| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6007322 | A. BUILDING: ____<br>B. WING ____ | C<br>10/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **AVANTARA EVERGREEN PARK** | **10124 SOUTH KEDZIE<br>EVERGREEN PARK, IL 60805** |

| (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 | S 000 | | |

Complaint investigations:
2497934/IL178696

Facility reported incident
FRI of 09.17.24 / IL178851
FRI of 09.19.24 / IL178852
FRI of 09.09.24 / IL178550
FRI of 09.11.24 / IL178553
FRI of 09.25.24/ IL179281

| | | | | |
|---|---|---|---|---|
| S9999 | Final Observations | S9999 | | |

Statement of Licensure Violations:
300.610a)
300.1210a)
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.

| 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 10/16/2024 |

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

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 1 | S9999 | | |

Continued From page 1

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 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:

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007322 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING | (X3) DATE SURVEY COMPLETED C 10/16/2024 |
|---|---|---|---|

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

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 2 | S9999 | | |

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 ensure fall prevention intervention to include supervision/monitoring were implemented to reduce the risk of falling, failed to ensure residents were assessed and able to use assistive device safely to prevent falls and injuries. This affected six of six residents (R1, R2, R4, R5, R6, R8) reviewed for falls and safety. This resulted in R1, R2, R6, and R8 having fall resulting lacerations to the scalp, R4 being in a fall incident attempting to use an assistive device and sustained a left fibula fracture, and R5 bumping into open door using a motorized wheelchair and sustain a right and left tibia fracture.

Findings include:

1. R4 face sheet shows diagnosis of hemiplegia, hemiparesis following cerebral infraction affecting right dominate side, other lack of coordination, and history of falling. R4 MDS assessment dated 7/25/24 denotes in-part section C for cognition shows a score of 3 (cognitive impairment).

R4 incident report dated 9/11/24 denotes in-part writer summons to room by CNA, upon entering I (writer) observed resident sitting on floor in front of her closet. Prior to sitting in wheelchair near closet. Predisposing physiological factors-

| 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 10/16/2024 |

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

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 3 | S9999 | | |

confused, gait imbalance. Predisposing situational factors- trying to stand without assist.

R4 fall risk evaluation dated 9/11/24 denotes in-part a score of 13 (high risk), R4 fall risk evaluation dated 9/29/24 denotes in-part a core of 18 (high risk).

R4 incident report dated 9/29/24 completed by V1 denotes in-part fall without injury, incident location, resident room. right at her residence bed alarm sounding upon entering residence room writer observed resident sitting on the edge of the bed holding her walker writer asked resident what she was trying to do, and resident stated she needed to use the restroom. While writer was assisting residents to the restroom, resident appeared to lose her balance, while assisting resident to the floor both the writer and resident fell resulting in resident falling on writer. Resident noted with non-skid socks on, room free of clutter. Call light in reach but not activated. Head to toe assessment completed no bleeding bruising or deformities noted at this time. Vitals assessed BP 110 / 60, heart rate 57, temp 97.6, blood sugar 100, respirations 18, O2sat 97% room air. Resident transfer back to bed via Hoyer lift, two staff assist, resident complaints of pain 0 of 10. Fall coordinator notified. Physician notified and orders received to send resident to (hospital name) hospital for further evaluation. Sister notified. Predisposing environmental factors none of the above. Predisposing physiological factor; use of blood thinners, diabetes, balance poor/balance disorders. Predisposing situation factors: ambulating with assist, recent room change, using walker. Agencies/people notified; DON/designee and family.

| 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 10/16/2024 |

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

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 4<br><br>R4 post fall investigation/ RCA (root cause analysis) dated 9/30/24 denotes in-part observed fall with injury, location- resident room, did incident result in injury-yes, type of injury- left closed fibula fracture. Activity at time- ambulating with staff, mental status- alert and orient 2-3, poor safety awareness, is resident at risk for falls- yes, does resident have history of falls- yes. Root cause analysis- R4 is a 68 year old female with diagnosis of bipolar disorder major depressive disorder hemiplegia and hemiparesis following cerebral infarction affecting right dominant side alert and oriented times 2 to 3 BIM score of three and a stand and pivot in transferring. R4 was changed in bed by CNA at 4:00 PM. The nurse responded to R4's bed it alarm sounding when the nurse entered the room R4 was observed sitting on the edge of the bed. When the nurse asked R4 what she was trying to do R4 stated she had to use the bathroom. The nurse was assisting a resident to the bathroom using a gate belt when R4 lost her balance the nurse eased the resident to the floor both resident and a nurse fell resulting in falling on top of the nurse resident was transferred out for evaluation per MD orders facility anticoagulation protocol. Therapy to evaluate and treat.<br><br>On 10/4/24 R4 said the nurse was helping her to bathroom and she fell. R4 said she broke her ankle.<br><br>On 10/8/24 at 11:48am V2 (CNA) said he has worked with R4, V2 said he has ambulated R4 using her walker. V2 said when he uses the walker, he put the wheelchair behind R4 just in case she gets weak and fall. V2 was asked how is R4 safe to use a walker if she might get weak and fall. V2 said "that's why I use the wheelchair too, it just depends on what she needs". V2 said | S9999 | | |

| 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 10/16/2024 |

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

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 5 | S9999 | | |

he was R4's aide when R4 had a fall on 9/11/24. V2 said he observed R4 on the floor in her room sitting on her buttocks, R4 told him her legs got weak and she fell, when she was at the closet.

