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 09/16/2024

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 Survey: 2496633/IL176969	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 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 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.	S9999		

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S9999	Continued From page 1 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 review, the facility failed to a.) ensure (R3's) fall risk assessment was accurate b.) failed to implement fall prevention interventions and failed to provide supervision for two (R2, R3) of four residents reviewed for falls. These failures resulted in the following: R2 fell on 06/29/24 and on 7/06/24. R3 fell on 06/27/24 (fall without injury) and R3 also fell on 7/04/24 (7 days later) and sustained a subdural hemorrhage (bleeding inside the head). Findings include: R2's face sheet dated 09/15/2024 documents that R2 is a 82-year-old resident with diagnoses not limited to: mild cognitive impairment of uncertain or unknown etiology, anxiety disorder, unspecified, unspecified fracture of t9-t10 vertebra, subsequent encounter for fracture with routine healing, metabolic encephalopathy, acute on chronic systolic (congestive) heart failure, insomnia, unspecified, type 2 diabetes mellitus with hyperglycemia, age-related osteoporosis.	S9999		

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R2's MDS section GG dated 8/20/2024 documents R2's interim assessment affirms R2 requires partial/moderate assistance with transfers form bed to chair, toilet transfers, and to walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space.

The facility fall log affirms R2 fell on 06/29/24 (fall without injury) and on 7/06/24 (fall without injury).

R2's fall risk evaluation dated 06/20/2024 documents R2 just had a fall and that R2 is a high fall risk.

R2's fall risk evaluation dated 06/29/2024 documents R2 just had a fall and that R2 is a high fall risk.

R2's care plan documents in part that R2 is at risk for falls related to weakness, fibromyalgia, chronic T8 com fracture, right shoulder pain, debility. Interventions: chair Alarm in place to alert staff when R2 reattempt to standup unassisted. Educated R2 the importance of calling staff if she needs assistance in anyway. Date Initiated: 02/15/2023.

09/15/2024 11:30 AM V4 (Registered Nurse) provided surveyor with a copy of the fall risk prevention list. Facility document dated 09/14/2024 titled "Fall Risk Prevention List" documents in part that R2 is marked for bed alarm, chair alarm, and floor mats; R4 is marked for bed alarm and chair alarm.

09/15/2024 11:51 AM observed R2 in her room, sitting on a recliner chair with two pillows behind her, observed bedside table in front of R2, observed R2 wearing her own clothes and gym

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shoes on. Observed R2 wearing glasses. Observed carpet flooring. Observed bed alarm, and observed chair alarm on a wheelchair that was against R2 ' s room wall. No observation of a chair alarm under R2 or around the recliner chair that R2 was sitting on. R2 states that she has had falls here. R2 states that she last fell out of her bed, R2 states now there is pad on the floor when she is in bed. R2 states that she has had 3 episodes that they have taken her to the hospital because R2 states that she has been sick. R2 states she honestly cannot remember what happened. R2 states that another fall she had, R2 states that it was pure accident, R2 states that her leg just buckled.

09/15/2024 12:16 PM surveyor questioned V3 (Director of Nursing) which CNA was assigned to care for R2. Observed V3 review the assignment sheet. V3 states that V6 is assigned to R2.

09/15/2024 12:20 PM V8 (Certified Nursing Assistant/CNA) states that if an alarm is not placed under a resident that is supposed to have bed or chair alarm, V8 states that the resident could have a fall. V8 states that it is a split second that a fall can happen. V8 states that the bed and chair alarms do not prevent a fall, but it is just alerting staff that the resident is moving out of the chair, V8 states or they are probably uncomfortable in the chair, V8 states they could probably need to go to the bathroom, V8 states or they can be reaching for something, want water. V8 states that staff can switch the chair alarm to the recliner. V8 states that the chair alarm is connected to a pad that will be triggered with movement.

9/15/2024 12:55 PM V6 (CNA) states that she is not sure which CNA has R2. V6 states that she

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thinks it was V7 (CNA) who was assigned to R2. V6 states that V7 walked out of the facility. V6 states that V7 said it was too much work and walked out of the facility. V6 states that the supervisors are aware. V7 states that she is not familiar with R2's care. V6 states that she would have to go to the nurse's station to review R2's care plan and V6 states to find out how R2 transfers, if R2 is a fall risk. V6 states that the chair alarm and bed alarm are pads and are motion sensor. V6 states that the pads should be under the resident. V6 states that the chair alarms are not built in the wheelchairs. V6 states that the chair alarm should be placed under any type of seating that the resident is sitting on. V6 states that she has never worked with R1 and R3 before.

09/15/2024 12:58 PM V6 states that the change in assignment must have just happened. V6 states that she has not seen R2 today. V6 states that she was not made aware that she was just assigned to R2.

R3's face sheet dated 09/15/2024 documents that R3 is a 75-year-old resident with diagnoses not limited to: disorder of brain, unspecified, traumatic subdural hemorrhage without loss of consciousness, subsequent encounter, unspecified fall, subsequent encounter, Parkinson's disease without dyskinesia, orthostatic hypotension, primary generalized (osteo)arthritis, benign prostatic hyperplasia with lower urinary tract symptoms, anxiety disorder, unspecified.

R3's MDS/Minimum Data Set dated 04/17/2024 documents that R3 has a BIMS/Brief Interview for Mental Status score of 15/15, indicating that R3 is cognitively intact.

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R3's MDS/Minimum Data Set dated 07/17/2024 (post R3's falls) documents that R3 has a BIMS/Brief Interview for Mental Status score of 10/15, indicating that R3 is moderately cognitively impaired.

R3's MDS section GG dated 4/24/2024 documents R3's annual assessment affirms R3 requires partial/moderate assistance with transfers form bed to chair, toilet transfers, and to walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space.

