STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145630	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVANTI WELLNESS & REHAB	6840 WEST TOUHY AVENUE NILES, IL 60714

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** Based on observation, interview, and record review, the facility failed to maintain dignity and privacy for 3 residents (R66, R68 and R99) in a sample of 69 residents. Findings include, On 03/09/20 at 10:55 am, V13 (Certified Nursing Assistant- Male) stated R66 has not been changed this morning and he was about to do it now; however, he was observed leaving the residents room after speaking with R66's family member. On 3/09/20 at 11:04 am, V14 (Staffing Coordinator) stated she will change R66's brief however needs to go and get another one. On 3/09/20 at 11:07 am V15 (R66's Family) stated R66 needs to be changed by female only and she has dementia, so he asked V13 to get a female to do it. V15 further stated, R66 is often wet when he comes to visit her, and they often have a male assigned to R66. On 3/09/20 at 11:16 am, V12 (Licensed Practical Nurse) per surveyor request came in to inspect R66's incontinence brief. V12 stated R66 was soaked and the resident had 2 incontinence briefs on. V12 further stated, R66 has not been up yet and she ate breakfast in bed this morning. On 03/10/20 at 9:55 am, R126 (R66's roommate) said R66 has not been changed all last night and this morning. On 3/10/20 at 10:02 am, V13 (assigned to R66) said he has not done incontinence care on R66 today since starting his shift, but he will do it now. On 03/10/20 at 10:05 am, V12 (Licensed Practical Nurse) per surveyor request came in to inspect R66's incontinence brief. V12 stated R66 was soaked and the resident had 2 incontinence briefs on. V12 further stated, R66 has not been up yet and she ate breakfast in bed this morning. On 3/09/20 12:49 pm, V17 (R66's Family Member) stated the main issue she has with the facility is with incontinence care, they do not do it on time. Some nights she will not be changed at all until the day at 10 am or so. V17 also said she have requested for a female aide; the family does not want a male to do incontinence care or bath. V2 (Director of Nursing) told her that the facility does not have female aides. On 3/11/20 at 9:47 am, V2 said she was not aware of R66's family request for a female aide with incontinence care or bathing. R66's instructions for staff displayed in her room document: IMPORTANT: MALE NURSE/CNA ARE NOT to attend to her bathroom needs nor bathe her. Facility policy Respect and Dignity in the Long-Term Care Facility documents in part: Staff members should emphasize respectful and dignified treatment first and foremost in long term care setting. Findings include: On 03/10/20 11:19 AM Resident # 99 urine collection bag noted with no privacy bag and visible to hallway. V11 RN (Registered Nurse) who was present at the time of observation stated there should be a privacy bag covering for the urine collection bag.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, interview, and record review, the facility failed to provide a clean homelike environment for 4 residents (R20, R31, R86 and R110) in a sample of 69 residents. Findings include, On 3/09/20 at 10:09 am, during the tour of room [ROOM NUMBER], R20 stated few days ago he reported the sink in the bathroom was clogged in his bathroom and it was written in the maintenance book by the nurses' station, however it was not fixed. R20 stated the clogged sink made him upset. On 3/09/20 at 10:10 am, during the tour of room [ROOM NUMBER] R86 stated the sink in her bathroom is clogged since last week. Review of unit census documents R20 and R110 residing in room [ROOM NUMBER]. Review of unit census documents R31 and R86 residing in room [ROOM NUMBER]. On 3/11/20 at 2:15 pm, V20 (Maintenance Director) stated it is his responsibility to unclog sinks in residents' rooms. V20 further stated, the work order book is at the nurses' station and they fill it out when something is not working. He checks the books daily, during the week it is fixed same day or within 24 hours. Facility Work Order Log Sheet (3/6/20) documents room [ROOM NUMBER] and 203 with clogged sink.
