STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145700	A. Building B. Wing	05/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Chicago Ridge	10300 Southwest Highway Chicago Ridge, IL 60415

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 - Actual harm Residents Affected - Few	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** 40718 Based on observations, interviews, and record reviews the facility failed to follow their policy and procedures for fall prevention by not providing toileting assistance as needed in a timely manner and by not ensuring fall risk assessments were completed quarterly and annually. This failure applied to one of three residents (R2) reviewed for falls and resulted in R2 sustaining a left foot fracture. Findings include: R2 is a [AGE] year-old female with a diagnoses history of Partial Paralysis following a Brain Injury, history of falling, Chronic Heart Failure, Peripheral Vascular Disease, Presence of Cardiac Pacemaker, Major Depressive Disorder, and Anxiety Disorder who was admitted to the facility 01/12/2023. On 05/24/2024 at 2:48 PM R2 observed with a stability shoe on her left foot. R2 stated her foot is in a lot of pain and is worse at night because she can't sleep with her stability shoe on. R2 stated she takes pain medication for her foot before going to sleep but wakes up at night and has to take more. R2 stated when she fell on [DATE] she had toileted herself. R2's current ADL (Activities of Daily Living) care plan initiated 01/25/2023 documents she requires assistance with ADL's including bed mobility, transfers, walking, personal hygiene, eating, dressing, and toileting related to signs and symptoms of Depression, Cognitive Deficit, history of falls, pain, decreased range of motion, diagnoses of left side weakness due to history of Stroke, Diabetes Mellitus, Congestive Heart Failure, Coronary Artery Disease, Anxiety, Peripheral Artery Disease, Atrial Fibrillation, Depression, medication side effects from Antidepressant, Opioids, impaired balance and pain with interventions including: assist with toileting at regular intervals and as needed (initiated 04/17/2024), Keep call lights within reach when in bedroom or bathroom. And encourage to ask for staff assistance as needed (initiated 01/25/2023). R2's current Falls care plan initiated 01/13/2023 documents she is high risk for further falls related to (signs and symptoms of depression, cognitive deficit, diagnoses of left side weakness due to history of Stroke, Diabetes Mellitus, Hypertension, Congestive Heart Failure, Coronary Artery Disease, Anxiety, Atrial Fibrillation, Depression, incontinence, medication side effects, decreased range of motion, pain, and history of falls with interventions including: Keep call light within reach when in bedroom or bathroom, encourage to ask for staff assistance as needed (Initiated 01/13/2023), toilet at regular intervals and as needed (Initiated 04/17/2023). (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 - Actual harm Residents Affected - Few	R2's quarterly Minimum Data Set, dated dated dated [DATE] documents she required substantial maximum assistance with toileting, toilet transfer, chair to bed or bed to chair transfer, and requires supervision or touching assistance with walking from 10-150 feet. R2's Fall Risk Evaluation dated 04/24/2024 documents she is continent of bowel and bladder, has an unsteady gait, just had a fall, and had a score of 17 indicating she is at high risk for falls. R2's hospital report dated 04/24/2024 documents R2 reported she was walking to the bathroom and slipped, falling, and striking her head on the left side of the floor; she presented to the emergency department after a fall. Radiology Results Report dated 04/29/2024 documents an x-ray was performed for R2 with results showing an acute fracture of the left foot, no Osteoporosis or Osteopenia. Fall Incident Report dated 04/24/2024 documents on 04/24/2024 V20 (Agency Nurse) heard R2 call out for help from her room bathroom, V20 ran down there to see her sliding off her wheelchair in the bathroom. R2 reported she was trying to use the bathroom by herself. Final Facility Incident Investigation Report dated 05/08/2024 documents R2 was observed on the floor in the bathroom, complained of pain to the left foot, the physician ordered an x-ray of the left foot which resulted in an acute fracture to the left 5th toe. R2 was sent to hospital for evaluation. R2 reported she hit her left foot on a pipe under the sink in the bathroom during a fall on 04/24/2024 while attempting to self-transfer from the toilet to the wheelchair. R2 was seen by ortho with recommendation for a postop shoe and follow up on x-ray in three weeks. On 05/24/2024 at 2:41 PM V14 (Registered Nurse) stated R2 requires assistance with transfers on and off the toilet and usually uses her call light if she needs assistance. On 05/24/2024 at 2:52 PM V15 (Certified Nursing Assistant) stated someone always assists R2 with going to the bathroom and she always asks for assistance for toileting. On 05/24/2024 at 3:03 PM when asked by V3 (Assistant Director of Nursing) how staff were alerted that she fell and needed help on 04/24/2024, R2 stated she yelled out for help and a nurse came to get her. On 05/24/2024 at 3:08 PM V16 (Certified Nursing Assistant) stated on 04/24/2024 R2 had put her call light on because she needed to be toileted, but she was busy providing care to other male residents. V16 stated she observed R2's call light was on when she went into the hall to get towels. V16 stated she responded to R2's call light, cut it off and let her know that she would return after she finished providing care to other residents and R2 agreed to wait. