STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145816	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER: Avantara Lake Zurich		STREET ADDRESS, CITY, STATE, ZIP CODE: 900 South Rand Road, Lake Zurich, IL 60047	

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20042 Based on observation, interview, and record review the facility failed to ensure least restrictive interventions were provided prior to the implementation of a physical restraint and failed to release the restraint during supervised activities for 1 of 2 residents reviewed for restraints in the sample of 27. The findings include: On 1/14/25 at 1:05 PM, R90 was sitting in his wheelchair at a table in the dining room. R90 had a lap belt restraint in place and secured closed. At 1:07 PM, R90 was served his lunch and his lap belt restraint remained intact. V21 CNA (Certified Nursing Assistant), V18 CNA, and V19 CNA were in the dining room passing trays and assisting residents. R90's lap belt restraint was not released during the supervised meal. On 1/15/25 at 12:05 PM, R90 was sitting in his wheelchair in front of the nurses's station with his lap belt restraint in place and secured closed. R90 was waiting to leave for an appointment. The surveyor directed R90's attention to his restraint and asked him what it was and if he could remove it. R90 stated he did not know what it was and that they put it on him. R90 was asked if he could remove the seat belt and he stated no. R90 touched the restraint and stated he did not know how or why he had it. On 1/16/25 at 10:16 AM, V2 DON (Director of Nursing) stated R90 had a self releasing seat belt and depending on the day he is able to release it. V2 stated R90 could not consistently remove the seat belt on command. V2 stated R90 had the seat belt in place for his safety. V2 stated the seat belt was in place because R90 was restrained in the hospital, had a history of agitation, and he had a fall within 24 hours of admission to the facility. V2 stated V24 RN (Registered Nurse/Restorative Nurse) does all of the assessments for restraints. V2 confirmed that least restrictive measures should be put in place prior to the use of a restraint. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145816	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/25 at 10:27 AM, V24 RN (Registered Nurse/Restorative Nurse) stated R90 was admitted to the facility on [DATE] and had a fall on 12/6/24. R90 had an alarm in place initially and after the fall the placed a cushion lap restraint on his wheelchair. V24 stated R90 was able to take the cushion lap restraint off and throw it. V24 stated they switched immediately to the self release restraint buckle on that same day. V24 stated R90 can release the restraint on good days. On bad days because of his cognitive deficits he cannot remove the restraint. V24 stated R90 cannot remove the self release buckle on command. V24 stated the restraint should be released when R90 is in the dining room and staff is with him. V24 stated in dining room before lunch they have activity staff and the restraint is to be released. V24 stated the restraint should be released at meals. V24 stated R90 came in at risk for falls. If a resident has a history of falls they try to initiate something. V24 confirmed there is an adjustment period when a resident is admitted to the facility and the resident needs to get acquainted with the environment. V24 stated when R90 first came in he was agitated and they had to keep an eye on him. On 1/16/25 at 10:37 AM, R90 was sitting in a wheelchair with his restraint buckle in place and closed. R90 was playing a ring toss game with V25 (Activity Aide). R90 was observed continuously from 10:37 AM - 11:08 AM at the supervised activity with his restraint not released. On 1/16/25 at 11:16 AM, V20 CNA stated R90 has the lap belt so he doesn't fall. V10 stated she doesn't do anything with the belt other than to make sure it is on. V20 stated when R90 first came in he was getting up from his chair every 5 minutes. R90 wouldn't stay sitting so the lap belt was put on him. Now R90 sits all of the time. The Face Sheet dated 1/16/25 for R90 showed diagnoses including dementia, insomnia, anxiety, paranoid personality disorder, dysphagia, weakness, transient ischemic attack, history of falling, hypertension, anemia severe protein calorie malnutrition, atherosclerotic heart disease, restlessness and agitation. R90's Care Plan showed, admitted : 12/5/2024. R90 is at high risk for falls related to history of fall. Self release belt while up in chair. May remove during activities of daily living and care. Date initiated: 12/5/2024. Bed and chair alarm to alert staff when resident attempts to get out of bed unassisted, so staff can assist resident and prevent falls - date initiated 12/5/24. Lap cushion restraint initiated but resident able to remove item from wheelchair. Self release belt initiated - date initiated 12/6/24. The facility's Restraints policy (8/19/24) showed, it is the facility's policy to ensure that each resident is not restrained for the purposes of discipline or convenience. The facility will utilize non-restraining interventions first before trying restrain-type devices which would be considered as last resort. Physical restraint is defined as manual method, physical or mechanical device, equipment or material that meets all of the following criteria: A) attach or adjacent to the resident's body; B) that the individual cannot intentionally remove easily, and; C) restricts freedom of movement or normal access to one's body.

