

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6009096</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/05/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>AVANTARA PARK RIDGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1601 NORTH WESTERN AVENUE PARK RIDGE, IL 60068</b>
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S 000	Initial Comments  FRI of 1/12/2022\IL143280	S 000		
S9999	<p>Final Observations</p> <p>Statement of Licensure Violations</p> <p>300.1210b) 300.1210d)6</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</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</p>	S9999	<p style="text-align: center;"><b>Attachment A</b> <b>Statement of Licensure Violations</b></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>facility failed to provide direct supervision for one resident with known history of falls. This failure affected (R1) of four residents reviewed for falls. As a result, R1 had injuries from the fall and was transferred to a local hospital via emergency services (911) and diagnosed with acute displaced right greater trochanteric fracture.</p> <p>Findings include:</p> <p>R1 is an 81 year old male originally admitted on 12-19-2021 with most recent readmission on 1-14-2022 with medical diagnosis that include and are limited to: frequent falls, Parkinson's and dementia. R1 is no longer a resident at the facility. Minimum Data Set dated 12-25-2021 reads: Brief Interview for Mental Status score: 2/15 severe cognitive impairment. R1 needs extensive assistance of one person for: bed mobility, transfer, locomotion in and off unit, dressing, toileting and personal hygiene. R3 is dependent on mobility devices: wheelchair. Care plan reads; R1 is at risk for falls related to Parkinson's disease, hydrocephalus, syncope, dementia and cognitive communication deficit. Interventions dated: 12-19-2021, bed and chair alarms, educate R1 on importance of calling staff if he needs assistance, staff to anticipate an meet R1's needs, staff to keep R1'd wheelchair and bed in locked position during transfer and nursing care.</p> <p>1-11-2022 R1 may be situated in common area while maintaining social distance Nursing Admission Assessment dated 12-19-2021 reads: Call light evaluation: 1. Is the resident cognitively able to use the call light? no. 2. Does the resident have a medical condition that can potentially affect R1 from pulling the call light string or pressing the call light button? yes.</p>	S9999		
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S9999	Continued From page 2  R1 is at risk for falls related to poor safety awareness, unsteady gait and disease process.  Progress notes dated: 1-11-2022 at 15:34 read: noise was heard from resident's room and staff including nurse on duty immediately went to the resident's room. Nurse on duty observed resident face down on the floor with his legs out behind him lying outside his bathroom door with his wheelchair close by his feet. Resident who is Alert and oriented X1-2 with periods of confusion and forgetfulness was unable to state what happen due to cognitive communication deficit. Local Hospital History and physical dated: 1-12-2022 reads: (R1) presented in the Emergency room after he fell, it was unwitnessed, and x-ray showed acute mildly displaced right greater trochanteric fracture.  On 3-4-2022 at 3:00pm V5 (Certified Nurse Assistant) said R1 was confused and everyday he was different. On 1-11-2022 R1 was in the dining room because he was a fall risk. I took (R1) to the toilet maybe by 2:00pm. I will never leave R1 in the bedroom alone because R1 is a high risk for falls. I only leave R1 in the bedroom if the family is visiting and they are supervising. I did not put R1 in his room and leave him alone, that is a big "no,no"  On 3-5-2022 at 9:45am V2 (Director of Nursing) said, my expectation is: patient safety first. R1 was left unsupervised in the bedroom that is inappropriate, (R1) is known to be a risk for falls. Residents that are at risk for fall should not be left unattended in the bedroom, the patients need to be in the common area for staff supervision. When we leave any patients in the bedroom they are going to try to transfer to the bed or go to the bathroom and that is when the falls happened,	S9999		

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S9999	<p>Continued From page 3</p> <p>because they forget their limitations. I do not know who left R1 in the room by himself. Leaving a high risk for fall resident in the bedroom without supervision is a big no.</p> <p>On 3-5-2022 at 11:40am V6 (Certified Nurse Assistant) said, All the residents that are at risk for falls need to be kept under supervision, never left alone in the bedroom, because they can fall to the floor easily.</p> <p>On 3-5-2022 at 9:45am V1- (Administrator) there is no specific supervision/monitoring policy.</p> <p>Fall occurrence Policy dated: 7-28-2021 (Revised) reads: Is the policy of the facility to ensure that residents are assessed for risk for falls. If a resident had fallen, the resident is automatically considered as high risk for falls. Therefore, the nurse does not have to fill out the fall risk assessment to determine if the resident is high risk for fall or not after the resident had fallen.</p> <p>(A)</p>	S9999		