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 05/24/2024 at 3:20 PM V17 (Certified Nursing Assistant) stated on 04/24/2024 while watching residents in the dining area a nurse came and asked her for help because R2 had fallen. V17 stated when she asked R2 what happened R2 stated she had gotten herself out of bed and went to the bathroom on her own. V17 stated she believed this was not true because R2 cannot physically transfer herself out of bed, into her chair, or onto the toilet. V17 stated R2 has become increasingly confused lately. V17 stated there were a total of four certified nursing assistants working during the evening shift when R2 fell . V17 stated R2 usually won't get up without assistance. V17 stated she heard R2's call light right before the nurse came and asked her for help with a resident who fell . On 05/24/2024 at 3:25 PM R2 stated sometimes it takes staff a long time to respond to the call light. R2 stated if staff take too long to respond to the call light when she has to urinate, she won't be able to hold it. Fall Incident Witness statement completed by V16 (Certified Nursing Assistant) dated 04/24/2024 documents V16 reported she was R2's assigned CNA during that shift, she last saw R2 a few minutes before her fall, she was giving care to another resident during R2's fall incident, she had answered R2's call light and she stated she needed to use the bathroom, she told R2 she was in the middle of giving care to another resident and asked if she could give her a few minutes to finish with them and she will be right back to assist her to the bathroom. Fall Incident Witness statement completed by V22 (Certified Nursing Assistant) dated 04/24/2024 documents the last time she saw R2 was at dinner, she was providing patient care during the incident, and she was not present at the time of the incident. Fall Incident Witness statement completed by V15 (Certified Nursing Assistant) dated 04/24/2024 documents she was giving care to a resident in her assigned area and was not aware of R2 falling until after she was back in bed. On 05/24/2024 at 3:40 PM V2 (Director of Nursing) stated fall risk assessments are completed on admission, when a fall occurs, after a change in condition, quarterly, and annually for minimum data set assessments. V2 stated R2 requires one person assistance with transfers and usually calls for assistance. V2 stated R2 uses her call light, verbalizes the need for assistance when in the dining area, and will ambulate in her wheelchair to the nurse's station to ask for assistance with toileting. V2 stated R2 walks with restorative as part of a program. V2 stated toileting assistance for R2 includes ambulating her in her wheelchair to the handrail so she can stand, then she'll turn and pivot to sit down on the toilet, then the staff will need to assist her with pulling down and up her pants and brief during the process. V2 stated after R2 is done with toileting staff will clean her, pull her brief, and pants up or change her brief if necessary. V2 stated R2 will then turn and pivot back to the wheelchair. V2 stated staff can then place R2 in front of the sink where she can wash and dry her hands independently. V2 stated typically staff will close the door to provide R2 privacy while toileting and she will pull the call light to inform staff she has finished toileting. V2 stated staff can either stand outside the bathroom or room door while R2 is toileting. V2 stated staff should definitely be in either area while R2 is toileting. On 05/24/2024 at 4:58 PM V2 (Director of Nursing) stated she recalls now that R2 transferred herself from the bed to the wheelchair and then to the bathroom on the day she fell [DATE]. V2 stated R2 shouldn't transfer herself but is capable of doing so. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 05/24/2024 at 5:31 PM V2 (Director of Nursing) stated if a resident who can be toileted needs to go to the bathroom and their certified nursing assistant can't immediately assist them the expectation is the aide would ask another aide or nurse to assist the resident, or for the aide to finish up their task and then assist the resident. V2 stated older residents may only be able to wait for assistance with toileting for 2-3 minutes because they can't hold their bladder very long. V2 stated the aide should ask for assistance with getting the resident toileted in a timely manner. V2 stated it would not have been safe for R2 to transfer herself from her bed to her wheelchair, from her wheelchair to her bathroom toilet, and then back to her wheelchair after toileting on 04/24/2024 when she fell . V2 stated V16 (Certified Nursing Assistant) could have gotten someone else to assist R2 with using the bathroom during that time if she was not available to assist her. V2 stated the appropriate thing for V16 to do if she couldn't immediately assist R2 with going to the bathroom would have been to get someone to assist R2 to the bathroom right away. V2 stated it is possible that having to wait to go to the bathroom could have placed R2 in a position to attempt to transfer herself to the bathroom. R2's medical records only included an admission fall risk assessment dated [DATE] and post fall risk assessment dated [DATE]. The facility's Fall Occurrence Policy received/reviewed 05/24/2024 states: It is the policy of the facility to ensure that residents are assessed for risk for falls. A Fall Risk Assessment form will be completed by the nurse or the Falls Coordinator upon admission, quarterly, and annually.