STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009096	A. BUILDING: _____ B. WING _____	C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PARK RIDGE	1601 NORTH WESTERN AVENUE PARK RIDGE, IL 60068

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S 000	Initial Comments Complaint Investigation: 2299884/IL154260	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)6 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Requirements were NOT MET as evidenced by:	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Based on interview and record review, the facility failed to ensure a resident was properly seated in her wheelchair during wheelchair transport. This affected 1 of 3 residents R2 reviewed for safety while transporting in a wheelchair. This failure resulted in R2 falling forward while being pushed in the wheelchair by facility staff, this fall incident resulted in R2 falling onto R2's face sustaining a facial laceration a treated at the local hospital with stitches. Findings include: On 12-27-22 at 12:00 PM, surveyor observed R2 in dining room during lunch meal under staff supervision. R2 was seated in her reclining high-back wheelchair with leg rests and footboard in place. R2 is confused and unable to carry conversation with surveyor. R2 was noted with resolving discoloration below her left eye. R2 was not showing any attempts to get up by herself. On 12-27-22 at 1:43 PM,V2 (Director of Nursing) said R2 is a fall risk. R2 had dementia and confusion. R2 is not directable due to cognitive deficits. R2 has poor safety awareness due to dementia and confusion. When CNA was bringing R2 back to her room via wheelchair, CNA stated R2 leaned forward. CNA was unable to prevent R2 from falling forward and sustaining facial laceration requiring stitches. Fall coordinator in-serviced CNA on safely transporting wheelchair residents. On 12-27-22 at 3:37 PM, V13 (CNA) said R2 is confused and forgetful. R2 is unable to make her needs known. R2 has poor safety awareness and will lean forward in wheelchair. During a transport to R2's room via wheelchair, R2 leaned forward and fell from the wheelchair. V13 said R2 hit her	S9999		

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S9999	Continued From page 2	S9999		

head on the floor and V13 saw R2's blood on the floor. The nurse came immediately. Nurse cleaned the blood, placed towel under the head, and called 911.

On 12-27-22 at 2:59 PM, V12 (LPN) said R2 is alert and oriented x1 with confusion and forgetfulness. R2 is unable to make her needs known. R2 has poor safety awareness because she is impulsive and tries to get up by herself. R2 has to be re-directed and monitored. R2 needs to be re-directed several times. V12 said after dinner (after 6:00 PM), V13 was transporting R2 to her room via wheelchair. V12 was at nursing station and heard a crash and chair alarm. In dining room, V12 saw R2 in the floor in front of the wheelchair. V12 saw blood on the floor. V12 left R2 on the floor to lessen any trauma and V12 called 911. V12 saw blood on the bridge of R2's nose on the side where R2 was laying. 911 came right away and transported to the hospital. R2 had no indication of pain. The hospital records indicated fracture to nose R2's nose was treated with steri-strips. R2 had 5-6 stitches on the side of her forehead. R2 returned to facility that same night. R2 is a fall risk.

On 12-27-22 at 2:51 PM, V11 (RN) said R2 is alert, oriented x 1-2, and mostly unable to make her needs known. R2 is confused and forgetful. R2 has no safety awareness. R2 is impulsive, will try to get up by herself, and takes multiple times for re-direction. V11 has seen R2 leaning forward in her wheelchair during transport in the past.

On 12-27-22 at 2:43 PM, V10 (CNA) said R2 is confused and forgetful. R2 is unable to make her needs known and carry conversation. R2 requires feeding assistance most of the time. R2 is a high falls risk. R2 has chair alarm, bed alarm, floor

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S9999	Continued From page 3 mat, reclining high back wheelchair, and foot board. R2 will attempt to get up by herself and R2 is not able to be re-directed. V10 said she sees R2 leaning forward in her wheelchair. V10 says she will ensure R2's back is upon the back of the wheelchair. CNA will not transport R2 unless her back is up on the back of the wheelchair. V10 will do this several times as needed. Initial State Reportable dated 12-1-22 documents: Description of what happened: On 11-30-22 prior to fall, resident was up in her wheelchair in dining area and around 6:12 PM, assigned nurse stated the CNA was wheeling resident to her room and resident tipped forward and landed on the floor with face down. No loss of consciousness. Neuro checks was done and no deficit. Resident was noted with scant bleeding from right forehead and sustained a cut to the right forehead and superficial skin tear was noted to the bridge of the nose. Range of motion to all extremities were within resident's baseline. Resident unable to relay the cause of the fall due to cognitive impairment. Vital signs were with resident's baseline. 911 was called. Nursing supervisor was notified. Resident was sent to ED for further evaluation and returned to facility same day with stitches to forehead and steri-strips to the bridge of the nose. Final State Reportable dated 12-6-22 documents: Final Investigation/Conclusion: Imaging done in ED as follows: CT Facial bone without contrast: Mildly comminuted fractures of the tip of the nasal bone without significant displacement. Resident Care Plan has been reviewed and updated upon returning to the facility. Hospital Record dated 11-30-22 documents: Reason For Exam: facial laceration/nasal bone	S9999		

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S9999	Continued From page 4 contusion/ laceration. Impression: Mildly comminuted fractures of the tip of the nasal bone without significant displacement. Fall Risk Assessments (dated 1-10-22, 2-11-22, 5-12-22, 11-9-22, and 12-15-22) document: R2 is high fall risk. (B)	S9999		