STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145816	A. Building B. Wing	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Lake Zurich	900 South Rand Road Lake Zurich, IL 60047

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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** 40798 Based on observation, interview, and record review, the facility failed to ensure the front entrance to the facility was safely supervised and/or secured to prevent 1 of 3 residents (R1) reviewed for safety and supervision in the sample of 6 from exiting the facility unbeknown to the staff. This failure resulted in R1 leaving the facility in the early morning hours and crossing four lanes of a major east-west arterial road where the speed limit is 50 miles per hour (MPH) wearing only a hospital gown, a brief, and shoes. R1 became hypothermic and was admitted to the hospital with an acute subdural hematoma, hypothermia due to cold environment, and unwitnessed fall. The Immediate Jeopardy began on [DATE] when staff could not find a resident in the facility. V1, Administrator, was notified of the Immediate Jeopardy on [DATE] at 4:20 PM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed, and the deficient practice corrected on [DATE], prior to the start of the survey and was therefore Past Noncompliance. The findings include: On [DATE] during travel to the facility, the noted speed limit of the four-lane highway directly in front of the facility was 50 miles per hour. R1's Admission Record dated [DATE] shows R1 was admitted to the facility on [DATE]. R1's diagnoses include, but are not limited to, traumatic subdural hemorrhage, metabolic encephalopathy, myocardial infarction (heart attack), nontraumatic intracerebral hemorrhage, abnormalities of gait and mobility, lack of coordination, weakness, contusion and laceration of the right cerebrum, need for assistance with personal care, malignant neoplasm of the large intestine and history of falling. R1's Minimum Data Set, dated dated dated [DATE] shows R1's cognition is severely impaired and R1 has no broken or loosely fitting full or partial denture or obvious or likely cavity or broken natural teeth. R1's care plan initiated on [DATE] shows R1 is at risk for altered thought processes and will be free from any injury related to accidents. R1's care plan initiated on [DATE] shows R1 is at high risk for falling and interventions include staff providing a safe environment. This same care plan also shows R1 has an alteration in neurological status and is at risk for altered thought process. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 11:15 AM, V11, CNA, said she saw R1 last around 3:30 AM on [DATE] where he was in bed, asleep, and dry. V11 said R1 was wearing a hospital gown and a diaper. V11 said she noticed R1 was not in his room at about 4:15 AM. V11 said she immediately asked the nurse if he had gotten R1 out of bed and the nurse answered, No, R1 should be in his bed. V11 said they both started looking for R1. V11 said she did not think R1 had gotten outside because she would have heard the alarms if he had gone through the doors going outside, and she had not heard any alarms. V11 said they continued to look for R1 for another 20 to 30 minutes and then someone called the Administrator, V1. V11 said at that point about an hour had gone by and they were told to keep searching for R1. V11 said they still could not find R1. V11 said she ended up checking the door alarms to see if the door alarm would go off, and it did not go off; the alarm was not triggered, and they realized the alarm was not turned on or it was not working. V11 said they were even more terrified now and they searched outside by the pond and all around the facility. V11 said it was very cold outside and R1 was wearing only a hospital gown and a diaper when she put him to bed. V11 said the police were eventually called and they found R1 across the four-lane highway where she believes the speed limit is 45 MPH. On [DATE] at 2:21 PM, V5, Registered Nurse (RN), said he was R1's nurse on [DATE] going into [DATE] during the night shift. V5 said he noticed V11 was looking for R1 and asked if he knew where R1 was. V5 said they both started looking for R1. V5 said R1's bed alarm did not sound and the door alarms for the building did not go off. V5 said it was cold outside that night and he had to get his coat when he went outside to look for R1. V5 said the police eventually found R1 across the four-lane highway outside of a fast-food restaurant. On [DATE] at 10:00 AM, V1 said she was informed on [DATE] by phone at about 5:13, AM that staff could not find R1. V1 said she was driving to