STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145734	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Evergreen Park	10124 South Kedzie Evergreen Park, IL 60805

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 - 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** 40066 Based on interview and record review the facility failed to follow the facility protocol to safely operate a full body mechanical lift by failing to use 2 staff persons when transferring a patient to a wheelchair from bed. This affected one of three resident (R1) reviewed for mechanical lift. This failure resulted in the full body mechanical lift tipping onto the floor and R1 falling to the floor, while still hooked by the sling to the lift. findings include: R1 incident report dated 11/1/24 states writer heard R1 yelling help. Writer observed R1 on the floor with the full body mechanical lift on the floor next to the resident. R1 complained of lower back pain, rated 10. R1's diagnosis include but are not limited to Encounter for Orthopedic Aftercare, Heart Failure, Atrial Fibrillation, Peripheral Vascular Disease, Chronic Kidney Disease, End Stage Renal Disease, Pain in Left hip, Displaced Fracture of Left Femur. On 11/8/24 at 10:13AM V8, R1's family, said R1 said the facility called me about 7:30AM. V8 said they said R1 was getting up for dialysis that morning and had a fall. V8 said they told me I didn't need to come in, but I came right in and R1 told me the mechanical lift fell on her. V8 said the whole time R1 said she was in pain, she had head and back pain. V8 said R1 said she hit her head. (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 - Few	On 11/8/24 at 1:58PM V7, CNA, said on 11/1/24 I was getting R1 ready for dialysis that morning. V7 said instead of getting someone to help spot me, I just did it. V7 said R1 was cooperative during the transfer, she was fine. V7 said I had R1 in the lift, and as it was going up it was not correct, I should have had someone there to spot. V7 said R1 was up in the air over the bed and as I was going towards the dialysis chair, moving to the chair, as lowering it, it happened quickly. V7 said I was turning it a little, I was getting ready to turn, getting over the chair, and as I was lowering R1 the fall occurred. V7 said everything went straight down. V7 said nothing came undone, R1 remained connected in the sling. V7 said V6, LPN, came in the room. V7 said we had to straighten the lift up, it was on one of the sides. V7 said R1 was all shook up. V7 said I am supposed to get a second person, a spotter, always, I did not on that day. V7 said I knew better that morning. V7 said I was just trying to get done. V7 said I have been inserviced yearly on the use of lifts. V7 said I would have to search for someone to help me. V7 said we used the same lift and put R1 back to the bed. V7 said V6 came and helped. V7 said R1 was all shook up. V7 said after the fall R1 was apologizing to me while we were putting her back to bed. On 11/8/24 at 11:16AM V6, Licensed Practical Nurse, said I had a resident fall last week. V6 said a Certified Nursing Assistant (CNA) said R1 had a fall during the transfer. V6 said I was walking down the hall, and I heard a resident yelling help. When I went in the room I had to push the door, I could not open it all the way, because R1 was up against the door. V6 said the CNA said the full body mechanical lift lost control. V6 said when I got in the room, I saw the lift and R1 on the floor. V6 said R1 was on the transfer pad and the lift was dangling over her. V6 said we unhooked the sling R1 was in from the lift. V6 said then I picked up the lift, it was on the floor on it's side, and we then put R1 back in the lift and into her bed. V6 said the CNA said she had R1 up in the lift and the lift got caught on the floor mat and tipped over. V6 said R1 was going from bed to dialysis chair. V6 said the only witness was V7, CNA, no other witness. V6 said for a mechanical lift transfer there are supposed to be 2 persons at all times. V6 said I spoke to V7 about using 2 persons, she knows, she was apologetic. V6 said V7 could have gotten me or another CNA to help with the transfer. V6 said this fall could have been avoided V6 said R1 got Tramadol for back pain. V6 said this is the first time R1 reported back pain to me. On 11/8/24 at 1:49PM V3, CNA, said R1 was cooperative with full body lift transfers. V3 said we always have 2 people for lift transfers. V3 said I was trained that way. On 11/8/24 at 12:29PM V2, Restorative Nurse, said when training staff on the use of the full body mechanical lift we tell them to use 2 people at minimum at all times. V2 said this is so 1 person to drive the lift and 1 person to stay with the resident and guide. V2 said the lift should be used with 2 people at all times, there is no time 2 people would not be required. V2 said the company comes out to check the lifts. V2 said I have not received reports that the lifts are not working properly. On 11/8/24 at 2:12 V9, Director of Nursing, was interviewed with V5, Administrator, present. V9 said the aid went in and transferred R1 and during the transfer the full body mechanical lift tilted and the resident ended up falling down and the lift was over her. V9 said I am not sure how the lift tilted. V9 said R1 was on the floor. V9 said on the incident report the incident was entered as other. The surveyor asked V9 what is the definition of a fall, V9 did not answer. V5 answered and said when there is a change in plane to another. V5 said R1 was in the sling. V5 said there was nothing mechanically wrong with the lift, we have them checked, it was fine. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 12:08PM V2, Restorative Nurse, provided document Transfer Status dated 10/29/24. V2 said this shows R1 is total dependent and X over box where V2 said that should be a picture of mechanical lift is not clear but that box means to use the mechanical lift. Restorative assessment dated [DATE] states R1 is Full Mechanical sling lift with 2 or more assist. The facility presented training record for V7 dated 11/1/24 which states when transferring a resident with mechanical lift two people should be transferring the resident. Employee skill observational competency test for V7 dated 4/20/24 Indicates while preparing the resident for transfers the following safe techniques are demonstrated placing the equipment in position with the assistance of a second staff member. Using the steering handle move the lift away from the bed with second staff member guiding the sling to ensure safety of resident. The facility provided patient lifts last passed inspection dated 9/11/24. Disciplinary record for V7 provided indicating suspension for 3 days due to improper mechanical lift transfer. 2 copies of suspension provided, one dated 11/1/24 but one dated 11/8/24 was initially presented. The facility policy Mechanical Lift Transfers dated 8/16/24 states there will always be two staff to assist resident. One person operating the machine while the other staff will guide resident and sling as resident is transferred and lowered.