

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 145868	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/19/2020
NAME OF PROVIDER OF SUPPLIER AVANTARA LONG GROVE		STREET ADDRESS, CITY, STATE, ZIP 1666 CHECKER ROAD LONG GROVE, IL 60047	
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 0695 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident in respiratory distress had their supplemental oxygen adjusted for one of three residents (R1) reviewed for oxygen therapy in the sample of three. The findings include: R1's Progress Notes showed a [DIAGNOSES REDACTED]. R1's Progress Note dated 5/23/20 showed R1 was receiving 2 liters of oxygen per minute by nasal cannula. At 10:35 AM, R1 was in distress, short of breath, had a respiratory rate of 24 (high), and R1's oxygen saturation was low at 80%. At 10:40 AM, R1's respiratory rate was 30 (high) and oxygen saturation was low at 71%. The same progress note showed at 10:50 AM, paramedics arrived and R1 was placed on a non-rebreather mask (15 minutes after R1 was identified as having respiratory issues). On 7/1/20 at 11:35 AM, V9 (Nurse) said she took care of R1 on 5/23/20. V9 said R1 was dependent on supplemental oxygen at 2 liters per minute by nasal cannula. V9 said on 5/23/20 R1 was in respiratory distress and R1's supplemental oxygen was not adjusted until paramedics arrived and placed a nonrebreather mask on R1. On 7/1/20 at 10:35 AM, V2 (Director of Nursing) said a resident in respiratory distress with a low oxygen level should be placed on a nonrebreather mask.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.