STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145510	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Lincoln Park	1366 West Fullerton Avenue Chicago, IL 60614

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35432 Based on observation, interview and record review, the facility failed to implement effective fall precautions for two of three residents (R37, R95) who were identified as fall risks. The facility also failed to provide effective interventions and monitoring to prevent falls, failed to provide access for ambulatory equipment per resident assessment and care plan to prevent fall. This failure includes 1 out of 1 resident (R95) who sustained multiple falls in a single month. R95 also sustained multiple knee abrasions. R37 and R95 were two of three residents identified in a total sample of 35 residents. 41356 1. On 06/05/2024 10:08 AM, R95 was seen alert but with confusion hard to maintain conversation. R95 was seen with cast on his left arm and abrasion on both knees. R95 [AGE] years old, initially admitted on [DATE]. R95 medical diagnosis includes schizophrenia, bipolar disorder, and dementia. R95 cognition impaired with brief interview of mental status (BIMS) score of 4 dated 3/16/2024. Per residents' record, R95 had 4 falls for the month in May 2024. R95 fell on the following dates: 5/1/2024, 5/15/2024, 5/24/2024, and 5/29/2024. On 06/05/2024 at 11:50 AM, V12 (Fall Coordinator / Registered Nurse) stated that R95 had six (6) falls for this year from January to May 2024. And in one of the falls R95 sustained abrasion on his bilateral knees. On the fall dated 5/1/2024, V12 stated that intervention was to place R95 in the center of the bed to prevent from rolling out of the bed. V12 stated, Yes, R95 fell because he rolled out of the bed. On the fall dated 5/15/2024, V12 stated that the cause was that R95 slip from the edge of the bed. V12 stated that it happened around 1:15 AM. V12 was asked since the fall that happened on 5/1/2024 happened because R95 rolled out of the bed. How did R95 slip at the edge of the bed? Was there monitoring done? V12 did not answer. V12 then stated, We did educate staff to adjust height of the bed to resident sitting level when he transferred back to bed. On the fall dated 5/24/2024, V12 stated that it happened around 2:00 PM, R95 claims he wanted to sit in the chair. R95 sat on his roommate wheelchair. R95 abruptly transferred back to bed. R95 forgot to lock brakes lost balance end up on the floor. (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 Note: The nursing home is disputing this citation.	On the fall dated 5/29/2024 stated that R95 attempted to get out of the bed without a walker and fall. The walker was at the foot of the bed. R95 cannot reach the walker easily. R95 landed on the floor through his knees then causing abrasions on both knees. V12 stated that falls of R95 was related to his behavior. V12 was asked if fall care plan includes R95 behavior to prevent R95 to fall. V12 reviewed the care plan and said, I don't see care plan for behavior to prevent R95 from falling. On 06/05/2024 at 01:09 PM, V23 (Restorative Director / Licensed Practical Nurse) stated that based on the last quarterly MDS (Minimum Data Set) R95 needs supervision during all transfers. R95 needs rolling walker or walker with the wheels. R95 needs a walker when ambulating because without the walker R95 is at high risk for fall. Resident goes to the bathroom or toilet at times by himself because of his cognition he does not ask for help. Ideally walker needs to be placed next to resident. R95 is at high risk of falling when ambulating without a walker. Per MDS assessment dated [DATE], R95 needs walker for mobility device. Per R95 fall care plan dated 4/4/2024 intervention includes have commonly used items, especially walker, within reach at all times. Post Fall Investigation for R95 are as follows: Dated 5/1/2024, time of the incident 5:37 PM. Documents that R95 has poor safety awareness and slid off the bed. Dated 5/15/2024, time of the incident 1:15 AM. R95 fell at the edge of the bed when trying to sit. R95 miscalculated how low the bed was and slipped fell on the floor. Dated 5/24/2024, time of the incident 2:00 PM. R95 fell after sitting on roommate's wheelchair and abruptly transferred back to bed. Dated 5/29/2024, time of the incident 2:47 PM. Abrasion of bilateral knees due to fall. R95's walker was at the foot of the bed not within reach. R95 attempted to go out of the bed without using his walker and landed on the floor resulting with abrasion on both knees. 45000 2. On 06/06/2024 at 11:41AM, surveyor located inside of R37's room and observes R37's bed in a high position, R37's bed observed to not be in the lowest position. R37 observed in a supine position with head of bed at 45 degrees. R37's bed observed in a high position that reaches surveyor's mid upper thigh measuring approximately 2 feet, 8 inches in height. R37 states she is not sure why her bed is positioned so high. R37 states she doesn't want to fall again because she fell in the facility sometime last year and broke her knee cap. R37 states she is still healing from her injuries. On 06/04/2024 at 11:45AM, surveyor makes V9 (Licensed Practical Nurse/LPN) aware of R37's bed being in a high position. V9 located inside of R37's room and observes R37's bed position and states R37's bed should not be this high. V9 observed operating R37's bed and lowering R37's bed to the lowest position. R37's bed is now in a position that reaches the bottom of surveyor's kneecap measuring approximately 1 feet, 6 inches in height. V9 states with R37's bed being in a high position, R37 could have reached for something, fallen, and sustained an injury. V9 states one of R37's fall precaution interventions is to have R37's bed in the lowest position when R37 is in bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 06/04/2024 at 11:54AM, V11 (CNA) states she is responsible for caring for R37. V11 states she recently was inside of R37's room changing R37's incontinence briefs. V11 states she forgot to lower R37's bed to the lowest position. V11 states she handed R37 the remote to lower the bed herself because that's what R37 likes to do. V11 states it is still V11's responsibility to make sure R37's bed is in the lowest position. V11 states R37 could have fallen and sustained an injury from R37's bed being in a high position. On 06/04/2024 at 1:52PM, V12 (Fall Coordinator/RN) states he has been the fall coordinator at the facility since January 2024. V12 states when a resident is admitted , they are assessed for their risk for falls by completing a fall risk assessment. V12 states a fall risk assessment should be completed upon admission and each time a resident fall. V12 states fall risk interventions are documented