| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145734 | A. BUILDING _____ B. WING _____ | 09/04/2020 |

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0584<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation and interview, the facility failed to follow their practice of cleaning wheelchairs to be free from debris and odor for 2 of 3 (R13 and R14) reviewed for clean personal wheelchairs. Findings Include: R13 was admitted to the facility on [DATE]. R13's minimal data set ((MDS) dated [DATE] documents R13 uses a wheelchair for mobility. R13's care plan dated 4/15/2020 documents: R13 has impaired mobility. R14 was admitted on [DATE]. R14's MDS dated [DATE] documents: R14 is always incontinent. On 9/3/2020 at 1:25pm, Surveyor observed, R13 sitting in the hallway in his wheelchair with a cushion with tan colored dry particles making a line in front of R13's wheelchair cushion. On 9/3/2020 at 1:30pm, V9 (Certified Nursing Assistant/CNA) and V10 (CNA) assisted, R13 to his room, helped R13 to stand with a gait belt and a walker. R13's wheelchair seat was observed with a row of dry crusted dry patches from wheelchair arm to wheelchair arm. The wheelchair cushion had a brown stain that was dry, fixed and large on the bottom right of the cushion which spread to the middle of the cushion. Brown liquid was observed running down R13's wheelchair cushion as V9 (CNA) held the cushion up away from R13's wheelchair seat. V9 said, R13's wheelchair was not clean. It has dried food on it. R13 just finished lunch. It looks like the food they had for lunch. V9 said, the night shift CNA's clean the wheelchairs. On 9/3/2020 at 1:47pm and 1:49pm V9 (CNA) took R14 to the bathroom. V9 took R14's adult brief off and said, I smell strong urine. I changed R14 around 11:00am -11:30am, R14 urine is normally strong. I encourage water. R14's adult brief was yellow with a strong urine smell. The strong urine smell was coming from R14 and his wheelchair cushion. On 9/3/2020 at 4:15pm. V2 (DON) said, housekeeping will clean the wheelchairs when a resident has been discharged or alerted by staff. The certified nursing assistants (CNA) are responsible for cleaning resident's wheelchair on their shower day. All shift are expected to clean the resident wheelchairs. If a resident is on the get up list the CNAs are expected to clean the wheelchair. The CNAs are updated about their responsibilities for cleaning the wheelchairs verbally in our stand up meeting. Facility dietary menu lunch dated 9/3/2020 documents: Beef Stroganoff On 9/4/2020 at 2:57pm, V2 (DON) said, we don't have a policy for cleaning resident's wheelchairs. Certified Nursing Assistant job description requested and not provided. |
| F 0695<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide safe and appropriate respiratory care for a resident when needed.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review ,the facility failed to follow its policy on oxygen therapy and administration policy and ensure the oxygen concentrator was delivering enough oxygen to keep the oxygen saturation level above 90% for 1 of 1 (R2) residents reviewed oxygen therapy This failure resulted in R2 complaining of shortness of breath and R2's oxygen saturation level dropping to seventy-nine percent while on three liters of oxygen using the oxygen concentrator. Findings Include: R2 was admitted on [DATE] with the [DIAGNOSES REDACTED]. R2's minimal data set (MDS) documents a brief interview for mental status dated 7/1/2020 documents a fifteen which indicates R2 is cognitively intact. On 9/1/2020 at 2:07pm, Surveyor heard, an audible alarm in the hallway as the Surveyor approached the back of unit five hundred. The alarm was coming from R2's room. Surveyor observed, R2 sleeping with head of the bed flat. At 2:25pm, the audible alarm was still sounding. The audible alarm could be heard from R2's nursing station. R2's audible alarm sounded twenty-three minutes On 9/1/2020 at 2:28pm, staff alerted V4 (Nurse) that R2 had an audible alarm sounding. On 9/1/2020 at 2:30pm, V4 (Nurse) said the alarm just started beeping. It's the oxygen