STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		IL6010482	B. WING		05/0	09/2023
VAME OF	PROVIDER OR SUPPLIER	OTTLETAL		TATE, ZIP CODE		
AVANTA	RA LIBERTYVILLE		JTH MILWAU VILLE, IL 600	KEE AVENUE 048		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D RE	(X5) COMPLE DATE
S 000	Initial Comments		S 000	<u> </u>		
	First Probationary L	icensure Survey				
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations:				
	1 of 3	2.		la la		
	300.696 d)1) 300.696 d)2)	19 Fr		3 1		
	Section 300.696 Inf	fection Prevention and Control				
	d) Each facility guidelines and toolk Control and Prevent Health Service, Dep Services, Agency for Quality, and Occupa Administration (see 1) Guideling Catheter-Associated	shall adhere to the following its of the Centers for Disease ion, United States Public artment of Health and Human r Healthcare Research and tional Safety and Health Section 300.340): e for Prevention of Urinary Tract Infections e for Hand Hygiene in				
i i	This REQUIREMENT by:	T was not met as evidenced				
i C fi a	nterview, the facility atheter drainage ba loor and failed to en	n, record review and failed to ensure a urinary g was not positioned on the sure staff changed gloves hygiene to prevent cross		8		
T tf	his applies to 2 of 1 nat were reviewed fo	8 residents (R102 and R110) or infection control in the		Attachment A Statement of Licensure Violations	8	

2.01

STATE FORM

6899

MPYC11

(X6) DATE

**FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6010482 05/09/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1500 SOUTH MILWAUKEE AVENUE AVANTARA LIBERTYVILLE LIBERTYVILLE, IL 60048 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID D (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 1 S9999 sample of 9. The findings include: 1. On 5/8/23 at 11:03 AM, R102's urinary catheter drainage bag was resting directly on the floor with no barrier present between the floor and the bag. On 5/9/23 at 10:15 AM, V9, Certified Nursing Assistant (CNA), said catheter drainage bags should be kept off the floor because it could increase the risk of introducing microorganisms and cause a urinary tract infection. R102's Admission Record, dated 5/8/23, shows his diagnoses include, but are not limited to: chronic kidney disease, malignant neoplasm of prostate, benign prostatic hyperplasia with lower urinary tract symptoms, and retention of urine. R102's Care Plan shows on 4/19/23 R102, "has a **Urinary Tract Infection."** 2. R110's Order Summary Report, dated 5/8/23, shows she was admitted to the facility on 11/30/21, with diagnoses including hemiplegia. aphasia, sarcopenia, convulsions, and right hand contracture. R110's Care Plan, initiated 6/20/16, shows R110 is incontinent. On 5/8/23 at 12:20 PM, V3 and V4, CNAs (Certified Nursing Assistants), provided incontinence care to R110. R110's incontinence brief had a large amount of urine in her

Illinois Department of Public Health

incontinence brief. V3 wiped R110's front peri area, then touched R110's body to help her turn to her side. V3 did not change her gloves or perform hand hygiene. V4 then cleansed R110's buttocks area. V4 then touched R110's blanket, the clean incontinence brief, and R110's body,

Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:			COMPLETED	
IL6010482		B, WING			05/09/2023		
NAME OF	PROVIDER OR SUPPLIER	0.0	DRESS, CITY, S	STATE, ZIP CODE			0.2020
AVANTA	RA LIBERTYVILLE	1500 SOU	ITH MILWAU	KEE AVENUE			
AVANTA	TA LIBERT FVILLE	LIBERTY	VILLE, IL 60	048		_	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETE DATE
\$9999	Continued From pa	ge 2	S9999				
	without changing he hygiene.	er gloves or performing hand					
	should be changed	PM, V10, CNA, said gloves after wiping the resident and w/clean items so the clean he contaminated.					
	shows, "To guide the the spread of infect contamination, to pre-	Usage policy, revised 3/23/2,3 ie use of gloves: To prevent ion, to protect wounds from rotect hands from potentially and to prevent exposure to or body fluids."					
	7/28/22, shows, "Hacontrolling infection: either hand washing Hand Hygiene using recommended during Before moving from clean body site on the contact with blood,"	Hygiene policy, revised and Hygiene is important in s. Hand Hygiene consists of g or the use of alcohol gel. g alcohol based hand rub is ng the following situations: a work on soiled body site to a he same residents and after body fluids or surfaces plood and body fluids."					
	(C)			,			
	2 of 3						
	300.1210 b)4) 300.1210 d)4)A)			· -			
,	Section 300.1210 ( Nursing and Person	General Requirements for nal Care				-	
-	care and services to	shall provide the necessary o attain or maintain the highest , mental, and psychological					

Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND I DAY OF CONTROL OF THE INCANTON HOUSEN.		the mark of the first of the control of the	A. BUILDING:			COIVIE	TETED
· · · · · · · · · · · · · · · · · · ·	-	IL6010482	B. WING			05/09/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
AVANTA	RA LIBERTYVILLE		ITH MILWAU VILLE, IL 60	JKEE AVENUE 0048			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID		LAN OF CORRECTIO	)N	(X5)
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	(EACH CORRECTI CROSS-REFERENCI	IVE ACTION SHOUL	COMPLETE DATE			
S9999	Continued From pa	ge 3	S9999				
	well-being of the res	sident, in accordance with					
		nprehensive resident care					
		properly supervised nursing					
		care shall be provided to each e total nursing and personal					
		esident. Restorative					
		ude, at a minimum, the					
	following procedure	s:					6
		ing personnel shall assist and				12	
		s so that a resident's abilities living do not diminish unless					
		e individual's clinical condition					
		minution was unavoidable.					
	This includes the re	sident's abilities to bathe,					
		ransfer and ambulate; toilet;					
		n, language, or other					
		cation systems. A resident rry out activities of daily living					
		rvices necessary to maintain					
,	good nutrition, groot	ming, and personal hygiene.					
ļ		subsection (a), general					
		nclude, at a minimum, the					
	seven-day-a-week	pe practiced on a 24-hour,					
		al care shall be provided on a					
		-a-week basis. This shall					
	include, but not be li	imited to, the following:	.0				
		n resident shall have proper					
		tion, including skin, nails, hair, addition to treatment ordered					
	by the physician.	addition to treatment ordered					
	by the physicians						
	This requirement wa	as not met as evidenced by:					
	Based on observation	on, interview, and record					
	review, the facility fa	ailed to ensure residents were					
	assisted with ADLs	(Activities of Daily Living).					_
	This applies to 2 of	9 residents (R110, R108)	E.				

MPYC11

PRINTED: 06/01/2023 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING IL6010482 05/09/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1500 SOUTH MILWAUKEE AVENUE **AVANTARA LIBERTYVILLE** LIBERTYVILLE, IL 60048 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE **DEFICIENCY**) S9999 Continued From page 4 S9999 reviewed for ADLs in a sample of 9. The findings include: 1. R110's Order Summary Report, dated 5/8/23, shows she was admitted to the facility on 11/30/21 with diagnoses including hemiplegia. aphasia, sarcopenia, convulsions, and right hand contracture. R110's MDS (Minimum Data Set), dated 2/22/23, shows, R110 requires extensive assistance with dressing, toilet use, and personal hygiene. On 5/8/23 at 12:20 PM, V3 and V4 CNAs (Certified Nursing Assistant), provided incontinence care to R110. R110's right hand was contracted and R110's fingers were folded into her palm. R110 was not able to open her fingers. R110's right thumb nail was about an inch long. and had grown at about a 90 degree angle. R110's right thumb nail was thick, dirty, and there was an odor noted to R110's hand. At 1:32 PM, V5, RN (Registered Nurse), went into R110's room, and was able to move R110's thumb, with no reaction from R110. There was some substance noted on R110's palm, and R110's thumb nail was noted to be growing out to form a 90 degree angle to R110's right thumb nail bed. On 5/9/23 at 12:06 PM, V10, CNA, said R110's thumb nail has been like that for a couple of weeks. V10 said she has not cut R110's thumb nail before.

Illinois Department of Public Health

The facility's Nail Care policy, revised on 7/28/22, shows, "The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. Nursing staff shall check the residents for nail care which includes cleaning

