

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145868	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Avantara Long Grove		STREET ADDRESS, CITY, STATE, ZIP CODE 1666 Checker Road Long Grove, 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639</p> <p>Based on observation, interview, and record review, the facility failed to provide dignity during personal cares for 2 of 2 residents (R31, R97) reviewed for dignity in the sample of 32.</p> <p>The findings include:</p> <p>1. R31's electronic face sheet printed on 8/8/24 showed R31 has diagnoses including but not limited to multiple sclerosis, pressure ulcer of left buttock unstageable, non-pressure chronic ulcer of right heel and midfoot, major depressive disorder, peripheral vascular disease, and dysphagia.</p> <p>R31's facility assessment dated [DATE] showed R31 has mild cognitive impairment.</p> <p>On 8/6/24 at 10:26AM, V13 (Certified Nursing Assistant) provided incontinence care to R31. R31 was rolled onto her left side with her buttocks uncovered, facing the window. R31's window had clear exposure to the parking lot where people could be seen walking by vehicles within view of R31's window. V13 stated, We don't close her blinds because she doesn't like the dark room. Normally we would but for her we don't. R31 then stated, It bothers me a little bit that my blinds were open because I'm a modest person and I wouldn't want anyone seeing me without clothes on coming to their car. I asked her to close it, but she still left it part way open.</p> <p>On 8/8/24 at 11:11AM, V11 (Clinical Care Coordinator) stated, When staff are providing personal cares for a resident, they should be ensuring that the door, privacy curtain, and window curtains are all closed so there are no opportunities for their privacy to be violated. This would also be a dignity concern as our residents are from a generation where they are very modest.</p> <p>The facility's policy titled, Privacy and Dignity reviewed 6/6/24 showed, It is the facility's policy to ensure that resident's privacy and dignity is respected by the staff at all times .1. During care that requires privacy such as incontinence care, the resident will be placed in bed and the privacy curtain will be drawn to provide full visual privacy. If the privacy curtain is not sufficient to provide full visual privacy, the combination of the privacy curtain and privacy screen will be used .door may also be closed to provide additional layer or privacy during care .</p> <p>39537</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. On 8/7/24 at 10:46 AM, V8 (Wound Care CNA - Certified Nursing Assistant) and V9 (CNA) were wearing gown and gloves to perform R97's incontinence care. R97 was instructed to roll toward V8. V8 assisted R97 with staying on his right side. R97 was wearing a gown that was open in the back. When R97 was turned, his back, buttock, scrotum and posterior legs were exposed. R97's door was open to the hallway. V7 (Wound Care Coordinator) was outside the door preparing his wound care supplies. At 10:50 AM, V7 entered the room and shut the door. After R97's care was completed, he said he wouldn't want people seeing him like that. R97 said that would be embarrassing.</p> <p>R97's Facesheet printed 8/8/24 showed R97 had diagnoses to include, but no limited to: general muscle wasting and atrophy; dysphagia; lack of coordination; chronic pain; chronic respiratory failure; obstructive sleep apnea; morbid obesity; diabetes; congestive heart failure; peripheral vascular disease; and generalized edema.</p> <p>R97's facility assessment dated [DATE] showed he had moderate cognitive dysfunction and was dependent on staff for rolling left and right.</p> <p>On 8/8/24 at 11:32 AM, V2 (DON - Director of Nursing) said the staff should ensure the door and privacy curtains are pulled to prevent the residents from being exposed. V2 said this is done for resident privacy and dignity.</p> <p>The facility's Incontinent and Perineal Care Policy reviewed 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 skin condition. Procedures: .2. Provide privacy. Avoid unnecessary exposure of the resident .</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>41639</p> <p>Based on interview and record review, the facility failed to obtain weights as ordered by a physician for 1 of 2 residents (R34) reviewed for quality of care in the sample of 32.