STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009096	A. BUILDING: _____ B. WING _____	05/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PARK RIDGE	1601 NORTH WESTERN AVENUE PARK RIDGE, IL 60068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure and Certification Survey Complaint Investigation #1893032/IL102522 - No findings Complaint Investigation #1892958/IL102437 - No findings	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.1210b) 300.1210d)6) 300.3240a) 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. Restorative measures shall include, at a minimum, the following procedures: d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements are not met as evidenced by:

Based on observation, interview, and record review the facility failed to prevent a resident from falling out of the wheelchair while being transported by staff, and also failed to document a root cause analysis identifying the cause of the fall for one of five residents (R262) reviewed for falls in a sample of 25. This failure resulted in R262 falling from the wheelchair sustaining a right humeral head fracture.

Findings include:

A Fall Occurrence policy dated 2/20/17 states, "It is the policy of the facility to ensure that residents are assessed for risk for falls and interventions are put into place to prevent them from falling. The Falls Coordinator will review the incident report and may conduct his/her own fall investigation to determine the reasonable cause of fall."

On 5/22/18 at 12:37p.m., R262 was laying in bed with a sling to R262's right arm. R262 stated that during the previous week a therapist was wheeling R262 in her wheelchair down the hall. R262 slipped out of the wheelchair causing R262 to fracture R262's right upper arm. R262 stated that R262 had been having a problem with slipping forward in the wheelchair and that facility

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S9999	Continued From page 2	S9999		

staff frequently need to reposition.

R262's fall investigation dated 5/19/18 documents that therapy staff was transporting R262 back to her room following therapy when R262 slid from the wheelchair and landed on R262's right side on the floor. The investigation documents that when R262 was asked what happened R262 stated, "I slid down from my wheelchair." The investigation also documents that R262 was sent to the emergency room for evaluation and treatment. The investigation does not document a root cause to the fall was identified, however, the investigation documents that a non-slip pad was then added to R262's wheelchair to prevent her from sliding out of the wheelchair in the future.

R262's emergency room X-ray report dated 5/19/18 documents that after R262 fell she sustained, "An acute, nondisplaced, mildly impacted, non-angulated right humeral head fracture."

On 5/24/18 V4 (Registered Nurse Fall Coordinator) stated that V4 investigated R262's fall on 5/19/18. V4 verified no root cause analysis was documented on R262's fall investigation however, V4 stated that R262 slipped out of the wheelchair as a result of "gravity" because R262 was not positioned correctly in the wheelchair.

(C)