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	07/12/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47304 Based on observation, interview, and record review the facility failed to properly assess, monitor, and evaluate one (R2) resident after a fall incident on 3/13/24 and 5/18/24. These failures could potentially affect one (R2) of three residents reviewed for improper nursing care. The findings include: R2's health record documented admitted on 2/1/2024 with diagnoses not limited to Unspecified fracture of left ilium, History of falling, Dysphagia oral phase, Thyrotoxicosis, Dementia in other diseases classified elsewhere, Major depressive disorder, Restlessness and agitation, Xerosis cutis, Atrophic disorder of skin, Depression, Insomnia, Iron deficiency anemia, Constipation, Alzheimer's disease, Unspecified protein-calorie malnutrition, Difficulty in walking, Other symptoms and signs involving the musculoskeletal system. On 7/10/24 At 10:10am R2 observed sitting up in wheelchair, wheeled by staff, alert and verbally responsive with bouts of confusion. At 12:01pm V17 (Fall and psychotropic Registered Nurse) requested if he could have V2 (Director of Nursing / DON) during the interview. V17 Stated he has been working full time in the facility for 3 years as a floor nurse then transitioned to Fall and Psychotropic nurse in January 2024. V17 stated the nurse should monitor / assess / document every 8 hours for 72 hours post fall incident. R2's EHR (electronic health record) reviewed with V2 and V17 states R2 is a fall risk. Had a fall incident on 3/13/24. It was an Unwitnessed fall. She was ambulatory with no device at that time. There was no injury post fall. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor and V17 reviewed 72hour documentation post fall incident, V17 stated with missing documentation. There was only one documentation on day 1 and day 3 that should have been three documentations as R2 should be monitored, assessed, or evaluated for any injury every 8 hours. There was no documentation found on day 2 post fall incident. V2 stated that documentation should be done by nurses every 8 hours x 72 hours post fall to ensure there are no changes or injury within 72 hours. V2 stated documentation is a tool that staff is monitoring or assessing the resident. V2 stated R2 was still ambulatory after the fall incident on 3/13/24, no changes physically with the resident. Standard nursing practice if no documentation, it was not done. V17 stated there was another Fall incident for R2 on 5/12/24 while she was out on pass. V2 stated R2's daughter informed the nurse on duty that R2 fell while she was running after her grandkids on the stairs at home. R2's daughter took R2 to the hospital with diagnosis of left iliac fracture. V2 stated prior to fall incident on 5/12/24, R2 was ambulating on and off, uses wheelchair for long distance. V2 stated after that fall incident with fracture, resident was Non ambulatory, there was a significant change in condition. V2 and V17 unable to find a significant change assessment. V2 stated resident should be monitored and assessed properly especially after a fall incident to provide appropriate care. At 1:15pm V18 (Restorative nurse) reviewed R2's EHR and stated there was a change in functional mobility from baseline. R2 needed more help with activities of daily living post fall incident with fracture. V18 stated that R2 uses wheelchair but able to stand and pivot. At 2:15pm V21 (Rehab Director) reviewed R2's HER and stated R2 was on skilled therapy 5/18/- 6/2/24. R21 stated upon discharge from therapy on 6/2/24, R2 needed moderate assistance with transfer and max assist with upper body and lower body dressing, bathing, and hygiene. At 2:51pm V22 (MDS coordinator) reviewed R2's EHR and stated R2 declined from the baseline upon readmission on 5/18/24 post fall with fracture. V22 stated there was no significant change assessment completed. V22 stated it was an oversight with coordination. V22 stated the team will complete a significant change assessment due to decline in R2's condition, she needed more help with bed mobility, transfer, and other activities of daily living. R2's MDS dated [DATE] showed R2's cognition was severely impaired and R2 needed Substantial / maximal assistance with oral and toileting hygiene, shower / bathe self, upper and lower body dressing, chair / bed, and toilet transfer not attempted due to medical condition or safety concerns. R2's MDS indicated R2 was always incontinent of bladder and bowel. R2's MDS dated [DATE] showed R2's cognition was severely impaired and R2 needed supervision / touching assistance with oral hygiene, upper body dressing, chair / bed transfer; Partial / moderate assistance with toileting and personal hygiene, shower / bathe self, lower body dressing, toilet transfer. R2's MDS dated [DATE] showed R2's cognition was severely impaired and R2 needed supervision / touching assistance oral hygiene, upper body dressing, chair / bed transfer; Partial / moderate assistance with toileting and personal hygiene, shower / bathe self, lower body dressing. Always incontinent of bladder and bowel. R2's post incident 72 hours follow up showed documentation completed on 3/13/24 and 3/15/24 with missing documentation on 3/14/24. Only one entry / documentation for 3/13/25 and one entry on 3/15/24. Per V2 and fall nurse documentation post fall should be done every 8 hours. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's progress notes showed she went out on pass with daughter on 5/11/24 and R2's daughter informed nurse on duty that R2 had a fall incident at home on 5/12/24. Admission Summary dated 5/18/2024 documented in part: R2 readmitted from Hospital and transported by local ambulance company via stretcher with diagnosis of Left closed hip fracture. Nurse Practitioner notes dated 5/19/24 documented in part: R2 was sent to emergency department due to left leg/hip pain after falling downstairs. Per hospital notes, R2 was chasing her grandchildren and fell down the last 4-5 stairs and hit head without LOC (loss of consciousness). Result revealed acute comminuted displaced fracture of the left iliac bone with adjacent soft tissue hematoma. Orthopedic surgery consulted and R2 deemed not a candidate for surgery. Facility's policy for notification procedures for change in resident condition dated 1/12/23 documented in part: If a significant change in the resident's physical or mental condition occurs, a significant change MDS will be completed as required.