</p> <p>The findings include:</p> <p>R34's electronic face sheet printed on 8/8/24 showed R34 has diagnoses including but not limited to hemiplegia and hemiparesis, chronic respiratory failure, dysphagia, hypertensive heart disease, and heart failure.</p> <p>R34's physician's orders dated 3/26/21 showed, Weekly weights: monitor for increased edema notify MD for weight gain of 5lbs in a week. R34's monitor record showed R34's weight was not obtained on 7/19/24, 7/28/24, and 8/2/24.</p> <p>R34's care plan dated 4/5/24 showed, Risk for fluctuating weights: (R34) has the following conditions and risk factors that put them at risk for fluctuating weights: diuretic use and diagnosis of heart failure .monitor weights per physician's orders.</p> <p>On 8/8/24 at 11:11AM, V11 (Clinical Care Coordinator) stated, Weights for residents are done on a monthly basis and as ordered by a physician. The nurses can see on the monitoring record when residents are due to be weighed so they can ensure the task is done. It would be especially important to weigh a resident with heart failure to determine if they are retaining fluid or not.</p> <p>The facility's policy titled, Weights reviewed on 6/6/24 showed, It is the facility's policy to obtain residents monthly weight unless otherwise ordered differently by the physician .</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20042</p> <p>Based on observation, interview, and record review the facility failed to ensure residents were free of accidental hazards by not removing razors from the room of residents with dementia and within reach of residents that have dementia that wander. This applies to 2 of 2 residents (R49 & R120) reviewed for safety in the sample of 32 and 8 residents (R79, R96, R103, R109, R119, R127, R142, & R149) outside of the sample.</p> <p>The findings include:</p> <p>On 8/6/24 at 12:51 PM, in the bathroom of room [ROOM NUMBER] there was a disposable razor in a clear plastic bag on the mirror ledge. The safety cover was off of the dry razor. R49 was one of two residents that resided in room [ROOM NUMBER].</p> <p>On 8/7/24 at 9:45 AM, in the bathroom of room [ROOM NUMBER] there was a disposable razor in a clear plastic bag on the mirror ledge. The safety cover was off of the dry razor.</p> <p>The Face Sheet dated 8/7/24 for R49 showed diagnoses including dementia, delirium, paroxysmal atrial fibrillation, lack of coordination, congestive heart failure, peripheral vascular disease, anemia, and type 2 diabetes mellitus.</p> <p>The MDS (Minimum Data Set) dated 6/11/24 for R49 showed severe cognitive impairment; resident uses a wheelchair and supervision or touching assistance to wheel 150 feet.</p> <p>The Care Plan dated 6/18/24 for R49 showed, R49 displays an acute confusional episodes and disorientation related to metabolic encephalopathy. R49 has an alteration in neurological status related to metabolic encephalopathy. R49 is on anticoagulant therapy related to atrial fibrillation.</p> <p>On 8/6/24 at 12:36 PM, in room [ROOM NUMBER], there was a disposable razor sitting in a plastic cup in the bathroom on the mirror shelf. The razor did not have a safety cover and had hairs in the blade. R120 was one of two residents that resided in room [ROOM NUMBER].</p> <p>On 8/7/24 at 9:41 AM, room [ROOM NUMBER]'s door was open and bathroom door was open. There were two dry disposable razors in the bathroom that had the safety covers off.</p> <p>The Face Sheet dated 8/7/24 for R120 showed diagnoses including dementia, depressive episodes, anxiety disorders, Wernicke's encephalopathy, and delusional disorders.</p> <p>The Psychiatry Progress Note dated 7/12/24 for R120 showed, irritable and frustrated behavior. Poor insight, judgement, and impulse control. Impairment of short term and long term memory. Appears distractible, suspicious, distrustful, disorganized with poor boundaries and judgement.</p> <p>The MDS dated [DATE] for R120 showed moderate cognitive impairment; set up or clean-up assistance to walk 150 feet.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/7/24 at 01:28 PM, V4 CNA (Certified Nursing Assistant) was shown the razors in room [ROOM NUMBER] and 110. V4 stated residents are not supposed to have disposable razors in their bathroom for resident safety. V4 stated they have a lot of residents that wander.