasal cannula, humidifier, and nebulizer mask will not be reused. 2. Once opened, this equipment will be dated and discarded after 7 days of use, whether used continuously or on a prn (as needed) basis. R101's face sheet documents in part the following diagnoses: end stage renal disease, hypertension, (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	peripheral vascular disease, acute pulmonary edema, acute respiratory failure with hypoxia, acquired absence of bilateral legs below the knee, anemia in chronic kidney disease, and major depressive disorder. R101's minimum data set (1/12/2026) documents in part a brief interview of mental status (BIMS) summary score of 15, indicating R101 is cognitively intact. R101 had a medical order in the electronic health record dated 4/14/2026 for oxygen continuous three liters per minute via nasal cannula by V14 (Nurse Practitioner). End date indefinite. On 4/28/2026 at 8:43 AM, observed R101 not wearing oxygen. Oxygen tubing and nasal cannula were laid over the machine and not in bag. R101 stated they (staff) took the oxygen off earlier this morning and did not put it back on me. On 4/28/2026 at 8:48 AM V32 (Certified Nursing Assistant) stated oxygen tubing and cannula should be in in a bag so it does not get dirty. Pointing to R101's oxygen tubing, V32 stated that oxygen tubing and cannula should be in a bag. It's not right. The risk is that R101 could get an infection. If R101 breathes in air that has dirt in it or if the tubing and cannula hit the floor, whatever is in the air or on the floor it could make R101 sick. On 4/28/2026 at 8:50 AM V18 (House Supervisor/Licensed Practical Nurse/LPN) stated R101 should be on oxygen. R101's order is for continuous oxygen. V18 pointed to R101's oxygen tubing and cannula and stated, That tubing should be in a bag. Policy titled Physician Orders revised 7/3/2025 stated it is the policy of this facility to ensure that all resident/patient medications, treatment and plan of care must be in accordance to the licensed physician's orders. The facility shall ensure to follow physician orders as it is written in the POS (plan of service). Policy titled Oxygen Therapy and Administration reviewed 7/2/2025 documented the procedure to include confirm order from physician which should include liter flow, FiO2 and delivery device).

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	04/30/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document post-fall charting and neurological checks (neurocheck) charting in a timely manner, in accordance with professional standards. This failure caused R197's medical records not to be readily accessible or accurate for up to 9 days after R197's fall. This failure affected one (R197) of 67 residents reviewed for resident records. R197's face sheet documents R197 was a [AGE] year-old resident with a prior medical history of chronic obstructive pulmonary disease, dementia without behavioral disturbance, restlessness and agitation, iron deficiency anemia, contusion of the head, and displaced supracondylar fracture of the right humerus. R197's minimum data set ([DATE]) documents R197 had a brief interview of mental status summary score of 3, indicating R197 had severe cognitive impairment. R197 required substantial/maximal assistance with personal hygiene (including washing/drying face) and required partial/moderate assistance with transferring. R197's progress notes document on [DATE] at 6:36 AM, (R197) was sitting in wheelchair when she leaned too far forward reaching for something and fell out of wheelchair striking head. Pt noted with hematoma, soft BP, slightly hypoxic requiring o2 application, amd on Asa. Due to culmination of all of this will refer to ED for eval. At 7:56 AM, (Private Ambulance Company) here to transport resident to (hospital) for eval. Resident is leaving in stable condition. At 10:57 PM, Resident returned from (Emergency Department), after a fall. Dx: closed supracondylar fx rt humerus, and traumatic hematoma to her forehead. Right arm is placed in a splint., intact and elevated. Resident is alert and oriented to baseline. Resident placed in bed and made comfortable, call light within reach. Fall precautions in place, plan of care ongoing. There is no progress notes documented in the records until [DATE] at 12:02 PM, LATE ENTRY Note Text : 9:10am While rounding resident observed resting in bed comfortably. 10:30am Resident offered medication and tolerated well writer took vitals BP 119/62, hr 88, r-18, O2-98%. 11:11am CNA was rounding on resident and noted in bed unresponsive to name. CNA alerted writer. Writer assessed resident and resident noted in bed unresponsive to verbal stimuli, painful and tactile stimuli. Writer verified code status, resident is a full code. Writer unable to palpate carotid or radial pulse. 11:12am Code blue initiated, CPR started and 911 called. AED applied with no shock advised. CPR continues with vitals unable to be obtained. CPR ongoing. 11:20am Evergreen Park paramedics and fire department arrive at the facility and took over compressions. 11:30am (Nurse Practitioner) notified of clinical status. 11:40am (V70 - Family Member) notified of change in condition and stated that (V70) was in route to the facility. 11:46am Paramedics CPR efforts cease and was pronounced deceased by (physician) 11:50am (EMS) left facility.12:00pm Postmortem care initiated.R197's neurochecks initiated after the fall on [DATE] document V73 signed neurochecks as complete on [DATE] and [DATE], V69 signed neurocheck as complete on [DATE], and V75 (Agency Registered Nurse) signed neurochecks as complete on [DATE].R197's post-fall follow up Day 1 2/3 was signed by V69 on [DATE] as complete. Day 2 (1/3, 2/3) were signed by V75 as complete on [DATE]. Day 2 (3/3) was signed as complete by V73 on [DATE]. There was no post fall charting completed for day 3 after the fall. On [DATE] at 2:02 PM, V18 (House Supervisor/Licensed Practical Nurse/Falls Nurse) affirmed V18 oversees the fall prevention program for the facility and assists with fall investigations. V18 explained the facility completed post-fall charting and neurological checks after the fall to check for level of consciousness, neurological decline. V18 affirmed the last neurocheck was due at 10 AM and was not completed by the nurse but all other neurochecks were