STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145868	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Long Grove	1666 Checker Road Long Grove, IL 60047

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** 39537 Based on observation, interview and record review the facility failed to identify a fall for a resident with a history of falling and failed to implement their fall policy for 1 of 3 residents (R1) reviewed for safety/supervision in the sample of 3. The findings include: On 1/22/25 at 9:41 AM, R2 had self-propelled from the dining room area, in her wheelchair. R1 was in the dining room, watching R2 leave. R1 had a clothing protector on his chest, and it fell to the floor. R1 was in a high back wheelchair, with no foot pedals. R1 reached forward and tried to pick up the clothing protector from the floor. There was not a staff member inside the dining room area. V4 (RN -Registered Nurse) was at the medication cart, outside the dining room, looking down. R1 continued to reach for the clothing protector and his buttocks came off the seat of his wheelchair. The surveyor informed V4 (RN) that R1 was reaching for something on the floor and was concerned he may fall. V4 instructed R1 to stop reaching and stated, He's always trying to pick stuff up off the floor. A staff member picked up the clothing protector and placed it on the table, in front of R1. R2 started self-propelling back to the dining room. V4 stated, [R2] can you take that away from him (R1). R2 self propelled to R1 removed the clothing protector from R1's reach, spoke to R1 and turned his chair toward the TV. R1 was nonverbal. V4 (RN) said R2 looks out for R1 and stated, They're friends. R1's Facesheet dated 1/22/25 showed diagnoses to include, but not limited to: Parkinson's disease; PVD (Peripheral Vascular Disease); dysphagia; abnormalities of gait and mobility; lack of coordination; muscle wasting and atrophy; osteoarthritis; dementia; seizures and intellectual disabilities. R1's facility assessment dated [DATE] showed he had long and short term memory problems; and required substantial to maximum assistance from staff for oral hygiene, shower/bathe/ personal hygiene, bed mobility, and transfers. R1's Fall Risk Evaluation dated 12/23/24 showed he was at High Risk for Falls. (continued on next page)

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	R1's Behavior Note dated 1/16/25 at 3:40 PM showed, Resident was received in the bedroom, (CNA - Certified Nursing Assistant) got him dressed and came to the dining area, writer (V4 - RN) noted resident going back to his room and was (R1) instructed to remain in the dining room, resident refused, writer then went to check on resident and noted him bending over to pick his toy and slid off the wheelchair, resident POA (Power of Attorney) was made aware, PCP (Primary Care Provider) made aware with an order to monitor. The R1's Electronic Medical Record (EMR) did not contain an Incident Report, Change of Condition, SBAR assessment, or post fall follow-up documentation related to this fall. R1's progress notes did not show an assessment was completed, vital signs were obtained, or the fall was identified. R1's Care Plan initiated 4/12/23 showed, [R1] is at high risk for falls due to impaired mobility and activity intolerance secondary to diagnosis of Parkinson's disease, osteoarthritis, metabolic encephalopathy, seizures, HTN (Hypertension - high blood pressure), and severe sepsis with septic shock. [R1] tends to reach for his stuffed animals when they fall (on) the floor that makes him a high fall risk . This care plan was not updated after the fall on 1/16/25. The facility's Fall Report printed 1/22/25 showed R1 fell on [DATE]. This report did not show R1 fell on [DATE]. On 1/22/25 at 12:40 PM, V4 (RN) said R1 always carries too many toys with him. V4 stated, If he drops his toys, then he will reach for them and he will slide out off the chair. V4 said R1 is alert and oriented to himself but is not verbal. V4 said she was working 1/16/25, when R1 slipped out of his wheelchair. V4 said the CNA (she couldn't remember the CNA's name) had dressed R1 and brought him to the dining room. V4 said R1 started to self-propel himself back to his room. V4 said she encouraged R1 to return to the dining room, but then she got busy. V4 said later she checked on R1, in his room, and noticed him leaning to pick up his snake from the floor. V4 said R1 slid from the wheelchair and landed on his buttocks, on the floor. V4 said she didn't consider R1 sliding from the chair a fall, she considered it a behavior. V4 stated, He (R1) has a behavior of dropping things (usually his toys) and reaching for them. That's why she didn't consider this a fall and she entered a behavior note. I called his POA and told her what happened. She wasn't surprised. V4 said this has happened several times but was unable to provide any details. V4 said she saw R1 slide to the floor, so she didn't consider it a fall. V4 said she didn't complete a fall incident report, nor did she report the fall to V6 (Restorative Director). On 1/22/25 at 12:51 PM, V5 (CNA - Certified Nursing Assistant) said she's familiar with R1. V5 said R1 had lots of stuffed animals. V5 said if he drops anything, then he will try to reach for it himself. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 1:23 PM, V6 (Restorative Director) said she investigates all the falls at the facility. V6 said a change of plane or surface to surface change is considered a fall. The surveyor asked if a resident reached for an item on the floor and slid from the chair to the floor, then is that considered a fall. V6 replied, Yes, that would be considered a fall. V6 said the nurses should perform a head to toe assessment, neuro checks, check ROM (Range of Motion), and assess for injuries. V6 said the nurse should notify the family, physician, and her of the fall. V6 said the nurse will complete the Incident Report and any other necessary documents (i. e. SBAR, Change in Condition, Post Fall Monitoring, Neuro Checks). V6 said she will investigate the fall by talking to the resident, staff, and possible witnesses to determine the root cause. V6 said she updates the resident's care plans and monitors the effectiveness of the interventions. V6 said she was not aware that R1 fell on [DATE]. V6 said it had not been reported to her, so she had not followed the Fall Policy and Procedure. V6 said the process should be completed to properly assess the resident and revise the care plan in an effort to prevent future falls. V6 said R1's fall on 12/23/24 was also due to him reaching for stuffed animals on the floor. V6 said R1 was sent to the hospital for evaluation but did not have any injuries. V6 stated, I'm still trying to figure out what interventions will work for him. V6 said she will need to provide education on definition of a fall. On 1/22/25 at 1:55 PM, V7 (CNA) said R1 needs frequent supervision. V7 said R1 can't stand himself and needs the staff to perform 98% of the work (to transfer). V7 said R1 carries a lot of stuff animals and toys with him. V7 said if R1 drops the toys, then he will reach for them and he will slide right out of the chair. V7 said R1 does it a lot. The facility's Fall Occurrence Policy revised 7/26/24 showed, It is the policy of this 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. Procedure . 4. An incident report will be completed by the nurse each time a resident falls. 5. The Falls Coordinator will review the incident report and may conduct his/her own fall investigation to determine the reasonable cause of fall. 6. The nurse may immediately start interventions to address falls in the unit, even prior to the Falls Coordinator's investigation. 7. Ultimately, the Falls Coordinator may change the interventions provided by the nurse if the Falls Coordinator's investigation identifies a more appropriate interventions for the individual fall. 8. The Falls Coordinator will add the interventions in the resident's care plan. 9. The incident may be written in the nurses' notes or other parts of the resident's medical record that will remain accessible to any person who has the right to access the resident's record. 10. Interventions will be reevaluated and revised as necessary.