concentrator. It needs to be served. R2s oxygen saturation should be at ninety-five to one hundred percent while on oxygen. I was told that R2's oxygen concentrator was beeping by the housekeeper at 2:28pm. On 9/1/2020 at 2:30 and 2:34pm, R2 who was alert and orient to person, place and thing said, I don't think, I'm getting any oxygen. On 9/1/202 at 2:32pm, V4 (Nurse) checked the nasal cannula per Surveyor request. V4 placed the nasal cannula in a cup of water to ensure the concentrator was working. Surveyor observed, the water in the clear plastic cup bubbling from the flow of air going through the nasal cannula. On 9/1/2020 at 2:33pm, V4 (Nurse) took R2's oxygenation with a pulse oximeter, per Surveyor's request. R2's pulse oxygen reading was documented as seventy-nine percent on three liters of oxygen per nasal cannula. On 9/1/2020 at 2:34pm and 2:35pm, R2's oxygenation with a pulse oximeter was still seventy-nine percent on three liters of oxygen per nasal cannula and the same oxygen concentrator that was beeping. V4 (Nurse) raised, R2's head of bed to a forty-five degrees. V4 said,I checked R4's oxygen saturation an hour ago. It was it was ninety-two percent on three liter of oxygen. On 9/1/2020 at 2:37pm, R2 was observed mouth breathing. Surveyor observed, R2's oxygen saturation was eighty-eight percent on three liter and the same oxygen concentrator that was beeping. R2 said, I feel short of breath. Surveyor observed, R2 breathing with mouth open. On 9/1/2020 at 2:40pm, Surveyor observed, V4 (Nurse) applied an oxygen tank to R2's nasal cannula. R2's oxygen saturation was observed to be at ninety - ninety one present on four liters of oxygen per nasal cannula. On 9/1/2020 at 2:41pm and 2:43pm, V4 (Nurse) saidd R2 is scheduled for three liters of oxygen per nasal cannula. If the oxygen concentrator is beeping, it needs to be serviced and we will replace the defective concentrator with a new one. I'm supposed to check to make sure oxygen is being delivered. The concentrator will beep when something is wrong and it's not working. On 9/1/2020 at 2:42pm, R2's oxygen saturation was ninety-two - ninety-three percent on four liters of oxygen per nasal cannula via an oxygen tank. Surveyor observed, R2's oxygen concentrator with a small white sticker that documents: service date 2/25/2020 by whom was blank. On 9/1/2020 at 2:48pm, V4 (Nurse) said I applied 4L of oxygen per nasal cannula. On 9/1/2020 at 2:51pm, V4 (Nurse), placed a sign on the oxygen concentrator that documented need service and placed concentrator in soiled utility room. On 9/1/2020 at 3:51pm, V2 (DON) said the oxygen concentrator may beep when you first turn it on, if it beeps continuously it must be checked. A patient pulse should be above ninety-two percent while on oxygen. On 9/2/2020 at 1:30pm, V24 (Oxygen Company Personnel) said We bring the oxygen concentrator to the facility and drop it off. We don't provide maintenance, once the machine is dropped off it is out of my hands. Before we delivery the concentrator, they go through a ten hour process to ensure they are working properly. The date listed on the concentrator indicates the date it needs to be serviced or the date it was served. On 9/3/2020 at 11:27am, V2 (DON) said R2 had oxygen, I saw R2's profile picture and she had a nasal cannula in her nose indicating R2 had oxygen. I don't know how the order was missed. On 9/3/2020 at 1:48pm, R2 said I'm am breathing much better today. I'm getting my oxygen. R2's physician order [REDACTED]. R2's physician order [REDACTED]. Medication Administration Record [REDACTED]. Four liters of oxygen via nasal cannula start date 9/1/2020. R2's care plan initiated 3/26/2020 documents R2 has [MEDICAL CONDITIONS]. Oxygen Therapy and Administration Policy dated 8/5/2016 documents: Oxygen therapy shall be administered to patients as indicated and upon a physician's orders [REDACTED]. |
| F 0755<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.**<br>**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** |

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

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.

