Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007322	A. BUILDING: ______ B. WING ______	C 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA EVERGREEN PARK	10124 SOUTH KEDZIE EVERGREEN PARK, IL 60805

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S 000	Initial Comments Facility Reported Incident Investigation FRI of 12/4/22/IL155153	S 000		
S9999	Final Observations Statement of Licensue Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 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	S9999	Attachment A Statement of Licensure Violations	

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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:

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:

Based on observation, interview, and record reviewed the facility failed to have identified fall prevention interventions in place, to develop individualized fall prevention interventions, to update the resident care plan post fall with new interventions, and failed to develop a resident specific root cause analysis for falls This affectes 3 of 3 (R1, R12, and R11) residents reviewed for falls. This failure resulted in one resident (R1) sustaining a head laceration requiring 6 sutures.

Findings include:

1. R1 is 74 years old with diagnosis including, but not limited to Metabolic Encephalopathy, Muscle

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S9999	Continued From page 2 Wasting and Atrophy, Anemia, Dementia, Bipolar Disorder, Alzheimer's Disease, Hypertension, Acute Kidney Failure, Chronic Kidney Disease, Dysphagia, Altered Mental Status, Gastrostomy Status, and History of Fracture of Left Tibia. R1 was initially admitted to the facility on 8/17/22. Functional Mobility on admission documents R1 required total dependence of 1 person for bed mobility. Mobility Criteria notes R1 is completely immobile and does not make even slight changes in body or extremity position without assistance. Fall Risk Evaluation notes R1 is in bed and is non-mobile. R1 received Physical Therapy from 10/5/22 until 11/10/22. Physical Therapy Discharge Summary notes Prior Medical History (in part) lists: altered mental status, fracture of left tibia closed fracture status post 7/9/22, falls. On 1/31/23 at 9:53 AM, V11, LPN said when R1 fell she was told by the CNA that he was giving care and R1 fell from the bed onto the blue mat. V11 said R1's baseline is that she can roll and move back and forth in the bed. V11 said the CNA said he was giving care and she rolled. V11 said R1 had been calm that morning and was in her usual behavior. V11 said she was a fall risk before the fall on 12/5/22. V11 said intervention in place were to have the bed in the lowest position, blue floor mat, bed and chair alarm as well. V11 said I saw the floor mats in place when I assessed R1 from the fall. V11 said she saw R1 had her head split (V11 pointed to the left forehead area of her head). V11 said she stopped the bleeding, got R1 up, made calls to family and doctor, and then sent R1 for hospital evaluation. V11 said when R1 returned she had 6 sutures in her head at the laceration. V11 said after the fall	S9999		

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R1 became a 2 person assist for all cares, the newest intervention is she is 2 person assist at all times.

On 1/31/23 at 10:46 AM, V13, Restorative and Falls Nurse, said R1 fell on 12/4/22 during the process of receiving care. V13 said the CNA was washing her and wringing out the towel and R1 rolled off the bed. V13 said the bed was at hip level, and the staff turned at the bedside to wring the towel and R1 rolled off the bed. V13 said R1 had been on her back on an air mattress. V13 said R1 is not very mobile but was able to throw her legs off the bed. V13 said prior to the fall R1 was not a fall risk. V13 said R1 did not have impulsive movements. V13 said following the fall, R1 had bleeding and was sent to the hospital for evaluation. V13 said R1 returned with 6 sutures. V13 said she did not know what R1 hit her head on to cause the open area.

On 1/31/23 at 3:17 PM, V23, CNA, said he was in the room with R1 on 12/4/22. V23 said he had seen R1 hanging out of the bed earlier during the shift and repositioned her 3 times. V23 said R1 has put both her legs out of the bed and was in slanted position with her legs out of the bed. V23 said on the third time he decided to get her washed up. V23 said he was washing R1 and he went to the bathroom to get another towel and rinsed a towel. V23 said he turned his back towards R1 and when he turned towards R1 he saw "she threw herself" out of the bed. V23 said the bed was in the raised position and not in the lowest position when he was in the bathroom. V23 said R1's behavior of moving around is her usual.

On 1/31/23 at 12:45 PM, V18, CNA, said R1 requires 2 staff persons when providing care

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because she resists and grabbed at staff hands.

R1's care plan for Focus for falls initiated on 8/18/22 noted R1 is at risk for falls. Undated intervention states bed in a lowest possible position.

R1's care plan focus for Activity of Daily Living Restorative Nursing, documents R1's goal will receive assistance from 1-2 CNA for all ADLs. Date initiated is 8/18/22

R1's incident report dated 12/4/22 at 11:11 AM, notes staff reports during care R1 rolled off the bed onto the floor. Nurse observed R1 lying on her left side. R1 bleeding from her left temple/scalp area. Noted R1 with 1cm laceration.

Post fall investigation for R1 states she has poor safety awareness and impulsive movements with periods of restlessness due to cognitive impairment.

Review of R1's Documentation survey from 1/6/22-1/31/22 denotes 2 person care has been provided 21 days, post the fall. V18 said R1 requires 2 person assist. V11 said her intervention was to always use 2 person care for R1.