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	145816	A. Building B. Wing	01/16/2025

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38488 Based on observation, interview, and record review the facility failed to ensure daily weights were done for a resident with congestive heart failure for 1 of 1 residents (R80) reviewed for weights in the sample of 27. The findings include: R80's face sheet showed she was admitted to the facility 8/21/24 with diagnoses to include Chronic Diastolic Congestive Heart Failure, Type 2 Diabetes, Hyperlipidemia, anxiety disorder, hypertension, and need for assistance with personal care. R80's facility assessment dated [DATE] showed she has moderate cognitive impairment and requires substantial to maximum assistance from staff for most cares. R80's care plan initiated 8/22/24 showed, [R80] has altered cardiovascular status related to hypertension, congestive heart failure,and atrial fibrillation . Vital signs as ordered and PRN (as needed). Notify physician of any abnormal readings . R80's January 2025 Physician Order Sheet showed an order dated 8/21/24 to Monitor weight daily before breakfast. Notify MD of a 2 lb weight gain in one day or 5 lb weight gain in one week. R80's January 2025 eMAR (electronic Medication Administration Record) showed weights documented 1/1/25 and 1/3/25. There were 14 of 16 weights that were not completed for R80. On 1/16/25 at 12:08 PM, V9 RN (Registered Nurse) said R80 is not a daily weight. V9 said residents are usually on daily weights to monitor fluid changes for heart issues such as Congestive Heart Failure. On 1/16/25 at 12:20 PM, V2 DON (Director of Nursing) and V26 ADON (Assistant Director of Nursing) were interviewed together. V26 said verified R80 has an order to be weighed daily with parameters to notify the physician for changes. V26 said R80 has a diagnosis of Congestive Heart Failure. V26 said the CNAs (Certified Nursing Assistants) complete the daily weights and report to the nurses who document them daily. V26 said the nurses would be monitoring the weights and notifying the physician of changes. V26 said R80's daily weight is not being done daily as it is ordered. The facility's policy and procedure with revision date of 2/27/24 showed, . Congestive Heart Failure Clinical Protocol . It is the policy of this facility to ensure implementation of the following clinical protocols for all residents/patients who are admitted with primary diagnosis of Congestive Heart Failure . Hydration and Fluid Balance . 3. Obtain and record the daily weight as ordered .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 20042 Based on observation, interview, and record review the facility failed to have a dressing in place for the suprapubic catheter and failed to ensure the dressing change to the suprapubic catheter was done as ordered for 1 of 3 residents (R32) reviewed for catheters in the sample of 27. The findings include: On 1/14/25 at 11:06 AM, R32 stated they put medication in his penis this morning because he couldn't pee. R32 stated his catheter was not draining all last night and this morning. R32 stated his groin hurt this morning until the nurse injected something into his catheter and it started draining. R32 stated it feels wet where the urine drains out of his stomach (suprapubic catheter) and he wanted the nurse notified. At 11:15 AM, V17 RN (Registered Nurse) was notified R32 complained that his catheter was leaking. V17 put gloves on and walked into R32's room. V17 went over to R32 and asked him if he felt wet. R32 replied, yes. V17 pulled back R32 covers and pulled down his incontinence brief in front. R32 did not have a dressing over his suprapubic catheter. Urine was draining out around the catheter tubing and the skin was reddened. R32 complained of some pain. V17 walked around to the catheter drainage bag, lifted the bag up and there wasn't any drainage in the bag. There was sediment in the catheter tubing. V17 removed his gloves and left the resident's room. On 1/14/25 at 11:24 AM, V17 went to V22 RN (Registered Nurse/Nurse Manager) and stated R32's catheter was leaking. V22 stated R32 was supposed to have a dressing in place around the suprapubic catheter. V22 stated that R32 did not have one in place and he hasn't done the dressing yet. The surveyor asked V22 about dressings, wound care/bosomy care and she confirmed that the care provided should be according