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review. the facility failed to ensure the resident is free from abuse in 1 (R439) of a sample of 69 residents by not conducting an abuse investigation on an incident with injury that was unwitnessed and of unknown origin to a confused resident. Findings Include: The facility did not determine probable cause of injury leading to two black eyes as observed on 3/9/2020. Document review states R439 is an [AGE] year old female with a [DIAGNOSES REDACTED]. R439 is Assyrian speaking and requires an interpreter for interview. 2/7/2020 Minimum Data Set scores cognitive of 7 for Brief Interview for Mental Status. On 3/9/2020 at 10AM R439 was observed by surveyor in the activity room/memory care unit in a chair with two black eyes. On 3/9/2020 at 2:17PM R439 was interviewed through interpreter V22 (Certified Nurses Aide). R439 responded, she fell five days ago but could not recall how or where. She stated a Nurse (Unidentified) looked at her. She could not recall description of nurse. R439 stated she did not go to the hospital and she is not receiving medications. Review of facility non reportable incidents reveals on 2/25/2020 in room [ROOM NUMBER] at 900PM R439 was brought back to her room to be put back in bed. Before being transferred to the bed V25 (Certified Nurses Aide) noticed a red a bump on R439's forehead. V25 immediately notified nurse on duty. There was no active bleeding with mild pain. No loss or change in level of consciousness. Cold compress was applied to affected site. Report further documents states Probable cause of injury : resident could have fallen asleep in the dining room , nodded down and hit her forehead onto the table. This report reveals no witnesses observed what happened to R439. MD and family were notified. Diagnostic x rays were taken with no sign of fracture. R439 was observed and treated per the facility protocol for residents with injury. Progress notes dated 2/26/2020 include statement Bump to forehead still visible with bruising to nasal area. Progress notes dated 2/28/2020 include facial bruise still visible. Progress note date 3/9/2020 includes fading bruise on the face. On 03/09/2020 at 3:43PM V1 (Abuse Coordinator/Administrator) stated he did not conduct an abuse investigation on the 2/25 2020 incident involving R439. Stated he will conduct abuse allegation investigation at this time. On 3/09/2020 at 3:55PM V1 (2nd time) and V2 (DON) stated there is nobody that they know of with two black eyes on the memory care unit. Asked surveyor if the right resident was identified. V1 and V2 then responded they did not look at the resident on the floor. V1 and V2 stated they were unaware of R439 having black eyes. V1 is the Abuse prevention Coordinator. On 3/11/2020 at 11AM V1 and V2 stated they did not consider 2/25/2020 incident an injury of unknown origin since they assumed R439 hit her head on table from falling asleep. Review of facility Abuse Prevention Program reveals the

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

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) facility did not follow its policy by determining that this incident was an injury of unknown origin, thus an abuse investigation was not conducted. The incident was not reported to the Illinois Department Of Public health.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to conduct and report results of an abuse prevention investigation to Illinois Department Of Public Health within 5 working days of the incident for 1(R439) of 69 residents included in the sample. Findings Include: The facility did not determine probable cause of injury leading to two black eyes as observed on 3/9/2020. Document review states R439 is an [AGE] year old female with a [DIAGNOSES REDACTED]. R439 is Assyrian speaking and requires an interpreter for interview. 2/7/2020 Minimum Data Set scores cognitive of 7 for Brief Interview for Mental Status. On 3/9/2020 at 10AM R439 was observed by surveyor in the activity room/memory care unit in chair with two black eyes. On 3/9/2020 at 2:17PM R439 was interviewed through interpreter V22 (Certified Nurses Aide). R439 stated she fell five days ago but could not recall how or where. She stated a Nurse (Unidentified) looked at her. She could not recall description of nurse. R439 stated she did not go to the hospital and she is not receiving medications. Review of facility non reportable incidents reveals on 2/25/2020 in room [ROOM NUMBER] at 9:00PM, R439 was brought back to her room to be put back in bed. Before being transferred to the bed V25 (Certified Nurses Aide) noticed a red a bump on R439's forehead. V25 immediately notified nurse on duty. There was no active bleeding with mild pain. No loss or change in level of consciousness. Cold compress was applied to affected site. Further in report document states Probable cause of injury : resident could have fallen asleep in the dining room , nodded down and hit her forehead onto the table. This report reveals no witnesses observed what happened to R439. MD and family were notified. Diagnostic x rays were taken with no sign of fracture. R439 was observed and treated per the facility protocol for residents with injury. Progress notes dated 2/26/2020 include statement Bump to forehead still visible with bruising to nasal area. Progress notes dated 2/28/2020 include facial bruise still visible. Progress note date 3/9/2020 includes fading bruise on the face. On 03/09/2020 at 3:43 PM V1(Abuse Coordinator/Administrator) stated he did not conduct an abuse investigation on the 2/25 2020 incident involving R439. Stated he will conduct abuse allegation investigation at this time. On 3/09/2020 at 3:55PM V1 (2nd time) and V2 (DON) stated there is nobody that they know of with two black eyes on the memory care unit. Asked surveyor if the right resident was identified. V1 and V2 then responded they did not look at the resident on the floor. V1 and V2 stated they were unaware of R439 having black eyes. V1 is the Abuse prevention Coordinator. 