Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007322	A. BUILDING: ______ B. WING ______	C 05/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA EVERGREEN PARK	10124 SOUTH KEDZIE EVERGREEN PARK, IL 60805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments 2192866/IL133319 2192881/IL133339 2193150/IL133692	S 000		
S9999	Final Observations Statement of Licensure Violations: Finding 1 of 2: 300.1210b)4) 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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good nutrition, grooming, and personal hygiene.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Service

b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements are not met as evidenced by:

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Continued From page 2

Based on interview and record review the facility failed to follow the plan of care and utilize a half side rail during care for 1 of 3 residents (R3) reviewed for safety intervention implementation. This failure resulted in R3 falling from the bed during direct resident care and sustaining a linear bruise measuring 32 cm x 6 cm to residents left side (under his left arm down to his waist), bruising, swelling to left ear, additional bruising to left arm, left hip and a verbalizing of increased fear of falling.

.Findings include:

R3 was admitted to facility on 10/31/19 with a diagnosis of cerebral infarction, presence of left artificial hip joint, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, chronic obstructive pulmonary disease, hypertension and hyperlipidemia.

R3's minimum data set (MDS) dated 4/8/21 documents a brief interview for mental status score of 11/15 which indicates moderately impaired. Under section G titled functional status under bed mobility documents self-performance score of 3, which indicates extensive assistance. Resident involved in the activity; staff provide weight-bearing support. Under support documents score of 2, which indicates a one person physical assist.
On 5/19/21 at 12:04PM, R3 who was alert and oriented said " V3 (CNA) came into my room to provide care. V3(CNA) let the half side rail down on the right side of the bed, rolled me onto my right my side, while I was on my side V3(CNA) walked to the other side of the bed, put his hand on my back and turned me some more causing me to roll out of bed. I fell out of bed on my left

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S9999	Continued From page 3 side. I landed on my left side. I hit my head on the floor. V3 tried to get me off the floor by himself, putting me on his knee to lift me up. V3 (CNA) hit my head three times on the bedside table while trying to get me up off the floor by himself. The bedside table was on the side of the bed by the window. It was parallel to the bed. I was not assessed by staff/nursing. A week past, when two CNAs(one restorative aide and another CNA) came into to change me and saw my side. V13 (previous Administrator) came to speak to me and I was discharge to the hospital and returned back to the facility around 3am. I have a fear of falling. I fell prior to coming to the facility and hurt my hip." R3 said his fear of falling has increased since incident. "V3 (CNA) has not worked with me since but I heard him in the hallway which made me feel uncomfortable." On 5/26/21 at 900am, R3 alert and oriented, reported same incident as above with no changes. On 5/20/21 at 12:40pm , R3 was observed to have bruising to left side (under arm to waist) measured by V15 (wound nurse) 32 cm long x 6 cm wide areas dark purple with shades of yellow around the edges. On 5/19/21 at 327PM, V3 (CNA) said he is familiar with R3 and care needs. V3 said he was performing incontinence care, bed bath and changing his linen for R3, unsure exact day. V3 denied placing side rails down during care. V3 said he turned R3 to the window on right side and R3's legs started to hit the bed side table, next to the bed. V3 said no other part of his body hit the bedside table. V3 said he reported to nurse on duty but unable to describe or name the nurse. V3 said R3 is alert and oriented and able to communicate needs. V3 said he took care of R3 following the incident with no observations of any injuries, bruising or changes in skin. V3 unable to describe how R3 sustained bruising to left side	S9999		

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S9999	Continued From page 4 and unsure of previous interview in facility reportable stating R3's back hit the bed side table. V3 said R3 is on blood thinner and that is how he sustained bruising. On 5/21/21at 324PM, V18 (nurse) said V3 (CNA) reported to him that R3 was about to fall but didn't fall. V18 said it was unusual because R3 is not mobile, so he went to check R3's vitals. R3 said he was ok. V18 said he did not ask R3 if he fell or do a body assessment. V18 said there was no injury to R3's face and R3 said he had no pain. V18 said it was not documented because there was no change or reported fall. On 5/19/21 at 232PM, V8 (restorative aid) said R3 is alert and oriented and able to communicate needs. V8 reported she was provided care to R3 and observed dark purple bruising to left side and left ear. R3 reported that last week V3(CNA) dropped him out of bed. On 5/21/21 at 127PM, V24 (NP) said R3 is alert and oriented and "knows what is going on." V24 said V2 (DON) requested R3 to be seen due to bruising. V24 said what is documented in her progress note is accurate to description. V24 said R3 reported V3 (CNA) put right side rail down and he fell out of bed about a week ago. The injury to left ear appeared older due to bruising was yellow which indicates healing but unable to determine the exact time of incident. The injuries did not appear to be have recently occurred. V24 said she had no comment on if the facility staff should of observed bruising prior to 4/28/21. On 5/21/21at 1125am, V2 (DON) said Residents use half side rails to help with repositioning and turning. V2 said it would not be expected for staff to put down half side rails during care. V2 said R3 did not fall and maybe thought that he fell. The investigation revealed that there was an incident because the resident sustained bruising but there was no intentional harm to the patient. V3 (CNA)	S9999		