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| F 0755<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to follow their medication policy by not ensuring that medication is not left at the bedside and is taken/consumed prior to signing the medication on the Medication Administration Record (MAR) as given for 1 (R3) of 1 residents reviewed for medication admiistration. Findings Include: R3 was admitted on [DATE] with the [DIAGNOSES REDACTED]. On 9/1/2020 at 3:07pm, R3 was noted in the bed with a pink pill in a clear plastic medication cup on her bedside table. On 9/1/2020 at 3:07pm, V3 (ADON) said the pill in the medication cup is a blood pressure pill. On 9/1/2020 at 3:14pm, V13 (Nurse) said R3 got here at twelve noon. I gave R3 the blood pressure medication. I could have sworn R3 took the medication. I'm supposed to make sure R3 takes/ingests the medication. The [MEDICATION NAME] blood pressure medication was due at 2:00pm. A [MEDICATION NAME] is used to treat high blood pressure. On 9/1/2020 at 3:22pm, Surveyor observed, R3's blood pressure being taken by V14 (Nurse). The machine read: 150/40 millimeter of mercury (mmHG) which indicated hypertension stage one. R3's heart rate: 57 beats per minutes which indicated a slow heart rate called [MEDICAL CONDITION]. [MEDICAL CONDITION] is a resting heart rate slower that 60 beats per minute. On 9/1/2020 at 3:51pm, V2 (DON) said, it is my expectation that the nurse make sure the patient is taking their medication. Facility vital sign dated 9/1/2020 documents R3's blood pressure at 11:55am was 139 / 53 mmHg which indicated hypertension. Medication administration sheet record dated 9/1/2020 documents: [MEDICATION NAME] blood pressure medication fifty milligram was given at 2:00pm by V13 (Nurse). Medication Pass Policy dated 8/5/2020 documents: It is the policy of the facility to adhere to all Federal and State regulations with pass procedure. 7e: After medication is administered to each resident, sign the medication administration record that it was given. |
| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to follow the infection control guidelines for COVID-19 and ensure droplet isolation precautions were maintained for one of three residents (R10) reviewed for isolation precautions, and failed to wear gowns and clean face shields after providing care to residents under investigation for COVID on droplet and contact precautions. In addition, facility failed to use recommended disinfectant for cleaning face shield for three (R10, R11, and R15) of three residents reviewed for infection control practices Findings include: R10 was admitted to facility on 9/20/19 with [DIAGNOSES REDACTED]. R10's brief interview for cognitive status dated is 8/15. A score of 08-12 indicates moderately impaired. R10's physician orders [REDACTED]. On 9/2/20 at 11:56 AM, R10 was observed self-propelling herself in her wheelchair and leaving room her room and entering an empty room across the hall. R10 was observed in empty room until 1:02 PM. At 12:18pm, V8 (nurse) observed in R10's room. At 12:21 pm, V9 (CNA) and V 10 (CNA) were passing lunch trays and V10 delivered lunch tray to R10's room. V8 (nurse) also delivered tray to R10's room. Staff continued passing lunch trays and assisting with feeding other residents. At 1:02 PM, V10 located R10 in adjacent room and assisted R10 back to her room for lunch. On 9/2/20 at 1:20 V10 (CNA) said she was assigned rooms 108-119. R10 was assisted with bathroom and then delivered her lunch tray. V10 said not sure when R10 left her room but she was in the room when lunch tray delivered. V10 reported that R10 is confused and will leave her room or go into room across the hall. Staff will redirect to her room. R10 has had no covid symptoms but is being monitoring as person under investigation. On 9/3/20 at 43:1PM, V2 (DON) said staff would be expected to immediately check for resident if not in their room during tray pass to see if out on appointment or where they may be. V2 said not familiar with R10's care needs or risks. On 9/4/20 at 10:30 am, V2 said they do not have a supervision or monitoring policy. R10's care plan dated 4/1/20 documents: I am an adult with advanced dementia. I have a poor self and environmental awareness and I am not capable of understanding specific infection control protections including social distancing, frequent and aggressive hand washing. Use of hand sanitizer, restriction on group activities, importance of staying in my room and separation of common areas. My behavior may include movement and wandering for no definite purpose. Given my level of cognitive impairment, it is not possible for me to understand the dangers of close contact and not following CDC guidelines. The following interventions dated 4/1/20 include Provide guidance, verbal explanation and nonverbal (body language/gestures) and supervision to me to show/demonstrate proper safety/infection techniques. These include proper handwashing, social distancing (6feet), use of hand sanitizer, not touching other persons, avoiding touching the face and staying inside the room. R10 has impaired cognitive function/dementia or impaired thought processes dated 10/3/19. The following intervention dated 10/3/19 documents Cue, Reorient and supervise R10 as needed. R10 is a high risk for falls dated 9/23/19. The following interventions: Dycem initiated 5/22/20; floor mats initiated 4/28/20; Keep bed in low position initiated 9/23/20; Keep all items like water pitcher, tissue box, waste basket