On 10/8/24 at 10:21am V1 (Nurse) said she heard R4 bed alarm sound, she went in the room and observed R4 sitting at the bedside with a walker. V1 said R4 stated she wanted to go to the restroom, V1 said she offered to help R4. V1 said she put a gait belt around R4 waist, she stood R4 up, R4 had the walker in front of her, as R4 was ambulating R4 lost her balance a fell backwards toward her, which caused her to fall with R4. V1 said R4 landed on top of her. V1 said R4 used a walker for ambulating.

On 10/8/24 at 1:14pm V9 (Fall coordinator) said she conducted the fall investigation for R4 fall, date of fall was 9/29/24. V9 said R4 had a fall while ambulating to the restroom. V9 said the root cause of R4 fall was that R4 was ambulating and fell. V9 said R4 was not assessed to use a walker, V9 said R4 ambulation status was not assess or evaluated. V9 said she had never observed R4 ambulating. V9 said R4 had a room change and she believes that walker was left in the room. V9 said she called R4's family and the said they did not give R4 that walker. V9 said R4 should not have a walker, that's why she removed the walker when she found out staff was using that walker for R4. V9 said she was not aware that staff was ambulating R4, she was not aware that staff was ambulating R4 with a walker. V9 said R4 family did not want R4 to have any functional decline. V9 said she did not refer R4 to therapy for functional decline until R4 had the fall on 9/29/24.

On 10/8/24 at 2:01pm V11 (Restorative Director)

| 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 10/16/2024 |

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

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 6 | S9999 | | |

said staff should not ambulate a resident without having an assessment completed. V11 said staff should not be ambulating R4 with a walker if R4 was not assessed to use a walker by therapy. During a follow up interview V11 said R4 did not receive an evaluation or an assessment from restorative after the fall for 9/11/24. R4 was referred to physical therapy after the 9/29/24 fall with injury.

On 10/11/24 at 1:59pm V22 (care plan coordinator) said she initiated R4 plan of care and the assistive device for ambulating should be a gait belt, V22 said she don't know why she did not document what assistive device that R4 uses.

V1 (Nurse) witness statement denotes in-part, resident was being assisted by staff to restroom when resident lost her balance and was shaky and fell down with staff member.

R4 current plan of care presented by V8 (Director of Nursing) denotes safety: fall admitted in unit was observed she is high risk for falls related to current medications use, poor safety awareness, unsteady gait, disease process: sarcoidosis, CHF, alcohol use with withdrawals cognitive impairment, gait problems, such as unsteady gait, even with mobility aid or personal assistance, slow gait, takes small steps, takes rapid steps or lurching gait, hemiplegia/hemiparesis, history of falls. Contributing factors: physical/function status, ambulation; needs physical and verbal assist, poor standing balance, unsteady gait, needs assist in transfers, on and off pain/ discomfort, incontinence, needs reminders: safety awareness, prev (prevention) of fall reminders to use call light. R4 will participate during safe transfer technique with 1-2 staff assistance from bed to chair w/o (without) resistance, w/o

| 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 10/16/2024 |

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

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 7 | S9999 | | |

undetected, unrepeated incident of fall. R4 need to wear nonskid socks/shoes, proper footwear, bed locks/WC (wheelchair), locks engage for transfer, use assistive devices during ambulation to prevent falls, skilled rehab therapy eval and treatment as indicates, ensure call light, phone and supplies within reach, keep mostly needed items within reach, ensure room is clutter free and dry. SPOST (status post) fall initial intervention5/3/24 sent to hospital for eval, signage (precaution) floor mat (1), bed alarm, restorative to evaluate/referral, therapy eval.

R4 hospital records dated 9/30/24 denotes in part clinical impression closed fibula fracture.

Facility falls occurrence policy with last revised date of 7/26/24 denotes 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. The fall assessment form will be completed by the nurse or the falls coordinator upon admission, quarterly, significant change and annually. Those identified as high risk for falls will be provided fall interventions. An incident report will be completed by the nurse by the nurse each time a resident fall. The falls coordinator will review the incident report and may conduit his/her own fall investigation to determine the reasonable cause of fall. The nurse may immediately start interventions to address falls in the unit even prior to the Fall Coordinator investigation. Ultimately, the falls coordinator may change the interventions provided by the nurse if the falls investigation identifies a more appropriate intervention for the individual.

Facility care plan policy with last revised date of 7/26/24 it is the policy of the facility to ensure that

| 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 10/16/2024 |

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

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 8 | S9999 | | |

all care plans including baseline care plans are in conjunction with the federal regulations. Comprehensive care plan must be developed after the comprehensive assessment of the resident.

2. R6 face sheet shows diagnose of history of falling, unspecified dementia. R6 MDS dated 9/12/24 denotes in part, BIMS score of 7 (cognitive deficits). Section GG for functional abilities and goals denotes toileting hygiene: 03 (partial to moderate assist).

