STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145607	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Palos Heights	7850 West College Drive Palos Heights, IL 60463

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45395 Based on interview, observation and record review; the facility failed to provide a safe environment by not adequately monitoring residents at risk for falls for 5 of 5 residents (R1, R2, R3, R4, R5) reviewed for falls; failed to follow facility policy of ensuring all staff were educated on residents at risk for falls and/or fall prevention program. This failure resulted in all five reviewed residents falling unsupervised. Findings include: Reviewed undated incident list with date range from 05/01/2024 through 08/04/2024 provided by facility that showed incident dates as follows: R1 and R5 both on 06/05/2024; R2 on 06/08/2024, 06/12/2024, and 06/12/2024; R3 on 06/21/2024; R4 on 06/23/2024. 1: R1's electronic medical record indicated resident last admitted to the facility on [DATE] and has a past medical history not limited to: dislocation of left humerus and right shoulder joint, vascular dementia, repeated falls, symbolic dysfunctions, depression, anxiety, encephalopathy, traumatic subarachnoid hemorrhage, scalp laceration, history of falling, and hypertension. R1's care plan last reviewed 03/25/2024, reads in part: at high risk for falls related to current medication use, poor safety awareness, unsteady gait, anxiety disorder, unsteady gait, even with mobility aid or personal assistance, slow gait, takes small steps, drags left foot, and history of falls with date initiated of 11/19/2023. R1's fall investigation report completed by V6 (Agency Licensed Practical Nurse) and dated 06/05/2024 indicted the following: R1 was observed on the floor in the dining room in front of her wheelchair on 06/05/2024 after an unwitnessed fall. R1 was sent to the local emergency room with a laceration to the middle area of her face between nose and her upper lip. Hospital paperwork dated 06/05/2024 indicated R1 was seen in the emergency room by V14 (Physician Assistant-Certified) and V15 (Doctor of Osteopathic Medicine) after a fall at facility. R1 sustained a facial laceration that was repaired in the emergency room by V14 then returned to facility. Fall Risk Evaluation dated 06/11/2024 showed R1 score of 17 which indicates high risk for falls per scoring section I. on page two of assessment. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Brief Interview for Mental Status (BIMS) dated 07/15/2024 revealed a score of 11 which indicates R1 is moderately cognitively impaired. On 08/06/2024 at 12:08 PM, V3 (Alzheimer Program Assistant/Activities) said on day of incident, she was in hallway by entrance doors to dining room on the Arcadia unit when she saw an aide push R1 up to a table in the dining room then locked the wheelchair because she is a fall risk. After the aide went to assist another resident, R1 immediately unlocked her chair and moved herself from in front of the table. V3 added that when R1 moved away from table, she began to lean forward but by the time the aide turned around, R1 was already falling out of her chair and landed face first on the floor. V3 then said R1 sustained a cut to her lip that was bleeding. R1 was sent out by ambulance. V3 added that she doesn't recall when the last fall training was that she received, could have been last month. 2: R2's electronic medical record indicated resident admitted to the facility on [DATE] and has a past medical history not limited to: left femur fracture, need for assistance with personal care, dementia, left side rib fracture, history of falls, urinary tract infection, depression, dizziness and giddiness, shortness of breath, and hypertension. Medical record also documented a date of discharge of 07/07/2024. Admission care plan with date initiated of 06/06/2024 indicated R2 is a risk for falls related to left femur fracture and a high risk for falls related to dementia, weakness, history of falls with date initiated of 06/11/2024. Fall Risk Evaluation dated 06/06/2024 showed score of 13 which indicates R2 is a high risk for falls per scoring section I. on page two of assessment. Brief Interview for Mental Status (BIMS) last dated 06/14/2024 revealed score of 2 which indicates R2 is severely cognitively impaired. R2's fall investigation report completed by V7 (Licensed Practical Nurse) dated 06/08/2024 indicted the following: resident had an unwitnessed fall with injury on 06/08/2024. R2 was observed lying on the floor in his room near the right side of bed in prone position at approximately 8:30 PM. Hospital transfer report dated 06/08/2024 indicated R2 was seen in emergency room after sustaining a fall out of bed. Imaging results reviewed and signed by V16 (Medical Doctor) indicated R2 sustained a fracture to the left lateral 10th rib. R2's admission summary back to facility dated 06/11/2024 indicated resident arrived from local hospital with admission diagnosis of urinary tract infection, acute on chronic renal failure, injury to left knee, and closed fracture of one rib of left side. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/06/2024 at 1:13 PM, V7 (Licensed Practical Nurse) said she was alerted by the aide (V10) that R2 was on the floor. V7 then said she observed R2 in the prone position on the floor next to his bed, didn't seem like he was in any pain. Physician ordered R2 be sent to emergency room because he was on blood thinner. V7 added that R2 was diagnosed with urinary trat infection and a rib fracture. V7 (Licensed Practical Nurse) also said that R2 was a fall risk and that fall education is usually done daily by the fall nurse during her rounding who also orientates new agency staff on the fall binder, fall risks and fall interventions. At 2:16 PM, V10 (Certified Nursing Assistant) said he does not recall R2's fall incident. 3: R3's electronic medical record indicated resident originally admitted to the facility on [DATE] and has a past medical history not limited to: hemiplegia and hemiparesis affecting right dominant side, right femur fracture, anxiety, dementia, adult failure to thrive, aphasia, major depressive disorder, cerebral infarction, history of falls, and convulsions. R3's care plan last reviewed 07/15/2024 reads in part: risk for falls related to weakness, seizures, potential medication side effects, history of falls and recent falls with date initiated of 02/14/2024. Fall Risk Evaluation dated 07/02/2024 showed score of 17 which indicates R3 is a high risk for falls per scoring section I. on page two of assessment. Brief Interview for Mental Status (BIMS) last dated 06/14/24 revealed score of 2 which indicates R3 is severely cognitively impaired. R3'S fall investigation report completed by V7 (Licensed Practical Nurse) dated 06/21/2024 indicated R3 had an unwitnessed fall with injury on 06/21/2024 at 10:36 AM. R3 was observed sitting on the bathroom floor of her room with her back against the wall, both legs extended in front of her wearing only socks with incontinence brief. R3 reported she attempted to transfer self from wheelchair to toilet, lost balance and fell to the floor with complaints of pain to right leg. Provider on-site assessed and ordered an emergent transfer to local hospital, but resident refused, and in-house x-rays were obtained. Radiology results report signed by V18 (Physician) and dated 06/21/2024 showed the following results: acute right femoral neck fracture. Radiology note dated 06/21/2024 indicated provider was notified by facility with orders received to send R3 to the local hospital for evaluation and treatment. Hospital paperwork dated 06/21/2024 indicated R3 presented from facility post fall and sustained right-sided hip fracture. Hospital discharge summary signed and dated on 06/25/2024 by V17 (Medical Doctor) indicated R3 was seen prior to discharge for postsurgical total hip arthroplasty. General Progress Note dated 06/26/2024 documented R3 readmitted from local hospital via stretcher. Surgical incision was noted to right trochanter (upper thigh) clean and intact with dry dressing in place. On 08/05/2024 at 1:03 PM, V25 (Family Member) said R3 told her on the day of incident, she pressed the call light because she had to use the bathroom. V25 added a nurse saw her attempting to get out of bed but told R3 to wait while she got help but R3 couldn't wait any longer, so she attempted to toilet herself. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/06/2024 at 12:41 PM, V5 (Certified Nursing Assistant) said she remembered seeing R3 sitting up in the bed after breakfast drinking her coffee but doesn't recall what time she saw her last. V5 then said shortly after seeing R3 sitting in bed, she was made aware that R3 was on the bathroom floor. V5 didn't recall whether R3's call light was on, and she believed that R3 is a fall risk. V5 (Certified Nursing Assistant) then said that she herself tries to check on all residents at least every two hours but it depends on the number of staff working on the unit for the shift. On 08/06/2024 at 1:22 PM V8 (Licensed Practical Nurse) said R3 had taken herself to the bathroom and prior to the fall incident, she was sitting on the side of her bed with a tray table in front of her. V8 didn't recall whether R3's call light was on but recalled as she walked past R3's room, V8 (Licensed Practical Nurse) could see R3's wheelchair in the doorway of the bathroom and knew her aide was not with R3 because she was on break. V8 entered the bathroom and saw R3 sitting on the floor with her back against the wall, she was facing the sink and both legs were stretched out with her brief down like she was trying to toilet herself. V8 asked R3 what happened, R3 pointed to toilet. V8 added that a provider was on the floor, so she had him assess R3 who had started guarding her right leg. R3 refused to be sent out to emergency room initially, stat x-rays were done at bedside with results that showed fracture to right hip. R3 was sent out emergently, had surgery then returned to the facility. 