STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012827	A. BUILDING: _____ B. WING _____	05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA OF ELGIN	1950 LARKIN AVENUE ELGIN, IL 60123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Second Probationary License Survey LP2 Change of Ownership Survey.	S 000		
S9999	Final Observations Statement of Licensure Violations. 300.1610 l) 300.1610 Medication Policies and Procedures l) Oxygen may be administered in a facility either as concentrated bottled oxygen or via means of oxygen concentrator. Storage and handling of the bottled oxygen supply shall be in accordance with 1977 National Fire Protection Association Standards, for nonflammable medical gas systems. Based on observation, interview, and record review the facility failed to safely secure oxygen tanks to prevent falling. This applies to all the residents on the 400-wing where the oxygen store room is located. Findings include: On 5/14/19 the oxygen store room on the 400-wing had five oxygen tanks that were not secured to prevent falling. The tanks were not behind barriers or in stands to keep them from falling over and possibly breaking the spouts off. When the spouts break off the pressurized gas escapes with enough pressure to propel the tanks. The escaping oxygen can enhance any spark or flame into a fire ball. Empty tanks must also be secured because there may still be some oxygen in them.	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012827	A. BUILDING: _____ B. WING _____	05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA OF ELGIN	1950 LARKIN AVENUE ELGIN, IL 60123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1	S9999		

V4 (Director Housekeeping) stated, the oxygen tanks are empty but all tanks should be stored in stands.

The facility oxygen storage policy/procedure states, "1) restrain or store securely oxygen tanks at all times."

(C)

Statement of Licensure Violations.

300.610a)
300.1210a)
300.1210b)
300.1210d)5)
300.1220b)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

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012827	A. BUILDING: _____ B. WING _____	05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA OF ELGIN	1950 LARKIN AVENUE ELGIN, IL 60123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2	S9999		

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

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

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:

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012827	A. BUILDING: _____ B. WING _____	05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA OF ELGIN	1950 LARKIN AVENUE ELGIN, IL 60123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		

services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

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

These Requirements are not met as evidenced by:

Based on observation, record review, and interview the facility failed to implement measures to prevent pressure ulcer development for a resident deemed at risk for pressure ulcers. The facility also failed to perform skin assessment on a newly admitted resident whom was in the facility 4 days with skin impairment.

This applies to 2 of 3 residents (R1, R2) reviewed for pressure ulcers in a sample of 4.

Findings include:

The Face Sheet documents R2 is 80 years old

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012827	A. BUILDING: _____ B. WING _____	05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA OF ELGIN	1950 LARKIN AVENUE ELGIN, IL 60123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4	S9999		

and was admitted on 4/26/19 with diagnoses including: cerebral infarction, morbid obesity, hyperlipidemia, hypertension, atrial fibrillation, difficulty in walking and lack of coordination. The Nursing Admission Assessment did not note any pressure ulcers for R2.

The Minimum Data Set (MDS) dated 3/5/19 documents R2 has a BIMS (Brief Interview for Mental Status) score of 15/15 indicating no cognitive impairment. The MDS also documents that R2 requires extensive staff assistance with toileting and is frequently incontinent of urine. The Skin Conditions section documents R2 has 0 unhealed pressure ulcers/injuries.

The facility Pressure Ulcer Report reads: R2 has a facility acquired unstageable pressure ulcer to the right buttock identified on 5/8/19.

On 5/14/19 at 11:43 AM, R2 was wearing an adult brief. V5 (Wound Care Registered Nurse) performed wound care treatment for R2. Observation showed R2 had an open wound on the right buttock. The wound bed was pink with yellow center and the peri-wound was macerated. V5 measured the wound at 2.2 X 2.4 (Centimeters/cm). After treatment was completed R2 was interviewed and stated "they leave me sitting on my butt too long. Sometimes I'm waiting 6-8 hours." R2 stated staff does not answer the call light in a timely manner to toilet R2. R2 stated "I wait and wait and wait. I put the light on to go to the bathroom. It takes them too long, then I'm wet."

On 5/14/19 at 3:01 PM, V5 stated R2 has a facility acquired pressure ulcer to the right buttock. V5 stated "the wound was unstageable

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012827	A. BUILDING: _____ B. WING _____	05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA OF ELGIN	1950 LARKIN AVENUE ELGIN, IL 60123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5	S9999		

when V11 (Registered Nurse) notified me."

On 5/14/19 at 3:16 PM, V11 stated V11 discovered the pressure ulcer on R2's right buttock on 5/8/19. When asked to describe what V11 saw, V11 stated "I don't remember if I documented a progress note but the wound was irregular in shape." V11 stated R2 is mostly up in the wheelchair.

On 5/15/19 at 10:00 AM, 11:30 AM, 12:00 PM and 1:00 PM, R2 was sitting in the chair in R2's room. At 1:00 PM R2 stated "I have been up since around 5:30 AM." R2 stated R2 had a shower and therapy around 9:00 AM and has been in the chair ever since. V8 (Occupational Therapy Assistant/OTA) stated R2 had OT at 8:00 AM after R2's shower. V9 (Physical Therapy Assistant/PTA) stated R2 had PT at 9:00 AM right after OT.

On 5/15/19 at 1:00 PM, V10 (Certified Nursing Assistant/CNA) assisted R2 to bed. R2 was wearing boxers. When asked why R2 was R2 wearing a disposable brief yesterday and regular boxers today, R2 replied "they put the disposable briefs on me when they are going to take too long to help me." When asked how long does R2 sit in the chair, V10 stated "I know he has a wound. I asked right now if R2 was having discomfort and R2 was, so I put R2 back to bed." V10 stated "I didn't ask earlier because R2 was with therapy today."