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S9999	Continued From page 5 reported that R3's leg slipped out of the bed and R3 did not fall. V3 (CNA) said he reported to V18 (nurse) that R3 leg slipped out of bed. V2 said V3 should have turned R3 to him first prior to turning to side to ensure he was positioned properly in bed which caused R3 to hit bed side table. V2 said the incident could have been avoided. R3's progress note dated 4/28/21 at 1615 by V24 (NP) Late Entry: Note Text: Was asked by V2 (DON) to see patient for concerns of bruising to his back and his left ear bruised and swollen. R3 seen this afternoon resting in bed. R3 states that he is fine. Noted his left ear is swollen and bruised (blue/black/yellow in color). Left side of chest from under left arm straight down to above waist dark blue line straight down about 3/4 inch in width and full length of his side. R3 was also noted to have a small yellowed bruise to left clavicle. R3 states that he is ok, asked if he notified anyone of his fall he said "nope". R3 denies any pain at this time. When asked what happened. R3 states that he was dropped on the floor. When asked how it happened, he stated that the CNA left the side rail down when changing him and have fell out of the bed. He states that the CNA then picked him up and he put him back in the bed by himself. Asked when this occurred he told me last Wednesday. Informed patient that he needs to go to the hospital for a CT scan and chest X-rays to check his ribs. R3 verbalized understanding. Asked if I could do anything for him he said "nope" he will go to the hospital. Informed staff will call your family. R3 verbalized understanding. Informed V2 (DON) R3 needs to go to the hospital for further evaluation. ? R3's progress note dated 4/28/21 at 1645 pm Text: CNA reported that resident had a bruise to his back (left side of trunk) and left ear. Skin	S9999		

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S9999	Continued From page 6 assessment done, bruise noted to back and left ear. He did not complain of any pain. Skin is intact. ADL care rendered by staff and made comfortable in bed. Daughter made aware. V24 (NP) made aware with order to send R3 to the hospital for further evaluation. Facility abuse reportable dated 4/28/21 documents injury of unknown origin. Staff reported bruise to R3's trunk and left ear. R3 had no complaints of pain. R3 sent to hospital for further evaluation. Final report undated documents V3 said that when performing AM care to R3, V3 turned R3 to his right side toward the window when R3's leg slipped out of bed. V3 said he caught R3 preventing him from falling But R3's back hit the tray table next to the window. Under summary documents R3 who is alert and oriented x3 said that a week ago when V3 (CNA) was completing his am care, V3 turned him to his right side toward the window when his leg slipped out of the bed hitting his back to the tray table next to his bed towards the window. V3 was able to catch him from falling. R3 did not report incident to any staff. Under findings document that there is no evidence to support an allegation of abuse or neglect. Under corrective action documents in-serviced staff to round more frequently and after providing care, staff to ask residents if they need anything else before they leave the room. Witness statement dated 4/28/21 documents R3 said a few days ago staff was changing him, he fell onto ta table out of bed. R3 described V3 (CNA). R3 said he did not tell anyone. R3 usually takes good care of him so he doesn't know why this happened. R3 denied any pain and that's why he did not say anything Local hospital record dated 4/28/21 documents bruising to left eat, left upper arm, left rib cage. Emergency Room diagnosis documents injury of head. Under physical exam documents patient	S9999		

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S9999	Continued From page 7 has bruising of left ear and mild swelling that appears a few days old. Patient is alert and oriented x3. R3 sent to emergency room from nursing home for evaluation for head injury that occurred 2 days prior. According to family "nursing home dropped him on his head and did not tell us until today." R3's plan of care dated 12/06/2019 documents potential for falls, R3 is at risk for falls. The following interventions: Keep blow call light within reach at all times. Date Initiated: 05/20/2021. Keep immediate environment free of clutter. Date Initiated: 12/06/2019. Maintain bed in lowest position Date Initiated: 12/06/2019. R3's plan of care dated 11/22/2019 may need to use two partial rails to enhance functional independence and promote skin integrity. Interventions included: I would like to use 2 side rails as assistive device to help me to turn and reposition and/or transfer. Date Initiated: 11/22/2019; I would like to use 2 side rails as an enabler during bed mobility and transfer Date Initiated: 11/22/2019; I would like staff to give me feedback and praise my efforts in demonstrating increased independence through the use of one or two side rails. Date Initiated: 11/22/2019; I would like my blow call light cord within easy reach. Date Initiated: 05/20/2021. R3's restorative UDA dated 1/21/21 documents under side rail/other devices used 2 half side rails used as assistive device to turn and reposition. Under mental status documents oriented to self, time, environment, able to use call light to make needs known, and aware of inability to stand or ambulate. (B) Finding 2 of 2:	S9999		

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300.610a)
300.1010h)
300.1210a)
300.1210b)4)
300.1210d)3)
300.1220b)3)
300.3240a)

Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1010 Medical Care Policies
h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care
a) Comprehensive Resident Care Plan. A facility,

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Continued From page 9

with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,

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seven-day-a-week basis:
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to follow their weight management policy by not obtaining weights as ordered, assessing and addressing weight loss for 2 of 3 residents (R1 and R9) reviewed for g-tube feeding and

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unplanned weight loss. The facility also failed to ensure the G-tube feeding infused consistently at a rate of 50 ml/hour for 1 of 3 residents (R8) reviewed for enteral feeding infusions This failure resulted in a significant unplanned, weight loss greater than 5 percent in one month for R1and R9 , leading to hospitalization.for weight loss of R1.

