Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057067	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA CHICAGO RIDGE	**10300 SOUTHWEST HIGHWAY , CHICAGO RIDGE, Illinois, 60415**

(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) COMPLETION DATE
S0000	Initial Comments Complaint Investigations: 2597099/IL2578716 2597020/IL2575584 2597117/IL2577593	S0000		
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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 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 Regulations are not met as evidenced by: Based on interviews and record reviews, the facility failed to implement interventions per resident's care plans and care assessment in preventing falls; and failed to follow policy related to fall investigation for two (R1 and R5) of five residents reviewed for accidents and falls. These deficiencies resulted in R1 sustaining a fall that resulted in bruising to the left side of the head and R1 being transferred to the local hospital for treatment after being found sitting on the floor with left arm hanging on the left bedrail with head slouched over to the left side. R5 who is confused with unsteady gait; had a fall requiring emergent transfer to the hospital and was diagnosed with acute nondisplaced fracture to the left parietal calvarium. Findings include: R5 is a 77 year old, female, admitted in the facility on 06/23/35 with diagnoses of Traumatic Subdural Hemorrhage without Loss of Consciousness, Subsequent Encounter; Syncope and Collapse; Muscle Wasting and Atrophy, Not Elsewhere Classified, Multiple Sites; Unspecified Dementia, Unspecified Severity, with other Behavioral Disturbance; Contusion of Unspecified Part of Head, Subsequent Encounter; Other Fracture of Base of Skull, Subsequent Encounter of Fracture with Routine Healing; Traumatic Subarachnoid Hemorrhage without loss of Consciousness, Subsequent Encounter; History of Falling and Unsteadiness on Feet. R5's MDS (Minimum Data Set) dated 07/07/25 documented: Section C: BIMS (Brief Interview for Mental Status) score of 7, which means severe cognitive impairment. Sec GG - Needs partial/moderate assistance when sitting to standing, in walking 10 feet; and dependent on staff when walking 50 feet. R5 uses a manual wheelchair. R5's Fall Risk Evaluations recorded the following scores: 06/26/25 - 13, high risk	S9999		

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S9999	Continued from page 2 06/29/25 - 15, high risk 06/30/25 - 12, high risk 07/15/25 - 12, high risk Facility's final incident report dated 07/23/25 documented that on 07/15/25 at approximately 7:30 PM, R5 was observed laying on the floor in the hallway near her room stating that she was walking to make her normal rounds when she slipped and fell. She complained of pain to her head. V10 (Physician) was notified and ordered R5 to be sent out to the hospital. She (R5) was admitted to the hospital and was diagnosed with an acute nondisplaced fracture to the left parietal calvarium. On 08/12/25 at 2:41 PM, V7 (Registered Nurse, Agency) was asked regarding R5's fall incident on 07/15/25. V7 stated, "That day, 07/15/25 was my first day of meeting her. I was endorsed that she is a wanderer and needs redirection. I was at the nurses' station that time, the CNA (Certified Nurse Aide) said, "I tried to catch her, but I couldn't catch her." The aide who reported was not my aide. I and the other nurse went there, and she (R5) was sitting on the floor, she (R5) said she hit her head but not enough to knock her out. I assessed her (R5) and she's able to move. We put her on the wheelchair and brought her to the nurses' station. I called physician and was ordered to send her out because she is on blood thinner. I called paramedics. Upon assessment, she didn't complain of any pain, her ROM (range of motion) was still intact. Paramedics came; she was not in pain. She was transported to the hospital. I was told she is a high risk for falls and told me she does walk but needs redirection. I didn't hear any alarm. Her room was not closed to nurses' station but close enough that I would be able to hear any alarm at the time. I was not aware about the alarm. The nurse who helped me said she has a bed alarm. The aide told me she was not sure if the alarm was on since V11 (Family Member) was still with her when she last saw her." V7 was also asked if R5 uses any type of assistive device to help with locomotion. V7 mentioned, "She is alert, oriented to self and place. She is able to verbalize needs and wants but mostly confused during afternoon and night. She is ambulatory, she does not use any walker or wheelchair, I have not seen her using one." According to change of condition progress notes dated 07/15/25, R5 complained of moderate head pain.	S9999		

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S9999	Continued from page 3 On 08/12/25 at 3:10 PM, V8 (Registered Nurse, RN) was interviewed regarding R5. V8 replied, “She is confused, I helped V7 last 07/15/25 when she (R5) had the fall. I saw her (R5) walking in the hallway without any assistive devices. I told V7 that she (R5) was walking by herself. I wasn't sure if she is supposed to be walking or not, so I called her (V7) attention. I don't know if she (V7) heard me or not. She (V7) was at the nurses' station. After a while, they called me to help because she (R5) was on the floor. I came, she was laying on the floor, by the door of another resident's room. She (V7) did the assessment. At the time, I didn't hear any alarm gone off. I sometimes see R5 walking in the hallway by herself, with unsteady gait. I think she is supposed to have a bed/chair alarm.” On 08/12/25 at 3:20 PM, V9 (CNA) was also asked regarding R5’s fall incident on 07/15/25. V9 verbalized, “On 07/15/25, last time I checked on her, I put her to bed. I put two blankets on her per her request. She was sleeping in bed and bed alarm was on. When I came back from break, I was informed that she had a fall. She has bed and chair alarm. She uses wheelchair. She likes to walk but she needs to use a wheelchair.” R5’s medical professional progress notes dated 07/14/25, documented: Current functional status: wheelchair On 08/13/25 at 11:21 AM, V2 (Director of Nursing) was asked regarding R5. V2 stated, “She is able to ambulate but for safety we don't want her to ambulate alone. She has a wheelchair that she uses for locomotion. She did have a bed/chair alarm, nurses and CNAs are responsible to check for the functionality of the alarm. Staff must ensure fall interventions are in placed properly. If they see something that resident is doing that is not safe, they have to redirect residents and report any safety hazard, safety concerns. R5 can ambulate but unsteady with her feet so she needs assistance when ambulating, she needs to use her wheelchair. She is very confused all the time. She has unsteadied feet. That time she had a fall on 07/15/25, she (R5) was seen by V8 walking and tried to catch her not to fall. V9 was the CNA and was on break at the time.” Progress notes dated 07/16/25 indicated R5 was admitted to the hospital due to skull fracture. R5’s care plan regarding at risk for falls, dated 06/25/24 documented: Interventions:	S9999		