to the physician's orders. On 1/14/25 at 11:33 AM, V13 LPN (Licensed Practical Nurse) went into R32's room with gloves on. V13 did not put a gown on. R32 had saline, gauze and a drain sponge. V13 went over to R32 and pulled his incontinence brief down in the front. R32 had drainage around the tubing that was going to the right side and left side of his groin area. V13 took the saline, put it on the gauze and cleaned around the reddened urostomy site. R32 made a noise and stated, that burned. V13 apologized and stated it needed to be cleaned. V13 discarded the gauze. V13 picked up the new gauze, put saline on it and cleaned around the urostomy again. R32 waved his hand over the suprapubic catheter ostomy site to dry it and decrease the burning sensation. V13 applied a drain sponge under the suprapubic catheter and secured it with tape. The Physician Order Summary Report dated 1/15/25 showed, wound care to catheter site, clean with normal saline, pat dry, apply skin prep then cover with a dry dressing two times per day and as needed if soiled. Suprapubic catheter: Monitor skin integrity around stoma. The Care Plan dated 12/17/24 for R32 showed, R32 is at risk for alteration of bowel and bladder functioning related to decreased strength and endurance. With suprapubic 18 french, 30 ml (milliliters) for retention of urine, BPH. Ostomy: maintain the ostomy site to keep it clean and dry to prevent irritation. Ostomy: perform ostomy care daily and as needed per physician's order. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Face Sheet dated 1/15/25 for R32 showed diagnoses including obstructive and reflux uropathy, chronic kidney disease, benign prostatic hyperplasia, moderate protein calorie malnutrition, atrial fibrillation, peripheral vascular disease, heart disease, spinal stenosis, hypertension, atherosclerotic heart disease, hyperlipidemia, lack of coordination, diarrhea, and chronic obstructive pulmonary disease. The facility's Indwelling Catheter policy (7/31/24) did not show care of a suprapubic catheter to include site care and dressing changes.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39537 Based on observation, interview, and record review the facility failed to ensure food was handled in a manner to prevent cross-contamination and failed to ensure a cook performed hand hygiene in a manner to prevent cross contamination. This affects all the residents residing in the facility. The findings include: The facility's CMS Form 671 dated 1/14/25 showed there were 138 residents residing in the facility. On 1/14/25 at 12:35 PM, V6 (Cook) washed his hands, walked with dripping hands to the box of gloves, near the steam table, and applied gloves with wet hands. V6 touched the exterior surfaces of the gloves with his dripping hands numerous times, in an attempt to apply the gloves. V6 went to the walk in-freezer and obtained a large box of frozen vegetable mix, containing several smaller plastic bags of vegetable mix. V6 obtained steel steamer pans from the shelves with the same gloves. V6 opened an individual bag of frozen vegetable mix and placed half of the bag into each steamer pan. V6 used his gloved hands to open the dirty trash can lid (there was food debris noted all over the top of the lid) and dispose of the plastic bag. V6 then obtained another bag of frozen vegetable mix, opened it and dumped the contents into the steamer pans. V6 used his contaminated gloves to spread the frozen vegetables in the steamer pan. V6 then used the same contaminated gloves to open the dirty trash can lid and dispose of the plastic bag. V6 continued this process to place 8 individual bags of frozen vegetables into steamer trays with the same contaminated gloves. V6 loaded the steamer trays of frozen vegetables into a cart with the contaminated gloves, then touched the walk-in freezer handle with the contaminated gloves, entered the freezer and obtained a box of frozen carrots. V6 placed them on his work station and turned to obtain additional clean steamer trays with is contaminated gloves. V6 obtained a stainless steel dish to scoop the diced carrots out of the box and into the steamer tray. V6 used the contaminated gloves to spread out the diced carrots. At 12:40 PM, V5 (Food Service Director) asked to speak with V6 and took him into the walk-in refrigerator. When V6 exited the walk-in, he was removing his contaminated gloves. V6 said the frozen vegetable mixes and frozen carrots were for the dinner meal today. V6 stated, I'm trying to get myself organized. At 12:44 PM, V6 washed his hands in the rear, food preparation sink. The kitchen had a designated handwashing station that was not it use. V6 did not dry his hands and walked to the box of gloves with dripping, wet hands and applied gloves. At 12:54 PM, V6 obtained a thermometer and reached into a large, stock pot of soup, cooking on the stove. V6 did not have gloves on and said he was checking the temperature of the chicken soup. At 1:03 PM, V27 (Cook) and V28 (Dietary Aide) were discussing the need for a mechanical soft hamburger. V6 stated, Speaking of hamburgers, and went to wash his hands. V6 applied gloves with dripping wet hands, obtained a baking sheet and sprayed it with non-stick cooking spray. V6 walked past the garbage can and touched the dirty lid with his gloved, right hand. V6 used the contaminated glove to open the walk in freezer, obtained 6 frozen frozen hamburger patties, and placed them on the baking sheet. V6 exited the freezer and walked to the oven. V6 used his contaminated glove to open the oven and turn the dial on the oven. V6 said he is the main evening cook and he's worked at the facility since September 2024. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/14/25 at 1:08 PM, V5, (Food Service Director) said there is a separate hand washing station for a reason. This (rear sink) is considered a food prep sink. V6 said the staff should not be washing their hands in the food prep sink because it increased the risk of cross-contamination and potential food borne illness. During this interview, V6 walked to the food prep sink and started washing his hands. The surveyor alerted V5 to V6 washing his hands in the food prep sink and V5 replied, He knows he's not supposed to do that. That's why he corrected himself and moved to the handwashing sink. The surveyor asked V5 what the proper technique was for hand washing. V5 said the staff use water and soap, lather for 30 seconds, rinse their hands, and dry their hands with a paper towel. V5 said staff should dry their hands to prevent bacteria from remaining on their hands. The surveyor asked V5 if the hands should be dry when applying gloves. V5 replied, Yes, of course. During this interview, V6 left the handwashing station with dripping wet hands and started to apply gloves. V5 told V6, You can't do that. Your hands have to be dry when you apply gloves. V6 replied, The water lubricates hands. it's the only way I can get the gloves on. V5 told V6, Dry hands, dry gloves. V5 said food should never be touched with contaminated gloves. V5 said if the garbage can is touched, then the gloves should have been removed and V6 should have washed his hands and applied clean gloves before touching the food. V5 said that's a cross-contamination issue. The surveyor explained that V6 touched the frozen vegetables multiple times with the same contaminated gloves. V5 replied, That's unacceptable. The [corporate contractor's] Hygiene Standards and Procedures revised 8/13/24 showed, Purpose: The Centers for Disease Control and Preventions (CDC) has reported that poor hygiene is one of the top five risk factors contributing to foodborne illness in food service environments. The CDC identified the main risk factors to be insufficient or improper hand washing and the improper use of disposable gloves. Pathogenic microorganisms, and physical and chemical contaminants (including allergens) can be introduced and cause foodborne illness, injury, or allergic reactions if food, drinks, and food-contact surfaces/equipment come in contact with the following: Hands that are not washed and gloved . Scope: The [corporate contractor] Hygiene Standards and Procedures apply to: All employees engaged in food preparation, production, or service . 4.1.1. Hand & Arm Hygiene: All employees and visitors entering into a food preparation, production, service, and warewashing area must wash their hands with soap and warm water and adhere to the standards stated below. Employees must wash hands when starting work, as well as: .Handwash after . Handling garbage, handling dirty equipment and utensils . Where to Handwash: Wash hands in designated handwash sinks. Do not wash hands in the food preparation sink, warewashing sink, or utility sink . 4.1.4. Disposable Gloves: Disposable gloves must be worn to protect food and food-contact surfaces from cross-contamination. Their intended use is not to protect employees from cross contamination. When to wear disposable gloves: Disposable gloves must be worn by everyone handling exposed foods that are raw or ready-to-eat, or engaged in food production in all production and service areas . How to use: Follow proper handwashing procedures before and after using gloves . The undated Chef (Cook) Job Description showed responsibilities to include: Prepare food in accordance with standard recipes, and special diets and following sanitary regulations as well as with established policies and procedures; Follow established Infection Control and Universal Precautions policy and procedure while performing tasks. The undated [corporate contractor's] Hand Washing, Chemical Use, and PPE Policy showed the proper handwashing process was: Wet hands with warm water; Lather hands with soap, making sure to get in between fingers, under nails and in any folds or crevices. Lather up past the wrist; Massage in lather for 30 seconds; Rinse thoroughly, and dry with paper towels; Use paper towel to turn off valves on sink and to open door to avoid re-contaminating hands.