STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0052423	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/23/2025

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

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S0000	Initial Comments Annual Health Survey Facility Reported Incident Investigation of 5/1/2025/IL192398	S0000		
S9999	Final Observations Statement of Licensure Violations: ONE OF TWO 300.610a) 300.1210b) 300.1210d)3) 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 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and	S9999		

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

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S9999	Continued from page 1 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. 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: 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. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to ensure that one resident who was on pain medication had an effective bowel regime program to prevent constipation. This affected one of one resident (R18) reviewed for quality of nursing care and prevention of constipation. This failure led to R18 being sent to the hospital with a diagnosis of severe fecal impaction with stool ball measuring over 8 centimeters (CM). Findings include: R18 was admitted to the facility on 12/7/24 with a diagnosis of dependence on supplemental oxygen, heart failure , spinal stenosis, type II diabetes and atrial fibrillation. R18's brief interview for mental status dated 3/4/25 documents a score of 9 which indicates moderate cognitively impairment. R18 physician orders document: tramadol 50 mg (milligrams), take one tablet by mouth twice a day for moderate to sever pain. Start date 12/11/24. Fentanyl patch 12mcg/hr (micrograms/hour). Apply one patch every	S9999		

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S9999	Continued from page 2 72 hours for pain. Start date 1/17/25. On 5/23/25 at 12:00PM, V27(Nurse Practitioner) said fecal impaction is caused by constipation which is preventable but can be attributed to lack of movement, nutrition, hydration and pain medications. R18 did not mention being constipated and were unaware that R18 was having concerns. V27 said she would expect staff to notify them of any changes in bowel movement or lack of bowel movements for three days. On 5/22/25 at 11:46, V17(ADON) said R18's hospital stay related to fecal impaction was preventable. R18 was taking a pain medication and had a medication related to constipation but was not effective. R18's medical doctor assisted with putting in an effective bowel management for R18. Point of care charting for March 2025 bowel movements documents 3/1/25 and 3/2/25 a small bowel movement; 3/3/25 - 3/7/25 documents none. R18's hospital record dated 3/9/25 documents under CT abdomen impression severe fecal impaction at the rectum with stool ball measuring over 8 centimeters. Mild perirectal inflammatory changes may reflect stercoral proctocolitis. Under history documents Patient is found to have sever fecal impaction with findings consistent with stercoral proctocolitis. Patient disimpacted with large amount of stool collected, no blood noted or black, and she is feeling better afterwards, also received enema. Bowel management revised 7/26/24 documents: it is the facility policy to record resident's bowel movement in the medical record. The certified nurse aide each shift will record the resident's bowel movement. The facility will assess the resident when the resident shows sign and symptoms of abdominal stress, if there is a change in the resident's pattern of bowel movements, the facility will notify the physician. (B) TWO OF TWO 300.610a)	S9999		

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S9999	Continued from page 3 300.1210a) 300.1210b)5) 300.1210c) 300.1210d)6) 300.1220b)8) 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 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, 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)	S9999		

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S9999	Continued from page 4 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: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 Services b) The DON shall supervise and oversee the nursing services of the facility, including: 8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out.	S9999		

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S9999	Continued from page 5 These requirements were not met as evidenced by: Based on observation, interviews, records reviews the facility failed to follow the identified mechanical lift transfer status while transferring onto the toilet and failed to follow their policy and use a gait belt to perform a safe transfer from bed to wheelchair for one resident. This affected one of three residents (R52) reviewed for safety during staff assisted transfers. This failure resulted in R52 falling during the bed to wheelchair staff assisted transfer and sustaining an acute impacted right femoral fracture. The findings include: R52 cognition on 4/21/25 was 13 and on 5/8/25 her cognition score decreased to 8. Facility reported incident report for R52 dated 5/1/25 states R52 was lowered to the floor during a transfer and found to have right hip fracture requiring right hip pinning. On 05/20/25 at 11:21 AM V9, Certified Nursing Assistant (CNA), assisted R52 into the resident bathroom in her wheelchair. V9 told R52 to stand to use the toilet. R52 hesitant and required verbal and physical cueing from V9 to stand. No gait belt was applied to R52 during the transfer onto the toilet. When V9 stood a wheelchair cushion was on the seat of the chair, no other device. V9 stood and R52 assisted with removing the soiled brief. R52 turned with V9 assisting and sat on the toilet. V9 removed the wheelchair from the bathroom, closed the bathroom door, and stepped out of the room. At 11:26AM V9 went to retrieve towels and a brief. At 11:28AM V9 returned to R52. V9 said I know how to transfer the resident with the care cards instruction. V9 said R52 is recovering from a hip fracture. R52 alert to name and situation but did not want to answer the surveyors questions regarding the fall on 5/1/25. On 5/21/25 at 9:48AM V5, Restorative Nurse, said transfer status for R52 prior to her fall on 5/1/25 was stand and pivot with 1 assist. V5 said currently R52 should be a mechanical lift transfer due to a diagnosis of hip fracture. V5 said the Kardex identifies R52 as 2 person transfer because of limited mobility with the	S9999		