R6's final incident report to the department dated 9/17/24 denotes in-part, diagnosis COVID, hypertension, anemia, hyperlipidemia, atherosclerotic heart disease, atherosclerotic coronary artery bypass graft, GERD, prostate hyperplasia, non-infective gastroenteritis colitis, type 2 diabetes mellitus, COPD, dementia. R6 was observed lying on the floor near his bedside. Body assessment was completed, resident noted with small cut to the left side of his head. Area was cleansed with normal saline and dry dressing applied. Pain medication administration per physician order. Range was limited as patient did not want to move. BP (blood pressure) 148/76, P (pulse) 77, R(respiration) 19, T(temp) 97.6, 02 sat 95%. Physician was notified. Resident transported to hospital for further evaluation. R6 readmitted back to the facility with three staples to the left side of his head. No additional injuries noted. The plan of care has been reviewed and updated to address the resident's needs. Injury: yes, 3 staples to left side of head. When interviewed R6 stated "I got up to go to the bathroom by myself I didn't push the call light for help because I thought I could make it by myself. I took a couple steps and lost my balance landing on floor." Based upon further investigation, staff

| 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 10/16/2024 |

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

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 9 | S9999 | | |

interviews, and medical records review. Prior to the incident at 11:30 PM the assigned CNA did rounds and noted the residence in the dry and resting comfortably. At 1:50 AM upon rounds the nurse heard R6 calling out for assistance, when she entered the room, she noted R6 laying on the floor his incontinence brief was open and urine on the floor. Body assessment was completed. Resident sustained a small cut to left side of his head. Area was cleaned with normal saline and dry dressing applied. Pain medication administered. V9 was asked if R6 had the mental capacity to remember to pull call light before going to the bathroom. V9 said R6 knew how to use the call light. V9 was asked does R6 have the mental capacity to understand safety concerns and that he could injury himself if he did not press the call light and wait for staff to coma and take him to the bathroom. V9 did not respond.

Facility incident report dated 9/11/24 denotes in-part upon doing rounds resident noted on the floor near his bedside with his brief off and urine on the floor. Prior to the incident resident was noted resting in bed comfortably with no distress noted. Injury type: top of scalp. Pain:8. Oriented to person. Wet floor, incontinent, weakness/fainted, altered mental status, dementia related behaviors, fragile skin. Physician, ombudsmen, and family notified.

Facility post fall investigation/ RCA (root cause analysis) R6 is an 83-year-old male with diagnosis of unspecified dementia, history of falls, COPD, type 2 diabetes, alert, and oriented x2-3 with periods of confusion. R6 was observed by CNA in the bed at 11:30pm, resting comfortably and dry. R6 stated he had to go to the bathroom and did not pull his call light for assistance, he got out the bed independently, took a couple of steps

| 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 10/16/2024 |

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

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 10 | S9999 | | |

and that's when he fell onto the floor. R6 couldn't remember if he had any socks or shoes on and 45 minutes prior to the incident, R6 was seen in bed asleep by the nurse.

R6 admission/ readmission assessment shows call light evaluation- is the resident cognitively able to use the call light, no is checked.

R6 fall risk assessment dated 9/11/24 shows a score of 17 (high risk).

On 10/10/24 at 10:02am V9 (Fall coordinator) said R6 was admitted on 9/9/24, R6 fell on 9/11/24. V9 said R6 was admitted for rehab and due to a respiratory infection. V9 said R6 was alert times 2 (person, place) with episodes of confusion. V9 said R6 root cause of his fall was due to R6 had a fall because he got up to go to the bathroom. V9 said the incident happened around 1:50am. V9 said R6 had a sitter that was provided by the family during the day. V9 said the unit Nurse's informed her that R6's family request that R6 have a chair alarm and that R6 had previous falls at home. V9 said she provided R6 with the chair alarm. V9 said she did not follow up with the family to inquire about R6 fall history at home and why the family was requesting a chair alarm. V9 said the nurse did not give her any information regarding R6 fall history. V9 said she don't know if the nurse asked the family about R6 fall history. V9 did not respond when asked if she asked R6 about his fall history at home. V9 said she don't know if R6 was getting up at night at home when his falls occurred. V9 said she should have inquired further about R6 fall history at home and that would have helped her to implement fall interventions for R6. V9 was asked why did R6 have a sitter, V9 did not respond. V9 said the aides do rounds every two hours. V9 said

| 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 10/16/2024 |

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

| (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 |
|---|---|---|---|---|
| S9999 | | S9999 | | |

Continued From page 11

R6 daughter did not want R6 getting out of bed. V9 said she did not ask R6 daughter why she did not want R6 getting in out of bed. V9 said she don't know if it was related to R6 having falls.

On 10/10/24 at 3:13pm V30 (LPN) said she initiated R6 plan of care for falls, V30 said R6 informed her that he had previously fell at home. V30 said she did not ask R6 about his fall history, she did not gather further information to determine what R6 was doing when he fell at home. V30 said next time she will ask more questions. V30 said Resident rounds are done every two hours or as needed. V30 said incontinent care is completed during resident rounds. V30 said R6 has dementia. V30 did not respond when will R6 remember to use the call light to call for assistance.

V31 statement presented by the facility denotes in part "I started my rounds at 1130pm, Resident was in bed resting comfortably, bed in lowest position call light within reach. Around 150am while doing rounds again, I heard the nurse call for assistance. When I entered the room, I observed the resident laying on the floor diaper was opened and urine on the floor and nurse assessing the resident."

V31 statement included in facility investigation does not show that she anticipated R6 needs for using the restroom.

V31 (CNA) was called and texted on 10/10/24 at 1:45pm, 10/16/24 at 10:34, for an interview, V31 did not respond to call or text message.