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891 Based on observation, interview, and record review the facility failed to ensure contact/droplet isolation precautions were maintained (R99, R131), failed to ensure enhanced barrier precautions were posted (R113), and failed to ensure personal protective equipment (PPE) was worn in a manner to prevent cross contamination (R131, R52, R32) for 5 of 5 residents reviewed for infection control in the sample of 27. The findings include: 1. R99's face sheet printed on 1/15/25 showed diagnoses including but not limited to influenza virus with respiratory manifestations, elevated white blood cell count, and dementia. R99's order summary report showed an order start dated 1/11/25 for: Maintain at all times: strict droplet isolation precautions due to an active infection. Single room, resident alone and not cohorted with a roommate. Resident remains in the room at all times. All services are done in the room. Every shift for 7 days. On 1/14/25 at 11:42 AM, R99's room had isolation signage, instructions for donning and doffing PPE, and a PPE supply bin outside of her room. The room was viewed from the doorway and R99 was not present. The isolation sign clearly showed STOP-CONTACT & DROPLET PRECAUTIONS. The sign showed to report to the nurses's station before entering the room. On 1/14/25 at 11:54 AM, V11 (Registered Nurse) was questioned regarding R99's isolation precautions and where abouts. V11 verified R99 was still on contact/droplet isolation. V11 said she was seated in the group dining room. V11 said R99 is allowed out of her room because she has dementia and is a fall risk. V11 said R99 does not understand she needs to stay in her room or wear a mask outside of it. This surveyor observed R99 in the dining room without any mask and was slowly self-propelling around the area. Multiple tables were filled with residents awaiting lunch. At 12:11 PM, R99 was at a four top table with other residents seated with her. At 12:52 PM, R99 and the table mates were eating lunch together. On 1/14/25 at 12:33 PM, V12 (Housekeeper) was in R99's room cleaning and was wearing the required PPE. V12 was able to indicate that PPE was required based on the signage and supplies posted outside resident rooms. On 1/15/25 at 9:42 AM, R99 was in the group dining room again and self-propelling her wheelchair. R99 was seated at a group table for breakfast and ate with the other residents. R99's room was still marked as contact/droplet isolation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/15/25 at 1:14 PM, V3 (Infection Control Preventionist) said R99 was diagnosed with influenza on 1/10/25 and put on contact/droplet isolation. V3 said contact isolation is necessary so other residents are kept away from any areas that R99 touches. V3 said droplet isolation is required to contain any of R99's sneezing or coughing. Other residents can get sick if they breathe in the germ droplets. V3 stated R99 needs to stay in her room and avoid other residents for the seven days as ordered. V3 said R99 should not be eating in the main dining room and meals should be delivered to her room. V3 said R99 does have dementia but can understand the need to stay in her room. V3 said a mask is necessary if there is any reason to leave the room. V3 said she had concerns with R99 eating with other residents. It is a very vulnerable population and the potential to spread influenza is very high. The facility's Influenza Management and Surveillance policy revision dated 8/28/24 states under the containment section: a. Implement Standard and Droplet Precautions for all resident with suspected or confirmed influenza. Droplet precautions should be implemented for patients with suspected or confirmed influenza for 7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer, while a patient is in a healthcare facility .Place patients with suspected or confirmed influenza in a private room or area. 2. R113's face sheet printed on 1/16/25 showed diagnoses including but not limited to Parkinson's disease, chronic kidney disease, disorders of the brain, and dysphagia (difficulty swallowing). R113's January 2025 order summary report showed medications, liquid nutrition, and water flushes were being given via G-tube (gastrostomy tube-surgically placed device to supply direct access to the stomach). On 1/14/25 at 11:37 AM, a gastrostomy feeding tube pump and supplies were next to R113's bed. A bagged piston syringe was hanging from the pole and was dated 1/14. There was no isolation signage or PPE bin outside of the room. On 1/15/25 at 9:36 AM, the feeding tube pump and supplies were next to R113's bed. There was still no isolation signage or PPE bin outside the door. On 1/15/25 at 1:14 PM, V3 (Infection Control Preventionist) stated any resident with a feeding tube needs to be on EBP precautions (enhanced barrier precautions). Staff need to wear gloves and gowns while providing any care. A mask