STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012967	A. BUILDING: _____ B. WING _____	C 01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA CHICAGO RIDGE	10300 SOUTHWEST HIGHWAY CHICAGO RIDGE, IL 60415

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2299532/IL153839	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3)6) 300.1220b)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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 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. 6) All necessary precautions shall be taken	S9999		

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S9999	Continued From page 2 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These Regulations are not met as evidenced by: Based on interviews, observations, and record reviews, the facility failed to implement interventions to prevent or reduce the risk for falling and failed to investigate the root cause of resident fall incidents for 4 of 4 residents (R2, R8, R9 and R7) reviewed for falls and fall prevention. This failure resulted in R2 falling face forward sustaining an acute depressed fracture of the distal nasal bone. Findings include:	S9999		

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S9999	Continued From page 3 R2 is an 88-year-old with diagnoses including, but not limited to Diabetes, Cataract, Dementia, Sciatica, history of Falling, Cerebral Infarction, and Chronic Pain. On 1/3/23 at 2:10PM surveyor knocked on R2's door which was closed. R2's room is the last room in the hallway, farthest from the nurses' station. Upon entering R2 was observed walking independently in his room. R2 was wearing a brief and one grippy sock to his left foot and no sock on his right foot, with a shoe on each foot. R2 was only alert to name. The surveyor spoke to R2 in Spanish, R2 still only smiled and waved On 1/3/23 at 2:15PM V22, Certified Nursing Assistant/CNA, stated R2 can walk alone in his room. V22 stated R2 removes his clothing and throws it away or puts in laundry bins. V22 stated I check R2 every 20 minutes. On 1/4/23 between 9:45AM and 11:09AM surveyor observed R2's room. Observation was continuous from 9:45 - 9:58AM, at which time the surveyor entered another resident room. At 10:12AM the surveyor resumed continuous observation of R2's room. Of note, staff must apply identified PPE including gown and gloves to enter room. The door is closed. No staff observed to open his door, At 11:10AM V7, Nurse observed entering R2's room, after applying gown and gloves. When she came out of the room V7 was heard stating she needed housekeeping to come to R2's room. On 1/4/23 at 11:10AM the surveyor observed R2's name plate outside of R2's door and it does not have his name, or a star placed on it.	S9999		

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S9999	Continued From page 4 On 1/4/23 at 1:44PM V12, Nurse, stated on 12/30/22 the CNA reported to her that R2 was on the floor next to the bed. V12 stated R2 was on the floor, wrapped in the comforter with a pillow and the bed was in the lowest position. V12 stated R2 could not say how he got on the floor. V12 stated R2 has Dementia and was a little combative when we were helping him to get off the floor. V12 stated R2 was in an isolation room and the door is supposed to be closed. V12 stated rounding is done hourly between the nurse and CNA.V12 stated she was aware that R2 is a fall risk, and he had a fall prior to 12/30. V12 stated fall interventions for R2 includes frequent rounding. V12 said she had notified the CNA that R2 will get up and ambulate and he may need assistance. V12 said R2's behavior could be related to his room change and having a COVID infection. V12 said following the fall on 12/30/22 the intervention was to continue frequent monitoring and keep the bed in the lowest position. V12 stated she asked about using floor mats but was told "they are in limited supply." On 1/4/23 at 3:04PM V7, Nurse, stated R2 is taking himself to the bathroom, I was told that is how he goes. V7 stated the CNAs do 30 minutes rounds on R2 because his environment is new to him. V7 stated she expects the CNAs to open the door and go into the room when checking on R2, "the only way to see him is to go in the room." V7 stated when I checked on R2 today he had urinated on the bathroom floor, and I had to call for Housekeeping to come clean the room. On 1/5/23 at 12:04PM V11, Director of Nursing stated a fall is when a resident changes planes. V11 stated a resident does not have to be seen on the floor to have fallen. V11 stated if a resident reports they fell then it is a fall. V11 stated R2's daughter reported he said he had fallen on	S9999		