in the resident's care plans and updated with each fall incident. V12 states he checks the facility's electronic health record/EHR system to check for resident's fall information in risk management. V12 states he also leaves his telephone number on the home page pf the facility's EHR home page and tell staff to call or text him to notify him of any resident fall. V12 states the staff also knows to call and inform the nurse practitioner/NP or the medical doctor/MD and wait for their orders. V12 states the protocol to follow when a resident fall is to: Not move the resident off of the floor, perform an assessment, if the resident hit their head or are on blood thinners, then the resident is sent to the ER for evaluation automatically, and document in risk management. V12 states after each fall he gathers information to perform a root cause analysis of why a fall may have occurred. V12 states he and the IDT/interdisciplinary team meet every Thursday to discuss the falls of the week and any interventions to implement. Surveyor and V12 has R37's fall risk assessment dated [DATE] deployed on the computer. V12 and surveyor observes that R37's fall risk assessment documents that R37 scores a 7, indicating that R37 is at low risk for falls. V12 states R37's fall risk assessment section F. Mobility f1 is documented incorrectly. V12 states section f1 should be checked no instead of yes because R37 does not ambulate via walking. V12 states this is not an inaccurate assessment but V12 is not sure if correcting section f1 would change R37's fall risk score. V12 states if R37's bed is positioned in a high position, then R37 could potentially fall and sustain a great injury. R37's Fall risk assessment dated [DATE] documents that R37's fall risk score is a 7, indicating that R37 is at low risk for falls. R37's Face sheet documents that R37 has diagnoses not limited to: History of falling, personal history of (healed) traumatic fracture, cardiac pacemaker, unspecified dementia, and atrial fibrillation. R37's MDS dated [DATE] documents that R37 ambulates via wheelchair and no other assistive devices. R37 requires substantial/maximal assistance with ADL/Activities of Daily Living care. R37's MDS documents in part Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed- Not attempted due to medical condition or safety concerns. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space- Not attempted due to medical condition or safety concerns. R37's care plan dated 10/05/2023 documents a fall precaution intervention for R37's bed to be in the lowest position, R37's care plan documents in part, Bed in low position with wheels locked. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Facility policy dated 07/17/2023 titled Fall Occurrence documents 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. Procedure- 2. Those identified as high risk for falls will be provided fall interventions. 3. If a resident had fallen, the resident is automatically considered as high risk for falls. 6. The nurse may immediately start interventions to address falls in the unit .8. The Fall Coordinator will add the interventions in the resident's care plan.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45111 Based on observations, interviews and record review, the facility failed to follow their hot food policy by failing to provide hot food to one (R172) of 5 residents in a sample of 35 reviewed. Findings include: R172 is a [AGE] year-old individual whose current face sheet documents R172's medical conditions to include but not limited to: methicillin resistant staphylococcus aureus infection as the cause of diseases classified elsewhere, urinary tract infection, site not specified, strain of right quadriceps muscle, fascia and tendon, subsequent encounter, effusion, left knee. R172's Brief Interview for Mental Status (BIMS) dated [DATE], documents R172's BIMS as 15/15, indicating he has intact cognitive abilities. 06/04/2024 at 1:00am The last food cart reached the fourth floor, and the last tray was tested by V35 at 1:14 with surveyor observing. The carrots and cabbage tested at 112 degrees F. V35 stated all the hot food should be at least 135 degrees when it reaches the units so the residents can enjoy warm food and to prevent food borne illness. On 06/05/2024 at approximately 12:15pm, R172 was observed in his room and his lunch tray was brought to his room. R172 uncovered his food plate, tasted the food and stated to surveyor, touch this, the food is warm but not hot. R172 stated It's not that I want to get anyone in trouble, but its good when I get a warm enough meal. R172 stated V1 (Assistant Administrator) was in his room earlier today and told him if his food is cold or he feels it's not hot enough for him, he can request a new tray because staff cannot take his food and warm in the microwave for him because the nursing staff are not dietary staff and there is a risk of warming it too hot. R172 stated no staff have offered to get him a new tray when he lets them know his food is cold and he would like a hot meal. On 6/5/2024 at 10:45am, V1 (Assistant Administrator)-stated staff can rewarm a resident's food or kitchen can rewarm it upon resident request. V1 stated there are microwaves on the units that staff use to rewarm the food for the resident for safety reasons to prevent residents getting burned if they try to warm their own foods. V1 said resident families can also warm the food for the residents if they want to. On 6/5/2024 at 11:34am, V37(Certified Nursing Assistant-CNA) stated residents have told her the food is cold and when they do, she calls the kitchen for another tray because some residents have told her they like really hot food. V37 stated before, they (Staff) were able to warm the food in the microwave, but management told the staff to stop warming in the microwave as a precaution because management did not want the unit staff to warm the food too much and residents getting burned. V37 stated management told staff to now call the kitchen to have the food warmed. V37 stated the residents who can walk can warm their own food and their family members are allowed too, but staff are not allowed to warm the food in the microwave for the residents because the unit staff might warm it too hot which can burn the resident. V37 stated If a resident cannot walk, then the staff should call the kitchen to bring a new tray for that resident. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy titled Food Temperature Maintenance dated11/27/23 documents: -Hot foods items should leave the kitchen or steam table and served to the residents at a temperature at a temperature above 135 degrees Fahrenheit. Policy Titled Kitchen, dated 7/23/2024 documents: - Food Temperature a. Hot food temperature should be 135 degrees F and above.