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 _____	C 08/10/2022

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

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S 000	Initial Comments Complaint Investigation: 2296212/IL149856	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)6 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Requirements were NOT MET as evidenced by:	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 Based on interview and record review, the facility failed to ensure a resident was securely seated in wheelchair while being transported to her room and fell forward from the wheelchair. This failure affected 1 resident (R1) of 3 reviewed for falls. This failure resulted in 1 cm laceration to R1's forehead. Findings include: On 8-9-22 at 11:28 AM, R1 is up to her wheelchair and seated at a table in the dining area with supervision. She has a table in front of her with a pillow. R1 was seen resting her head on the pillow at times. R1 was seen frequently leaning forward and resting her head on the pillow. She is alert and unable to carry meaningful conversation. R1 has purple/yellowish discoloration to bilateral lower periorbital areas. On 8-9-22 at 1:17 PM, V2 (Acting DON/Regional Nurse Consultant) said R1 is alert, oriented x 1-2, and not able to make her needs known. R1 has Alzheimer's and dementia with behavior disturbance. R1 is fall risk and has poor safety awareness. R1 has a behavior to lean forward in wheelchair. Staff use a pillow when she is seated at the table. R1 leaning forward can be a fall hazard in the wheelchair. Prior to incident, R1 has a chair alarm, table in-front with pillow, and placed in common area for supervision. V2 said R1's primary nurse instructed V4 (agency CNA) on how to transfer R1 by pushing wheelchair and securing R1's shoulder to keep resident back to seat back of wheelchair. R1 was not secured to back of wheelchair, leaned forward, and fell out of the wheelchair. V4 was unable to prevent R1's fall. After this incident, facility is using 2 person transfers for R1. One person will be pushing the wheelchair and another person will be on the side	S9999		

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S9999	Continued From page 2 of wheelchair to ensure R1 is upright and secure in her wheelchair. On 8-9-22 at 10:25 AM, V3 (Nurse) said V4 (agency CNA) was getting R1 ready for bed, transferring R1 by wheelchair to her room. V4 was pushing R1 in dining area to her room and R1 fell forward. R1 is high fall risk due to memory. R1's footrests were on the wheelchair. V3 was at nurse station when she heard the R1's fall in dining area. V3 saw R1 on floor and on her side. There was bleeding on the left side of forehead. V3 cleaned R1, controlled bleeding, and called 911. R1 was unable to say what happened. V4 said R1 fell forward from wheelchair. V3 said R1 can have difficulty holding herself upright in wheelchair. V3 instructed V4 on how to transport R1 via wheelchair. When pushing the R1 in the wheelchair, you must ensure R1's back is against the seat back of the wheelchair and hold R1's shoulder. During this transfer, R1 fell out of the wheelchair and V4 was unable to prevent fall. V3 noted laceration and blood to R1's forehead. V3 did see footrests on R1's wheelchair. V4 was unable to maintain R1 upright in wheelchair. On 8-10-22 at 9:24 AM, V4 (agency CNA) said V4 was in the process of returning R1 to her room after dinner. During transport, R1 leaned forward in wheelchair while V4 was pushing the wheelchair. R1 was not aware of this leaning behavior. The staff did not tell V4 about this behavior and V3 (Nurse) did not instruct V4 on how to transport R1 in wheelchair. When R1 leaned forward CNA was unable to stop R1 from falling. This was the first time working with this resident. V4 did not know R1 was a fall risk and is not sure if R1 can make her needs known due to her confusion. V4 said R1 had footrests in place.	S9999		

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S9999	Continued From page 3 When R1 fell, V4 saw R1 with laceration to her forehead. On 8-9-22 at 11:38 AM, V5 (CNA) said R1 is alert, confused, and unable to make her needs known. R1 is a high risk for falls because she is confused and demented. R1 is impulsive and will try to get up by herself and lean forward in wheelchair. The dementia and confusion make it difficult to redirect R1. R1 will always lean forward when transferring in wheelchair. V5 will ensure R1 has her back against the back of the wheelchair and V5 keeps her hand on R1's shoulder to keep resident back against the wheelchair back. All staff transfer R1 this way. If R1 leans forward during transfer, V5 will stop pushing, redirect and ensure R1's back is against the seat back of the wheelchair before proceeding forward. After the incident, there should be 2 staff during the transfer back to room. On 8-9-22 at 11:51 AM, V6 (Nurse) said R1 is alert, oriented x 1-2, and can sometimes make her needs known. R1 has Alzheimer's disease and dementia. R1 leans forward in her wheelchair. R1 is a high fall risk with history of falls. When transporting R1 by wheelchair it takes 2 staff because she is totally dependent. R1 is 2 person assist for safety reasons. On 8-9-22 at 12:43 PM, V7 (Fall Nurse) said R1 is alert, oriented x 1-2, and can sometimes make her needs known. R1 is a high fall risk. R1 has a lack of safety awareness at this time. R1 will try to get up by herself from wheelchair and leaning forward in wheelchair. R1 requires frequent redirection and verbal cues. When transporting R1, R1 would have leg rests on her wheelchair, staff ensure R1 is properly upright in chair with	S9999		

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S9999	Continued From page 4 back against the seat back of wheelchair, and not leaning to the side. If needed, staff may support shoulder against the back of chair. After this incident, facility uses 2 staff when transporting R1 via wheelchair. One staff pushes R1's wheelchair that the other staff walking along side as a spotter to ensure she is not leaning forward and remains upright. There was one CNA assisting R1 at the time of the incident. This was an agency CNA who was not aware of supporting R1's shoulder to the wheelchair backrest during turning or initiating movement. R1's Face Sheet documents: Diagnosis Information (not limited to): difficulty in walking, unspecified lack of coordination, abnormal posture, need for assistance with personal care, dementia with behavioral disturbance, major depressive disorder, anxiety disorder, Alzheimer's disease, and age-related physical debility. R1's MDS (ARD 7-8-22 and 8-4-22) documents: BIMS Summary Score= 99 (unable to complete interview), Transfer (Self) 3= Two+ persons physical assist, (Support) 3= Two+ persons physical assist. R1's Falls Risk Assessments (dated 11-4-20, 12-4-20, 12-27-20, 12-31-20, 3-23-21, 7-27-21, and 7-25-22) document R1 is high risk for falls. R1's Initial State Reportable (dated 7-26-22) documents: Around 6:50 PM, the CNA on duty was pushing R1 in the wheelchair and R1 fell forward from the wheelchair and the CNA was unable to break the fall. A small amount of bleeding is noted from the left side of forehead. R1 was treated, bleeding controlled, and dressing applied. 911 was called and R1 was transferred to local hospital for evaluation. R1's Final State Reportable (dated 7-30-22) documents: Final Investigation/Conclusion: R1 was being transported from the dining area to her room.	S9999		

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S9999	Continued From page 5 CNA was standing behind R1's wheelchair and begin to roll the wheelchair. when R1 leaned forward suddenly and the CNA was unable to break the fall. Hospital Record dated 7-25-22 documents: HPI: 83-year-old adult presents with a fall from wheelchair. This 83-year-old is brought by paramedics, who states that she fell forward out of her wheelchair striking her head on the ground. She sustained a small 1 cm laceration with well approximated skin on her forehead without foreign body. After cleaning the skin, MD approximated the skin using the fingers and secured it with cyanoacrylate glue. Patient tolerated procedure well. Clinical Impressions: Fall from wheelchair, initial encounter. (B)	S9999		