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S9999	Continued From page 5 11/19/22. The surveyor asked V11 what the root cause of R2's 11/19 fall was. V11 stated "we do not know what happened." V11 said following R2's fall on 12/30 we make sure he has proper footwear and do frequent rounds when R2 is in his room alone. (R2 is positive for COVID and is in an isolation room with his door closed.) V11 stated when rounding on R2 she expects staff to open the door to see him. V11 stated R2 is safe to walk around the room by himself. V11 stated R2 has an unsteady gait. V11 stated R2 has mild Dementia that caused him to fall. V11 said R2 had a change in routine, because he was moved to another room once he was COVID positive, and he was already a high risk for falls. Additionally, V11 stated staff was new to R2. V11 stated the facility standard time to check residents is every 2 hours. V11 said to check a resident frequently means "at least 2 hours." V11 said residents at high risk for falls are near the nurses' station. On 1/5/23 at 2:31PM V20, Restorative Nurse Director, stated R2 has grooming, dressing, and walking restorative programs. V20 said R2 uses a rollator walker to ambulate when the restorative staff is assisting him, but he is not able to use the walker independently. V20 stated no additional programs have been provided to R2 related to his falls. V20 provided documentation supporting R2's restorative program for ambulation with staff initiated on 6/24/21 and a bathing/grooming program initiated on 10/24/22. At 3:28PM V20 stated the purpose of restorative assessments are to assess if the patient needs a new task to be implemented. If a resident is unable to balance without staff assistance, then they need hands on to be steady during a transfer in the event of instability. V20 stated R2 attempts to walk alone. V20 said R2 does not have a goal to walk	S9999		

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S9999	Continued From page 6 independently. V20 stated she has not received a concern that R2 is walking independently. R2's cognitive pattern assessment dated 10/28/22 score is 6 and unable to answer questions of orientation and needing cueing with recall. R2's Health condition assessment dated 10/28/22 notes he had a fall in the past. R2's fall risk evaluation on 7/14/22 has a score of 10 and on 12/30/22 he has an increased score of 14. On 12/30/22 R2 is noted to have an unsteady gait. Incident report for R2 dated 11/19/22 notes R2's daughter reported that R2 said he fell. No one witnessed him on the floor. An incident report dated 12/30/22 notes the CNA reported that R2 had fallen. Progress notes dated 11/22/22 note attempting to ambulate to restroom independently. Noted siting on buttocks with urine in pants. R2 has inappropriate footwear. There was no incident report provided for this fall. Progress note dated 11/11/22 note Fall Precautions. A progress note written on 12/19/22 for R2 notes he is attempting to get up without assistance and transfer self. Interventions noted offer assistance with transfers and ADL cares. There was not an incident report provided for this fall. The facility provided a list of incident reports for R2 for 12 months. The list notes incident nature other on 11/19/22; 7/14/22 falls; 7/1/22 other, and	S9999		

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S9999	Continued From page 7 1/24/22 skin tear. Progress notes and incident report document falls on 11/19/22; 11/22/22; 12/19/22 and 12/30/22. Restorative Assessment for R2 dated 10/24/22 notes R2 is alert with confusion. He is ambulatory has a decline in self-care and cognition and is unable to use his call light. History of falls is identified on the assessment. Balance is identified as only able to balance with staff assistance. Restorative programs include walking initiated on 6/24/22. Program notes to ambulate with side by assistance. R2's Care Plan identifies him to be a high risk for falls related to Cognitive Deficit, Vision and Hearing Deficits, Medication Side Effects, Dementia, Cerebral Vascular Accident, Incontinence, history of Falls, and Wandering. This Care Plan was initiated on 9/7/21. There is no intervention following the 11/19/22; 11/22/22 and 12/19/22 falls. There are interventions dated 12/30/22 to ensure R2 has proper footwear and frequent wound on R2 while in his room, and to offer assistance with toileting. On 1/6/22 V3, Administrator, provided a Care Plan initiated on 1/5/23 for R2's Impulsive Behaviors which place him at risk for falls. All interventions are dated 1/5/23. R8 is a 74-year-old with diagnoses including, but not limited to Diabetes, Metabolic Encephalopathy, Pressure Ulcer of Right Heel, Chronic Kidney Disease, Vitamin D Deficiency, and History of Falling. R8 has a history of sustaining a Communicated Fracture of the Nasal Bone.	S9999		