3/11/ 1AM V1 and V2 stated they did not consider 2/25/2020 incident an injury of unknown origin since they assumed R439 hit her head on table from falling asleep. Review of facility Abuse Prevention Program reveals the facility did not follow its policy by determining that this incident was an injury of unknown origin, thus an abuse investigation was not conducted. The incident was not reported to the Illinois Department Of Public health.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, interview, and record review, the facility failed to provide ADL (Activities of Daily Living) care to 4 residents (R31, R44, R66, R83, R126 and R129) in a sample of 69 residents. Findings include, On 3/09/20 at 10:15 am, R31 stated she was wet and the last time she was changed was around 1 am this morning. V12 (Licensed Practical Nurse) per surveyor request came in to inspect the incontinence brief. V12 stated R31 was soaked and the resident had 2 incontinence briefs on. On 3/09/20 at 10:21 am, V13 (Certified Nursing Assistant) stated he got to the floor today around 7:20 am however he has not done incontinence care on R31. V13 further stated R31 asked him to change her brief 20 minutes ago however he was busy. On 3/09/20 at 10:23 am, R126 stated she just had her brief changed however the last time it was done around 4 am and it happens often, she sits in urine for a long time. On 3/09/20 at 10:30 am, R44 stated, he was changed last night around 8:30 pm, and not since then. R44 also stated, he had 2 incontinence briefs under him. On 03/09/20 at 10:55 am, V13 (Certified Nursing Assistant) stated R66 has not been changed this morning and he was about to do it now; however, he was observed leaving the residents room. On 3/09/20 at 11:04 am, V14 (Staffing Coordinator) stated she will change R66's brief however needs to go and get another one. On 3/09/20 at 11:07 am V15 (R66's Family Spouse) stated R66 needs to be changed by female only and she has dementia, so he asked V13 to get a female to do it. V15 further stated, R66 is often wet when he comes to visit her, and they often have a male assigned to R66. On 3/09/20 at 11:16 am, V12 (Licensed Practical Nurse) per surveyor request came in to inspect R66's incontinence brief. V12 stated R66 was soaked and the resident had 2 incontinence briefs on. V12 further stated, R66 has not been up yet and she ate breakfast in bed this morning. On 03/10/20 at 9:55 am, R126 (R66's roommate) said R66 has not been changed all last night nor this morning. On 3/10/20 at 10:02 am, V13 (assigned to R66) said he has not done incontinence care on R66 today since the start of his shift but he will do it now. On 03/10/20 at 10:05 am, V12 (Licensed Practical Nurse) per surveyor request came in to inspect R66's incontinence brief. V12 stated R66 was soaked and the resident had 2 incontinence briefs on. V12 further stated, R66 has not been up yet and she ate breakfast in bed this morning. On 3/11/20 at 9:47 am, V2 (Director of Nursing) stated, staff should not place double incontinence briefs on residents. Facility Policy ACTIVITIES OF DAILY LIVING documents in part: Resident self-image is maintained. Facility Certified Nurse Aide duties include: 3. Give or assist resident with bathing. 5. keep incontinent residents clean, dry and odor free; check every two hours to maintain. On 03/09/2020 at 10:56am R129 stated she has to ask for a basin filled with hot water to wash her face and hands every morning. R129 stated no one brings the basin of water unless she asks. Surveyor asked had she received a shower or bed bath since her admission and she stated no. Surveyor asked if her legs and feet had been washed, R129 stated no. R129 stated she did not know her shower days. On 03/10/2020 at 10:38am Surveyor asked R129 if she had received a shower or bed bath and she stated no. On 03/10/2020 at 10:49am V11 (Registered Nurse) stated R129 shower days are on Monday and Thursdays. V11 stated CNA's complete a wound and skin referral sheet when a shower or bed bath are completed. She stated the nurses have to sign off on the sheet. Surveyor asked to see the wound and skin referral sheet for R129. She stated that the sheets had been pulled from the book to be scanned into the system. Wound and Skin Referral sheet could not be produced for R129 by V11. V11 stated due to R129 being on isolation she has not be receiving showers. She should be getting bed baths. On 03/10/2020 at 11:04am V22 (Certified Nursing Assistant) stated he gave R129 a bed bath yesterday (03/09/2020). Surveyor asked to