R6 care plan with initiated date of 9/10/24 denotes in-part safety/fall, admitted in the unit on 9/9/24 and was observe that R6 is at risk for fall/

| 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 10/16/2024 |

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

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 12 | S9999 | | |

safety injury due to multiple medical functional, mental, and physiological conditions resulting to be at risk for falls. Contributing factor's physical function status, ambulation; need assistance in walking, poor sitting balance, poor standing balance, unsteady gait, needs assistance in transfer, pain, and discomfort. Forgetful needs reminders cues, poor safety awareness regarding prevention to use call light. Call for assistance, periods of restlessness and agitation. Newly admitted to the facility, new environment, admitted with recent decline in function, multiple aches and pains, discomfort. Provide privacy to the resident, staff to make sure bed in a lowest possible position, staff to give friendly approach to resident and anticipate needs, provide safe therapeutic environment (free from clutter), manage pain for comfort and facilitate free movement. Remind me to ask for assistance. Reorient me to how to use the call light if necessary. Please make sure that my call light is within my reach and encourage me to use it for assistance as needed. I would like staff to address my needs with prompt response to all request for assistance. Chair alarm, bed alarm, fall mat, vision/sound monitor.

R6 hospital records dated 9/11/24 denotes in 83-year-old male with history of CAD, COPD, dementia presents for evaluation for unwitnessed fall. Physical exam 2 cm left posterior partial scalp laceration. Laceration repair, two staples.

3. R5 diagnosis hemiplegia, hemiparesis following a cerebral infraction, cerebral ischemia, difficulty in walking, optic neuritis, repeated falls, retinal ischemia, glaucoma of right eye, primary open angle glaucoma of left eye severe stage, corneal edema, diabetes mellitus type 2,

| 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 10/16/2024 |

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

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 13 | S9999 | | |

pseudophakia of both eyes, branch retinal artery occlusions of right eye, ocular ischemic syndrome. R5 MDS dated 8/21/24 denoted visual impairment. R5 MDS section for functional abilities dated 8/21/24 denotes for mobility devices is documented for "no" for wheelchair use (manual or motorized). Does the resident use a motorized wheelchair or scooter, no is documented. R5 MDS dated 8/21/24 section GG for mobility devices denotes in-part check all that were normally used in the last 7 days, none of the above were used (cane/crutch, walker, wheelchair, limb prosthesis).

R5 facility final incident report to the State department dated 9/13/24 with date of incident 9/9/24 denotes in-part osteoporosis osteoarthritis, chronic pain, hyperlipidemia, polyneuropathies, anal fistulas. Other type of incident not listed here: wheelchair incident. Location of incident 500-unit hall. R5 was transporting himself in his electric wheelchair down the hall as he turned his wheelchair around to go in the opposite direction R5's wheelchair rolled over his right foot before R5 was able to stop his wheelchair. Body assessment was completed resident noted with a small abrasion to the right inner ankle. This area was cleansed with normal saline and dry dressing applied. Pain medication administered per physician order. Range of motion within normal limits. B/P (blood pressure) 127/74, P90, R18, T97.6. Physician was notified new orders received for state X-ray of right ankle right foot. Responsible party was notified. Resident transported to hospital for further evaluation and subsequently admitted. The plan of care would be addressed upon readmission. Injury: yes. Acute nondisplaced fracture at the visualized distal tibia and fibula. Final investigation/conclusion- R5 was transporting himself in his electric wheelchair

| 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 10/16/2024 |

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

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 14 | S9999 | | |

down the hall as he turned his wheelchair around to go in the opposite direction he bumped into the wall, R5 accidently rolled over his right foot with his wheelchair. When interviewed, R5 stated "I was rolling down the hallway when I bumped into the wall. I didn't feel my wheelchair rolling over my foot. I didn't even know I rolled over my foot until the staff came to assist me." Resident transported to hospital where he was subsequently admitted with right distal tibia and fibular shaft fractures. The plan of care will be addresses upon readmission.

V18 statement included with facility investigation denotes in part, "I (V18) while rounding on the 500 unit heard a boom. I observed the resident R5 right foot under his motorized wheelchair. I instantly called for help from my nurse. I told R5 to stop so we could help him because his foot was under his wheelchair. R5 told me he didn't need any help and proceeded to move his wheelchair backward rolling over his right foot again. After that my nurse arrived along with additional help. When I asked R5 where he was going because this is not his unit, he proceeded to tell me that he was just riding down the hall trying to turn around.

V29 statement denotes in part, R5 stated he was riding in his wheelchair and his leg dropped and he ran over his foot.

R5 physical therapy discharge summary, with discharge date of 6/13/24 denotes in-part current reason for referral patient referred to skill PT (physical therapy) intervention for motorized wc (wheelchair) mobility training. LTG (long term goal) 2 IND (independent) with manual wc (wheelchair) but is SUP (supervision) with motorized (wc) wheelchair management and

| 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 10/16/2024 |

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

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 15 | S9999 | | |

operations for safety. Education and instruct on safety precautions and how to maneuver his motorized wc. Performed really well but will need SUP with his wheelchair to better carry over of safety instructions regarding motorized wheelchair. Treatment results communicated with interdisciplinary team. Discharge recommendations- recommend to continue with restorative nursing therapy for wc (wheelchair) management.

R5 incident report dated 2/6/24 denotes in part writer was notified by resident that he hit his leg on the wheelchair ramp with his wheelchair after his appointment at u of c medicine. R5 stated he was moving his wheelchair into the medicar and ran his wheelchair into the ramp and hit both his legs when getting in the van.