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S9999	Continued From page 8 On 1/4/23 at 11:10AM the surveyor observed R2's name plate on her door does not have a star. On 1/4/23 at 1:05PM V9, Licensed Practical Nurse (LPN), stated on 11/26/22 I was walking past R8's room when I saw she was not on the bed. V9 stated R8 was face down on the floor, there was "blood everywhere." V9 stated R8 said she was trying to get up on her own. V9 stated R8 usually requires supervision for transfers. V9 stated R8 was sent to the emergency room for evaluation due to the bleeding. V9 stated R8 was not considered a fall risk, but she had a history of falls. On 1/4/23 at 3:04PM V7, Nurse, stated on 10/28/22 R8 was on the floor and stated her leg was weak and she fell. V7 state R8 was able to safely self-transfer. V7 stated she reminds R8 to use the call light, but R8 won't use it. V7 stated the wheelchair was in the room and R8 had locked it. V7 stated R8 had fallen before, and she was already a fall risk patient. V7 stated fall interventions included re-educating R8, keep the call light close to her, keep her wheelchair locked for transfers, and I would tell her we are close just call us for assistance. Surveyor asked what intervention was implemented after this fall and V7 responded, post fall "I can't think of anything new added." On 1/5/23 at 10:24AM V8, Certified Nursing Assistant (CNA), stated on 1/1/23 she had seen R8 sitting on her bed, as usual, around 3:40 or 3:45PM. V8 stated I was answering another call light when I noticed R8 was on the floor in her room. V8 stated R8 told her she was trying to go to the washroom. V8 stated R8 requires one	S9999		

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S9999	Continued From page 9	S9999		

person assistance for transfers, she is not independent with transfers. V8 stated R8 is not steady on her feet. V8 stated R8's wheelchair was in the room, but it was pushed back away from R8. V8 stated I don't if the wheelchair was locked. V8 said R8 "rarely" uses the call light for help. V8 stated she assisted R8 to the bathroom after she had been assessed by the nurse and R8 did urinate."

On 1/5/23 at 12:04PM while discussing R8's falls, V11 stated the intervention to prevent a further fall after 11/26 was "to focus more on transfers." V11 stated R8 "needs to listen to education and be more compliant." V11 stated following R8's fall on 1/1/23 the new intervention is to keep the call light in reach. V11 said the intervention had nothing to do with her fall because she wasn't feeling good." V11 stated "we know she falls when she doesn't use the light."

On 1/6/23 at 10:51AM V19, Orthopedic Surgeon, stated I met R8 a couple years ago from her past injuries. V19 said R8 has had other fall related injuries. V19 stated we (the partners) don't treat nasal fractures. V19 said he was asked to look at R8's fracture. V19 said R8's nasal fracture looked to be in the same location as a prior fracture. V19 stated when you have trauma in the same areas, such as the R8, you can have more bleeding. V19 said when he saw R8 in November, following the 11/26 fall, she had bruising, and it was an acute injury. V19 said any women over the age of 65 is at higher risk for fractures and a Vitamin D deficiency can affect her potential for fractures. V19 stated anyone who has fallen numerous times will always be a high risk for falls and V19 would expect staff to be vigilant. The surveyor reviewed R8's balance assessment from 10/6/22 which states R8 is only able to stabilize with staff