Findings include:

R1 was admitted on 4/22/21 with the diagnosis of unspecified protein-calorie malnutrition, pharyngeal dysphagia and gastrostomy. Minimum dated set (MDS) section K (nutritional status) dated 4/23/21 documents: R1 weighs 156 pounds, not on a physician weight loss regiment, weight loss of 5% or more in last month or loss of 10 % or more in last 6 months and receives fifty-one percent or more via an abdominal feeding tube while as a resident. R1's physician order sheet dated 4/23/21 -5/21/21 documents: (4/23/21) Protein supplement give one package twice a day was discontinued. Enteral feeding of 75ml/hour goal 1500ml-active (5/19/21) weights three time a week on Monday, Wednesday and Friday.

On 5/25/21 at 2:12pm, Surveyor requested, that R1 be weighed. Surveyor observed, R1's weight at 97.5lbs.

On 5/25/21 at 2:56pm, V33 (Dietician) said "R1 had a weight loss. R1 should not be losing weight. I walked into R1's room the other day and the feeding was not running when it should have been. R1 may not be getting all of the g-tube feeding as ordered. R1's weight lost was not planned. R1 had a significant weight loss. I clarified R1's water flush and added the sugar

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 12	S9999		

free protein to R1's profile. R1 remained on the same enteral feeding. No other intervention were in place other than weekly weight, clarifying the water flush and adding protein, I am responsible for the care plan. I don't see any care plan intervention for nutrition for R1.

On 5/26/21 at 2:01pm, V36 (medical doctor) stated " I asked R1 to be weighed more frequently after the 5/11/21 weight was recorded. Not monitoring R1's weight may cause a delay in care. We could have identified R1's weight loss sooner and implemented a plan of care. They called me yesterday to report R1's weight loss. I ordered R1 weights to be taken three times a week which wasn't done. My expectation is for my orders to be followed. The importance of monitoring the weight is, the weights reflects the resident's nutritional status. If a resident is getting g-tube feeding and not gaining weight something has to be changed. I was wondering if R1 was actually getting the g-tube feeding."

Weight Summary documents: R1's weight for April/May 2021: 4/23/21 - 156.4 pounds (lbs.), 5/11/21 - 113.0 lbs., 5/14/21 - 112.0 lbs., 5/19/21 - 105.0 lbs., 5/24/21 - 101.0 lbs. and 5/25/21 - 97.5 lbs.

On 5/26/21 at 2:36pm, V35 (wound doctor) said, R1's low albumin levels show malnutrition.

On 5/26/21 at 4:25pm, V2 (DON, Director of Nursing) said, the water flush is calculated in the pump. Both the water flush and the g-tube will run at the same time.

R1's lab dated 5/12/21 documents: Albumin 2.2 low (normal range 3.4 -4.8) Pre-albumin 7 low (normal range 12-35).

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007322	A. BUILDING: ______ B. WING ______	C 05/27/2021

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S9999	Continued From page 13 Dietary note dated 5/14/21 documents: R1 with unintended weight loss of 28.3% in the past month. Current weight of 112 lbs. R1's usual weight is 145 -150lbs. R1 estimated needs based on current weight 1275-1800 calories/day. R1 is tolerating current feeding well at 75ml/hr starting at 4pm and infusing to 1500ml per day is reached. Pre-albumin 7 (low) Plan: monitor tolerance to diet and supplement. Add liquid protein 30 ml twice a day via g-tube. Weigh R1 weekly and change protein powder to one packet twice a day r/t unintentional weight loss. Dietary note dated 5/19/21 documents: R1 with continued weight loss of 6.25% in the past five days. Seven percent weight loss in the past eight days. R1's current weight of 105 pounds. R1 17.5 BMI is underweight status. Plan Continue to monitor tolerance to g-tube feeding regimen. Recommendation: Continue current by mouth and G -Tube feeding regimen. Clarification of feeding water flush. Transfer Form dated 5/25/21 documents: R1 was discharged to the hospital for weight loss. R9 was admitted to facility on 1/29/21 with a diagnosis of dysphagia and a history of Covid-19. Minimum data set (MDS) section K (nutritional status) dated 5/3/21documents: R9 weighs 136 pounds, not on a physician weight loss regiment, weight loss of 5% or more in last month or loss of 10 % or more in last 6 months and receives fifty-one present or more via an abdominal feeding tube while as a resident. R9 physician order sheet dated 5/21 documents: g-tube feeding rate 65ml/hour until 1300ml is reached each day. Order dated 2/6/21 -5/21/21 documents: g-tube feeding 60ml/hour is tolerated.	S9999		

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S9999	Continued From page 14 (B)	S9999		