Illinois State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057026 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 05/12/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AVANTARA LAKE ZURICH | 900 SOUTH RAND ROAD , LAKE ZURICH, Illinois, 60047 |

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| S0000 | Initial Comments<br><br>Complaint Investigation: 2513950/IL191647 | S0000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations: (1of 2)<br><br>300.690b)<br><br>300.690c)<br><br>Section 300.690 Incidents and Accidents<br><br>b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.<br><br>c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.<br><br>This REQUIREMENT was not met as evidenced by:<br><br>Based on interview and record review, the facility failed to report a serious incident to the Department | S9999 | | |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| S9999 | Continued from page 1<br>and Regional Office for 1 of 6 residents (R1) reviewed for safety and supervision in the sample of 6.<br><br>The findings include:<br><br>R1's Admission Record dated 4/14/25 shows R1 was admitted to the facility on 4/4/25. R1's diagnoses include, but are not limited to, traumatic subdural hemorrhage, metabolic encephalopathy, myocardial infarction (heart attack), nontraumatic intracerebral hemorrhage, abnormalities of gait and mobility, lack of coordination, weakness, contusion and laceration of the right cerebrum, need for assistance with personal care, malignant neoplasm of the large intestine and history of falling. R1's Minimum Data Set dated 4/7/25 shows R1's cognition is severely impaired and has no broken or loosely fitting full or partial denture or obvious or likely cavity or broken natural teeth. R1's care plan initiated on 4/7/25 shows R1 is at risk for altered thought processes and will be free from any injury related to accidents. R1's care plan initiated on 4/4/25 shows R1 is at high risk for falling and interventions include staff providing a safe environment. This same care plan also shows R1 has an alteration in neurological status and is at risk for altered though process.<br><br>On 5/8/25 at 11:15 AM, V11, CNA, said she saw R1 last around 3:30 AM on 4/13/25 where he was in bed, asleep and dry. V11 said R1 was wearing a hospital gown and a diaper. V11 said she noticed R1 was not in his room at about 4:15 AM. V11 said she immediately asked the nurse if he had gotten R1 out of bed and the nurse answered, "No," R1 should be in his bed. V11 said they both started looking for R1. V11 said she did not think R1 had gotten outside because she would have heard the alarms if he had gone through the doors going outside, and she had not heard any alarms. V11 said they continued to look for R1 for another 20 to 30 minutes and then someone called the Administrator, V11 said the police were eventually called and they found R1 across the four-lane highway where she believes the speed limit is 45 MPH.<br><br>On 5/7/25 at 2:21 PM, V5, Registered Nurse (RN), said he was R1's nurse on 4/12/25 going into 4/13/25 during the night shift. V5 said he noticed V11 was looking for R1 and asked if he knew where R1 was. V5 said they both started looking for R1. V5 said R1's bed alarm did not sound and the door alarms for the building did not go | S9999 | | |

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| S9999 | Continued from page 2<br>off. V5 said it was cold outside that night and he had to get his coat when he went outside to look for R1. V5 said the police eventually found R1 across the four-lane highway outside of a fast-food restaurant.<br><br>On 5/8/25 at 10:00 AM, V1 said she was informed on 4/13/25 by phone at about 5:13 AM that staff could not find R1. V1 said she was driving to the facility and on the way, she received a call from the police that R1 had been located across the four-lane highway from the facility. V1 said when she later reviewed the video, she could see R1 walking out the front door of the facility and turning left wearing a gown, a diaper, and shoes. V1 said the video has no sound, so she cannot say if the door was alarmed or not. V1 said the police called an ambulance for R1 and he was taken to the hospital. V1 acknowledged that a human body temperature of 93.2 degrees Fahrenheit (F) is considered hypothermia. V1 said R1 had a tooth knocked out and an abrasion. V1 said they did not report the incident to the state because it was not significant enough to notify the state.<br><br>On 5/8/25 at 1:24 PM, V13, Medical Director said he would be very concerned about a person's body temperature of 93.2 degrees F. V13 said hypothermia can cause a heart attack, a stroke, or respiratory arrest, then eventually death. V13 said it was cold outside when R1 eloped, and he could have died.<br><br>On 5/7/25 at 1:52 PM, V2, Director of Nursing (DON), said R1 had a head injury from his fall when he eloped. V2 said the elopement reporting would have been done by the Administrator. V2 said significant injuries, falls, or fractures and lacerations must be reported to the state. V2 said she herself did not report the elopement with subsequent injuries regarding R1.<br><br>The police report dated 4/13/25 shows police were dispatched on 4/13/25 at 5:41 AM to the facility for a missing adult. Police officers who were originally at the facility left and went to where R1 had been found across the highway from the facility by other police officers. The report describes R1 as wearing a hospital gown, being confused, and having small cuts on his arms and legs with a bloody mouth.<br><br>R1's Emergency Department (ED) notes dated 4/13/25 show R1 presented via ambulance for an unwitnessed fall | S9999 | | |