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S9999	Continued From page 10 assistance while moving from seated to standing position, moving on and off toilet, and surface to surface transfers (between bed and chair or wheelchair) with V19. Based on this review V19 stated I would not expect her to be doing it independently. V19 stated since he told the staff face fractures are not his area of expertise, he did not bill for this visit with R8, nor did he write a progress note. On 1/6/23 V3, Administrator, stated the facility would use the appropriate physician to evaluate any situation or change in resident condition. Incident report dated 11/26/22 notes R8's roommate called for help and R8 was observed on the floor, laying faced down, "in a pool of blood." R8 stated she stood up and lost her balance. Predisposing factors note gait imbalance, recent change in condition, recent illness, and weakness/fainted. Predisposing physiological factors note R8 has a lack of safety awareness, lower extremity weakness, and recent change in medication. Incident report dated 1/1/23 notes R8 found in her room on the floor next to her bed lying on her right side. R8 stated she was trying to get out of bed to use the bathroom and fell. Mental status notes R8 is oriented to person and time. Predisposing factors indicate a gait imbalance. R8's Functional Status assessment dated 10/6/22 notes she requires extensive assist with bed mobility, transfers, and toilet use. R8's Health Condition history dated 10/6/22 notes she has a history of one fall one month prior and in the last 2-6 months. R8's Fall risk evaluation dated 10/28/22 notes a	S9999		

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S9999	Continued From page 11 score of 16 = high risk. R8's Care Plan initiated on 10/5/21 notes R8 is high risk for falls related to impaired balance, incontinence, medication side effects, visual deficits, pain, and history of falls. Interventions include assist with toileting (date 7/22/21). Encourage resident to lock wheelchair before transfers to prevent falls (date 10/28/22). Keep bed in low position (date 1/1/23). R8's Care Plan includes focus on her impulsive behavior, does not wait for help, will attempt to self-transfer with intervention to monitor for safety. Focus initiated on 7/30/21. Focus on R8's need for assistance due to poor endurance, impaired mobility, and history of falls initiated on 10/4/22. X-Ray nasal bones dated 11/26/22 documented mildly Depressed Fracture of the Distal Nasal Bone. Final Incident report provided to IDPH dated 11/30/22 states on 11/28/22 at around 1:11PM received Nasal Bone x-ray result with impression - mildly Depressed Fracture of the Distal Nasal Bone. Report notes R8 attempted to get up unassisted without activating the call light or asking for assistance and fell to the floor causing bleeding from old mildly Communicated Fracture of the Nasal Bone. R9 is an 81 years old with diagnoses including, but not limited to, Parkinson's, Unsteady on Feet, Chronic Kidney Disease, Legal Blindness, Dementia, Restless Leg Syndrome, Polyneuropathy, and history of falling. On 1/3/23 at 12:30PM the surveyor observed a	S9999		