On 5/15/19 at 1:21 PM, V5 stated R2 should not be up in the chair more than an hour. When asked how V5 communicates R2's care to the CNAs, V5 stated it's in the EHR (Electronic Health Record). V5 stated R2 was at risk for pressure ulcer development on admission. When

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012827	A. BUILDING: _____ B. WING _____	05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA OF ELGIN	1950 LARKIN AVENUE ELGIN, IL 60123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 6	S9999		

asked what preventive measures were placed for R2 on admission, V5 stated "Well R2 didn't have any pressure ulcers when R2 came in. We don't put interventions if they don't have pressure ulcers when they come in." V5 stated R2 received pressure relief devices after the wound was identified. V5 stated "we gave the chair cushion and air mattress that day." When asked the conclusion as to what caused R2's pressure ulcer, V5 stated V5 didn't do a cause analysis. V5 stated "I know R2 is continent."

The Skin Risk Assessment (Braden Scale) in the Electronic Health Record (EHR) dated 4/26/19 showed R2 was at risk for breakdown on admission.

The Pressure Ulcer care plan shows it was initiated on 5/8/19, the same day the pressure ulcer was identified.

The policy titled Wound Care Program reads:

Procedures:
Timely identification of residents assessed to be at risk for skin breakdown.

a). The Braden Scale has to be completed by a licensed nurse on admission/readmission and weekly for the first 4 weeks of admission in the facility.

c). Each risk factor and potential cause(s) identified should be reviewed individually and addressed into the resident's care plan.

d). Facility shall develop a plan of care and implement intervention according to the resident's Braden Score and/or identified individual risk factor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012827	A. BUILDING: _____ B. WING _____	05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA OF ELGIN	1950 LARKIN AVENUE ELGIN, IL 60123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 7	S9999		

Prevention of skin breakdown.

e). Keeping local areas of skin clean, dry and free of body wastes, perspiration, and wound drainage.

Activity, Mobility, and Positioning.

c). While in bed or in wheelchair, resident should be turned/repositioned at least every 2 hours or as indicated in the residents' plan of care.

f). Frequency of position changes is individualized according to the resident's plan of care.

i). Evaluate and utilize appropriate pressure reduction or pressure relieving surface modalities while in bed and/or up in wheelchair
The Face Sheet for R1 documents the following diagnoses: Cellulitis, chronic pain syndrome, hypertension, foot drop, chest pain, anxiety disorder, and ataxia. R1 was admitted to the facility on 5/10/19. R1's initial BIMS (Brief Interview for Mental Status) was completed by social services on 5/13/2019 and R1 was scored 15 indicating that R1 had no cognitive impairment. The facility's wound report dated 5/11 to 5/14, 2019 did not include R1's name as having a wound.

On 5/14/19 at 10:00 AM, R1 was in bed filling out R1's dietary menu for the week. R1 was still in R1's bed clothes with padded foot protectors on both feet. R1 stated "please close the door so we can talk I'm upset." R1 continued, "I was admitted on Friday 5/10/19. V6 (Registered Nurse) did my assessment except for my skin I don't want a male nurse to look at me without clothing on. V6 never took off my booties to check

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012827	A. BUILDING: _____ B. WING _____	05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA OF ELGIN	1950 LARKIN AVENUE ELGIN, IL 60123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 8	S9999		

my feet and I have sores. On 5/11/19 V7 (Nurse Practitioner) from the doctor's office, did my assessment but V7 never took off my booties to look at my feet either."

A review of R1's clinical record dated 5/11/19 indicated that at 1:09 PM V7 (Nurse Practitioner) did an initial assessment for R1. On V7's assessment there was no documentation or description of right heel wound or left toe ulcer. R1's Care Plan did not contain any information or treatment for R1's right heel pressure ulcer, or ulcers on left toes.

On 5/15/19 at 1:15 PM, V6 (Registered Nurse-RN) stated "I admitted R1 on 5/10/2019 at 12:15 PM. I was busy and working a double shift and did not complete assessment on R1 until 8:00 PM. R1 did not want me to do the skin assessment because I was a male, so that portion of assessment was not completed. At 11:00 PM when I gave report to the night nurse I and explained the skin assessment needs to be completed."

On 5/14/2019 at 11:15 AM, V5 (Wound Care Nurse) stated "residents are initially assessed by the admitting nurse within 24 hours. If there is a skin concern they would contact me to assess the resident." V5 stated "R1 has not had a skin assessment since R1's admission in the facility."

On 5/14/2019 at 2:30 PM, V3 (Assistant Director of Nursing) stated "R1 does not have a completed Care Plan because R1 has only been here for 4 days.

On 5/15/2019 at 11:35 AM, V5 did an assessment on R1's right heel which showed ".5cm length x 1.cm width no depth necrotic hard firm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012827	A. BUILDING _____ B. WING _____	05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA OF ELGIN	1950 LARKIN AVENUE ELGIN, IL 60123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 9 unstageable pressure ulcer. On 2nd toe left foot a .50cm length x .80cm width no depth necrotic hard firm pressure ulcer on tip of toe." The Policy & Procedure: Titled Wound Care Program dated May 01, 2015 provides: Policy: It is the policy of this facility to ensure that residents whose clinical conditions and medical diagnosis potentiate the risk for skin breakdown and development of pressure ulcers are properly identified, assessed and managed according to current regulatory guidelines and standard of care. Procedures: d) Facility shall develop a plan of care and implement intervention according to the resident's Braden Score and/or identified individual risk factors. (B)	S9999		