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| S9999 | Continued from page 3<br>outside of his living facility. R1 had a missing tooth with dried blood and abrasions to his upper and lower extremities consistent with a fall. R1's rectal temperature was 93.2 degrees F. R1's ED diagnoses are acute subdural hematoma, hypothermia due to cold environment and unwitnessed fall. R1 was admitted to the hospital from the ED on 4/13/25 at 9:52 AM.<br><br>The facility's Incident Reporting Policy (reviewed/revised 1/3/25) shows any serious injury sustained by a resident that is not an expected outcome of the disease process will be reported to IDPH Regional Office. (C)<br><br>Statement of Licensure Violations: (2of 2)<br><br>300.610a)<br><br>300.1210b)<br><br>300.1210d)6)<br><br>Section 300.610 Resident Care Policies<br><br>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<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 | S9999 | | |

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| S9999 | Continued from page 4<br>supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.<br><br>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<br><br>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.<br><br>This REQUIREMENT was not met as evidenced by:<br><br>Based on observation, interview, and record review, the facility failed to ensure the front entrance to the facility was safely supervised and/or secured to prevent 1 of 3 residents (R1) reviewed for safety and supervision in the sample of 6 from exiting the facility unbeknown to the staff. This failure resulted in R1 leaving the facility in the early morning hours and crossing four lanes of a major east-west arterial road where the speed limit is 50 miles per hour (MPH) wearing only a hospital gown, a brief, and shoes. R1 became hypothermic and was admitted to the hospital with an acute subdural hematoma, hypothermia due to cold environment, and unwitnessed fall.<br><br>The findings include:<br><br>On 5/7/25 during travel to the facility, the noted speed limit of the four-lane highway directly in front of the facility was 50 miles per hour.<br><br>R1's Admission Record dated 4/14/25 shows R1 was admitted to the facility on 4/4/25. R1's diagnoses include, but are not limited to, traumatic subdural hemorrhage, metabolic encephalopathy, myocardial infarction (heart attack), nontraumatic intracerebral hemorrhage, abnormalities of gait and mobility, lack of coordination, weakness, contusion and laceration of the right cerebrum, need for assistance with personal care, malignant neoplasm of the large intestine and history of falling. R1's Minimum Data Set dated 4/7/25 shows | S9999 | | |