</p> <p>On 8/7/24 at 1:37 PM, V6 LPN (Licensed Practical Nurse) stated she is at the facility every day and R119 is completely demented. R119 wanders into others room. R79 is very demented. R103 is forgetful, demented, hoards, goes in and out of resident's rooms. R49 has dementia, goes into others rooms and gets angry when redirected. V6 stated razors cannot be left in resident's rooms because it is dangerous; residents can cut themselves.</p> <p>On 8/8/24 at 12:49 PM, V2 DON (Director of Nursing) stated razors are not to be left in resident's rooms for resident safety.</p> <p>The facility's Residents at Risk for Elopement/Wandering (no date) received from V1 (Administrator) on 8/8/24 at 11:30 AM showed R103, R142, R149, R119, R96, R127, R120, R79, and R109 were on the list for the 100 unit.</p> <p>The Face Sheet dated 8/8/24 for R103 showed diagnoses including mood disorder, dementia, anxiety, schizoaffective disorder, major depressive disorder, and psychosis.</p> <p>The Face Sheet dated 8/8/24 for R142 showed diagnoses including dementia and Alzheimer's disease.</p> <p>The Face Sheet dated 8/8/24 for R149 showed diagnoses including traumatic brain injury, mood disorder, attention deficit hyperactivity disorder, and depressive episodes.</p> <p>The Face Sheet dated 8/8/24 for R119 showed diagnoses including insomnia, anxiety, and dementia.</p> <p>The Face Sheet dated 8/8/24 for R96 showed diagnoses including Alzheimer's disease, anxiety, dementia, and major depressive disorder.</p> <p>The Face Sheet dated 8/8/24 for R127 showed diagnosis including dementia and bipolar disorder.</p> <p>The Face Sheet dated 8/8/24 for R79 showed diagnoses including metabolic encephalopathy, psychotic disorder, dementia, and insomnia.</p> <p>The Face Sheet dated 8/8/24 for R109 showed diagnoses including major depressive disorder, schizophrenia, schizoaffective disorder, and mental disorder.</p> <p>The facility's Hazards policy (7/30/24) showed, It is the facility's policy to ensure the safety of each resident in the building and remove hazardous items and correct situations to prevent accidents. Ensure that residents have no access to medications, sharps, and chemicals that would be hazardous to them.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>20042</p> <p>Based on Observation, Interview, and Record Review the facility failed to ensure an indwelling urinary catheter drainage bag was not placed on a resident's bed or lifted above the level of the resident's bladder for 1 of 4 residents (R53) reviewed for catheters in the sample of 32.</p> <p>The findings include:</p> <p>On 8/7/24 at 1:52 PM, V4 CNA and V5 CNA went into R53's room to provide catheter care. V5 completed the catheter care and put a clean incontinence pad and incontinence brief under R53. V5 lifted the drainage bag and laid it on R53's bed. V4 picked up the drainage bag, held it up above the level of the resident's bladder as she moved the bag to his left side of the bed and attached it to the side rail. V4 and V5 adjusted the incontinence brief and incontinence pad under part of the resident's bottom. V5 turned R53 towards her. V4 unhooked the drainage bag from the side rail, lifted the drainage bag approximately a foot above the resident's bladder as she passed it over to V5 who attached the bag to his lower right side of the bed. V5 stated the drainage bag shouldn't be placed on the bed for infection control reasons. V4 and V5 both stated the catheter drainage bag should be kept below the level of the bladder.</p> <p>On 8/7/24 at 2:05 PM, V6 LPN (Licensed Practical Nurse) stated the catheter drainage bag should not be on the bed for infection control. The drainage bag should be kept below the level of the bladder otherwise the urine can back up and cause infection.</p> <p>The Face Sheet dated 8/8/24 for R53 showed medical diagnoses including retention of urine, benign prostatic hyperplasia with lower urinary tract symptoms, obstructive and reflux uropathy, urinary tract infection, hypokalemia, muscle wasting, type 2 diabetes mellitus, transient ischemic attack, dementia, and hypertensive heart disease.</p> <p>The Physician Orders dated July 2024 for R53 showed, indwelling catheter, 18 French, 10 cc balloon. Reason for use: due to obstructive and reflux uropathy.</p> <p>The Antibiotic Note dated 7/17/24 for R53 showed he was on amoxicillin 500 mg, three times per day for 10 days due to a urinary tract infection.