completed. Observed the neurocheck charting and post fall charting with V18 and noted multiple neurocheck entries and post fall entries were charted on or after [DATE] (6+ days after the resident had passed away). V18 explained the purpose of charting timely is to ensure accuracy of the records and make sure changes in condition were not missed. V18 recalled coming back from a leave and noticed they were completed but not signed out so (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V18 had to notify the non-compliant nurses and have them complete their charting. On [DATE] at 3:51 PM, V69 (Licensed Practical Nurse) affirmed V69 was assigned to care for R197 in the past and was familiar with R197. V69 affirmed V69 was assigned to care for R197 when she came back from the hospital and completed neurochecks. V69 didn't recall anything abnormal with R197's neurological status. V69 did not recall completing the neurochecks or the fall follow up at a later date but affirmed V69 did them while caring for R197. On [DATE] at 4:15 PM, V2 (Director of Nursing) affirmed V2 was familiar with R197 and completed the investigation into the fall. V2 reviewed the post-fall charting/neurochecks and affirmed multiple entries were signed as complete on [DATE]. V2 stated the facility standard is to be charting as you go, so you don't miss anything. If charting isn't completed timely, it may not be as accurate. Facility policy for timely documentation was requested from V2. This policy was not recieved prior to the exit of the survey. Record review of the facility nursing schedule indicates V69 (Licensed Practical Nurse), V73 (Licensed Practical Nurse), V75 (Agency Registered Nurse), and V76 (Agency Licensed Practical Nurse) were assigned to care for R197 after the fall occurred and before R197 expired. On [DATE] at 10:35 AM, V75 (Agency Registered Nurse) affirmed V75 was assigned to work AM and PM shift on [DATE]. V75 could not remember any details about the shifts or R197. V75 could not remember if V75 completed neurochecks on any resident while at the facility. V75 denied any knowledge of charting neurochecks or fall follow up documentation after the shifts on [DATE]. V75 stated, Yeah, I worked my day there with my agency and haven't been back. I haven't been back to chart anything late, I don't remember doing that. On [DATE] at 12:45 PM, V73 (Licensed Practical Nurse) affirmed V73 was assigned to care for R197 on [DATE] when R197 fell and [DATE] the following night before R196 expired. V73 recalled R197 was confused and impulsive at baseline and incontinent. On night shift, R197 was typically sleeping through the night but was an early riser get up. V73 recalled on [DATE], V73 gave R197 medication between 4-5 AM and R197 was in bed. Around 6:30 AM, V73 was sitting in the nurses' station and V72 came to V73 and stated R197 fell. V73 initiated fall protocols and assessed R197 for injury. One arm was moving better than the other and R197 had a large hematoma to her forehead that was about the size of a golf ball. V73 applied an ice pack to R197's head, started neurochecks and notified EMS. V73 denied any abnormal findings during neurological assessment. V73 denied observing floormats on the floor of R197's room. V73 stated, R197 was on the floor on the ground of the room, there was no mat. V73 stated, Hmm . should (R197) be left alone in the room? Well, I don't think any resident should be in a wheelchair while in the room unsupervised. I remember (V72) told me (V72) was getting another resident up when (R197) fell. V73's late charting of the post fall/neurochecks was reviewed with V73. V73 stated, I don't recall doing my charting late, I thought all of it was in there. I did double check my work. All of the neurochecks should be documented prior to the end of shift, that is the standard. I don't recall why it says I completed them after.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure the required daily nurse staffing information was accurately completed. These failures have the potential to affect all 164 residents residing in the facility.Findings include:On 4/27/26 at 9:32AM, V1 (Administrator) stated the facility census is 164 residents residing at the facility.On 4/27/26 at 10:08am, surveyor observed the Daily Nurse Staffing information posted near the receptionist area. The posting was dated 4/27/26, with a census of 177.V1's (Administrator) e-mail, dated 4/28/26 at 10:49am, documents the facility's census is 163 residents residing in the facility on 4/28/26.On 4/28/26 at 10:32am, surveyor observed the Daily Nurse Staffing information posted near the receptionist area. The posting was dated 4/28/26, with a census of 177.On 4/28/26 at 11:01am, V27 (Staffing Coordinator/Scheduler) said, I am responsible for the daily staffing posting. It is supposed to be accurate. Oh, I have to change that (census number). That's not right. I probably didn't look at it right. I was moving fast.V1's (Administrator) e-mail, dated 4/28/26 at 11:57am, documents, in part, Daily Staffing we follow regulation.Record review of the facility's Daily Nursing Staffing form posted on 4/27/26, documents in part, (Name of facility) Daily Nursing Staffing Hours; Date: 4/27/26, failed to document the correct census of the residents residing in the facility.Record review of the facility's Daily Nursing Staffing form posted on 4/28/26, documents in part, (Name of facility) Daily Nursing Staffing Hours; Date: 4/27/26, failed to document the correct census of the residents residing in the facility.Record review of facility policy titled, Postings, dated 7/03/25, documents, in part, It is the policy of the facility to comply with federal regulations in regard to posting of information for the resident. Other federally required postings such as names and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, Medicare and Medicaid contact numbers, Grievance procedures, and the Medicaid Fraud Control Unit will be posted in a form and manner accessible and understandable to residents and resident representatives.Record review of Pamphlet titled, Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities, revised date 11/18, documents, in part, Your facility must provide services to keep your physical and mental health, at their highest practical levels. Your facility must be safe, clean, comfortable, and homelike.