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	08/18/2025

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 Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(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 Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [AGE] year old, female, admitted in the facility on [DATE] 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 [DATE] 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:[DATE] - 13, high risk[DATE] - 15, high risk[DATE] - 12, high risk[DATE] - 12, high riskFacility's final incident report dated [DATE] documented that on [DATE] 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 [DATE] at 2:41 PM, V7 (Registered Nurse, Agency) was asked regarding R5's fall incident on [DATE]. V7 stated, That day, [DATE] 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 [DATE], R5 complained of moderate head pain.On [DATE] at 3:10 PM, V8 (Registered Nurse, RN) was interviewed regarding R5. V8 replied, She is confused, I helped V7 last [DATE] 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 [DATE] at 3:20 PM, V9 (CNA) was also asked regarding R5's fall incident on [DATE]. V9 verbalized, On [DATE], 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