STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012827	A. BUILDING: _____ B. WING _____	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA OF ELGIN	1950 LARKIN AVENUE ELGIN, IL 60123

(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 Annual Licensure Survey Facility Reported Incident of 6/13/24/IL174708	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	S9999		

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S9999	Continued From page 1	S9999		

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 regulations are not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure safe transport of resident to the shower room when a shower chair was utilized for the transfer in place of a wheelchair. This failure resulted in R24 falling from the chair and fracturing both of her legs. This applies to 1 of 4 residents (R24) reviewed for accidents in the sample of 26.

The findings include:

R24 is a 64-year-old female admitted to the facility on May 16, 2019, with diagnoses that include Multiple Sclerosis, Chronic pain, and Polyneuropathy. R24's MDS (Minimum Data Set) Assessment dated May 12, 2024, documents that resident requires substantial to maximal assistance with lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed and with no back support. R24 was also assessed to be cognitively intact as evidenced by a BIMS (Brief Interview of Mental Status) score of 15/15.

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The Facility Reported Incident dated June 13, 2024, stated that at approximately 6:30 AM Certified Nursing Assistant (CNA) was transporting R24 to the shower room via shower chair. The report documents the chair suddenly stopped at the metal transition strip on the floor. This caused the chair to become unstable and the resident to lose balance and fall to the floor. Resident complained of pain to bilateral legs and knees. The resident was sent to the hospital and sustained a fracture of the right femur and fracture of the left tibia and fibula.

On July 8, 2024, at 10:36 AM, R24, stated that on June 13, 2024, at about 6:20 AM, V10 (CNA) helped her into a Polyvinyl Chloride pipe (PVC) shower chair via a full body mechanical lift and wheeled her towards the shower room. R24 stated the shower chair was made of PVC pipe and had a footrest board. R24 stated the shower room closet to her room was occupied so he started to wheel her to the next closet shower room. R24 stated that when they got to the metal strip on the floor, the wheels locked, and the chair stopped abruptly, and she kept going and landed on her legs and knees. R24 stated when the staff is pushing you in the shower chairs the wheels lock and the shower chair jerk you forward then you see black marks on the floor behind you. R24 stated she has been complaining the shower chairs were not in good repair for 2.5 years. R24 stated she has told CNA's V18, V23, V24, and V26 that the shower chairs are in poor repair, stop abruptly, and the chairs jerks you forward.

On July 9, 2024, at 9:02 AM, V9 (CNA) stated she has been working at the facility for 3 years. V9 stated the shower chairs are "hard to move. They lock on their own" while you are pushing them. V9 stated it is hard to get over the metal strips

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with the residents in the shower chairs. V9 stated when you go over the strips, with residents in the shower chair, the chairs tilt. V9 stated "You have to push slowly so they don't tilt over." Observed 3 shower chairs 2 with PVC pipe and one gray metal one to be hard to push and pull with the locks on or off. They were very stiff with brown substance around the wheels.

On July 9, 2024, at 2:12 PM, V10 (CNA) stated, the day of the incident, he lifted R24 into a shower chair with a whole-body mechanical lift, then proceeded to wheel R24 to the shower room. V10 stated when the chair reached the metal transition strip on the floor, the chair abruptly stopped and tipped forward. V10 stated he is not sure if it was the wheels that locked, the shower chair got caught on something, or her feet were dangling that caused the shower chair to stop and tip forward. V10 stated the transitions where higher at the time of the accident. V10 stated the chair he used to transport R24, is no longer in the facility. V10 stated, the shower chair was made of PVC pipe with a gray seat and a foot stand that was not movable but part of the chair. V10 stated some of the chairs stop abruptly and are hard to push. V9 stated there were no straps on the chair to hold the resident.

On July 9, 2024, at 2:49 PM, V2 (Director of Nursing, DON) stated it could be multiple factors that caused R24 accident. V2 stated that it could have been that the resident's feet could have stopped the chair, the chair could have locked, and there may have been a problem with transition strip on the floor. V2 stated they ordered new chairs, pounded the metal strips down, and took the particular chair out of circulation and trashed it. V2 stated that the best practice for transporting residents to the shower

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room is to transfer them from bed to wheelchair, use the wheelchair to wheel the resident to the shower room, and then transfer the resident back to wheelchair before transporting the resident back to their room.

On July 11, 2024, at 8:53 AM, V22 (Occupational Therapist) stated transporting residents in a shower chair would not be safe if the chair abruptly stopped or tilted while resident is in it.

R24's Hospital imaging report dated June 13, 2024, showed fractures to her left tibia and fibula and her right femur.

The facility's provided manufacture's owner's manual for the shower chairs and it shows the following: Do not use device if it appears wobbly or unstable, the casters are rusted or fail to move easily, the fabric appears torn or weak, cracks are observed in the fittings, or the device appears to be compromised in anyway. If you suspect a device is not functioning as intended, do not use device, and contact your distributor for assistance. Do not abruptly turn or stop the device. Do not abruptly turn or stop the device. (A)