

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014138	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LAKE ZURICH	STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH RAND ROAD LAKE ZURICH, IL 60047
---	---

(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 FRI of 2/15/2024/IL170452	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999		

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/14/24
---	-------	------------------------------

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014138	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LAKE ZURICH	STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH RAND ROAD LAKE ZURICH, IL 60047
---	---

(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	<p>Continued From page 1</p> <p>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:</p> <p>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.</p> <p>These Requirements were NOT MET as evidenced by:</p> <p>Based on interview and record review the facility failed to ensure a resident with a history of falls and right sided weakness was safely transferred. This failure resulted in R1 sustaining a fall, hitting her head on the bedside table, and falling on her left side during a transfer. R1 was sent out to the local hospital and CT showed acute displaced fracture of the right ilium and right acetabulum. This applies to 1 of 3 residents (R1) reviewed for safety in the sample of 5.</p> <p>The findings include:</p> <p>R1's face sheet shows she is a 77-year-old female admitted to the facility on 2/13/24. R1's diagnoses include hemiplegia and hemiparesis following cerebral infarct affecting right dominant side, osteoarthritis, low back pain, overactive bladder, unsteadiness on feet, weakness, contusion of scalp, fracture of right pubis, history of falling and presence of left artificial hip joint.</p> <p>R1's undated Admission/Hospital Report documents she is alert and oriented x2,</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014138	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LAKE ZURICH	STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH RAND ROAD LAKE ZURICH, IL 60047
---	---

(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	<p>Continued From page 2</p> <p>maximum two person assist and right sided weakness.</p> <p>R1's Final Incident Report dated 2/15/24 documents (R1) admitted to the facility on 2/13/24 after a fall at home on 2/6/24 resulting in a contusion of the scalp and acute non-displaced right inferior pubic rami fracture. She can verbalize her needs and requiring one person assist, she is weight bearing as tolerated and uses the wheelchair for locomotion ...At around 9:00 AM breakfast was served (R1) only drank a cup of hot tea and told V7 (Certified Nursing Assistant) to take her back to her room ...V7 assisted her from the wheelchair using the gait belt, (R1) stood up holding the rail and with right hand but lost her balance ...(R1) reached for the tray table with her left hand and the table moved ...(R1) hit the left side of her head on the tray table and she landed on her left side ...911 was called and she was sent out to the local hospital ...A subtle acute nondisplaced fracture of the right ilium ...no surgical intervention was indicated.</p> <p>R1's CT report dated 2/15/24 documents acute mildly displaced fracture of the right inferior pubic ramus (present on admission). Subtle acute displaced fracture of the right ilium with fracture lines involving the iliac wing, anterior and medial acetabulum.</p> <p>On 3/4/24 at 10:48 AM, V7 (CNA) said she gets report from the nurse and physical therapy how a resident transfers. She was told R1 was a one person transfer. On 2/15/24, in the morning R1 "did okay getting up." I took her to the dining room and around 9:00 AM, she said she felt nauseous. I wheeled her back to her room. I was trying to get her back in bed. R1 grabbed the bedrail with her right side and lost her balance and grabbed</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014138	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/04/2024
NAME OF PROVIDER OR SUPPLIER AVANTARA LAKE ZURICH		STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH RAND ROAD LAKE ZURICH, IL 60047		
(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	<p>Continued From page 3</p> <p>the table with her left hand and fell on her left side. I was positioned behind her with the gait belt holding on to the back of her pants during the transfer. Therapy instructs us to stand in front of the resident or to the side of them. She was a new admit, I had not seen her walk yet. In the morning she seemed alert and oriented, but then she could not recall who I was. I would probably have a second person with me to transfer and be positioned in front of her holding on to the gait belt. Max assist usually means transfer with two people.</p> <p>On 3/4/24 at 11:08 AM, V5 (Licensed Practical Nurse-LPN) said R1 was alert and oriented x2 with periods of forgetfulness. She was a one person assist with transfers and would complain of pain. On 2/15/24, I heard V7 scream. I entered the room and saw R1 lying on the floor beside her bed. R1 said she was in pain but could not tell me what happened. 911 was called and she was sent out to the local hospital. V7 reported she was transferring R1 back to bed and she lost her balance while getting up. Therapy instructs us to stand in front of the resident during transfers. Max assist usually means two person assist with transfers.</p> <p>On 3/4/24 at 12:33 PM, V3 (Unit Manager) said R1 was admitted to the facility with a right pelvis fracture. She had a fall at home and hit her head. She was a fall risk. Fall risk assessments are done at admission with interventions put in place. R1 had a history of a stroke with right sided weakness. On 2/15/24, I was notified of R1's fall. I entered the room and was lying on her left side. She was complaining of right hip pain. 911 was called and she was sent out to the local hospital. She sustained a new fracture and did not require surgical intervention.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014138	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LAKE ZURICH	STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH RAND ROAD LAKE ZURICH, IL 60047
---	---

(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	<p>Continued From page 4</p> <p>On 3/4/24 at 11:20 AM, V4 (Physical Therapist) said he did R1's therapy evaluation on 2/14/24. R1 did not receive any therapy services yet. She was admitted with a right pubis fracture. R1 required max assist with bed mobility and transfers. She requires more than 75 % assistance could assist with some portion of the transfer. Max assist could be max assist with one staff or two staff it depends on the resident's limitations. It should be documented if a resident requires one or two persons assist. We instruct the staff to always have the resident pushing off the seated surface and reaching for the armrest. For safety staff should be positioned in front or to the side of the resident with a gait belt during transfers. Staff should make sure the bed side table is out of reach of the during transfers.</p> <p>R1's nurses note dated 2/13/24 documents R1 admitted to the facility; contusion related to fall at home ...stroke with right sides weakness, sciatica, chronic back pain. Weight bearing as tolerated with max assist for transfers ...per husband R1 has had multiple falls at home.</p> <p>R1's Fall Risk assessment dated 2/14/24 shows she is HIGH RISK for falls.</p> <p>R1's care plan initiated on 2/14/24 shows his is high risk for falls related to multiple fall incidents at home with interventions to provide 2-peron assistance during transfers as my strength and balance varies throughout the day to prevent further falls (2/15/24). R1's care plan did not show her transfer status until 2/15/24.</p> <p>R1's Therapy Evaluation dated 2/14/24 documents R1 with a recent fall resulting in a pelvic fracture on the right side. At this time, she</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014138	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LAKE ZURICH	STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH RAND ROAD LAKE ZURICH, IL 60047
---	---

(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	<p>Continued From page 5</p> <p>is having difficulty with overall mobility and activities of daily living ...(R1) anxious due to pain in right lower extremity. Does patient feel unsteady when standing and walking: "yes" does patient worry about falling "yes." Transfers sit to stand= substantial/maximum assistance, chair/bed to chair transfer=substantial/maximum assistance.</p> <p>R1's Fall Occurrence Policy revised 2023, states, "It is the policy of the facility to ensure that residents are assessed for risk for falls, that interventions are reevaluated and revised as necessary those identified as high risk for falls will be provided fall interventions ..."</p> <p>(B)</p>	S9999		