see the shower sheet for R129. V22 stated that he forgot to complete the shower sheet but he did give her a bed bath after lunch. No shower sheet was provided for 03/09/2020. On 03/10/2020 at 11:10am R129 stated she did not receive a bed bath yesterday (03/09/2020) after lunch. Surveyor asked R129 did she receive a bed bath at all yesterday (03/09/2020 by a male CNA and she stated no. Facility Transfer/Discharge report dated 03/11/2020 under [DIAGNOSES REDACTED]. Per Minimum Data Set ((MDS) dated [DATE] in section C Cognitive Patterns R129 has a Brief Interview for Mental Status (BIMS) summary score of 15. Section G indicates that R129 needs one person physical assist. Findings include: On 03/09/20 at 11:05 AM, in R83's room four white soiled used towels noted on the bare floor in the room. R83 was noted in the room sitting in the wheel chair with long nails and caked blackish particles underneath the nail bed. On 03/09/20 at 11:09 AM, V7 CNA (Certified Nurse's Aide) brought a plate of breakfast for the resident, V7 did not help R83 in cleaning the nails. R83 ate the food and was touching the food with his hands.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** Based on interview, and record review, the facility failed to assess a resident (R35) after a fall, failed to ensure wound care was performed as ordered by a physician for one resident (R194) and failed to administer medications as prescribed to 6 residents (R54, R66, R79, R96, R118 and R126) in the sample of 69 residents. Findings include, On 3/9/20 at 10:49 am, surveyor inquired about the (2nd floor) 9:00 am medication administration. V12 (Licensed Practical Nurse) accessed the EMR (Electronic Medical Record) and several residents were highlighted in red. V12 stated, those residents (R54, R66, R79, R96, R118 and R126) are in red because their medications were due at 9 am. She further stated, usually she passes medications

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) around 11 am and her shift starts at 9 am. On 3/09/20 at 11:19 am, R35 stated she is weak on the right side of her body. R35 was observed with a cut on the right arm. R35 stated, last week (unsure of date) she had a meeting with V1 (Administrator), V2 (Director of Nursing) and V3 (Assistant Director of Nursing) regarding an incident that had occurred with V18 (Certified Nursing Assistant) and that the resident did not want V18 to care for her anymore. R35 said, one day V18 came in to transfer her and she was instructing V18 on how to do it. However, V18's foot was preventing her to move, and R35 fell across the chair and hit her right side. R35 said she has a cut to her right arm, and no one assessed her after the incident. R35 did say her hip and arm were hurting, however nothing was done about it and she was not assessed by staff. On 3/9/20 at 12:36 pm, V14 (Staffing Coordinator) stated, she was present last week (unsure of date but was 3/5/20 or 3/6/20) during the meeting with R35, V1 (Administrator), V2 (Director of Nursing) and V3 (Assistant Director of Nursing). R35 called her and wanted V14 to be present also. R35 had concern with general staffing and didn't want V18 (Certified Nursing Assistant) to care for her anymore because V18 does not follow directions. V14 stated, R35 expressed to everyone that V18 transferred the resident wrong and the resident hit her arm and hip during the incident. On 3/9/20 at 3:30 pm, V2 (Director of Nursing) stated last week facility had a meeting with R35 about her concerns. V2 further stated, the resident did not want V18 to care for her because she was not transferred properly. V2 further stated, she told the nurse on duty to do an assessment on R35 because she complained of pain and for the nurse to document the assessment. V2 also stated, the plan was to in-service all staff on resident transfer and not to assign V18 to R35 anymore. Surveyor inquired to why V2 did not assess R35 on the spot and V2 said because the resident does not like her. V2 also stated, she will present the documentation from the assessment by the nurse. On 3/9/20 at 4:02 pm, V2 stated the resident assessment was not documented in the electronic health record. On 3/11/20 at 9:47 am, V2 (Director of Nursing) said medications are to be administered one hour before or after the due time. Facilities (3/8/20) 11 pm-7 am assignment documents V18 was assigned to R35. (V18 called off that night) Review of R35's progress notes from (2/20-3/8) does not document the incident. Facility policy (11/13) INCIDENTS & ACCIDENTS) documents in part: 4. if an incident or accident occurs, a full investigation will be initiated, including staff interviews, equipment checks, and follow through on policy and procedures. 5. If incident or accidents is found to be preventable, immediate actions, including disciplinary actions, will be implemented to ensure prevention of further incidents. 6. physicians and families will be immediately notified if incident or accident involves a resident. 