On 10/9/24 at 10:58am V18 (CNA) said she was in a resident's room, when she heard a boom sound and she came out the room, and observed R5 in his motorized wheelchair, the wheelchair against the door. V18 said R5 hit the one of the double doors that was open. V18 said R5 right foot was observed behind the wheel of his motorized wheelchair. V18 said she said told R5 "wait let me help you" R5 said he did not need help and R5 rolled over his right foot again, trying to turn around. V18 said she summons the nurse and the nurse arrived to assess R5. V18 said R5 complained of pain after rolling over his foot the second time. V18 said R5 leg rest was up and R5 right foot was behind the leg rest, and behind the wheels of the chair. V18 said she had never seen R5 leg in that position. V18 said she is familiar with R5, R5 would complain of visual problems during activities. V18 said she used to be an activity aide. V18 said she believed R5 had trouble seeing. V18 said she don't recall if R5

| 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 10/16/2024 |

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

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 16 | S9999 | | |

wore glasses. V18 said she don't recall if R5 had on glasses on the day of the incident. V18 said she summons the nurse.

On 10/9/24 at 2:38pm V23 (Physical therapist) said R5 was referred to physical therapy for wheelchair training. V23 said he don't know why R5 needed wheelchair training. V23 said R5 did mention to him that he could see shadows and could not see details V23 said he did not report to anyone in the facility that R5 complain of not being able to see details and saw shadows. V23 said he dropped the ball. V23 said R5 could not see the power on and off button on the wheelchair, R5 was able to steer the wheelchair. V23 said he worked on steering, turning, and going around tables with R5. V23 said the recommendations upon discharge was independence with manual wheelchair and supervision for motorized wheelchair. V23 said supervision for R5 was that staff should walk along side R5 while he steers the wheelchair. V23 said it's for safety so that R5 does not bump into things. V23 said when the staff walk alongside R5 it's considered contact guard and not one on one. V23 said R5 could not see the power on/ off button on the wheelchair. V23 was asked how is R5 safe to use a motorized wheelchair if he saw shadows/ visual impairment and needed someone to walk along side of him. V23 did not respond. On 10/10/24 V23 followed up with surveyor and said R5 was safe to use a motorized wheelchair.

On 10/9/24 at 1:52pm V11 (Restorative Nurse) said R5 was referred to physical therapy for wheelchair management and safety in May 2024. V11 said R5 was not in any restorative programs for motorized wheelchair safety after discharging from physical therapy in June 2024. During a

| 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 10/16/2024 |

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

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 17 | S9999 | | |

follow up interview V11 said R5 sustained an injury in his motorized wheelchair, that's why he was referred to physical in May 2024.

On 10/11/24 at 2:30pm V8 (Director of nursing) said eye contact was the intervention implemented to reduce the risk of injury for R5, when R5 used his motorized wheelchair. V8 said there was staff present when R5 ran into the door with his motorized wheelchair. V8 said the eye contact was an effective intervention for R5. V8 was asked how was "eye contact" an effective intervention for R5, and R5 ran into an open door and broke his right leg. V8 said the staff could not get to R5 fast enough. R5 previous incident reviewed with V8, V8 discussed R5 bumped into the ramp of the vehicle and injured his left leg. R5 history of visual impairment was discussed with V8, V8 said R5 could see. V8 was asked how did R5 run into an open door if he did not have any issues with his vision. V8 said it was an accident, accidents happen. V8 said R5 did not go to his appointment to check his visual field. V8 omitted reason why R5 did not go to his appointment to check his visual field. V8 was asked why did R8 need an exam to check his visual field if he did not have visual impairment. V8 said residents have rights, and R5 wanted to use his motorized wheelchair. R5 physical therapy recommendation reviewed with V8 denoting that R5 was independent with manual wheelchair and supervision with motorized wheelchair. V8 continue to say R5 was a proud man and he begged her to use his motorized wheelchair, after the motorized wheelchair was removed from R5 use after R5 incident of running into a vehicle ramp in February. V8 said R5 did not have a care plan in place for the motorized wheelchair, and R5 did not have a care plan in place for the supervision while using a motorized wheelchair.

| 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 10/16/2024 |

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

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 18 | S9999 | | |

V8 said she does not know why R5 did not have a care plan in place for the motorized wheelchair and supervision.
V8 omitted discussing risk and benefits with use of motorized wheelchair for R5. V8 suggest surveyor request the consultation for R5 optometrists visit.

R5 after visit summary from the eye clinic shows R4 had an appointment on 8/14/24 for visual field and return appointment for the eye doctor. V8 said R4 did not go to the follow up appointment with the eye doctor and the visual field.

R5 hospital records dated 9/9/24 denotes in part comminuted right tibia shaft fracture, comminuted right distal tibia fibula fracture, comminuted left tibial plateau fracture.

Facility care plan policy with last revised date of 7/26/24 it is the policy of the facility to ensure that all care plans including baseline care plans are in conjunction with the federal regulations. Comprehensive care plan must be developed after the comprehensive assessment of the resident.

4. R1 diagnosis include but not limited to Alzheimer's Disease, History of Falling, Unsteadiness On Feet, Repeated Falls, Scoliosis, Age Related Osteoporosis, Dementia, Mood Disorder, Generalized Anxiety Disorder.

Fall with Injury report dated 9/17/24 stated R1 observed laying on floor. Facility Final Incident Report stated 9/25/24 states R1 transported to hospital for evaluation. R1 return to the facility with 8 sutures to forehead and a closed nondisplaced fracture of second metacarpal bone of right hand.

| 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 10/16/2024 |

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

| (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 |
| --- | --- | --- | --- | --- |
| S9999 | Continued From page 19 | S9999 | | |

R1 fall without injury dated 7/16/2024 notes R1 on the floor. R1 stated she was trying to transfer herself from wheelchair to bed. Root cause analysis states R1 was trying to get back in bed.