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S9999	Continued from page 4 Encourage R5 to use her wheelchair when trying to ambulate around the unit to promote safety. Provide bed/chair alarm, and redirect R5 when seen restless or anxious. R1 is a 71-year-old, male, originally admitted in the facility on 11/04/2023 with diagnoses of Malignant Neoplasm of Oropharynx, Unspecified; Malignant Neoplasm of Prostate; Secondary and Unspecified Malignant Neoplasm of Lymph Nodes of Head, Face and Neck; Polyneuropathy, Unspecified; Spinal Stenosis, Cervical Region and History of Falling. MDS dated 05/14/25 documented R1's BIMS score is 11, which means moderate impairment in cognition. R1 requires supervision or touching assistance during sit to stand; chair/bed to chair transfer; walking 10, 50 and 150 feet. He has no impairment on both upper and lower extremity but uses walker for locomotion. Fall incident report dated 07/26/25 recorded R1 was observed on the floor with left arm hanging on the left bedrail with head slouched over to the left side. An attempt was made to arouse R1 but did not verbally respond, only with eyes closed and opened. His level of consciousness was stuporous and only responsive to vigorous stimulation. On 08/11/25 at 12:25PM, V4 (CNA) was interviewed regarding R1 and R's fall on 07/26/25. V4 replied, "On 07/26/25, I went back to his room after giving morning shower to the other resident. He (R1) was sleeping. I went back in there after lunch, and he was on the floor on the left side of bed. He was sitting up on the floor. I asked him and he did not respond. He was still alert but not verbally responsive. I called the nurse. He was on a low air loss mattress; his left hand was in the rail." V5 (RN, Agency) was also interviewed regarding R1 on 08/11/25 at 12:52PM. V5 stated, "On 07/26/25 morning shift, the CNA (V4) reported to me he was sitting on the floor. When I saw him, his arm was still holding the side rail. His head was slumped to the side of left side rail. I did head to toe assessment, he was not verbally talking, he can open his eyes a bit but not saying anything. He was sitting on the floor. I don't know if he slid down. He wouldn't keep his eyes open when I call his name. I called paramedics. He kept on grunting and kept closing his eyes. I noticed mild swelling on the left side of his face, by the eyes. There was no laceration, no issues with his eyes. He	S9999		

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S9999	Continued from page 5 was not verbally responsive, his mental status is my focus, that is why I called emergency. I saw him on the floor and my first thing is to call paramedics because he was not responding." According to ambulance report dated 07/26/25, paramedics found patient (R1) lying in bed, alert to painful stimuli only. Nursing staff stated that they were in the room, left for about 5-10 minutes and when they came back, they found patient (R1) half on the floor with his arm wrapped around the side rail of bed. Staff stated the patient (R1) normally alert, oriented to self, time, place and situation and able to hold conversations. Patient (R1) was spitting up mucous and bruising was noted to the left side of his face and his left eye pupil was in a slit and rotated. No other injuries were noted. Emergency department attending physician notes dated 07/26/25 recorded R1 has bruising to the left side of head; and left eye is irregularly shaped, not circular, linear, not reactive. On 08/12/25 at 12:19 PM, V2 was asked on what was the cause of R1's fall. V2 verbalized, "Based on what I received there was no injury related to the fall. He had a fall; he was observed on the floor by the CNA who reported to the nurse. And upon the nurse entering the room, she noted him not be responding. I did his fall investigation I have witness statements only, but there was no injury noted upon assessment prior to sending out to the hospital. The nurse said she did not know any swelling, nothing pretty much." Facility presented two witness statements related to R1's fall on 07/26/25, as follows: V5 was asked about representative notification; any bruising; hospital endorsement; last time R1 was seen and how long R1 was transferred to the hospital. V4 was asked when was the last time R1 was seen and his condition; and if she (V4) was the staff who observed R1 on the floor. There was no specific investigation related to the cause of his (R1) fall and how he fell. On 08/13/25 at 10:38 AM, V10 (Physician) was interviewed regarding R1 and R5. V10 stated, "R5 has dementia, had traumatic subdural hematoma and has history of syncope and collapse. On 7/15/25, I was informed that she had a fall. She was sent to the hospital. R1 has multiple significant medical issues. Alert, he has cancer of the head and neck and was	S9999		

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S9999	Continued from page 6 getting treatment from the hospital. He has cancer of the prostate, chronic kidney disease and multiple several medical issues: chronic or acute. He is getting blood thinners. On 07/26/25, I was notified that he had a change of condition, so he was sent out to the hospital, and he had a fall. The assumption was he had a fall, and he needs to go to emergency room. Staff should make all efforts to prevent falls. The goal is to prevent falls. Fall interventions should be patient centered." Facility's policy titled "Fall Occurrence" dated 6/30/25 stated in part but not limited to the following: Policy Statement: 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. Procedure: 5. The Falls Coordinator will review the incident report and may conduct his/her own fall investigation to determine the reasonable cause of fall. (B)	S9999		