7. Facility will monitor the effectiveness of the interventions including adequate supervision consistent with the resident's needs, goals, plan of care, and current standards of practice in order to reduce the risk of an accident. Facility policy (9/1/15) Medication Administration documents in part: 4. Medication preparation/Administration Right Time- 60 minutes before or after the scheduled time unless otherwise specified. Findings include: On 03/09/20 at 11:14am R194 noted in bed with wound dressing dated 3/7/20 noted to both forearms. V5 RN (Treatment Nurse) stated the dressing to the wound is supposed to be done as ordered every day, but the resident family requested for female staff with R194's care. V5 stated this might be the reason why it was not changed and I'm a male so I can't go inside the room. On 3/11/20 at approximately 9:15am, V2 DON (Director of Nursing) stated apparently V11 (RN) signed out for the treatment dressing. But with the date on the dressing showing 3/7/20 the dressing was not done. The facility job description policy for Registered Nurse presented with revised date 4/11/07 listed essential duties that includes but not limited to administering prescribed medications and treatments according to policy and procedures. Documenting nursing care rendered. The facility policy on Wound Care program presented with no date indicated that the comprehensive wound management results in healing rates, decreased acquisition and cost management. Having a comprehensive program is necessary for appropriate care, treatment prevention and outcomes management. And the goals listed includes but not limited to assessing
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** Based on observation, interview, and record review, the facility failed to ensure that hand splints or other restorative devices were applied on residents' extremities. This failure affects 2 residents (R66 and R126) in the sample of 69 residents. Findings include: On 3/09/20 at 10:23 am, R126 was observed with both hands contracted, however no splints applied on the resident. R126 stated the splints are not on because there is only one nurse that knows how to put them on. R126 also said, she should be wearing the splints all the time. Other staff do not know how to put them on, they were not trained on how to do it. R126 said the person in charge of restorative, V28 (Restorative Nurse) does not know how to either. On 3/09/20 at 10:29 am, R66 was observed with left hand contracted, no splint applied. On 3/10/20 at 9:55 am, both R66 and R126 were observed without splints on. On 3/10/20 at 3:05 pm, V28 (Restorative Nurse) stated, restorative aide or the assigned nurse should be applying splints for the residents. Facility's SPLINTING TRACKING LOG documents R66 and R126 with the use of splints. Facility Contracture Prevention & Management documents: Orthotics: Application of a supportive device to maintain an affected limb in a functional position to prevent or reduce contractures.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** Based upon observation, interview, and record review, the facility failed to implement fall prevention interventions for 4 residents (R31, R44, R126 and R133) out of 4 reviewed for falls in a total sample of 69 residents. Findings include, On 3/09/20 at 10:05 am, R133's fall mattress observed against the wall and not on the floor next to the resident's bed. R133's (2/19/20) Fall Risk Evaluation documents resident as high risk. On 3/09/20 at 10:15 am, R31 was observed in bed in high position. R31's (1/6/20) Fall Risk Evaluation documents resident as high risk. R31's (10/10/19) fall care plan documents risk for falls with intervention bed in low position when in bed. On 3/09/20 at 10:23 am, R126 was observed in bed in high position. R126's (6/27/19) fall care plan documents risk for falls with intervention bed in low position when in bed. R126's (2/25/20) Fall Risk Evaluation documents resident as high risk. On 3/09/20 at 10:30 am, R44 was observed in bed in high position. R44's (1/15/20) Fall Risk Evaluation documents resident as high risk. R44's (3/18/19) fall care plan documents risk for falls related to bilateral knew weakness, fall and severe obesity. On 3/10/20 at 2:50 pm, V2 (Director of Nursing) stated residents beds need to be in low position as a universal fall precaution. Facility (undated) FALL PREVENTION PROGRAM documents in part: 4. Interventions to be tried to reduce falls may include but are not limited to: B. Low Bed C. Floor mattress
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** Based upon observation, interview, and record review, the facility failed to ensure that sufficient nursing staff were available to meet the needs of 4 of 43 (unit 2-0) residents (R31, R44, R66 and R126) reviewed. This failure has the potential to affect all 43 (unit 2-0) residents. Findings include, The (3/8/20) daily census includes 43 residents on Unit 2-0. On 3/09/20 at 10:15 am, R31 stated she was wet and the last time she was changed was around 1:00 am this morning. V12 (Licensed Practical Nurse) per surveyor request came in to inspect the incontinence brief. V12 stated R31 was soaked and the resident has 2 incontinence briefs on. On 3/09/20 at 10:21 am, V13 (Certified Nursing Assistant) stated he got to the floor today around 7:20 am however he has not done incontinence care on R31. V13 further stated R31 asked him to change her brief 20 minutes ago however he was busy. On 3/09/20 at 10:23 am, R126 stated she just had her brief changed however the last time it was done around 4 am and it happens often she sits in urine for a long time. V13 was observed doing incontinence care on R126. On 3/09/20 at 10:30 am, R44 stated he was changed last night around 8:30 pm, and not since then. R44 also stated, he had 2 incontinence briefs under him. On 03/09/20 at 10:55 am, V13 (Certified Nursing Assistant) stated R66 has not been changed this morning and he was about to do it now; however, he was observed leaving the residents room. On 3/09/20 at 11:04 am, V14 (Staffing Coordinator) stated she will change R66's brief however needs to go and get another