On 10/5/24 at 10:41AM R1 in regular wheelchair, no pommel cushion, R1 wearing black slacks. R1 crescent shape bruise, yellow/light blue under right eye, right arm dressed in what looks like a white ace wrap.

On 10/8/24 at 11:05AM V3, Registered Nurse (RN), said on 9/17/24 R1 was in the wheelchair. V10, CNA, said she got R1 up for lunch and she was eating in her room. V3 said V10 said she left the room to care for another patient. V3 said V10 said she left R1 alone about 10 minutes. V3 said R1 said she did not know what she was trying to do when she fell. V3 said R1 probably fell forward. V3 said R1 was a resident at risk for falls.

On 10/8/24 at 12:22PM V10, Certified Nursing Assistant (CNA), said on 9/17/24 I got R1 up for lunch and sat her at the side of the bed, with her tray table. V10 said after R1 ate I picked up her tray and went to the bathroom and then I stopped by another resident's room. V10 said in that time a co worker came and told me R1 was on the floor. V10 said the Nurse and coworker were in R1's room when I got there. V10 said when I left the room R1 had been sitting in the wheelchair. V10 said R1 had one cushion in her wheelchair at the time. V10 said I was in the room with R1 while she ate and after I got her tray I left her alone. V10 said I am not sure if R1 could sit in her room alone. V10 said I knew she was a fall risk.

On 10/8/24 at 12:09PM V6, CNA, said R1 has

| 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 10/16/2024 |

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

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 20 | S9999 | | |

confused memory. V6 said R1 is a two person assist for transfer and she can be resistant. V6 said R1 can stand. V6 said I would not recommend R1 be left in her room in her wheelchair alone because she tries to get up unassisted. After interview V6 showed the surveyor R1 sitting on royal blue pommel cushion during meal. Surveyor observed R1 also sitting on black wheel chair cushion. V6 with ace bandage on right wrist. (R1 had not been on this cushion during earlier observation.) At 12:55PM the surveyor observed R1 with only the one blue pommel cushion, the black one had been removed.

On 10/8/24 at 1:03PM V9, Fall Coordinator, said R1's intervention since the July fall is to not leave her alone in the room when in her wheelchair. V9 said R1's 2nd fall (9/17/24) they left her in the room and when staff returned R1 was on the floor. V9 said they should have taken R1 to activity and not left her alone in her room. V9 said we place the interventions on the care plan. V9 said I don't put the dates on the careplan interventions.

R1 fall report on 7/16/24 stated R1 mental status confused, alert and oriented times one, poor safety awareness. R1 attempting to stand/transfer without assistance. Root cause analysis of fall states R1 stated she was trying to get back in bed when she fell.

R1's safety fall care plan initiated on 9/12/22 includes risk factors of poor sitting balance, poor standing balance, poor safety awareness, unsteady gait, and needs assistance in transfer. Interventions dated 9/12/24 include therapy evaluation, floor mats, pommel cushion.

| 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 10/16/2024 |

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

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 21 | S9999 | | |

R1's hospital emergency department record dated 9/17/24 reads, noted to have large laceration to head. Laceration repair performed to 3cm laceration on forehead, 8 sutures.

R1's hospital emergency department record dated 9/19/24 states R1 presenting for evaluation of right hand pain. Sent back for evaluation of right wrist pain that has been going since her fall 2 days ago. Right wrist and right hand x-rays an acute nondisplaced oblique fracture involving the proximal metadiaphysis of the right second metacarpal.

5. R2 diagnosis include but are not limited to Alzheimer's Disease, Dementia, Hallucinations, and Encounter for Palliative Care.

R2 incident report dated 9/19/24 at 3:00AM states writer heard a thump, upon investigation, R2 observed sitting on the floor. Post fall investigation notes R2 was attempting to get out of bed. R2 alert, poor safety awareness. Root Cause Analysis states a summary of the fall. R2 was unable to explain the nature of the incident. Interventions to address incident noted perimeter cover and room change close to the nurses station. Actual cause of the fall is not included.

On 10/10/24 at 10:09AM V12, CNA, said on 9/19/24 the last time I saw R2 she was asleep in the bed. V12 said when I saw R2 on the floor she was sitting with her legs up, with squatting legs, looked like she was trying to get up. V12 said R2 was in the middle of the room, between the beds. R2 was barefoot, she was not on the floor mat. V12 said I had never had R2 try to get up before. V12 said R2 is usually a check and change at night. V12 said I didn't think R2 could walk. V12 said I had not worked with her again. V12 said to

| 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 10/16/2024 |

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

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 22 | S9999 | | |

my knowledge R2 had not fallen before.

On 10/4/24 at 2:00PM R2's bed observed in her room. Air mattress in use and white flat sheet.

On 10/8/24 at 12:55PM R2 bed observed, no ridged/lipped mattress on the bed. Air mattress in place, pump at foot of the bed.

On 10/8/24 at 11:20AM V4, CNA, said R2 requires total care to get into her reclining chair. V4 said once she is up she is to come out to a supervised area. V4 said R2 is a fall risk, she scoots to the edge of the bed.

On 10/8/24 at 1:57PM The surveyor asked V15, Licensed Practical Nurse (LPN), to show R2's perimeter cover. V15 looked in the computer and paper and was unable to answer. V14, Medical Records, walked to R2's room with the surveyor. V14 removed the covers on R2's bed and presented only the air mattress. V14 said the perimeter covers need to be brought to the unit when needed. V16, Clinical Manager, approached and surveyor asked if R2 is supposed to have a perimeter cover. V16 went to get a list and said R2's name is on the list and yes she should have one. V16 showed the surveyor what a perimeter cover looks like. Perimeter cover has raised bolster like areas along the head of the bed and foot of the bed. On the surveyors observations 10/4/24 and 10/8/24 R2's bed did not have the device in place.