</p> <p>The Care Plan dated 6/10/24 showed, R53 has indwelling urinary catheter due to obstructive uropathy. No interventions in place for keeping the urinary drainage bag below the level of the bladder.</p> <p>The facility's Indwelling Catheter policy (7/31/24) showed, indwelling catheter bag will always be positioned below the bladder region to prevent backflow if the catheter bag has no anti-backflow valve.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639</p> <p>Based on observation, interview, and record review, the facility failed to administer oxygen as ordered by a physician for 3 of 4 residents (R34, R95, R519) reviewed for oxygen therapy in the sample of 32.</p> <p>The findings include:</p> <p>1) R34's electronic face sheet printed on 8/8/24 showed R34 has diagnoses including but not limited to hemiplegia and hemiparesis, chronic respiratory failure, dysphagia, hypertensive heart disease, and heart failure.</p> <p>R34's facility assessment dated [DATE] showed R34 receives oxygen therapy.</p> <p>R34's physician's orders dated 11/23/21 showed, Oxygen at 2L/min (liters per minute) via nasal cannula at bedtime.</p> <p>R34's care plan dated 7/1/19 showed, (R34) is on oxygen therapy related to ineffective gas exchange, heart failure. She is on oxygen continuous on 2L/min (liters per minute) via nasal cannula .give oxygen as ordered by the physician.</p> <p>On 8/6/24 at 10:18AM, R34 was in bed sleeping with her oxygen applied via nasal cannula. The oxygen concentrator was set at 3 liters.</p> <p>On 8/8/24 at 10:57AM, R34 was sitting up in bed with her oxygen cannula laying on her chest (not in her nose) and the oxygen concentrator was set at 3 liters.</p> <p>On 8/8/24 at 11:11AM, V12 (Registered Nurse Supervisor) stated, We do rounds on all of the residents every 2 hours. During those rounds, we should be checking the oxygen concentrators to ensure they are functioning and set at the correct liter flow. R34 cannot change her own liter flow so I'm not sure why it would be set incorrectly. Oxygen should be set per physician's orders for all residents.</p> <p>On 8/8/24 at 11:27AM, V11 (Clinical Care Coordinator) stated, Oxygen should be given as ordered by the physician because that is what has been determined to be therapeutic. If it is discovered during rounds that the oxygen is not set correctly, it should be corrected immediately.</p> <p>The facility's policy titled, Oxygen Therapy and Administration reviewed 6/6/24 showed, Oxygen therapy shall be administered to patients as indicated and upon a physician's order .</p> <p>2) R95's electronic face sheet printed on 8/8/24 showed R95 has diagnoses including but not limited to fracture of head and neck of right femur, sepsis, osteomyelitis, pressure ulcer of sacral region, stage 4, flaccid hemiplegia, post laminectomy syndrome, and cord compression.</p> <p>R95's physician's orders dated 8/1/24 showed, Oxygen continuous 2L/min via nasal cannula.</p> <p>R95's care plan dated 8/2/24 showed, (R95) has pneumonia-oxygen therapy as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/6/24 at 10:23AM, R95 had her oxygen applied via nasal cannula with her oxygen concentrator set at 4.5 liters.</p> <p>On 8/8/24 at 10:54AM, R95 had her oxygen applied via nasal cannula with her oxygen concentrator set at 4 liters.</p> <p>3) R519's electronic face sheet printed on 8/8/24 showed R519 has diagnoses including but not limited to metabolic encephalopathy, dysphagia, generalized anxiety disorder, bipolar disorder, hypertensive urgency, and acute respiratory failure.</p> <p>R519's physician's orders dated 7/12/24 showed, Oxygen at 2-3L/min via nasal cannula.</p> <p>R519's care plan dated 7/14/24 showed, (R519) has an altered respiratory status/difficulty breathing related to anxiety and acute respiratory failure .give oxygen as ordered by the physician (oxygen continuous 2-3l/min via nasal cannula).</p> <p>On 8/6/24 at 10:42AM, R519 had her oxygen applied via nasal cannula with her oxygen concentrator set at 4 liters.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891</p> <p>Based on observation, interview, and record review the facility failed to ensure physician prescribed medications were administered as ordered for 1 of 2 residents (R1) reviewed for medication administration in the sample of 32.</p> <p>The findings include:</p> <p>R1's face sheet printed on 8/8/24 shows diagnosis including but not limited to neuropathy, heart disease, asthma, schizoaffective disorder, dysphagia, gout, anemia, depression, pancreatitis, diabetes mellitus, and functional quadriplegia. R1's facility assessment dated [DATE] showed no cognitive impairment or memory problems.