4: R4's electronic medical record indicated resident admitted to the facility on [DATE] and has a past medical history not limited to: left femur fracture, left pubis fracture, insomnia, depression, history of falling, cervical vertebra fracture, and hypertension. Care plan last reviewed 07/05/2024 reads in part: at high risk for falls regarding decreased strength, endurance, balance, osteoarthritis, osteoporosis, and possible untoward effects related to medications with date initiated of 04/06/2023. Brief Interview for Mental Status (BIMS) dated 07/18/2024 revealed score of 14 which indicates resident has no cognitive impairment. Fall Risk Evaluation dated 07/02/2024 showed score of 15 which indicates high risk for falls per scoring section I. on page two of assessment. Conclusion/Narrative Summary indicated a recent fall on 06/23/2024. R4's fall investigation report completed by V13 (Registered Nurse) dated 06/23/2024 indicated R4 had an unwitnessed fall with injury on 06/23/2024 at 05:30 AM. R4 was observed in her room, lying on the floor face up with legs extended straight out and sustained skin tear to left elbow. R4 was sent emergently to the local hospital. Hospital paperwork dated 06/23/2024 indicated R4 was seen at hospital post fall and diagnosed with left femur and ramus of left pubis fractures. Computed tomography (CT) result note read by V19 (Medical Doctor) and signed on 06/23/2024 indicated fracture of greater trochanter (left femur) and possible fracture of inferior pubis ramus post fall with complaints of left hip pain. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	General Progress Note dated 06/23/2024 documented R4 returned to facility via medical transport by stretcher. Resident was discharged from local emergency room with diagnosis of nondisplaced fracture of greater trochanter of left femur and closed fracture of ramus of left pubis. Physician was notified of resident's arrival and diagnosis with orders received to send patient back to emergency room for surgical treatment for fractures. Assessment Plan with print date of 06/24/2024 documented R4 refused initial admission to hospital post fall. Orthopedic appointment was scheduled for 06/27/2024. Admission Summary dated 07/12/2024 documented R4 returned from hospital status post recent surgery to left hip. Dressing to site clean and intact and to remain in place for seven days. Follow up appointment within two weeks. Patient weight bearing as tolerated to extremity. On 08/05/2024 at 1:14 PM, observed R4 sitting in chair next to bed who said on day of the incident, she heard someone calling and got out of bed by herself, no one was around to help her. She recalled breaking her left femur and had pain to her groin. R4 then said most days, staff only check on her every 3-4 hours. 5: R5's electronic medical record indicated resident admitted to the facility on [DATE] and has a past medical history not limited to: dementia, scalp laceration, history of fall, atrial fibrillation, anxiety, major depressive disorder, Alzheimer's disease, osteoarthritis, COVID-19, and hypertension. Report indicated that R5 discharged home with family on 06/15/2024. Admission care plan initiated 05/31/2024 reads in part: at high risk for falls related to rhabdomyolysis, obesity, COVID-19. Fall Risk Evaluation dated 06/01/2024 showed score of 16 which indicates high risk for falls per scoring section I. on page two of assessment. Brief Interview for Mental Status (BIMS) dated 06/03/2024 revealed score of 5 which indicates resident is severely cognitively impaired. R5's fall investigation report completed by V9 (Agency Registered Nurse) dated 06/5/2024 indicated R5 had an unwitnessed fall with injury on 06/05/2024 at approximately 04:15 PM. R5 was observed sitting on the floor in his room at the left side of his bed with his back against the chair. R5 was sent out emergently to local hospital for evaluation and treatment. Hospital paperwork dated 06/05/2024 indicated R5 was seen for head injury to top/back of head post fall out of bed. Computed tomography (CT) result note read by V20 (Medical Doctor) and signed on 06/05/2024 indicated R5 sustained small posterior parietal scalp laceration with associated hematoma (bruise). Emergency department provider notes dated 06/05/2024 indicated laceration repair was ordered and performed by V21 (Doctor of Osteopathic Medicine). R5 received eight staples to his scalp. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/06/2024 at 1:57 PM, V9 (Agency Registered Nurse) said R5 was a fall risk due to previous falls but did not recall what fall interventions resident had in place. She then said V11 (CNA) alerted her that R5 fell out of bed and does not recall last time she saw resident. V9 recalled assessing R5 after his fall but doesn't recall any injury but knew R5 had a previous fall with injury prior to admitting to facility. V9 (Agency Registered Nurse) then said R5 was soiled of bowel and bladder when he was on the floor. V9 received the order to send R5 out emergently and he returned with staples to his scalp. V9 was unsure if the staples were already in place from his previous fall prior to admission. On 08/06/2024 at 2:50 PM, V11 (Certified Nursing Assistant) said on day of incident, he heard a voice calling out and started to check on the residents on his set when he found R5 on the floor in his room, sitting on his buttocks by his bed on the left side towards the window at around 4:00 PM. V11 added that he could see a cut on the bridge of R5's nose, and an injury to his right arm. V11 (CNA) then said that his shift started at 2:30 PM and that was approximately the last time he saw R5 prior to finding him on the floor. V11 added that there was feces on the floor on the opposite side of bed and R5 told V11 that he (R5) removed the feces from his brief and threw it on the floor. When asked if R5 was a fall risk and/or part of the falling star program, V11 (Certified Nursing Assistant) said he wasn't in the fall binder and had no star on his wheelchair or name placard by room door. V11 added that the fall risk binder is located at the nurse's station on each floor and staff are supposed to review binder prior to going on the floor to look for changes. V11 then said he did not review this binder prior to starting work but did review prior to finding R5 on the floor. On 08/05/2024 at 1:11 PM, V22 (Agency Certified Nursing Assistant) said today was her first time at the facility and working on the third floor. When asked what type of orientation she received by facility, V22 said the nurse told her that most of her get up list are fall risks. V22 then indicated that no staff member reviewed any type of fall binder with her prior to working on the floor. On 08/05/2024 at 1:19 PM, during interview with V23 (Certified Nursing Assistant) when asked which residents are fall risks, V23 said most of the residents on third floor have a yellow star on their wheelchairs and the stars on the name placards next to resident room doors are just decoration. When asked where resident fall intervention information is located, V23 said there should be a sheet on their room door. V23 (Certified Nursing Assistant) proceeded to enter multiple rooms on unit but was unable to locate any info sheets. When asked if there was any other source to identify fall risk residents and their interventions, V23 indicated there is a binder at the nurse's station that he looks through at times. On 08/06/2024 at 12:22 PM, V4 (Restorative Director) said upon hire, staff are oriented on fall risk residents, the falling star program binder, interventions, and how fall risks are identified with a yellow star on the back of their wheelchair and on the name placard next to room door. He added that there are no information sheets hanging in resident rooms. V4 then said staff should be rounding on all residents frequently, at least every two hours but sooner for fall risks and that agency staff are in-serviced on the fall binder/fall risk residents by the manager on duty or fall nurse prior to going on the floor. At 2:35 PM, V2 (Assistant Director of Nursing) said agency staff are in-serviced by either the Director of Nursing, herself, unit manager, or the fall nurse prior to providing any resident care. Reviewed undated fall risk/falling star list and noted R1, R3, and R4 were all listed. R2 and R5 were not listed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/07/2024 at 3:02 PM, V1 (Administrator) said R2 and R5 were both on the falling star program at the time of their incidents based on their initial fall assessment scores of 13 for R2, and 16 for R5. Fall occurrence policy last reviewed 06/06/2024 reads in part: 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. Undated High Risk Fall Identification Program policy reads in part: program is intended to aide nursing home staff with easy identification of residents with a heightened risk of falling. A visual identifier, such as a yellow star, is placed close to the resident. This allows staff to be diligent with safety measures, response times, and fall prevention measures for those residents. To determine residents, appropriate for this program, consider the following: fall risk evaluation of 7 and below is low risk, 8 and above is high risk; falls within past 30 days and multiple falls within a 7-day period; other pertinent factors related to current or past history. All staff will be educated regarding the high-risk identification program and their role in preventing falls. All staff members are to respond to resident call lights in a timely manner. Preventing a fall may include, but is not limited to: providing mobility, toileting, and activities of daily living (ADL) assistance and close supervision of high-risk residents.