On 10/9/24 at 11:52AM V9, Fall Coordinator, said after R2's fall on 9/6/24 we had got a new bed that goes lower to the floor than her prior bed. On 9/19/24 R2 had a fall. V9 said they probably removed her socks. V9 said proper footwear can be shoes or non-skid socks. V9 said on 9/6/24 R2

| 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 10/16/2024 |

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

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 23 | S9999 | | |

has a 15 fall risk score, it means she is a high fall risk. V9 said the interventions for R2 were not effective to prevent an injury on 9/19. V9 said the perimeter cover was added after R2's fall on 9/19/24.

R2's care plan date initiated 1/9/24 states if resident is ambulating staff to make sure that resident is wearing proper footwear. Interventions include low bed, fall mats, and perimeter cover.

R2 was high fall risk with a score of 15 on 9/6/24. R2's cognition assessment on 9/5/24 score is 6, severely impaired. R2 Functional Abilities assessment dated 9/5/24 states she is dependent on staff for eating, toileting, bathing, dressing, personal hygiene, and rolling when in bed. Walking and transferring was not attempted.

R2 fell on 9/6/24 at 7:45AM. R2 observed sitting on the floor at the foot of the bed. Post fall investigation states R2 was attempting to get out of bed, was confused, poor safety awareness, R2's last fall was 8/21/24. Root cause analysis notes R2's diagnosis, BIMS score 6, alert times 1. R2 observed in a sitting position on the floor by her bed. R2 was unable to recall the nature of the incident. Intervention notes low bed (hospice). Actual cause of fall is not included.

R2's hospice records reviewed. Medical equipment provided does not include the mattress perimeter cover.

Employee statement dated 9/19/24 written by V17, LPN, reads R2 was bare foot when she fell.

R2's hospital record states has a 3cm laceration above her right eye. Laceration repair performed on 9/19/2024 for 3cm length laceration to right

| 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 10/16/2024 |

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

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 24 | S9999 | | |

eyebrow region, 6 sutures.

6. R8 diagnosis include but are not limited to End Stage Renal Disease, Malignant Neoplasm of Bronchus, Anemia in Chronic Kidney Disease, Depression, Anxiety, Chronic Right Heart Failure, Cirrhosis of Liver, Arthritis, Adult Failure to Thrive, Dependence on Renal Dialysis, and Difficulty in Walking.

The facility Incident Report initial date 9/25/24; final dated 10/1/24 states R8 received sutures to his right eyebrow. On 9/25/24 at 00:30AM R8 observed on the floor on front of his walker near his bed. Noted with an open area to his right eyebrow. R8's cognition score is 11/15. R8 said I got up from my bed with a walker in the dark to walk to the bathroom. I tripped over a wheelchair and fell hitting my head and face on the floor. According to assigned CNA, around 10:20PM R8 was toileted and made comfortable in bed.

On 10/15/24 at 11:13AM V24, CNA, said R8 was in bed asleep, I rounded on him about 10:45PM him and all his room mates. V24 said I sat down at the nurses station, the call light came on, when I went in the room I saw R8 on the floor with the walker by his side. V24 said R8 said he was walking to the washroom, I called the nurse, and she came in. V24 said the room mate had called with the call light. V24 said R8 was by bed one and bed two at the foot of the roommates' bed. V24 said R8 had not made it to the bathroom. V24 said we put him in the bed 911 was called and they came and got him. V24 said R8 was not wet when we found him. V24 said R8 had a bowel movement after he was in the bed. V24 said I was not assigned to R8. V24 said before that day, there are times, I had seen him in the bathroom calling for assistance with the call light. V24 said I

| 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 10/16/2024 |

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

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 25 | S9999 | | |

had not taken R8 to the bathroom on my shift, he was in bed asleep when I last saw him. V24 said my shift started at 2:30PM, I did a double.

On 10/15/24 at 2:42PM V25, LPN, said R8 had his walker in front of him. V25 said the CNA, V24, notified me of the fall I was getting ready to go have lunch. V25 said the walker on the floor was the walker that was in his room. V24 said R8 had been using that walker before by himself. V25 said R8 had walked with that walker to the nurses' station to get snacks on other days. V25 said R8 was on the floor, right in front of the bathroom door. V25 said there were a couple of wheelchairs in the room. V25 said I didn't see a wheelchair that he said he tripped on. V25 said R8 said when he was turning he went down. V25 said I assume the room mates called for help, but I didn't ask them anything.

On 10/15/24 at 1:41PM V16, Unit Manager, said I helped R8 in a wheelchair. V16 said I never seen R8 walking with nursing. V16 said R8 was in a dialysis chair and I am not aware of R8 having a walker.

