

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0052423		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/07/2025	
NAME OF PROVIDER OR SUPPLIER AVANTARA EVERGREEN PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 10124 SOUTH KEDZIE , EVERGREEN PARK, Illinois, 60805			
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S0000	Initial Comments		S0000			09/22/2025	
	Complaint Investigation:						
	2598080/IL2598203						
S9999	Final Observations		S9999			09/22/2025	
	Statement of Licensure Violations						
	300.610a)						
	300.1210b)						
	300.1210d)2)3)						
	Section 300.610 Resident Care Policies						
	a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.						
	Section 300.1210 General Requirements for Nursing and Personal Care						
	b) The facility shall provide the necessary care and 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:						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. This requirement is NOT met as evidenced by: Based on interview and record review, the facility failed to follow their clinical treatment guidelines for sepsis; failed to promptly transfer a resident to a higher level of care when a resident exhibited signs of sepsis with severe organ dysfunction. This failure affects 1 resident (R1) reviewed for quality of care. This failure caused harm to R1 as evidenced by R1 developing septic shock requiring hospitalization. Findings include: R1 is a 67 year old resident with diagnoses including but not limited to Benign Neoplasm of Cerebral Meninges, Other Seizures, Spastic Hemiplegia Affecting Right Dominant Side, Encephalopathy, Unspecified, Neoplasm of Unspecified Behavior of Brain, Type 2 Diabetes Mellitus Without Complications, Hyperlipidemia, Unspecified, Depression, Unspecified, Cerebral Edema, Cerebral Infarction, Unspecified, Gastro-Esophageal Reflux Disease Without Esophagitis, Shortness of Breath, Aphasia, Anemia, Thrombocytopenia, Unspecified, Acute Embolism and Thrombosis of Unspecified Deep Vein of Left Lower Extremity, Localized Swelling, Mass, and Lump, Unspecified R1's hospital records (7/10/2025) documents (in part), R1 presented to the ER (emergency room) due to abnormal labs and leukocytosis. Per the ER physician, EMS (emergency medical staff) reported that R1 was on 2 L(liters) nasal cannula but was hypoxic on the 2 L, and R1 was placed on a non-rebreather mask. On arrival to the ER, R1 had a 103-degree Fahrenheit fever, 22 respirations per minute, and tachycardia between 120-140 beats/min (minute). R1 was subsequently diagnosed with pneumonia and septic shock. R1's "Speech Therapy Treatment Encounter Note" (7/10/2025 at 11:10 AM) completed by V7 documents in part that during R1 was warm to the touch and grimaced at time (non-verbal indication of pain). V7 notified		S9999				

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S9999	Continued from page 2 the nurse on duty, vital signs were assessed and R1 had "increased heart rate and low BP" (potential signs of sepsis). On 7/10/2025 at 10:14 AM, V4 (Registered Nurse) documented, "Was notified by ST (Speech Therapist) that resident's skin is hot to touch. Vitals checked as follows: BP (blood pressure) 97/58 PR (pulse rate) 135 RR (respiration rate) 30 rapid shallow Temp 98.8 non-contact O2 RA (oxygen room air) 85-90% no verbal complaints of pain but resident is observed to be grimacing with movement. Checked g tube site as well - site is dry, no redness/ swelling. Abdomen is soft to touch. (V6 Nurse Practitioner) made aware - orders for STAT KUB (kidneys ureters and bladder x-ray), CXR (chest xray), EKG (electrocardiogram), CBC (complete blood count) and BMP (basic metabolic panel), hold feeding for now, put on o2 (oxygen), 0.9 nacl (sodium chloride, Intravenous solution) x 83ml/hr (milliliters/hour) x 1 liter and respiratory panel and covid testing. All orders in place, carried out and called in. Resident placed on o2 via nasal cannula at 1LPM (liter per minute)- sat 96%". On 7/10/2025 at 12:47 PM (Late Entry, created on 7/20/2025 at 1:51 PM), V6 (Nurse Practitioner) documented, "(R1) was seen on 7/10/25. His blood sugars have been elevated. He was placed on 1 liter n/c (nasal cannula). He has coarse breath sounds. He did have an episode of n/v (nausea/vomiting) yesterday per the nurse. No fever or chills noted. Vitals are stable... PMH: T2DM (Type 2 Diabetes Mellitus), CVA (cardiovascular accident), hyperlipidemia, PE (pulmonary embolism), depression, DVT (deep vein thrombosis). Upon examination, pt was seen lying in bed. NAD (no acute distress). Normocephalic. Conjunctivae clear. Oral mucosa is moist. Neck supple, no JVD (jugular vein distention) or carotid bruit. Heart rate is regular, normal S1 and S2, no murmurs. Lungs are coarse throughout, no wheezes, on 1 liter n/c. Abdomen is soft, non-tender, non-distended, bowel sounds present, PEG tube in place. No LE edema. Right side is flaccid. Right ankle swelling noted. A/P (assessment/plan): #1 Acute hypoxic respiratory failure, on 1 liter n/c (this indicates organ failure, signs of severe sepsis) #2 T2DM w/hyperglycemia #3 Acute/subacute left ACA (Anterior Cerebral Artery) stroke #4 Benign neoplasm of cerebral meninges s/p (status post) bilateral frontal craniotomy with mass resection #5 h/o (history of) CVA w/right-sided weakness #6 Dysphagia s/p PEG #7 Depression #8 h/o DVT/PE on Eliquis #9 Hyperlipidemia #10 Fall risk #11 Right ankle pain/swelling #12 Seizures on Keppra #13 At risk for malnutrition Plan: Stat chest xray, KUB and		S9999				