within reach initiated 2/6/20; supervised area when out of bed initiated 1/9/20. R10 's fall risk dated 5/22/20 documents score of 13. A score of 8 or above equals a high fall risk. Under conclusion documents upon rounds Resident observed in sitting position, alert x1-2, stated she sat on the floor. Call light within reach. Facility's policy titled Covid 19 Guideline and Emergency Preparedness Plan revised 7/22/20 documents under isolation for suspected person under investigation (PUI) PUI'S may remain in his or her room with the door closed and the privacy curtains drawn at all times. On 9/1/20 at 10:00am V2 (DON) said there were three residents under investigation for covid which included R10, R11 and R15. R10 and R15 were roommates in one room and R11 was in private room. Facility census dated 8/31/10 documents 21 residents on 100 unit. On 9/2/20 at 12:18 PM, V8 (nurse) entered R10's and R15's room with lunch tray. V8 did not put on gown or gloves prior to entering but wearing face shield and mask. At 12:22PM, V10 (CNA) entered R10's and R15's room gown and gloves donned. V10 wearing face shield and mask. No observations of face shield being cleaned upon exiting rooms. On 9/2/20 from 1:55 - 2:09 PM, V 9 (CNA) and V10 (CNA) observed in R11's room providing care. Staff donned gown and gloves prior to entering. Staff had on mask and face shield prior to entering. V9 and V10 observed exiting R11's room removing gown and then performing hand hygiene but did not clean face shields. On 9/3/20 at 1:42 PM, V17(housekeeping) was observed cleaning face shield with hand sanitizer. On 9/3/20 at 142 PM, V17 (housekeeping) said she cleaned her face shield with hand sanitizer. She said she usually will clean with hand sanitizer or sometimes there is a spray. V17 said they are supposed to clean face shields after exiting everyone room. On 9/2/20 at 1:20 V10 (CNA) said they use spray to clean face shield and would clean after direct care with patients. On 9/3/20 at 9:25 Am, V3 (ADON) said Staff wearing Face shield during any direct care of residents should clean face shield when coming out of resident's room. Staff should clean with bleach wipes or there is spray we would use. On 9/3/20 at 11:11, V2 (DON) said face shield are s to be cleaned when soiled. After leaving person under investigation (PUI) room face shield should be cleaned to ensure no cross contamination. At 430PM, V2 said hand sanitizer should not be used to clean face shield. R10's physician orders [REDACTED]. R11's physician orders [REDACTED]. Facility policy undated titled actual covid 19 case scenario guidance documents under reprocessing cleaning and disinfecting of goggles or face shield: carefully wipe the face shield or goggles using a wipe or clean cloth saturated with EPA registered hospital disinfectant solution. |
| F 0885<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review the facility failed to notify residents and family representative for 2 new COVID cases reported on 8/9/20 within 12 hours but not exceeding 5pm the next calendar day for four (R2, R11, R13 and R16) of four residents reviewed for notification. Finding include: V25 (admissions liaison) covid test reported date 8/9/20 documents a positive result. R12's covid test reported date 8/9/20 documents a positive result. On 9/3/20 at 4:30 PM, V2 stated prior to June 24 2020, staff would make calls to resident representatives to inform of new covid positive cases. After June 24 a letter was sent to all families which provided a number that the families can call in to get updates about facility. V2 unsure of any other methods used to inform families of positive cases at facility. V2 said the families and residents are supposed to call the number for updates. R11 was admitted to facility on 8/5/2020 with [DIAGNOSES REDACTED]. There is a phone number listed but no address listed on face sheet On 9/3/20 at 3:58 Pm, V19 (R11's family member) said she is the responsible party for R11. She stated she has not received any notifications, phone call or letters related to any positive COVID cases at the facility since R11's admission. V19 unaware of any telephone number to contact for updates. On 9/4/20 at 1240PM, V26 (R2's family member) said she is the responsible party for R2. V26 stated she has only received 2 letters from the facility related to COVID-19 cases a few months ago. She has not received any other form of communication from the facility and did not receive any notifications in August. V26 was unaware of any phone number needed to call to get updates related to cases at the facility. V26 said she would expect the facility to communicate new cases for the safety of her loved one. On 9/3/20 at 1:25 Pm, R13 alert and oriented said he has not received any updates that he can recall related to COVID cases. On 9/3/20 at 2:05 Pm, R16 ,alert and oriented, said does not recall any updates or information related to positive COVID cases. Facility's policy titled Covid 19 Guideline and Emergency Preparedness Plan revised 7/22/20 documents under notification of residents and representatives: Facilities must inform residents, their |

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| F 0885<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 2)<br>representatives and families within 12 hours but not exceeding 5pm the next calendar day following the occurrence of either: a single confirmed case of covid-19 or three or more residents or staff with new onset of respiratory symptoms that occur within 72 hours of each other. |