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S9999	Continued from page 6 fracture. At 1:11PM V5 said I am in charge of training staff on using gait belt for 1 assistance. V5 said all staff are issued a gait belt. V5 said gait belts are issued by Human resources. On 5/21/25 at 11:39AM V6, Fall Nurse, said when investigating a fall, I gather witness statements from staff and I try to speak with the patient. V6 said I do a root cause analysis, and we discuss with the team to develop interventions. V6 said I notify the staff about the interventions, and I update the care plan. V6 said R52 was not a fall risk before her fall, she was a low risk. V6 said R52 has no history of falls. V6 said when R52 fell, her bed was at about waist height, she was wearing shoes, and as she was going from bed to chair. V52 said I don't know what R52 was wearing when she fell. V6 said R52 said her leg gave out and she was lowered to the floor. V6 said after the fall R52 was referred to therapy and her transfer status was changed. V6 said staff should utilize the identified transfer technique on residents for safety. On 5/21/25 at 12:55PM V2, Director of Nursing, was asked who is in charge of training staff on transfer techniques? V2 said that would be V5, Restorative Nurse. On 5/21/25 at 12:46PM V7, CNA, said I was transferring R52 from her bed to wheelchair. V7 said R52 didn't say anything and her knees were buckling, she was :too heavy for me to hold up." V7 said "she hit kind of hard. V7 said I had transferred R52 before. V7 said R52 was wearing pants, a shirt, a sweater and footies with her non skid shoes. V7 said I did not use any equipment to transfer her. V7 said R52 does not use a walker or cane for transfers. V7 said I don't recall using the gait belt, everything happened so fast. V7 said R52 was a stand and pivot with 1 person assist with transfers. V7 said after the fall the nurse and I got R52 off the floor and assisted her into the wheelchair. On 5/22/25 at 10:40AM V1, Administrator said the only policy for transfer is in the Restorative Nursing Program policy dated 8/19/24. V1 pointed in the policy where it reads Nursing and restorative services may include the following, transfer. V1 said the CNAs are expected have a gait belt as part of their uniform and restorative department does the training with CNAs for transfer of residents.	S9999		

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S9999	Continued from page 7 On 5/22/25 at 10:41AM V20, CNA, said for 1 person assisted transfer we always use a gait belt. V20 said we have to use a gait belt to balance the resident if they are falling we can hang on. ON 5/22/25 at 10:45AM V21, Human Resources, said I tell CNAs at orientation that gait belts are part of their uniform. CNAs perform competency at orientation. V21 provided Competencies for V7 and V9. On 5/22/25 at 10:56AM V2, Director of Nursing, said staff should not leave residents at risk for falls on the toilet alone. V2 said the resident might forget to not get up and stand up and fall. V2 said the patient might forget they are here because they need help. R52's x-ray report from the hospital identifies an acute mild impacted right subcapital femoral fracture. According to the hospital records R52 underwent surgery for her hip. The surveyor requested a fall risk assessment for R52 prior to 5/1/25 fall and the facility provided 5/1/25 identifying her score as high risk. On a review of R52's chart the only Fall Risk Evaluation found is dated 5/1/25. On 5/21/25 at 1:18PM unsuccessful in attempting to contact V8, LPN, nurse on duty when R52 fell 5/1/25. V21 provided the employee handbook that includes Gait Belt Policy, page 57, states in part CNA is expected to use the gait belt whenever ambulating got transferring a resident for the safety of the resident and the employee. Gait belts will be used when helping the resident mover from bed , chair or commode/toilet. MDS dated 4/21/25 section GG states R52 utilizes a walker. Partial to moderate assistance for sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. Partial to moderate assistance Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).	S9999		

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S9999	Continued from page 8 R52's care plan does not identify use of a gait belt or 1 person assist for period prior to 5/1/25. Facility Fall Prevention Program Guidelines dated 12/5/21 states this program shall include measures to determine the individual needs of each resident by assessing the risk for fall and the implementation of evidence-based prevention interventions. A fall risk assessment shall be completed upon admission, re-admission, quarterly, significant change, annually, an after each fall. Safety interventions shall be initiated and implemented for each resident identified at risk for fall. All nursing personal and facility staff shall be responsible for ensuring ongoing precautions are put into place. Interventions shall include staff, family and resident education, programs, purchase of equipment or other environmental -related alternative to prevent the resident from falling. (NO VIOLATION)	S9999		