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S9999	Continued From page 12 star on R9's name plate on the wall, next to her door. On 1/4/23 at 2:17PM V13, Nurse, stated on 12/24/22 she went into R9's room and R9 was observed sitting on the floor. V13 stated R9 said she had been reaching for her sock that was on the floor. V13 stated she saw the sock on the floor. V13 said R9 had no shoes or socks on when she was on the floor. V13 said she saw the bed had moved and R9 said the bed moved when she got up. V13 stated the facility usually has the bed wheels locked, for safety. V13 stated "I believe she (R9) had fallen before." Change in condition form for R9 dated 12/24/22 at 6:40AM notes R9 responded to a voice yelling and entered R9's room and observed R9 sitting on the floor in her room. According to notes R9 stated she sat at the side of her bed to pick up her sock off the floor. R9 said when she tried to stand the bed started moving and she slid to the floor. Additional information notes staff nurse educated resident about calling for assistance and engaged brakes on the bed. (No Incident Report was provided for this fall.) R9's Functional Status Assessment dated 10/18/22 notes she requires assistance to balance with moving from seated to standing position and surface to surface to surface transfer. R9's cognitive status assessed on 10/26/22 notes a score of 9, cognitively impaired. R9's Functional Status assessment dated 10/26/22 noted R9 requires extensive assistance with transfers and toilet use R9's Care Plan noted she is high risk for falls. The last interventions are dated 10/31/22 assess	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012967	A. BUILDING: _____ B. WING _____	C 01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 13 for pain and treat if present and Restorative Program as indicated to prevent further falls, gait strengthening, and transfers. R7 is an 88 years old with diagnoses including, but not limited to Diabetes, Obese, Dementia, Pain in Shoulder, Hypothyroid, hyperlipidemia, Restless Leg Syndrome, Macular Degeneration, Glaucoma, Hypertension, Atrial Fibrillation, Heart Failure, Chronic Obstruction Pulmonary Disease, History of Falling, Transient Ischemic Attack, and Vertigo. Progress Notes dated 12/26/22 notes R7 observed by CNA on her buttocks by her bed and R7 states she was trying to transfer herself in bed. There was no incident report provided for R7's fall on 12/26/22. R7's Care Plan does not include an intervention for fall prevention after 10/21/22 which is to offer and assist with toileting at regular intervals and as needed. R7's Care Plan notes Focus statements including R7 requires assistance with Activities of Daily Living, Limited Active Joint Movement in extremities, Impaired Bed Mobility related to poor motivation and decreased strength and coordination due to diagnosis of Transient Ischemic Attack. R7 is cognitively impaired. R7 is "high risk for falls." R7's Fall Risk Evaluation dated 10/4/21 notes a score of 14 = high risk. R7's Functional Status Assessment dated 10/18/22 notes she requires extensive staff assistance for bed mobility, transfers, and toilet use. R7's balance assessment notes she can only stabilize her balance with staff assistance when moving from seated to standing position,	S9999		

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S9999	Continued From page 14 moving on/off toilet, and during surface-to-surface transfers. On 1/4/23 at 9:07AM V11, Director of Nursing, state following a fall a new intervention should be implemented "right away." V11 stated the facility uses a "leaf symbol" where the resident name is on the door. V11 stated she is currently the fall coordinator. At 12:45PM V11 stated fall root cause investigations are done while developing the intervention but is not documented. On 1/5/23 at 12:04PM V11 stated there is no other Fall Policy for Fall Prevention or Fall Program. V11 said the nurses are responsible for entering the fall intervention into the Care Plan as it is being done. V11 said "if it is not documented, then it was not done." V11 said when a fall occurs, she is notified. V11 stated a fracture "is a serious injury." V11 stated high fall risk residents are placed near the nurses' station. On 1/6/23 at 11:30AM V11 stated the intervention for R9 was not in the Care Plan and the nurse forgot to write an Incident Report. V11 said she found out about R9's fall on 1/5/23 when the surveyor asked about the root cause of R9's fall. The surveyor asked V11 about R7's 12/26/22 fall and what intervention were in place. V11 said R7 is prone to call when she has a urinary tract infection. V11 said she was not sure if the urine analysis/culture was received and if treatment was started. V11 said the Care Plan was not updated since the fall. The facility Fall Occurrence police revised 5/17/22 notes: It is the policy of the facility to ensure that	S9999		

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S9999	Continued From page 15 residents are assessed for risk for fall, that interventions are put in place, and interventions are re-evaluated and revised as necessary. If a resident had fallen the resident is automatically considered as high risk for falls. An incident report will be completed by the nurse each time a resident falls. The nurse may immediately start investigations to address falls in the unit, even prior to the Falls Coordinator's investigation. The falls Coordinator will add the intervention in the resident's Care Plan. The interventions will be re-evaluated and revised as necessary. The facility policy for Physician Visits revised 7/28/22 notes Physician visits should not be superficial visits but must include an evaluation of the resident's condition and total program of care, including medications and treatments, and a decision about the continued appropriateness of the resident's current medical regimen. (B)	S9999		