</p> <p>On 8/6/24 at 11:04 AM, R1 was seated in a wheelchair in his room. Four medication cups were on the bedside table next to him. One cup contained a blue liquid, one contained three capsules, one contained a single blue tablet, and one contained six assorted colored tablets. R1 stated the nurse dropped those off a while ago. They are my 9:00 medicines. I asked her to just leave them. They do it all the time.</p> <p>R1's MAR (medication administration record) was reviewed and showed 12 assorted medications were signed off as been given at his 9:00 AM medication pass.</p> <p>On 8/7/24 at 2:24 PM, V2 (Director of Nurses) stated residents are allowed to take their own medication if they have been assessed to be safe. They need a safety assessment, physician order to leave at bedside, and care plan interventions in place before they can self-administer their own medications.</p> <p>R1's EMAR (electronic medical record) was reviewed, and no documentation of the required forms were found.</p> <p>On 8/8/24 at 10:10 AM, V2 reviewed R1's EMAR and verified the required safety assessment, physician order, and care plan were not present. V2 said they are important to ensure residents can properly manage their own medications.</p> <p>The facility's Self-Administration of Medication policy revision dated 6/6/24 states: 1. The IDT will assign a staff to evaluate resident's ability to safely administer medication. A Self-Administration Evaluation will be filled out to determine capability. A return demonstration will be done to accurately evaluate resident's ability after the health teaching. 2. The resident may store the medication at bedside if there is a physician order to keep it at bedside.</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38488</p> <p>Based on interview and record review the facility failed to ensure bedtime snacks were offered to residents for 3 of 3 residents (R58, R112, and R526) reviewed for bedtime snacks in the sample of 32 and one resident (R1) outside of the sample.</p> <p>The findings include:</p> <p>R58's face sheet showed he was admitted to the facility on [DATE] with diagnoses to include generalized osteoarthritis, anemia in other chronic diseases, hypothyroidism, hyperlipidemia, and depression. R58's August 2024 Physician Order Sheet showed, 8/5/23 Offer Bedtime Snack. R58's Nutrition-Snacks documentation for the last 30 days was reviewed and showed he was offered a snack two times.</p> <p>R526's face sheet showed she was admitted to the facility on [DATE] with diagnoses to include seizures, dysphagia, Type 2 Diabetes Mellitus, and hypertensive heart disease. R526's August 2024 Physician Order Sheet showed, 7/26/24 Offer Bedtime Snack. R526's Nutrition-Snacks documentation since admission to the facility was reviewed and showed no snacks offered.</p> <p>R112's face sheet showed she was admitted to the facility on [DATE] with diagnoses to include primary generalized osteoarthritis, peripheral vascular diseases, major depressive disorder, and generalized anxiety disorder. R112's August 2024 Physician Order Sheet showed, 1/31/23 Offer Bedtime Snack. R112's Nutrition-Snacks documentation for the last 30 days was reviewed and showed one snack offered.</p> <p>R1's face sheet showed he was admitted to the facility on [DATE] with diagnoses to include hypertensive heart disease without heart failure, hypothyroidism, hyperlipidemia, iron deficiency anemia, Type 2 Diabetes Mellitus without complications, major depressive disorder, and functional quadriplegia. R1's Nutrition-Snacks documentation for the last 30 days was reviewed and showed snacks were offered two times.</p> <p>On 8/7/24 at 10:42 AM, During the resident council meeting, R1, R58, R112, and R526 stated they do not get offered snacks often and they are unsure of where to get them. R1 stated he thinks he has seen snacks at the nurse's station, but staff eat them, so he assumes they are for staff and does not ask for them.</p> <p>On 8/8/24 at 11:11 AM, V11 (Clinical Care Coordinator) stated, Snacks are passed out by the floor staff each night. Not all residents are offered a snack each night, but all of the diabetic residents are offered one. Snack acceptance or refusal is documented under the physician's orders. I think the aides can also document under the tasks in the plan of care but I'm not completely sure.