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F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) one. On 3/09/20 at 11:07 am V15 (R66's Family Spouse) stated R66 needs to be changed by female only and she has dementia, so he asked V13 to get a female to do it. V15 further stated, R66 is often wet when he comes to visit her, and they often have a male assigned to R66. On 3/09/20 at 11:16 am, V12 (Licensed Practical Nurse) per surveyor request came in to inspect R66's incontinence brief. V12 stated R66 was soaked and the resident had 2 incontinence briefs on. V12 further stated, R66 has not been up yet and she ate breakfast in bed this morning. On 03/10/20 at 9:55 am, R126 (R66's roommate) said R66 has not been changed all last night nor this morning. On 3/10/20 at 10:02 am, V13 (assigned to R66) said he has not done incontinence care on R66 today since the start of his shift, but he will do it now. On 03/10/20 at 10:05 am, V12 (Licensed Practical Nurse) per surveyor request came in to inspect R66's incontinence brief. V12 stated R66 was soaked and the resident had 2 incontinence briefs on. V12 further stated, R66 has not been up yet and she ate breakfast in bed this morning. Facility assessment documents in part: Staffing is acuity based. Considerations that will warrant additional staffing include, but are not limited to: increased number of patients who have extensive personal and/or psychosocial needs.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** Based on observation, interview, and record review, the facility failed to implement safeguards and systems, to ensure that the shift change accountability records are accurately maintained for periodic reconciliation for controlled medications stored in 1 of 4 medication carts observed. This has the potential to affect all 42 residents on unit 2-0 of the second floor. Findings include: 1. On 3/10/2020 at 10am, V1 (Administrator) presented the facility census that shows that 42 residents reside on the unit 2-0 of the facility. 2. On 3/10/2020 at 10:40am during a review of the medication carts on unit 2-0, the Controlled Substance Shift Change accountability sheet reviewed with V12(Licensed Practical Nurse, LPN) showed two missing entries for the following dates and times: 11pm-7am shift on 3/7/2020 7am-3pm shift on 3/8/2020 V12 stated I don't know whose signature is missing, but I will let my supervisor know. On 3/11/2020 at 11:16am, V2 (Director of Nursing) stated that all nurses should sign in at the beginning of their shift, and also sign out at the end of their shift. There should be no missing entries. At this time, V2 presented the facility's policy titled Narcotic Monitoring with revision date April 2011. This policy states in #6: Two nurses must count narcotics at the beginning and end of each shift, initialing the narcotic count record. The two nurses counting should be the in-coming and out-going nurses. The facility did not follow this policy.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure medication error rates are not 5 percent or greater.** Based upon observation, interview, and record review, the facility failed to ensure a medication error rate of <5% for two of three residents (R79 and R126) observed for medication administration. There were 25 opportunities and 6 errors resulting in an 24% medication error rate. Findings include; R79's Medication Administration Record [REDACTED]. On 3/09/20 at 10:43 am, V12 (Licensed Practical Nurse) during medication pass, administered the above medications to R79. R126's Medication Administration Record [REDACTED]. On 3/09/20 at 11:05 am, V12 (Licensed Practical Nurse) during medication pass, administered the above medications to the R126. On 3/11/20 at 9:47 am, V2 (Director of Nursing) said medications are to be administered one hour before or after the due time. Facility policy (9/1/15) Medication Administration documents in part: 4. Medication preparation/Administration Right Time- 60 minutes before or after the scheduled time unless otherwise specified.