STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145734	A. Building B. Wing	09/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Evergreen Park	10124 South Kedzie Evergreen Park, IL 60805

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145734	A. Building B. Wing	09/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Evergreen Park	10124 South Kedzie Evergreen Park, IL 60805

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their guidelines of promptly transferring a resident who exhibited signs and symptoms of sepsis for six hours prior to transfer. This failure affected one (R1) of three residents reviewed for quality of care. This failure resulted in R1 requiring hospitalization and diagnosed with septic shock and pneumonia. Findings include:R1 is a [AGE] 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, UnspecifiedR1's hospital records ([DATE]) 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 ([DATE] 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 the nurse on duty, vital signs were assessed and R1 had increased heart rate and low BP (potential signs of sepsis).On [DATE] 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 [DATE] at 12:47 PM (Late Entry, created on [DATE] at 1:51 PM), V6 (Nurse Practitioner) documented, (R1) was seen on [DATE]. 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. Conjuctivae 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 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 [DATE] 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 [DATE] at 9:34 PM, V5 (Registered Nurse) documented a late-entry SBAR note for [DATE] that documents (in part) R1's change in condition and identifies that R1 had abnormal labs and labored