is needed right now too due to the influenza in the building. V3 said EBP precautions signs and PPE should be right outside resident doors. There is no way staff know to wear the PPE if the signs are not up to indicate what is needed during cares. V3 said R113 is on the dementia unit and it is possible another resident moved the items. V3 said staff should be checking daily that the signs and bins are still outside EBP rooms. The facility supplied enhanced barrier precaution sign showed staff must wear gloves and a gown for high-contact resident care activities. The sign included the use of a feeding tube. 34491 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. R131's Admission Record, provided by the facility on 1/16/25, showed he had diagnoses including bipolar disorder, seizures, and influenza due to identified novel influenza A virus with other respiratory manifestations. The onset date was 1/10/25. The record also showed R131 had a cough, with an onset date of 1/9/25. R131's Order Summary Report, provided by the facility on 1/16/25, showed an order dated 1/10/25 to Maintain at all times: Strict droplet isolation precautions due to an active infection. Single room, resident alone and not cohorted with a roommate. Resident remains in the room at all times. Services are done in the room every shift for 7 days. R131's facility assessment dated [DATE] showed he had moderate cognitive impairment, required set-up or clean-up assistance for eating, and partial to moderate assistance with showering/bathing. R131's care plan, initiated on 1/10/25, showed R131 required strict droplet/contact precautions related to Influenza A. The care plan showed Observe isolation precautions as clinically indicated. Use appropriate protective equipment. Utilize proper hand washing technique. Discard all infected waste in the appropriate biohazard container placed in the resident's room. On 1/14/25 at 12:38 PM, R131 was sitting in his room, in a wheelchair. Signage on the door to R131's room showed he was on contact/droplet precautions. The sign showed prior to entering the room, staff should clean their hands and don the following PPE (personal protective equipment): gloves, gown, and face protection. The signage showed staff should make sure their eyes, nose, and mouth are fully covered before entering. The signage also showed staff should remove all the PPE before exiting the room and clean their hands. V14 (Agency CNA-Certified Nursing Assistant) entered R131's room carrying R131's lunch tray. The only PPE worn by V14 was a surgical face mask. V14 exited R131's room and walked back down to the dining room to pass lunch trays to other residents. V14 did not perform hand hygiene prior to entering or exiting R131's room, did not wear the PPE listed on the signage, and did not discard the face mask he wore into the room. At 12:42 PM, V14 was walking back up the hall after delivering a meal tray to another resident. This surveyor asked V14 the name of the resident that was on contact/droplet isolation that he delivered the tray to previously as there were two names on the wall outside the room. V14 entered the room again wearing only the face mask, walked up to the resident, bent over and asked the resident his name. V14 exited the room and identified the resident as (R131). V14 did not clean his hands prior to entering or exiting R131's room again, did not wear the PPE listed, and did not discard the mask worn into the room prior to exiting the room. On 1/15/25 at 2:12 PM, V15 (CNA) entered R131's room wearing gloves and a surgical face mask. V15 grabbed towels and items needed for R131's shower, and propelled R131 down the hall to the shower room. R131 had a surgical mask on while he was being transported to the shower room. At 2:20 PM, V15 was in the shower room giving R131 a shower. R131 did not have a face mask on. V15 had a face mask and gloves on. No other PPE was worn by V15. 4. R52's Admission Record, provided by the facility on 1/16/25, showed she had diagnoses including cerebral infarction (stroke), bipolar disorder, and schizophrenia. R52's facility assessment dated [DATE] showed she was cognitively intact and dependent on staff for toileting and personal hygiene. R52's ADL (activities of daily living) care plan, initiated on 4/2/24, showed she requires assistance with bed mobility, transfers, dressing, walking, personal hygiene, eating and toileting. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145816	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER: Avantara Lake Zurich		STREET ADDRESS, CITY, STATE, ZIP CODE: 900 South Rand Road Lake Zurich, IL 60047	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/15/25 at 2:42 PM, V15 and V16 (CNAs) went into R52's room to provide incontinence care. V15 donned two pairs of gloves. V15 cleaned R52's vaginal area, then V15 and V16 rolled R52 onto her right side. V15 cleaned R52's buttocks area, removing barrier cream that was on R52's buttocks, then applied new barrier cream. V15 removed the top pair of gloves, leaving the pair on that was under the top pair. V15 put a brief on R52, placed pillows under R52's legs to offload her heels, and covered R52 up. At 2:50 PM, V16 was asked if she would have done anything different than V15. V16 said she would not have double gloved. V16 said she was going to say something to V15, but she did not want to say it in front of this surveyor and the resident. V16 said V15 should have removed the gloves used for incontinent care, performed hand hygiene and applied new gloves before touching the resident or her blankets and pillows. At 2:52 PM, V16 was asked what PPE should be worn when entering a resident's room when they are on contact/droplet isolation. V16 said staff were told by management that if they were just going to go into a resident's room on contact/droplet to drop a tray off, as long as they did not touch anything or the resident, such as boosting the resident up, then they did not have to wear a gown or goggles/face shield. they could just wear a face mask and gloves. V16 said when giving a resident who is on contact/droplet a shower, staff should wear full PPE including N95 and goggles, gown and gloves. On 1/15/25 at 1:46 PM, V3 (Infection Preventionist-IP/LPN) said if a resident is on contact/ droplet isolation, the resident stays in their room. If staff are providing care, they need to wear PPE. We are dealing with an influenza outbreak. V3 said if staff are passing a meal tray, or just going in to ask the resident a question, if they are not providing any direct care, they need to wear a surgical mask and gloves. V3 said upon exiting the room, staff hands should be sanitized, and the mask should be changed, so they do not spread the infection to others. V3 said R131 is positive for Influenza A. On 1/15/25 at 2:25 PM, V9 (Registered Nurse-RN) said if a resident is on contact/droplet isolation, staff should wear a mask, gown, and gloves, even if going into the room really quick. V9 said all of these should be removed prior to exiting the isolation room and hand hygiene should be performed. On 1/15/25 at 2:58 PM, V3 (Infection Preventionist- IP/LPN) said when staff are giving a resident on contact/droplet isolation a shower, they should wear full PPE- including a gown, gloves, goggles or face shield, and an N95 mask. V3 said the CNA should not have double gloved; she should have removed the gloves after incontinent care, performed hand hygiene, and put new gloves on before touching the resident or her environment to prevent cross-contamination. The facility's policy and procedure titled Hand Hygiene, with a revision date of 7/30/24, showed Hand hygiene is important in controlling infections. Hand hygiene consists of either hand washing or the use of alcohol gel. The facility will comply with the CDC (Center of Disease Control) guidelines in regards to hand hygiene .1. Hand hygiene using alcohol-based hand rub is recommended during the following situations .c. Before and after entering isolation precaution settings unless the infectious organism is C. Difficile or Norovirus. d. Before and after assisting a resident with meals .f. Before and after assisting a resident with toileting .h. After contact with blood, body fluids, or surfaces contaminated with blood and body fluids. i. After removing gloves including during wound dressing change. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy and procedure titled Incontinent and Perineal Care, with a revision date of 7/31/24, showed It is the policy of the facility to provide perineal care to ensure cleanliness and comfort to the resident, to prevent infection and skin irritation, and to observe the resident's condition .4. Perform hand hygiene before the procedure. Put on gloves and appropriate personal protective equipment if indicated .6. Wash the perineal area and gently dry after the procedure. 7. discard disposable items into designated containers/plastic bag. 8. Remove gloves and dispose to designated plastic bag. Wash hands. 9. Put on new set of clean gloves to put on clean briefs/incontinent pads, to make resident comfortable, groom and change clothing . The facility's policy and procedure titled infection and Prevention Control, with a revision date of 11/21/24, showed 13. While on transmission-based precaution, the resident may only leave the room to participate in required and necessary procedures, like appointments, dialysis, etc. as long as the infection is contained . Precautions to Prevent Transmission of Infectious Agents and Transmission Based Precaution .2. Contact Precaution-intended to prevent transmission of infectious agents spread by direct contact with patient or the environment. Examples of infectious organisms requiring contact precaution are C. Difficile, Scabies, Norovirus, etc. and are outlined in CDC Appendix A (type and duration of precautions recommended for selected infections and conditions) a. Single room is required .b. Use of gown and gloves is