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	IL6010912	A. BUILDING: ______ B. WING ______	C 01/29/2024

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AVANTARA PALOS HEIGHTS	7850 WEST COLLEGE DRIVE PALOS HEIGHTS, IL 60463

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S 000	Initial Comments Facility Reported Incident of 12/31/23/IL168565	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)2)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. 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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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:

2) All treatments and procedures shall be administered as ordered by the physician.

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 have effective interventions in place to monitor/supervisor a resident identified to be high risk for falls. This affected one of four residents (R1) reviewed for fall prevention. This failure resulted in R1 falling from wheelchair on 12/31/23 while in dining/group room, R1 complained of right-hand pain. On 1/2/24 R1 Xray showed 5th metacarpal fracture with mild displacement, R1 sent to hospital for evaluation and treatment.

Findings include:

R1 face sheet shows R1 has diagnosis of displaced fracture of base of fifth metacarpal

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bone (12/31/23), right hand unspecified dementia with other behavioral disturbance, other specified muscle disorders, Parkinson's disease without dyskinesia, hypertension, orthostatic hypotension, repeated falls.

R1 radiology report dated 1/2/24 denotes in-part procedure - hand 2V (views) pain in right hand, findings-fifth metacarpal fracture with mild displacement, soft tissue appears swollen. Acute appearing fifth metacarpal fracture.

Facility final report to the department dated 1/8/24 denotes in-part: "Prior to the fall around 2:30 pm, resident was noted sitting in the dining room watching TV with chair alarm in place and functional. Few minutes later, staff responded to the alarm sounding and observed resident sitting in the dining room on his buttocks in front of the wheelchair. Resident unable to say what he was trying to do at the time of the fall. Resident assessed for injury and safety. Full body assessment completed with resident complaining of right shoulder and wrist pain. No discoloration or swelling observed. Doctor was notified of the fall with orders for STAT x-ray of right shoulder, elbow, and wrist. X-ray results received on 12/31/2023 and showed no acute fracture or dislocation, degenerative changes only. Resident medicated for pain with scheduled and PRN medication with relief. He was monitored by staff post fall. Today, 01/02/2024, resident was noted with swelling to right hand fingers and discoloration to the right hand. Nurse Practitioner was present on the unit and assessed the resident. STAT x-rays to right hand and fingers were ordered with result showing right hand 5th metacarpal fracture with mild displacement. Resident denies pain upon assessment; area was immobilized. Nurse practitioner notified of the

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S9999	Continued From page 3 results and ordered to send resident to ED for further evaluation and treatment. Wife notified of orders and present in the facility at this time. Resident still in the emergency room at the time of the reporting. Staff interviews were conducted, and clinical review was completed by the Director of Nursing. Resident was re- admitted to the facility on 12/22/2023 for short -term rehabilitation from (hospital name) after he was discharged home from skilled nursing facility and fell at home. He has PMH of metabolic encephalopathy, Parkinson's disease, repeated falls, dementia, insomnia, depression, orthostatic hypotension, HTN, benign prostatic hyperplasia, disorder of muscle, history of Covid, history of UTI and dysphagia. Per wife and hospital records patient's Parkinson's disease has been getting progressively worst over months and she reports that resident has multiples falls at home. Resident saw neurologist couple weeks ago, who referred him to the specialist for 2nd opinion and has an appointment after discharge back to the community. Resident is alert, oriented x 2 with periods of forgetfulness and very poor safety awareness. His BIMS is 13/15. He requires partial/moderate assistance with most ADL care. Per therapy notes, he is able to ambulate 50 feet with moderate assistance, but his gait is very unsteady due to Parkinson disease. He is incontinent of B/B, but able to make his needs known to staff. Resident is repeatedly observed by staff trying to get up and ambulate on his own. He is not accepting his limitations and progressive illness and often overestimates his physical abilities. On 12/31/2023 resident was noted sitting in the dining room watching TV with chair alarm in place and functional. Wife visited in the morning and left prior to the incident. Around 14:30 staff was at the door of the dining room and heard chair alarm sounding. Patient attempted to	S9999		

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walk and fell in front of his wheelchair. Resident was immediately assessed for injury and safety. He complained of right shoulder, wrist, and hand pain and after serious of x-rays he was diagnosed with right hand 5th metacarpal fracture with mild displacement. 01/03/2024, resident returned from (hospital name) emergency department with orders to follow up with (proper name) Orthopedics- (Doctor proper name). Appointment scheduled for Monday, 01/08/2024. He has immobilizer in place. NWB (non-weight bearing) status to right hand until ortho appointment. Resident is receiving scheduled Norco for pain with relief. Wife is aware of all orders. Based on the investigation, prior to the fall, staff provided necessary care for the resident, including incontinence care. He has been clean and dry at the time of fall and had his shoes on. He was sitting in the dining room, watching TV and within staff sight with chair alarm in place and functional. Care plan updated. MD and wife were updated and agreeable of current interventions. Full investigation completed, no abuse or neglect substantiated."