</p> <p>The facility's policy with review date of 7/26/24 showed, Bedtime (HS) Snacks . Policy Statement: The facility will provide the residents bedtime snacks in accordance with the federal regulations. Procedures; 1. The facility must offer snacks at bedtime daily .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145868	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Avantara Long Grove		STREET ADDRESS, CITY, STATE, ZIP CODE 1666 Checker Road Long Grove, 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639</p> <p>Based on observation, interview, and record review, the facility failed to implement contact isolation precautions for a resident (R95) with methicillin-resistant Staphylococcus aureus (MRSA), failed to wear the appropriate personal protective equipment (PPE) for 3 residents (R31, R11, R154) on enhanced barrier precautions, and failed to perform glove changes during incontinence care for 1 resident (R154). These failures apply to 4 of 9 residents reviewed for infection control in the sample of 32.</p> <p>The findings include:</p> <p>1. R95's electronic face sheet printed on 8/8/24 showed R95 has diagnoses including but not limited to fracture of head and neck of right femur, sepsis, osteomyelitis, pressure ulcer of sacral region, stage 4, flaccid hemiplegia, post laminectomy syndrome, and cord compression.</p> <p>R95's physician's orders dated 8/1/24 showed, Isolation: contact precautions, reason for isolation MRSA sacral wound.</p> <p>R95's care plan dated 4/13/24 showed, (R95) is on isolation. Contact isolation due to MRSA of sacral wound initiate proper precaution.</p> <p>On 8/6/24 at 10:23AM, R95's doorway had a sign showing, Enhanced Barrier Precautions. No sign was located outside of R95's room showing that she is on contact isolation.</p> <p>On 8/8/24 at 10:54AM, R95's doorway continued to only have a sign showing, Enhanced Barrier Precautions. No sign was located outside of R95's room showing that she is on contact isolation.</p> <p>On 8/8/24 at 11:11AM, V12 (Registered Nurse Supervisor) stated, (R95) should be on contact isolation for MRSA in her wound. I'm not sure why the correct sign is not outside of her door.</p> <p>On 8/8/24 at 11:47AM, V3 (Infection Preventionist) stated, (R95) is on contact isolation. I just checked all of the signs earlier this week so I have no idea how she couldn't have the right sign unless someone moved it. If staff aren't wearing the correct PPE in there, then they could potentially spread MRSA. Any resident on enhanced barrier precautions should be cared for with a gown and gloves and if any splashing is expected, staff should be wearing eye protection as well.</p> <p>The facility's policy titled, Infection Prevention and Control revised 7/31/24 showed, The facility has established a policy to Identify, Record, Investigate, Control, Test, and Prevent infections in the facility .8. A sign will be provided outside the room for residents on transmission-based precaution indicating the type of precaution (contact, droplet, EBP) .</p> <p>2. R31's electronic face sheet printed on 8/8/24 showed R31 has diagnoses including but not limited to multiple sclerosis, pressure ulcer of left buttock unstageable, non-pressure chronic ulcer of right heel and midfoot, major depressive disorder, peripheral vascular disease, and dysphagia.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Avantara Long Grove		STREET ADDRESS, CITY, STATE, ZIP CODE 1666 Checker Road Long Grove, IL 60047	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R31's care plan dated 5/28/24 showed, (R31) is on enhanced barrier precautions due to Foley catheter use . change gown and gloves before caring for the next resident, 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 (Multi Drug Resistant Organisms) to staff hands and clothing.</p> <p>On 8/6/24 at 10:26AM, R31's doorway had a sign showed, Enhanced Barrier Precautions: Clean hands when entering & leaving room, providers must also wear gown and gloves for the following high contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting w/ toileting. V13 (Certified Nursing Assistant) was in R31's room providing incontinence and catheter care for R31. V13 only wore gloves during R31's care. (No gown was applied at any time during cares). V13 stated R31 was not on any isolation and that she was just on precautions so no personal protective equipment other than gloves is required when caring for her.