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| S9999 | Continued from page 5<br>R1's cognition is severely impaired and R1 has no broken or loosely fitting full or partial denture or obvious or likely cavity or broken natural teeth. R1's care plan initiated on 4/7/25 shows R1 is at risk for altered thought processes and will be free from any injury related to accidents. R1's care plan initiated on 4/4/25 shows R1 is at high risk for falling and interventions include staff providing a safe environment. This same care plan also shows R1 has an alteration in neurological status and is at risk for altered thought process.<br><br>On 5/8/25 at 11:15 AM, V11, CNA, said she saw R1 last around 3:30 AM on 4/13/25 where he was in bed, asleep, and dry. V11 said R1 was wearing a hospital gown and a diaper. V11 said she noticed R1 was not in his room at about 4:15 AM. V11 said she immediately asked the nurse if he had gotten R1 out of bed and the nurse answered, "No," R1 should be in his bed. V11 said they both started looking for R1. V11 said she did not think R1 had gotten outside because she would have heard the alarms if he had gone through the doors going outside, and she had not heard any alarms. V11 said they continued to look for R1 for another 20 to 30 minutes and then someone called the Administrator, V1. V11 said at that point about an hour had gone by and they were told to keep searching for R1. V11 said they still could not find R1. V11 said she ended up checking the door alarms to see if the door alarm would go off, and it did not go off; the alarm was not triggered, and they realized the alarm was not turned on or it was not working. V11 said they were even more terrified now and they searched outside by the pond and all around the facility. V11 said it was very cold outside and R1 was wearing only a hospital gown and a diaper when she put him to bed. V11 said the police were eventually called and they found R1 across the four-lane highway where she believes the speed limit is 45 MPH.<br><br>On 5/7/25 at 2:21 PM, V5, Registered Nurse (RN), said he was R1's nurse on 4/12/25 going into 4/13/25 during the night shift. V5 said he noticed V11 was looking for R1 and asked if he knew where R1 was. V5 said they both started looking for R1. V5 said R1's bed alarm did not sound and the door alarms for the building did not go off. V5 said it was cold outside that night and he had to get his coat when he went outside to look for R1. V5 said the police eventually found R1 across the four-lane highway outside of a fast-food restaurant.<br><br>On 5/8/25 at 10:00 AM, V1 said she was informed on | S9999 | | |

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| S9999 | Continued from page 6<br>4/13/25 by phone at about 5:13, AM that staff could not find R1. V1 said she was driving to the facility and on the way, she received a call from the police that R1 had been located across the four-lane highway from the facility. V1 said when she later reviewed the video, she could see R1 walking out the front door of the facility and turning left wearing a gown, a diaper, and shoes. V1 said the video has no sound, so she cannot say if the door was alarmed or not. V1 said the police called an ambulance for R1 and he was taken to the hospital. V1 acknowledged that a human body temperature of 93.2 degrees Fahrenheit (F) is considered hypothermia. V1 said R1 had a tooth knocked out and an abrasion. On 5/12/25 at 3:00 PM, V1 said the video she reviewed from 4/13/25 showed R1 exiting the facility through the front door between 4:05 AM and 4:10 AM.<br><br>On 5/8/25 at 1:24 PM, V13, Medical Director said he would be very concerned about a person's body temperature of 93.2 degrees F. V13 said hypothermia can cause a heart attack, a stroke, or respiratory arrest, then eventually death. V13 said it was cold outside when R1 eloped, and he could have died.<br><br>On 5/7/25 at 1:52 PM, V2, Director of Nursing (DON), said R1 had a head injury from his fall when he eloped. V2 said the doors are all alarmed from 8:00 PM until 8:00 AM and a code is needed to enter or leave during those hours.<br><br>On 5/12/25 at 11:25 AM V14, Nurse Practitioner (NP), said hypothermia is a body temperature being lower than normal. V14 said a normal human body temperature is 98.6 degrees F. V14 said the dangers of hypothermia include death.<br><br>The police report dated 4/13/25 shows police were dispatched on 4/13/25 at 5:41 AM to the facility for a missing adult. Police officers who were originally at the facility left and went to where R1 had been found across the highway from the facility by other police officers. The report describes R1 as wearing a hospital gown, being confused, and having small cuts on his arms and legs with a bloody mouth.<br><br>R1's Emergency Department (ED) notes dated 4/13/25 show R1 presented via ambulance for an unwitnessed fall outside of his living facility. R1 had a missing tooth with dried blood and abrasions to his upper and lower | S9999 | | |

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| S9999 | Continued from page 7<br>extremities consistent with a fall. R1's rectal temperature was 93.2 degrees F. R1's ED diagnoses are acute subdural hematoma, hypothermia due to cold environment and unwitnessed fall. R1 was admitted to the hospital from the ED on 4/13/25 at 9:52 AM.<br><br>The facility's Elopement Policy (reviewed 8/27/24) shows it is the policy of the facility that all residents are afforded adequate supervision to provide the safest environment possible.<br>(A) | S9999 | | |