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to date residents' opened multi-dose eye drops stored in the medication carts, and failed to dispose of residents' expired eye drops from the medication carts, in 2 of 4 medication carts observed. This has the potential to affect four residents (R39, R122, R132, and R237) reviewed for medication storage, from the total sample of 69 residents. Findings include: 1. On [DATE] at 10:15am during observation of the medication carts on the first floor with V11 (Registered Nurse, RN), the following opened eye drops were observed: R132's 5ml (milliliters) bottle of [MEDICATION NAME] Acetate 1 percent (%) ophthalmic solution with no open date; R39's 3.5 gram of 0.5 %(percent) Ophthalmic ointment tube with no open date; R122's 2.5ml bottle of Latanoprost 0.005% solution with open date [DATE]. V11 stated that she knows that some eye drops are good for only 30 days once opened, so, the open date should be put on the bottle. V11 added that Latanoprost eye drops opened on [DATE] was old. 2. On [DATE] at 10:27am during observation of the medication carts on the second floor with V24 (Licensed Practical Nurse, LPN) on the second floor, the following medication was found: R237's 5ml (milliliters) bottle of [MEDICATION NAME] Acetate 1% ophthalmic solution with no open date; V24 stated that the bottle should be dated when opened. On [DATE] at 11:50am, V2 (Director of Nursing) stated that all eye drops should be dated when opened, but the liquid oral medications are good till the manufacturers' expiration dates and should not need dating. At this time, V2 presented the facility's policy titled Medication Storage in the Facility. This policy dated ,[DATE] states in #C: Certain medications or package types, such as multiple dose injectable vials, ophthalmic, [MEDICATION NAME] tablets, blood sugar testing solutions and strips, once opened, require an expiration date shorter than the manufacturer's expiration date to insure medication purity and potency. The facility did not follow this policy.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview, and record review, the facility failed to ensure all staff wear hairnets when in the kitchen, failed to provide enough plates to feed all residents during mealtime, failed to maintain infection control practice when checking food temperatures, and failed to date food stored in the produce/dairy refrigerator and freezer to ensure safe food handling practice, placing all 126 residents at risk for food borne illness who receive meals in the facility. Findings: On 03/09/2020 at 10:00am observed a 5 pound container of Nature's Best Sour cream with no open date in the walk in refrigerator for produce/dairy. Used by date 2/21/2020 on the container. On 03/09/2020 at 10:01am asked V9 (dietary manager) what happens to foods beyond their use by date, he stated, we throw it out. Asked V9 what the date stands for on the container and he stated it was date the item came in. On 03/09/20 at 10:06am observed an undated open box of Holten's seasoned beef patties. The patties were covered by paper in the box and open to air. Observed an open box of Hormel sausage patties not covered without an open date. On 03/09/2020 at 10:07am asked V9 what does that date on the box mean and he stated that is the date that the item came in. V9 stated there is no open date because once they open it they use it all because of the number of residents fed in the facility. On 03/09/2020 at 11:20am observed V10 (cook) not cleaning and sanitizing the thermometer in between checking food temperatures. V10 used the same alcohol wipe to clean and sanitize the thermometer when checking the temperatures for the sweet and sour meatballs, mechanical soft meat and broccoli. V10 used another alcohol wipe to clean and sanitize the thermometer when checking the temperatures for the pureed mashed potatoes, vegetables and pureed meat. 03/09/2020 at 11:28am Asked V10 should he used a different alcohol wipe between each dish and he said yes. On 03/09/2020 at 11:30am observed V19 (dietary aide) with sections of her hair not secured under the hairnet. On 03/09/2020 at 12:00pm observed V21 (dietary aide) using paper plates instead of regular plates. On 03/09/2020 at 12:07pm Asked V21 why was he using paper plates and he stated they ran out. V21 stated it didn't happen on a regular basis. On 03/09/2020 at 12:15pm observed 15 residents using paper plates in the 2nd floor dining room. On 03/11/2020 at 10:06am V9 stated that all hair should be in hairnet. On 03/11/2020 at 10:17am V9 stated the thermometer should be cleaned and sanitized with alcohol wipe between each food dish. No policy was received about dishware requirements. On 03/11/2020 at 1:04pm V9 stated that one of the aides broke about 70 plates last week. He stated more plates have been ordered. Policy with revised date May 20, 2014 titled Hair Restraints/Jewelry/Nail Polish in part states hairnets will be worn at all times in the kitchen. Undated policy titled Labeling and Dating Foods, states in part to decrease the risk of food borne illness and to provide the highest quality, foods is labeled with the date received, the date opened and the date by which the item should be discarded. Under procedures it states in part once opened these items are refrigerated and labeled with the date opened and with discard or use by date. Undated policy and procedure titled Food & Nutrition Services Meal Serve states in part utensils and condiments that are appropriate for the meal and the resident's diet will be on the tray. Undated policy and procedure titled Hand Washing it states in part food & nutrition services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145630	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVANTI WELLNESS & REHAB	6840 WEST TOUHY AVENUE NILES, IL 60714