</p> <p>The facility's policy titled, Enhanced Barrier Precautions revised 7/26/24 showed, The facility will use Enhanced Barrier Precautions (EBP) to reduce transmission of multi-drug resistant organisms in the nursing home. EBP involves the use of gown and gloves to reduce transmission of resistant organisms during high-contact resident care activities for residents known to be colonized or infected with MDRO's as well as residents with wounds and/or indwelling devices.</p> <p>34891</p> <p>3. R111's face sheet printed on 8/8/24 showed diagnoses including but not limited to dementia, chronic kidney disease, schizoaffective disorder, traumatic subdural hemorrhage, and obstructive uropathy. R111's August 2024 physician order summary report showed orders start dated 6/17/24 for the use of an indwelling catheter and catheter care to be done on every shift.</p> <p>On 8/6/24 at 1:09 PM, signage was posted outside R111's door showing he was on enhanced barrier precautions. The sign stated gloves and gown must be worn for high-contact resident care activities. The sign listed the activities which included the use of urinary catheters.</p> <p>On 8/7/24 at 1:14 PM, V15 (CNA-Certified Nurse Aide) entered R111's room and donned a pair of gloves. V15 emptied R111's urinary drainage bag, adjusted the leg strap, and emptied the urine into the toilet. V15 did not don a gown at any time during the catheter care. V15 stated he does not wear a gown when he is doing catheter care for any resident. V15 said he only wears a gown if the resident has an open area on the skin.</p> <p>4. R154's face sheet printed on 8/8/24 showed diagnoses including but not limited to intracerebral hemorrhage, dysphagia, and attention to gastrostomy. R154's August 2024 physician order summary report showed orders start dated 11/9/23 for NPO (nothing by mouth) and the use of a G-tube (gastrostomy tube). R154's facility assessment dated [DATE] showed severe cognitive impairment and always incontinent of urine and bowel.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Avantara Long Grove		STREET ADDRESS, CITY, STATE, ZIP CODE 1666 Checker Road Long Grove, IL 60047	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/6/24 at 10:05 AM, signage was posted outside R154's door showing he was on enhanced barrier precautions. The sign stated gloves and gown must be worn for high-contact resident care activities. The sign listed the activities which included the use of feeding tubes (G-tubes).</p> <p>On 8/6/24 at 10:07 AM, this surveyor entered R154's room and V16 (CNA) was in the process of performing incontinence care. V16 wore gloves but no gown. R154 was incontinent of urine and while V16 was removing the wet brief, V4 (CNA) came to the bedside to assist with incontinence care. V4 wore gloves but no gown. R154's groin area, buttocks, and back were cleansed of urine. R154's urine-soaked shirt was removed. V16 continued wearing the urine contaminated gloves to put on a fresh brief and clean shirt. R154's G-tube was touched and adjusted repeatedly with the contaminated gloves during the process. V16 wore the same gloves to lower the bed to the floor, place fall mats down, put on heel protectors, and place a pillow to R154's side. V16 and V4 did not don a gown at any time during cares for R154.</p> <p>On 8/8/24 at 10:15 AM, V2 (Director of Nurses) stated staff should be following the isolation signage outside resident rooms. Any resident on enhanced barrier precautions require staff to wear gloves and a gown during care. That includes residents with catheters and feeding tubes, just as the sign shows. It helps to stop the spread of germs. V2 said gloves need to be changed once they are dirty or soiled. Urine on gloves is considered a type of contamination. Staff need to change gloves before going onto any other areas or touching anything. It is important for stopping the cross contamination of germs.</p> <p>The facility's Incontinent and Perineal Care policy revision dated 7/31/24 states under the procedure section: 6. Wash the perineal area and gently dry after the procedure .8. Remove gloves and dispose to designated plastic bag .9. Put on a new set of clean gloves to put on clean briefs/incontinent pads, to make resident comfortable, groom and change clothing.</p>		