necessary prior to room entry. Face protection may be necessary if performing activity with risk of splashing or spraying .c. Residents are restricted to leave the room except for medically necessary procedures and appointments. The policy showed 3. Droplet Precaution-intended to prevent transmission through close respiratory or mucous membrane contact with respiratory secretions. Examples of infectious organisms requiring Droplet precaution includes Covid-19, Flu, Rubella, Monkey Pox, etc . a. Single room is required .b. Eye protection, and mask should be worn for close contact with the resident. If there are infectious material that can be transmitted through contact, then gloves and gown should also be used. c. Resident is restricted inside the room and may wear mask when transported outside of the room for medically necessary procedures and appointments. 20042 5. On 1/14/25 at 11:06 AM, R32 stated they put medication in his penis this morning because he couldn't pee. R32 stated his catheter was not draining all last night and this morning. R32 stated his groin hurt this morning until the nurse injected something into his catheter and it started draining. R32 stated it feels wet where the urine drains out of his stomach (suprapubic catheter) and he wanted the nurse notified. At 11:15 AM, V17 RN (Registered Nurse) was notified R32 complained that his catheter was leaking. V17 put gloves on, stopped outside R32's room door and shut the isolation container drawer that was under the enhanced barrier precaution sign. V17 did not put a gown on and walked into R32's room. V17 went over to R32 and asked him if he felt wet. R32 replied, yes. V17 pulled back R32 covers and pulled down his incontinence brief in front. R32 did not have a dressing over his suprapubic catheter. Urine was draining out around the catheter tubing and the skin was reddened. R32 complained of some pain. V17 walked around to the catheter drainage bag, lifted the bag up and there wasn't any drainage in the bag. There was sediment in the catheter tubing. V17 removed his gloves and left the resident's room. V17 was stopped outside of R32's room and asked why there was an EBP (enhanced barrier precaution) sign up. V17 stated the sign was due to the resident having a catheter. V17 stated a gown, gloves and mask were to be worn in the resident's room. V17 stated the EBP was in place to prevent infection/contamination etc for residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/14/25 at 11:33 AM, V13 LPN (Licensed Practical Nurse) went into R32's room with gloves on. V13 did not put a gown on. R32 had saline, gauze and a drain sponge. V13 went over to R32 and pulled his incontinence brief down in the front. R32 had drainage around the tubing that was going to the right side and left side of his groin area. V13 took the saline, put it on the gauze and cleaned around the reddened urostomy site. R32 made a noise and stated, that burned. V13 apologized and stated it needed to be cleaned. V13 discarded the gauze. V13 picked up the new gauze, put saline on it and cleaned around the urostomy again. R32 waved his hand over the suprapubic catheter ostomy site to dry it and decrease the burning sensation. V13 applied a drain sponge under the suprapubic catheter and secured it with tape. V17 was in the room, with gloves on and no gown. V17 wrote on the dressing with a black marker the date the dressing was changed. On 1/15/25 at 2:15 PM, V3 (Infection Control Nurse) stated for EPB anybody with a catheter, feeding tube, intravenous access, and wounds are automatically put on EBP to protect the resident from spreading infection. When there is any close contact like shower, dressing, changing, wound care, catheter care, etc the staff are to wear all PPE (personal protective equipment) to protect the resident. V3 stated she always posts and EPB sign in front of the residents room. V3 stated she has PPE outside of the room and posts donning and doffing signs. V3 stated if anyone is handling a catheter and/or the dressing around catheter then they have to wear the gown and gloves. The Care Plan dated 12/17/24 for R32 showed, R32 is on Enhanced Barrier Precautions. 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 (multidrug resistant organism) to staff hands and clothing. The Face Sheet dated 1/15/25 for R32 showed diagnoses including obstructive and reflux uropathy, chronic kidney disease, benign prostatic hyperplasia, moderate protein calorie malnutrition, atrial fibrillation, peripheral vascular disease, heart disease, spinal stenosis, hypertension, atherosclerotic heart disease, hyperlipidemia, lack of coordination, diarrhea, and chronic obstructive pulmonary disease. The facility's Enhance barrier Precaution policy (7/26/24) showed, the facility will use enhance 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. The EBP requires the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of XDROs (extensively drug resistant organism) to staff hands and clothing.