On 10/15/24 at 12:39PM V26, Director of Rehab said R8 had diminished strength and endurance. V26 said R8 was non ambulatory with physical therapy because he had a lot of pain with range of motion and bed mobility. V16 said R8 used a manual wheelchair with supervision. V26 said therapy did not give R8 a walker because R8 could not even stand. V26 said therapy never gave R8 a walker and we (therapy) would have been the ones to give it to him. V26 said if restorative gave R8 a walker we would have been asked to assess him for the need. V26 said we never leave assistive devices in the room, unless it is someone who has been here long term. V26

| 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 10/16/2024 |

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

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 26 | S9999 | | |

said if we leave a walker in the room then we would say it is safe for the resident to use. At 2:28PM V26 provided the evaluation and plan of treatment for R8. V26 said R8 was unable to ambulate and he was disoriented when I attempted to screen after admission (period of 9/6/24-9/25/24). I attempted to screen R8 multiple times. V26 said R8 told us he was able to walk and take care of himself. During treatment we saw R8 was unsafe for a lot of physical therapy things and he had poor endurance even to sit up. V26 said when we had the care plan and we spoke with the family they said he was mainly here for therapy. V26 said the family said R8 was needing assistance with care. V26 said on R8's evaluation the goal was for R8 to ambulate 50 feet with a walker, but due to his safety and medical condition he couldn't even stand. V26 said when the evaluation states "not attempted due to medical conditions or safety concerns" it means R8 could not stand that was for transfers and gait. V26 said my goal for R8 was to spread out his therapy to prevent. V26 said R8's posture was poor, he couldn't even tolerate sitting. The surveyor asked if the staff should have been allowing R8 to walk without assistance? V26 said R8 should not have been walking.

On 10/15/24 at 12:29PM V9, Fall Coordinator, said R8 got up in the dark to go to the bathroom attempting to take himself. V9 said V24 was the aid and she had taken him to the bathroom earlier. V9 said when R8 was taking himself he tripped over a wheelchair. V9 said I don't know who's wheelchair he tripped on. V9 said R8 needed assistance of 1 to ambulate. V9 said R8 had not received a urinal before so we gave him one and a nightlight. V9 said I am not sure if R8 was needing to have a bowel movement or urinate at that time. At 1:03PM during a follow up

| 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 10/16/2024 |

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

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 27 | S9999 | | |

interview, V9 said R8 tripped over the roommates wheelchair and hit his head. V8 said the Therapy Department gives the ambulation status and assistive devices. V9 said I gave R8 a urinal after the fall, when he came back from the hospital (10/1/24). V9 said I don't know if R8 had a urinal in the room the night of the fall. The surveyor asked if the resident tripped on a chair, how was his path free of clutter. V9 did not answer.

Physical Therapy Evaluation and Plan of Treatment record dated 9/12/24-10/11/24 states R8 Transfer and Gait goals were not attempted due to medical conditions or safety concerns. Precautions listed fall/safety risk intense low back and right thoracic area with movements. Dialysis. Bed mobility sit to lying and lying to sitting on side of bed not attempted due to medical conditions or safety concerns (unable to perform due to intense back and right thoracic pain with movement.

R8's Medication Administration Record for September 2024 includes Amiodarone (cardiac anti-arrhythmic drug) start dated 9/10/24 and Sertraline (Antidepressant) start date 9/7/23.

R8's Restorative assessment (UDA) dated 9/6/24 states requires assist with ambulation and transfer. Adaptive Equipment notes Walker (therapy said they did not give R8 a walker). R8 is one person assist for transfer. Fall risk score is not documented on this form. Medications listed on Fall Risk Evaluation list no for antidepressants. Mobility the resident is able to walk with assistant and/or assistive devices: yes. The residents gait is steady

R8's care plan initiated on 9/6/24 Safety/ Fall R8 is at risk for fall due to multiple medical, functional, mental and physiological condition

| 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 10/16/2024 |

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

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 28 | S9999 | | |

resulting to be at risk for fall. Ambulation: needs assist in walking, poor sitting balance, poor standing balance, unsteady gait, needs assistance in transfer, pain and discomfort. Forgetful needs reminders. Poor safety awareness regarding preventions to use call light. Period of restlessness and agitation. Interventions dated 9/6/24 include: Use assisted device during ambulation to prevent falls (therapy said R8 can not walk). Keep needed items, like urinal within reach (9/6/24) and staff to provide a safe environment free of clutter (9/6/24).

Employee Statement dated 9/25/24 for V24, CNA, notes Yes I am the assigned CNA for the resident. (V24 said I was not assigned to R8.)

R8's incident report dated 9/25/24 at 12:30AM stated observed on floor face down in room next to walker. Active bleeding to right eyebrow. R8 stated I fell trying to go to the washroom. I tripped. Laceration right eyebrow. R8 incident factors note ambulating without assist, using walker, toileting needs.

R8 Post Fall Investigation for the fall on 9/25/24 notes R8 ambulating independently, has poor safety awareness, poor lighting, R8 not at risk for falls. R8 was toileted at 10:20PM, last seen in bed at 11:40PM by his CNA. R8 said I had to go to the bathroom. I got out of bed using a walker in the dark and tripped over a wheelchair. I fell and hit my face and head on the floor. I was feeling weak. Interventions to address incident: Night light and urinal. Date completed 9/25/24 (same day as the fall).

The facility Incident Report initial date 9/25/24; final dated 10/1/24 states R8 the wheelchair the R8 tripped on was identified as the roommate's

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6007322 | A. BUILDING: ______<br>B. WING ______ | C<br>**10/16/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **AVANTARA EVERGREEN PARK** | **10124 SOUTH KEDZIE**<br>**EVERGREEN PARK, IL 60805** |

| (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 |
|---|---|---|---|---|
| S9999 | Continued From page 29<br>wheelchair, which was properly adjacent to the roommate's bed, not posing a hazard. R8 received sutures (No procedure report was included in the hospital record and no count of sutures was documented in R8's electronic record.) to his right eyebrow.<br><br>(A) | S9999 | | |