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING IL6010482 05/09/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1500 SOUTH MILWAUKEE AVENUE **AVANTARA LIBERTYVILLE** LIBERTYVILLE, IL 60048 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 5 S9999 and regular trimming. CNA to report to the nurse if there is evidence of ingrown nails, infections, pain, or if nails are too hard or too thick to cut with ease." 2. R108's Order Summary Report, dated 5/8/23, shows she was admitted to the facility on 2/1/23 with diagnoses including bipolar disorder. hypertension, major depressive disorder, lupus. malnutrition, cognitive communication deficit, and syncope. R108's MDS (Minimum Data Set), dated 4/19/23, shows she is cognitively intact. R108 requires extensive assistance with dressing, toilet use, and personal hygiene. R108's Care Plan, initiated 1/16/23, shows ADL (Activities of Daily Living) self-care deficit as evidenced by weakness related to physical limitations. Assist to bathe/shower as needed and assist with daily hygiene, grooming, dressing, oral care and eating as needed. On 5/8/23 at 11:53 AM, R108 had facial hair on her chin and her upper lip. R108 said she hasn't been shaven and said "it looks awful" in reference to her facial hair. R108 said the staff don't have time to shave her face. On 5/9/23 at 12:11 PM, V11, CNA, said she tries to shave female residents on their shower days. V11 said the residents get two showers per week. At 12:06 PM, V10, CNA, said she has never shaved a female resident before. V10 said she asks the female residents if they want to be shaved. The facility's General Care policy, revised on

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING IL6010482 05/09/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1500 SOUTH MILWAUKEE AVENUE **AVANTARA LIBERTYVILLE** LIBERTYVILLE, IL 60048 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) S9999 Continued From page 6 S9999 7/28/22, shows, "It is the facility's policy to provide care for every resident to meet their needs." (C) 3 of 3 300.1630 a)3 Section 300.1630 Administration of Medication a) All medications shall be administered only by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course in pharmacology or have at least one year's full-time supervised experience in administering medications in a health care setting if their duties include administering medications to residents. Self-administration of medication shall be permitted only upon the written order of the licensed prescriber. This REQUIREMENT was not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were monitored while taking their medications. This applies to 2 of 18 residents (R101 and R107) that were reviewed for medication administration. in the sample of 9. The findings include: 1.On 5/8/23 at 10:28 AM, R101 was lying in her

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6010482 05/09/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1500 SOUTH MILWAUKEE AVENUE AVANTARA LIBERTYVILLE LIBERTYVILLE, IL 60048 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) S9999 Continued From page 7 S9999 bed. A pulmonary inhaler (Trelegy Ellipta) was on R101's bedside table. R101 said they leave the medication for her to use. On 5/8/23 at 10:37 AM, V6, Registered Nurse (RN), said she passes all the medications to the residents, and she has no residents who self-administer their medications. V6 said if a resident wanted to self-administer their medications, she would need to get a doctor's order. V6 said she watches the residents take their medications to make sure they receive the medications, and she does not leave medications for a resident to take on their own. R101's Order Summary Report, dated 5/8/23. shows an order for Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 200-62.5-25 MCG/ACT (Fluticasone-Umeclidinium-Vilanterol) 1 puff inhale orally one time a day for SOB (shortness of breath) ordered on 4/25/23. There is no order for R101 to self-administer her medications or to keep medications at the bedside. The facility's Medication Pass Policy (revised 3/28/23) shows, "It is the policy of the facility to adhere to all Federal and State regulations with medication pass procedures." The facility's Self-Administration of Medication Policy (revised 7/28/22) shows, " ... A resident who requests to self-administer medications will be assessed to determine if resident is able to safely self-medicate ... The resident may store the medication at bedside if there is a physician order to keep it at bedside ..." The facility was unable to provide a Medication

PRINTED: 06/01/2023 FORM APPROVED

	Department of Public	Health		0	FURI	M APPROVEL	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY DMPLETED	
-	IL6010482		B. WING		05	05/09/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
AVANTA	RA LIBERTYVILLE	1500 SOU		KEE AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 8	S9999			_	
		Evaluation Form for R101.		2.0			
	shows he was adm with diagnoses incluneuromuscular dyst	mmary Report, dated 5/8/23, itted to the facility on 8/21/17, uding quadriplegia, anemia, function of bladder, long termesic, depressive episodes, teomyelitis.					
	room alone. There v R107's room. R107	AM, R107 was in his private was no nurse noted to be near had a cup of medications. s medications with no nurse					
	R107's nurse signed iron/vitamin C, vitam	Administration Record shows d off R107 received nin B12, gabapentin, the morning of 5/8/23.		= :			
		dministration of medication ned on R107 prior to 5/8/23.	ů.				
	Practical Nurse), sai medications at resid	PM, V14, LPN (Licensed id she never leaves ents' bedside because the the medications or not take		#1 0	2		
	(C)			1/2			

MPYC11