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S9999	Continued from page 3 labs ordered. Titrate O2 to keep sats >92%. I will add a sliding scale for better bs (blood sugar) control. Continue PT/OT/ST (physical therapy, occupational therapy, speech therapy). Dietician following, continue tube feeding recommendations. Maintain fall precautions per facility protocol. Plan discussed with pt.'s nurse". (Per this documentation, there was no assessment of R1's vital signs or addressing the abnormal vital signs and symptoms that V4 reported/obtained.) On 7/11/2025 at 10:54 AM, V4 (Registered Nurse) documented, "Follow up made with (Hospital) spoke with RN (REDACTED)- (R1) to be admitted. Dx: Pneumonia and septic shock". On 7/17/2025 at 9:34 PM, V5 (Registered Nurse) documented a late-entry SBAR note for 7/10/2025 that documents (in part) R1's change in condition and identifies that R1 had abnormal labs and labored breathing. V6 (Nurse Practitioner) was notified at 6:30 PM and R1 was transferred to the hospital for evaluation. On 9/5/2025 at 9:50 AM, V9 (R1's Family Member) recalled on 7/10/2025, a nurse had called in the morning saying R1 had elevated blood sugar levels and R1's blood pressure was 80/64. V9 told the nurse to send R1 to the hospital because R1 "was clearly septic, this is always what (R1) does when (R1) develops sepsis. They didn't send him when I requested for (R1) to be sent out. (R1) got sent out later that night and developed shock. (R1) could have died. I told them (the facility) he was septic." On 9/5/2025 at 11:27 AM, V4 (Registered Nurse) stated that sepsis is a whole-body response that is caused by infection. V4 explained that signs of sepsis include elevated temperature, elevated pulse rate, elevated respiratory rate, and low blood pressure. V4 reviewed R1's electronic health record with surveyor and recalled caring for R1 on 7/10/25. V4 explained, V4 was doing rounds and asked R1 if he was in pain and R1 didn't respond. R1 was usually able to respond with a smile or shaking R1's head, but that day R1 didn't. V4 stated, "He wasn't at his baseline, I thought there was something wrong". V4 recalled assessing R1's vital signs and noted that R1 had increased heart rate and rapid shallow breathing. V4 affirmed that V4 was concerned that R1 was potentially developing sepsis so V4 contacted V6 (Nurse Practitioner) and recalled telling V6 about the change in status. V4 stated, "I didn't say anything to (V6) about sepsis, (V6) was		S9999				