The facility fall log affirms R3 fell on 06/27/24 (documents fall without injury) and on 7/04/24 (documents fall without injury).

R3's fall risk evaluation dated 06/27/2024 documents R3 did not have a fall and that R3 is a high fall risk.

R3's fall risk evaluation dated 07/04/2024 documents R3 just had a fall and that R3 is a high fall risk.

R3's care plan documents in part that R3 is at risk for falls related to Parkinson disease, orthostatic hypotension, past fall, lack of coordination and abnormalities of gait. Interventions: staff should anticipate and frequently round. Date initiated 04/14/2023.

09/15/2024 2:03pm V9 (Fall preventionist/RN) states that she has been working for the facility for almost 2 years. V9 states that she has been the fall coordinator for a year and 4 months. V9 states that she completes the residents' fall risk care plans. V9 states that she inputs the fall risk care plan interventions too. Surveyor inquired

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how V9 determines that the chair and bed alarm interventions should be put in place. V9 states that if the resident has had history of falls, diagnosis of dementia, pain, UTI, or upon admission assessment, V9 states that it determines if the residents need to have bed and/or chair alarm. V9 states that she completes assessments upon admission. V9 states that also if the residents have weakness. V9 states that the bed and chair alarm intervention can help prevent residents from falling, V9 states that the chair alarm should be placed on whatever chair the resident is sitting on. V9 states that R2 fell on June 20th, V9 states that R2 said that she wanted to get out of bed, V9 states that R2's bed was in a low position. V9 states that R2 was found at the side of her bed at 1:00 am. V9 states that R2 did not suffer any injuries. V9 states that this fall could have been prevented if R2 would have used her call light. V9 states that R2 had another fall on June 29th, in the morning shift. V9 states that R2 said that she was trying to ambulate to the washroom, V9 states that R2 said that she lost her balance and fell. V9 states that for this fall, she would have to say that the same still applies, V9 states that R2 is a retired nurse, and V9 states that she encouraged R2 to use the call light. V9 states that R2 can use her walker and V9 states that R2 can go by herself to the washroom unsupervised. Surveyor inquired as to why did R2 had a chair alarm and bed alarm if she is able to go by herself to the washroom unsupervised. V9 states that that she wanted to discuss the previous fall R2 had, V9 states that R2 had an infection when she had her first fall on June 20th, V9 states that to prevent R2 from falling, R2 and her family were ok with R2 having a bed and chair alarm. V9 states that R2 still wants to have the alarms in place. V9 states that she feels that it is safer for R2 to have the bed

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and chair alarm, V9 states because R2 has had multiple falls, and V9 states that the root cause of R2 falling is that R2 is not calling for her. V9 states that staff need to anticipate R2's needs. V9 states that staff need to make rounds and anticipate needs. V9 states that she does not do reportables. V9 states that her director does the reportables. V9 states that R3 was a long-term care resident, and V9 states that R3 was declining. V9 states that R3 fell on June 27th, V9 states that R3 didn't call for help. V9 states that R3 had refused to go to the hospital the first time that R3 fell. V9 states that after his fall on June 27th, V9 states that she revised R3's care plan and implemented chair alarm, and R3 was reeducated to call for help. V9 states that R3 did not suffer any injuries from his fall on 06/27/2024. V9 states that R3 did not have bed and chair alarms in place prior to his fall on 06/27/2024, V9 states because R3 became very strong, and it had resolved. V9 states that prior to R3 having a fall on 06/27/2024, V9 states that R3 wasn't much of a fall risk, V9 states that R3 could do things by himself, V9 states that R3 went out by himself, V9 states R3 was independent. V9 states that R3 was this way for 9 to 10 months. V9 states that she noticed a decline in R3. V9 states that R3 had lab work done and no new orders were given. V9 states "And we continued neuro check in house after fall on 27th. Why did he fall on June 27th, he said he wanted to use the washroom, I usually have, and he tripped going past the bedside table, it was in his way, and then he fell. And he verbalized that he didn't hit his head, and didn't have any pain, and that was the fall that he refused to go to the hospital. V9 states that R3 fell again on 7/4/24. V9 states that the nursing assistant found R3 on the floor. V9 states that prior to this fall, staff saw R3 watching T.V. (television), sitting on his recliner chair. V9 states

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that R3 didn't call for help. V9 states that R3 fell in front of his recliner. V9 states that R3 wanted to get up. V9 states that at that time, R3 couldn't engage a lot in conversation, V9 states that R3 didn't say where he was going, V9 states that R3 had denied any pain and denied hitting his head. V9 states that she insisted that R3 needed to go to the hospital. V9 states that she was concerned that R3 was declining. V9 states that he didn't look too good. V9 states that when R3 returned to the facility from being in the hospital, V9 states "I put back the floor mats, and low position, after that he returned under hospice". V9 states that she does in-services regarding fall precautions every day, V9 states that she encourages staff and reminds staff about fall precautions in place, to check that fall precautions are in place every day, V9 states that she also reminds staff to review and understand the fall precautions in place for the residents from the care book binder, V9 states that she also reminds staff to rounds and anticipate residents' needs while rounding.

09/16/24 4:01pm via telephone V12 (Nurse Practitioner) states that if a resident falls and hits their head, the resident can have Subdural hematoma, V12 states which is bleeding in the brain. V12 states that for older residents, if they have a fall, V12 states that they can potentially suffer many complications with a fall, V12 states they can break their bone, lacerations, fat embolism.

Facility document dated 07/26/2024 titled "Fall occurrence" documents in part "It is the policy of the facility to ensure that residents are assessed for risk for falls, that interventions are put in place, and interventions are reevaluated and revised as necessary".
(A)

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