the facility and on the way, she received a call from the police that R1 had been located across the four-lane highway from the facility. V1 said when she later reviewed the video, she could see R1 walking out the front door of the facility and turning left wearing a gown, a diaper, and shoes. V1 said the video has no sound, so she cannot say if the door was alarmed or not. V1 said the police called an ambulance for R1 and he was taken to the hospital. V1 acknowledged that a human body temperature of 93.2 degrees Fahrenheit (F) is considered hypothermia. V1 said R1 had a tooth knocked out and an abrasion. On [DATE] at 3:00 PM, V1 said the video she reviewed from [DATE] showed R1 exiting the facility through the front door between 4:05 AM and 4:10 AM. On [DATE] at 1:24 PM, V13, Medical Director said he would be very concerned about a person's body temperature of 93.2 degrees F. V13 said hypothermia can cause a heart attack, a stroke, or respiratory arrest, then eventually death. V13 said it was cold outside when R1 eloped, and he could have died . On [DATE] at 1:52 PM, V2, Director of Nursing (DON), said R1 had a head injury from his fall when he eloped. V2 said the doors are all alarmed from 8:00 PM until 8:00 AM and a code is needed to enter or leave during those hours. On [DATE] at 11:25 AM V14, Nurse Practitioner (NP), said hypothermia is a body temperature being lower than normal. V14 said a normal human body temperature is 98.6 degrees F. V14 said the dangers of hypothermia include death. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The police report dated [DATE] shows police were dispatched on [DATE] at 5:41 AM to the facility for a missing adult. Police officers who were originally at the facility left and went to where R1 had been found across the highway from the facility by other police officers. The report describes R1 as wearing a hospital gown, being confused, and having small cuts on his arms and legs with a bloody mouth. R1's Emergency Department (ED) notes dated [DATE] show R1 presented via ambulance for an unwitnessed fall outside of his living facility. R1 had a missing tooth with dried blood and abrasions to his upper and lower extremities consistent with a fall. R1's rectal temperature was 93.2 degrees F. R1's ED diagnoses are acute subdural hematoma, hypothermia due to cold environment and unwitnessed fall. R1 was admitted to the hospital from the ED on [DATE] at 9:52 AM. The facility's Elopement Policy (reviewed [DATE]) shows it is the policy of the facility that all residents are afforded adequate supervision to provide the safest environment possible. The Immediate Jeopardy that began on [DATE] was removed on [DATE] when the facility The Immediate Jeopardy that began on [DATE] was removed and the deficient practice was corrected on [DATE] when the facility conducted a full house audit of all residents to identify those who are an elopement risk on [DATE], conducted in-services with all staff on the elopement policy which was completed by [DATE], evaluated and inspected the front door alarm system and found it to be in good working condition on [DATE]. A lock box was installed on [DATE] over the kill switch which is located in the ceiling. Only supervisory/authorized staff have access. A new code panel was installed on the internal set of glass doors requiring a code to exit the facility on [DATE]. All other exit doors were checked and found to be fully engaged and functioning on [DATE]. All bed/chair/personal alarms were checked and found to be in good working condition on [DATE]. The doors equipped with the Wander Guard system were checked and properly functioning on [DATE]. A QA audit tool was initiated on [DATE] for maintenance to check the alarmed doors and wander guard equipped doors for proper functioning three times a day for 12 weeks. All staff were in-serviced on the importance of immediately responding to exit door alarms and completed by [DATE]. All staff were in-serviced on ensuring that the front exit door alarm is consistently activated between 8:00 PM and 8:00 AM. This in-service was completed between [DATE] and [DATE]. A QA audit tool was initiated on [DATE] to ensure that the front alarm door is properly functioning. It will be done three times a week for 12 weeks. An emergency QAPI meeting which was attended by the Medical Director via phone was held around 2:00 PM or 3:00 PM on [DATE]. The Medical Director was in agreeance with the plan of correction developed by the committee. All trends identified will be discussed in the monthly QAPI meeting until resolution. These corrections were implemented and/or completed prior to the start of the current survey.