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S9999	Continued from page 4 aware of the signs and symptoms (R1) was experiencing. (V6) gave orders and I carried them out". V4 affirmed that sepsis is potentially life-threatening and would normally immediately send a resident to the hospital if a resident was experiencing a life-threatening change in condition. V4 could not recall speaking to V9 about R1's change in condition. On 9/5/2025 at 11:38 AM, V2 (Director of Nursing) was familiar with R1 but did not recall the events that led to R1 being sent to the hospital on 7/10/2025. V2 explained that sepsis is potentially life-threatening whole-body response to an infection and signs of sepsis include fever, low or high blood pressure, increased pulse, and increased respirations. V2 affirmed that the facility is not able to treat sepsis within the facility and sepsis requires a higher level of care. V2 stated that if a nurse suspects or has signs of sepsis that they call the physician immediately and expect to send the resident out to the hospital. V2 explained that if sepsis is not treated, it can lead to septic shock and death. On 9/5/2025 at 12:47 PM, V6 (Nurse Practitioner) affirmed that V6 is supervised by V8 (Medical Director). V6 explained "any infection can cause sepsis" and sepsis can present with changes in condition including low blood pressure, tachycardia, tachypnea, fever, changes in mental status, and abnormal laboratory values. V6 stated, "if sepsis is not treated patients can crash, deteriorate and can develop septic shock but not always". V6 recalled being told about a change in condition for R1 from V4 on 7/10/2025. V6 stated, "I do not recall them (abnormal vital signs). I do recall visiting (R1) a few hours after I talked to (V4) but (R1) seemed fine to me. I did not assess (R1's) vital signs during my visit. Tachypnea and tachycardia, I thought maybe aspiration pneumonia because (R1) had vomited the day before which is why I ordered for a chest x-ray and CBC, CMP. (R1) did have crackles in (R1's) lungs". V6 denied knowledge that R1's family members requested R1 to be sent to the hospital. V6 affirmed that V6 was not notified of any other changes in condition after V6's visit and did not give the order to send R1 to the hospital. V6 stated, "I think they (facility staff) sent (R1) out because of an increase white count". R1's vital signs from 7/10/2025 were reviewed with V6 and V6 stated, "yeah in the hospital they would have called a code sepsis. But if I were to send people out every time, they had an increased pulse and respirations, we would be sending people out all the time".		S9999				

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S9999	Continued from page 5 On 9/5/2025 at 1:47 PM, V7 (Speech Therapist) affirmed that V7 was familiar with R1 and recalled treating R1 on 7/10/2025. V7 explained that V7 went to treat R1 and R1 wasn't acting per R1's baseline. V7 stated, "(R1) usually wasn't too happy to see me as (R1) had a lot of difficulties speaking and would struggle with speech therapy. That day, (R1) grabbed my hand and it was really warm, there was something off. I (V7) recall asking (R1) if (R1) wanted to go to the hospital. (R1) couldn't speak well, so I told (R7) to squeeze my hand if (R1) wanted to go the hospital and (R1) squeezed my hand. I told him I would go get the nurse and (R1) didn't want me to leave. This wasn't (R1's) baseline at all. I left and got the nurse. I heard afterward, (R1) was hospitalized". On 9/5/2025 at 2:43 PM, V2 (Director of Nursing) and V3 (Infection Preventionist, Registered Nurse) reviewed R1's electronic health record and confirmed that no screening for sepsis was completed for R1, per the facility policy. V2 affirmed that R1 was not comfort care, and there was no indication that R1 requested not to go to the hospital. V2 affirmed there is no records that blood cultures, a CMP, coagulation tests or a lactate were ordered or drawn, per facility policy. V3 recalled seeing R1 on 7/10/25 and recalled that R1 was experiencing malaise and the facility obtained respiratory panel lab work to rule out infection. V2 was unsure if the facility had a sepsis screening UDA (user defined assessment) within the electronic health record that could be used to screen for sepsis. V3 affirmed that R1 was not sent out by the time V3 left for the day around 5:00 PM. On 9/5/2025 at 3:44 PM, V5 (Registered Nurse) affirmed that V5 was the nurse that sent R1 to the hospital on 7/10/2025. V5 recalled seeing that R1's white count was elevated during V5's medication pass. V5 could not recall if R1 had any changes in condition, labored breathing or assessing R1 for a change in condition. V5 stated that V5 received a call from R1's family and they were concerned about R1 going into sepsis as R1 had a history of sepsis. V5 sent R1 to the hospital "because the family requested it, so I called an ambulance and sent him out". V5 recalled leaving V6 a voicemail to notify V6 of R1 being sent out. V5 affirmed that paramedics did place R1 on a non-rebreather mask prior to leaving the facility. V5 could not recall if V5 completed an assessment of R1's health status and could not recall vital signs. V5 could not recall if V5 listened to R1's breath sounds. On 9/5/2025 at 4:30 PM, V8 (Medical Director) stated, V8 is the medical director for the facility, and is the		S9999				