On 1/27/24 at 1:08PM V1 (LPN) said on 12/31/23 she heard R1's chair alarm sounding and residents saying "it's R1 he fell", V1 said she and V3 went into the dining room, and she observed R1 sitting on the floor on his buttocks, R1 complained that his right hand hurt. V1 demonstrated the right hand below the wrist. V1 said she notified the provider, and the provider gave orders for Xray of the right shoulder, right arm, and right hand. V1 said she doesn't remember giving R1 anything for pain. V1 explained it was toward the end of the shift and she was helping the other nurse V2 (LPN). V1 said she and V3 (RN) lifted R1 up using the mechanical lift and placed R1 back in the chair.

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V1 said she assessed from R1 head to toe. V1 said she placed R1 at the nurse station for monitoring. V1 said there was no aide in the dining room when R1 fell. V1 said the aide had left and did not wait for her relief. V1 said it was only a couple minutes. V1 explained that a fall can happen quickly, V1 explained that R1 has a lot of falls, and "it's like as soon as the staff turn their back, R1 falls." V1 said the aides are in the dining room to monitor/supervise the residents and high fall risk resident. V1 said they monitor the residents to try and prevent them from falling, or so that they can intervene if the resident is trying to get out the chair. R1 X-ray dated 12/31/23 reviewed with V1, V1 verified there was not an Xray completed for the right hand but instead the right wrist. V1 explained that when the technician takes the images of the wrist the hand is placed down, and she thought that the entire right hand would be X-rayed. V1 said the report does not denote that R1 right hand was X-rayed, there are no results for the right hand.

On 1/27/24 at 3:04PM V3 (RN) said on 12/31/23 she was in the office when she heard commotion and she went to the area of the commotion. V3 said when she got to the dining room, she observed R1 on the floor, in a sitting position. V3 said she assisted with lifting R1 with the mechanical lift and placed R1 in the wheelchair. V3 said V1 took R1 away for assessment. V3 said she stayed in the dining room to monitor the residents because there was no aide there to monitor. V3 explained the shift was changing.

On 1/27/24 at 12:35pm V2 (LPN) said she was the R1's Nurse on 12/31/23 when R1 had the first fall and second fall. V2 said V1 handled the first fall because she was managing another situation with another family. V2 said V1 informed her that

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R1 had a fall in the dining room during shift change. V2 said V1 informed her that R1 had an injury of bruising to the head and swelling or pain to the hand. V2 said she was not sure if it was the right or left hand. V2 said when R1 had the second fall she was summons to the dining room by the aides. V2 said when she got there, R1 was back in his chair. V2 said she don't know how R1 got back in the chair. V2 said R1 complained of right-side rib pain. V2 said she observed R1 right hand swollen and bruising to the forehead. V2 said she did her assessment and placed R1 at the nurse's station for monitoring. V2 said she was not concerned about the bruise to the head and swelling to the hand because that happened on the first fall, it was not due to the second fall. V2 said she doesn't remember what the aides said about how they got R1 back into the chair. V2 said she doesn't remember who the aides were that was in the dining room for the second fall.

On 1/27/24 at 3:28PM V4 (fall coordinator) said the root cause of R1's falls are due to R1 being impulsive. V4 said R1 is a high fall risk. V4 said R1 had 20-22 falls at home and that's why he was admitted to the facility. V4 said R1 fell in the bathroom on 12/26/23 when he got up from the commode and tried to walk to the sink to wash his hands. V4 said the aide was on the other side of the door and when she heard the noise she went into the bathroom and observed R1 on the floor. V4 was asked who assisted R1 with peritoneal care, who helped R1 pull his clothes up. V4 said she doesn't know if R1's clothing was down when the aide found R1 on the bathroom floor. V4 said the intervention is to maintain visual supervision while using the bathroom to prevent falls. V4 said R1's second fall was on 12/29/23 and R1 was assisted to the floor by staff. V4 said

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S9999	Continued From page 7 the aide was in the dining room, however the manager on duty was speaking to the aide and back was to R1 so she could not see R1. V4 was asked how the monitoring is effective if the aide is distracted by the conversation with the manager. V4 said the aide is in the dining room to monitor residents, to keep a visual on the residents to intervene if the resident tries to get up from their chair. V4 explained R1 is impulsive, and R1 will wait until no one is looking and try and get up from the chair. V4 said first fall on 12/31/23 was due to R1 impulsive behaviors. V4 said staff was in the dining room when R1 fell from the wheelchair and his hands went out in front of him. V4 said she thinks staff said they were in the dining room. V4 said R1 complained of pain to the right hand and the physician ordered and Xray of the right hand, right shoulder, and right arm. V4 reviewed the Xray report of 12/31/23. V4 said she doesn't see that an Xray of the right hand was completed. V4 said the Xray on 1/2/24 showed R1 had a fracture of the right fifth metacarpal. V4 said the Xray of the right hand should have been completed on 12/31/23 as ordered by the physician. V4 said R1 second fall on 12/31/23 occurred in the dining room also. V4 said R1 was agitated that his wife had left for the day and fell from the wheelchair. V4 said staff was there and assisted R1 back to the wheelchair. V4 was asked how the monitoring and supervision is effective if R1 continues to fall in the presence of the staff. V4 said R1 doesn't like staff too close to him. V4 said the facility is doing everything they can for fall prevention. V4 said R1 discharged on 1/22/24 and R1 last fall was 1/8/24. V4 was asked if the facility reviewed the records and noted that R1 had 20-22 falls at home, how did the facility plan for this admission and develop fall interventions. V4 said R1 had a lot of interventions in place. V4 said part of the	S9999		