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 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) employees will practice safe food handling to prevent foodborne illness.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, the facility failed to follow standard infection control practices with regards to respiratory equipment storage, and urine collection bag tubing placement. This failure applies to four residents (R61, R83, R113 and R117) reviewed for infection prevention and control in the sample of 69. Findings include: On 03/09/20 at 10:42 AM R61's urine drainage bag tubing was noted touching the floor. Two oxygen concentrator left running in the toilet with tubing noted touching the bare floor. On 03/09/20 at 11:05 AM In R83 four white used soiled towels noted on the bare floor in the room. On 03/09/20 at 11:09 AM V7 CNA (Certified Nurse's Aide) stated the towels are supposed to be inside a plastic bag. V6 CNA stated I was orienting V7 (CNA) and we will take the towels off the floor. On 03/09/20 at 11:20 AM R117 was noted in the room with oxygen tube noted on the chair uncontained. V4 LPN (Licensed Practical Nurse) stated the oxygen tubing should be stored in a plastic bag. V4 stated the urine collection bag touching the floor the tubing, V4 stated it should be off the floor. On 03/10/20 at 11:02 AM, R61 oxygen mask with tubing left on the table in the room uncontained humidifier machine labeled clean stored on the bare floor uncontained. V4 LPN (Licensed Practical Nurse) stated the respiratory therapy staff left it uncontained and they should have kept the equipment in a plastic bag for infection prevention. On 03/10/20 at 11:15 AM, R113's C-PAP (Continuous Positive Airway Pressure) mask left on the side-table in the room uncontained. V11 RN (Registered Nurse) stated the C-PAP mask should be placed in a plastic bag when not in use. On 03/10/20 at approximately 02:56pm, When V2 DON (Director of Nurse) was made aware by the surveyor concerning soil linen storage. V2 stated the soil linens should be put in the utility room in a green plastic bag. The facility policy on Respiratory Equipment Storage with revision date December 2019 indicated that the respiratory equipment that includes nasal cannula, tubing, mask or mouthpiece when not in use should be placed inside a clean plastic bag.
F 0883 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to have documentation that: the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and that the resident either received or refused the pneumococcal immunizations. This affects five residents (R51, R68, R66, R99 and R189) reviewed for immunizations, in a total sample of 69 residents. Findings include: On 3/10/20 at 1:00pm, V23 (Infection Control Nurse) was asked to present the facility's immunization records for review. The records reviewed showed that R51, R68, R66, R99 and R189, (who are over [AGE] years old), were not on the list of residents who received or refused pneumococcal immunizations at the facility or historically. V2 was asked for the records that residents and/or residents' representatives were educated regarding the immunization or refused the immunization. On 3/11/20 at 12:40pm, V23 was not able to find any records for these five residents regarding the pneumococcal immunization. V2 (Director of Nursing)) later explained that they will offer the residents and make sure the records are updated. Facility's Pneumococcal Vaccine Policy with revision dates 2012, 2013, and 2017 states To reduce morbidity and mortality from pneumococcal disease by vaccinating all adults who meet the criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices. #V (a) of the policy states: Record the date the vaccine was administered, and the manufacturer and the lot number, the vaccination site and route, and the name and title of the person administering the vaccine. If the vaccine was not given, record the reason for non-receipt of the vaccine (e.g. medical contraindication, patient refusal). The facility did not follow this policy.
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** Based on observation, and interview, the facility failed to provide a safe environment for 41 residents in a sample of 69 by not providing a safe environment to residents. Findings include: On 3/9/2020 at approximately 10:00am during the initial tour, a cabinet with a floor length cracked mirror with exposed sharp edges observed on the memory care locked unit housing 41 residents. This cracked mirror with sharp edges was accessible to all 41 confused residents residing on this unit. On 3/11/2020 at 2:00PM V20 (Maintenance Director) stated that cabinet should have been disposed of a long time ago. V20 removed the cabinet at this time.
F 0923 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have enough outside ventilation via a window or mechanical ventilation, or both.** Based on observation, and interview, the facility failed to provide proper ventilation for 41 residents in a sample of 69 residents in the sample. Findings include: On 3/9/2020 at 10:00AM the facility 2nd floor memory care locked unit was observed and smelled of urine, feces, and other foul odors throughout the unit. On 3/11/2020 at 2:00pm V20 (Maintenance Director) stated the unit is ventilated to the outside . The ventilation is functioning however at certain times the residents are incontinent and staff need to change them before the odor will diffuse from the unit.