2. R12 is 79 years old with diagnosis including, but not limited to, of nontraumatic subdural hemorrhage (onset 10/22/22), Difficulty in Walking, Unspecified Fall, Alcohol Dependence with Intoxication, Mild Cognitive Impairment, Seizures, Hypertension, Chronic Obstructive Pulmonary Disease, Osteoarthritis, and Altered mental Status.

On 1/31/23 at 1:12 PM, R12 observed in bed with

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no floor mats on either side of the bed.

On 1/31/23 at 1:31 PM, R12 observed with V20, CNA, and no floor mats in place. V20 showed the surveyor R12's wheelchair. The surveyor observed a black wheelchair with a wheelchair cushion in it. There is no nonskid device on top of the wheelchair cushion. V20 lifted the wheelchair cushion, and no non-skid device was in place under the cushion. V20 said she was going to clean R12's wheelchair but had not done it yet.

On 1/31/23 at 1:41 PM, V21, RN, said she was assigned to R12 on 1/30/23 and he was sitting up in his wheel chair on 1/30/23. V21 said R12 is a fall risk.

On 1/31/23 at 9:53 AM, V11, LPN said R12 is a "very high" fall risk. V11 said R12 can walk if assisted 3 to 5 steps. V11 said R12 needs a wheelchair. R12 said V11 safety intervention included bed in the lowest position, floor mats, bed and chair alarms. V11 said R12 never used the call light and was placed in a room across from the nurses' station.

On 1/31/23 at 10:46 AM, V13, Restorative and Falls Nurse, said R12 is at risk for falls due to his poor safety awareness. V13 said R12's fall on 12/29/23 was due to his poor safety awareness and improper transfers. V13 said R12 was attempting to use the toilet. V13 said the CNA told her that she heard R12's alarm and when she responded she saw R12 on his knees, kneeling by the sink in the bathroom. V13 said R12's safety interventions included a low bed and bed and chair alarms. V13 said R12 was wheel chair bound and did not use a walker.

Fall report dated 12/29/22 at 6:43 PM, documents

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S9999	Continued From page 6 R12 was observed on his knees in the bathroom. R12's statement was that he was trying to get on the toilet and slipped to the floor. R12's care plan fall focus initiated on 10/24/22 notes an undated intervention for bed in lowest position and fall mats. 3. R11 is 96 years old with diagnosis including but not limited to Chronic Diastolic (congestive) Heart Failure, Dementia, Alzheimer's Disease, Unsteadiness on Feet, and History of Falling. On 1/31/23 at 2:37 PM, V11 said she was doing rounds at the start of her shift and saw R11 was holding himself from the bed rail. V11 said R11 was sitting on his but on the floor on the right side of his bed. V11 said R11's bed was at regular height, he had a chair alarm and a bed alarm. V11 said R11's bed was not low. V11 said I don't recall hearing it or shutting it off. V11 said R11 was confused and could not tell me what was going on, but he had been trying to get up. V11 said R11 went to the emergency room for evaluation. V11 said at the time of the fall R11 complained of hip pain, but that was from an old injury. V11 said following the fall we added floor mats as an intervention. R11's Admission report dated 1/6/23 states R11 requires extensive assistance with bed mobility, transfers, and toilet use. R1's cognition is documented as impaired. R11 is confused, or in stupor or in coma due to cognitive deficit, resident will be unable to use the call light system effectively. R11's fall report dated 1/28/23 states upon rounds the nurse observed R11 lying on the floor next to his bed with his feet pointing towards the top of	S9999		

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S9999	Continued From page 7 the bed, holding on to the side rail. R11's Post Fall Investigation notes R11 has a history of fall in the facility on 1/10/23. Interventions in place state "low bed', V11, LPN, said during interview the bed was at a regular height. Root cause notes R11 has poor safety awareness and impulsive movements with periods of restlessness due to cognitive impairment. R11's Baseline Careplan dated 1/6/23 notes R11 has cognitive deficit and with a goal to be free from injury. R11's Baseline Careplan dated 1/6/23 includes fall risk due to poor safety awareness. Intervention includes keep call light in reach when in bedroom or bathroom. (Admission assessment documented R11 is unable to use the call light.) R11's Comprehensive care plan for fall has date initiated 1/17/23 notes intervention to ensure call light is within reach. R11's care plan does not include the use of alarms. R11's care plan received on 1/31/23 does not include new interventions, after 1/29/23, to prevent future falls. The root cause analysis for R1, R11, and R12 all state resident has poor safety awareness and impulsive movements with periods of restlessness due to cognitive impairment. The facility Fall Occurrence policy revised on 5/17/22 states 3. If a resident had fallen, the resident is automatically considered as high risk for falls. 6. The nurse may immediately start interventions to address falls in the unit, even prior to the Falls Coordinator's investigation. 7.Ultimately, the Falls Coordinator may change the interventions provided by the nurse if the Falls Coordinator's investigation identifies a more	S9999		

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S9999	Continued From page 8 appropriate intervention for the individual fall. 8. The Falls Coordinator will add the intervention in the resident's care plan. The facility policy on Falls revised 8/5/20 states 2. To gather accurate, objective and consistent data for the purpose of implementing an individualized Plan of Care designated to meet the resident's needs. 6. Residents who have been identified at risk or who have experienced a recent fall have all recommended interventions in place. (B)	S9999		