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S9999	Continued From page 8 issue is that R1 wants to keep his independence. On 1/27/24 at 4:50pm V6 (Director of Nursing) said the facility can't offer 1 to 1 monitoring more than 48 hours. R1 fall risk evaluation dated 12/31/23 denotes a score of 19 (high risk for falls). R1 fall incident report dated 12/31/23 at 4:03pm completed by V2 denotes in-part informed by second nurse and CNA that an unwitnessed fall occurred in the group room. Resident unable to give description. Resident had second fall, an hour later this time complaining that his head hurts, his wrist hurts and his back hurts, MD (medical doctor) aware initial orders for Xray of right hand from initial fall. R1 comprehensive Plan of Care present by V6 (Director of Nursing) with initiated date of 12/23/23 denotes in part, R1 is high risk for falls related to difficulty maintaining standing position. Fatigue, weakness, gait problem, such as unsteady gait, even with mobility aid or personal assistance, slow gait, takes small steps, takes rapid steps, or lurching gait, Impaired balance during transitions, Incontinence, Muscle weakness, other dementia, Parkinson's disease, Recent fall in last 2-6 months. Recent fall in last month. Use of Other medications that cause lethargy or confusion. R1 will resume usual activities without further incident through next review initiated 12/26/23. Interventions denotes, bed/chair alarm to alert staff when resident attempts to get out of bed unassisted, so staff can assist resident and prevent falls. Ensure patient is using leg rest for wheelchair. Ensure that R1 is wearing appropriate footwear (Specify and describe correct client footwear i.e., brown	S9999		

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S9999	Continued From page 9 leather shoes, tartan bedroom slippers, black non-skid socks) when ambulating or mobilizing in w/c. Ensure that R1 is able to use the call light. If the light is difficult to press, consider giving him a foam pad call light or other adaptive call lights. Ensure that R1 visitors are aware of the use of assistive and adaptive devices. Frequently remind R1 to ask for assistance to stand or transfer to prevent falls. I would like PT/OT to evaluate and treat me as ordered to increase my strength and mobility and prevent further falls. Instruct spouse to activate call light prior to leaving room during visitation to prevent falls, so resident can be brought to common area for monitoring. Keep all needed items like water pitcher, tissue box, urinal, etc. within R1 reach. Maintain visual supervision while using bathroom to prevent falls. Offer R1 toileting at bedtime and when he is up at night. Offer toileting at bedtime and when patient is awake at night. Patient to stay in common supervised area when visitors are not present or when patient is awake. Place chair alarm in wheelchair. Provide me with activities to minimize the potential for falls while providing diversion and distraction to prevent falls. Room moves closer to the nurses' station for closer observation. 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 a prompt response to all requests for assistance. R1 medical provider progress notes dated 12/30/23 denotes in-part- note is previous and discussed with the staff to monitor closely for any issue or concerns including fall prevention. Overall looks comfortable. Fall precaution/skin care and other preventive measures per facility policy.	S9999		

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R1 progress note dated 1/2/24 denotes in-part send to (hospital name) ER (emergency room). R1 change in condition progress note dated 1/2/24 denotes in-part the change in condition, symptom or signs observed and evaluated is /are fracture to right metacarpal.

R1 progress note dated 1/3/23 denotes in-part patient returned from ER, bed alarm in place and functioning, no s/s (signs/ symptoms) of distress, ACE wrap to right fourth and fifth finger.

R1 physician progress note dated 1/3/24 denotes in-part fell and had been to the ER, noted with fifth digit fracture and will be given a splint to assist with healing and pain control and fall prevention discuss with RN.

Facility policy titled Fall occurrence with last revised date of 7/17/2023 denotes in-part it is the policy of the facility to ensure that resident is assessed for risk for falls, that interventions are put in place, and interventions are revaluated and revised as necessary.
Facility policy titled general care with last revised date of 7/28/23 denotes in-part it is the facility's policy to provide care for every resident to meet their needs.

Facility policy titled care plan with last revised date of 7/27/23 denotes in-part it is the policy of the facility to ensure that all care plans including baseline care plans are in conjunction with the federal regulations. After the comprehensive assessment is completed, the facility will put in place person centered care plans outlining care for the resident with-in 7 days. These will be periodically reviewed and revised by a team of qualified person after each assessment.
On 1/27/24 during survey tour staff was observed

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S9999	Continued From page 11 in dining room when residents were present. At 238pm when first shift was over V5 (activity aide) observed in dining room/group room with residents. Aides were observed giving report to the oncoming aides. (B)	S9999		