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S9999	Continued from page 6 supervising physician for V6. R1's vital signs were reviewed with V8 and V8 stated the vital signs "could indicate sepsis, it's a possibility, there's a lot of things that could cause that". R1's progress notes were reviewed with V8 and V8 stated, "You know, facilities can treat sepsis in house now. V6 did everything right, the hospital wouldn't have done anything different than V6 did". The facility's "Sepsis Nursing Care Guidelines" were reviewed with V8, and surveyor asked if staff should have followed the facility-approved guidelines. V8 became aggressive and stated, "Let me ask you something. Did the patient die? No? Then (V6) did everything (V6) needed to. In my professional opinion, (V6) sent (R1) out due to change in condition, that's my answer." Facility policy titled, "Sepsis Nursing Care Guidelines" (undated) documents in part "Purpose: The facility will use a standardized, physician approved, nursing assessment and care guidelines to help identify sepsis as early as possible in its course in order to provide early treatment and prevent progression leading to hospitalization or adverse event. II. Criteria/ Definitions: 1. Sepsis: Sepsis in an infection, regardless of the primary site of the source that manifests with select systemic symptoms, signs and/or functional capacity changes and may be associated with one or more organ dysfunction and/or failure. 2. Systemic Inflammatory response Syndrome (SIRS) Criteria a. Fever greater than or equal to 100.4 Fahrenheit or less than or equal to 96.8 Fahrenheit. b. Heart rate greater than 90 beats per minute c. Respiratory rate greater than 20 breaths per minute d. Systolic blood pressure less than 90 mmHg. 3. SIRS screening results a. Sepsis: Suspicion or documentation of infection AND two or more SIRS criteria b. Severe Sepsis: Sepsis and one or more organ dysfunctions 4. Organ Dysfunction a. Assessed through observation and clinical assessment (clinical correlation and comparison to patient's baseline vital signs are important consideration): i. Respiratory SQ02 less than 90 percent or increasing O2 requirements ii. Cardiovascular: Systolic blood pressure less than 90 mmHg or 40 mmHg less than baseline iii. Renal: Urine output less than 0.5 ml/kg over the last 8 hours iv. Central nervous system: New mental status changes b. Assessed through laboratory results with clinical correlation and comparison to baseline levels (use results during last 24 hours) 1. Platelets less than 100,000 ii. INR greater than 1.5 (if not on anticoagulant therapy with Coumadin/Warfarin) iii. Bilirubin greater than or equal to 4.0 ml/dl iv. Serum lactic acid greater than or equal to 2mEq/l. III> Process: 1. All residents/patients with a confirmed or suspected		S9999				

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S9999	Continued from page 7 infection will be screened for sepsis using SIRS criteria by the IP/IC nurse or designee. Confirmed or suspected infection includes but is not limited to... d) myalgia... f) vomiting... h) localized, redness, heat pain swelling purulent discharge... 2. If a resident/patient with a confirmed or suspected infection meets two or more SIRS criteria, the Sepsis Nursing Care Guidelines will be implemented by the IP/IC nurse or designee... IV. Procedures: 1. The nurse will review assess the SIRS screening results and assess for organ dysfunction. 2. If the resident screens positive for sepsis or severe sepsis, the IP/IC nurse or designee contacts the physician and initiates the physician approved sepsis care guidelines by starting IV fluids stat. 3. The Interact Care Path recommends that all patients/residents with suspected or confirmed infection and possible sepsis be considered for transfer to an acute care hospital unless; a) the patient is on comfort or palliative care plan or is on hospice with an order for no hospitalization from the attending physician. b) the patient or decision maker wants the condition to be treated but not in the acute care hospital and understands the risks; and the facility has the capability of managing sepsis according to recommended interventions... 4. Family or resident representative is contacted about change in condition. 5. If sepsis is being considered and patient/resident is not being immediately transferred to the acute care hospital by the physician (See item #3), blood will be drawn for cultures, CMP, coagulation tests and lactate level stat before starting antibiotics as indicated. 6. Nurse will assess the residents response to IV fluids as soon as possible. Additional fluid administration should be guided by frequent reassessment of hemodynamic status. 7. If the decision is to transfer to acute care hospital, nurse will contact ER to give nurse to nurse report/handoff. 8. Ensure that all recent lab results and completed SBAR are communicated to the ER and included in the transfer documents" (A)		S9999				