

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/14/2024
NAME OF PROVIDER OR SUPPLIER  Avantara Lincoln Park		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32819</p> <p>Based on observation, interview, and record review the facility failed to follow policy procedures, failed to ensure that admission fall risk assessments are completed and include a score with actual risk, failed to ensure that Nursing staff are aware of residents at risk for falls, failed to ensure that Nursing staff are aware of resident fall prevention interventions, failed to implement fall prevention interventions, failed to ensure that alarms (in use) are functioning properly, failed to ensure that predisposing factors which contributed to a fall are included on the incident report, and/or failed to provide supervision to three of three residents (R2, R3, R4) reviewed for falls. These failures have the potential to affect 224 residents.</p> <p>Findings include:</p> <p>The (11/6/24) facility census includes 224 residents.</p> <p>On 10/24/24, the State Agency received allegations including a resident fall.</p> <p>R4's diagnoses include dementia, Parkinson's disease, lack of coordination, and abnormalities of gait/mobility.</p> <p>R4's (7/24/24) admission fall risk evaluation was not completed (Did the resident have a fall incident that occurred in the past 3 months? was not answered) and excludes a score and/or conclusion (indicating actual risk).</p> <p>R4's (7/30/24) BIMS (Brief Interview Mental Status) states resident is rarely/never understood and disorganized thinking is present.</p> <p>R4's (7/30/24) functional assessment affirms partial/moderate assistance is required for sit to stand, chair/bed to chair transfer, toilet transfer and walking.</p> <p>R4's (7/24/24) care plan includes risk for falls related to cognitive impairment, weakness, limited mobility, decreased activity endurance and history of falls. Interventions: bed and chair alarm to alert staff when resident transfers out from bed or chair without staff assistance, so staff can assist with resident's needs. Resident will be encouraged to be in a high visible area if she is awake and in wheelchair.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The facility fall log affirms R4 fell on [DATE], 9/8/24, and 9/11/24.</p> <p>R4's (9/3/24) incident report states incident location: resident's room (1:03am). Resident was found on the floor, after the chair alarm went off [therefore the fall was not witnessed].</p> <p>R4's (9/8/24) incident report states incident location: resident's room (9:50am). Manager on duty was in the hallway near resident's room when she heard the alarm go off. Upon entering observed resident sitting upright on the floor [therefore the fall was not witnessed].</p> <p>R4's (9/11/24) incident report states incident location: resident's room (9:15am). Bed alarm sounded off, CNA (Certified Nursing Assistant) informed Nurse on duty that resident was on the floor [witnesses are excluded].</p> <p>R4's (9/13/24) fall risk evaluation determined a score of 13 (high risk).</p> <p>On 11/6/24 at 3:06pm, R4 was observed in a wheelchair propelling herself in the hallway and unsupervised by staff.</p> <p>On 11/6/24 at 3:08pm, surveyor inquired about R4's fall prevention interventions, V12 (RN/Registered Nurse) stated She's close to the Nurse's station and we have mats placed by the bedside. She also has a bed and chair alarm. Surveyor inquired about R4's current location V12 walked to R3's room and responded, She's right here. R3 was at the doorway threshold entering her room and unattended by staff. Surveyor noted an alarm dangling from R4's wheelchair and the pad beneath R4's buttocks. Surveyor inquired about R4's chair alarm, V12 immediately grabbed the device to inspect it however a light (indicating the alarm was working) was not on. R4 subsequently stood up from the wheelchair (as requested) and the alarm failed to sound. Surveyor inquired if R4's chair alarm was working, V12 replied No, it didn't go off. Surveyor inquired if there should be a flashing light on the alarm (indicating its working) V12 stated Yeah.</p> <p>R3's diagnoses include fibromyalgia, chronic pain syndrome, spinal stenosis, morbid obesity, abnormalities of gait/mobility, and repeated falls.</p> <p>R3's (9/15/24) BIMS determined a score of 15 (cognition intact).</p> <p>R3's (9/15/24) functional assessment affirms partial/moderate assistance is required for rolling left/right, sit to stand, chair/bed to chair transfer, and walking.</p> <p>R3's (9/14/24) care plan includes risk for falls related to history of falls, current medication use, and disease process [interventions exclude keep commonly used items within reach].</p> <p>On 11/6/24 at 2:00pm, R3 was lying in bed however the over bed table and belongings were adjacent the foot of the bed (out of reach). R3 was noted to be struggling while attempting to turn/reposition herself due to morbid obesity. Surveyor inquired if R3 can walk R3 stated I use the wheelchair here cause they told me too. I could walk but it's not as good as when I first came in.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 11/6/24 at 2:12pm, surveyor inquired about R3's fall prevention interventions V10 (LPN/Licensed Practical Nurse) stated in part We put her (R3) table with all her things within reach to her. V10 subsequently entered R3's room (as requested) and proceeded to place R3's over bed table adjacent the bed. Surveyor inquired why V10 moved R3's over bed table V10 responded I make sure that she can reach.</p> <p>On 11/7/24 at 10:50am, V2 (Director of Nursing) presented R3's (9/13/24) admission fall risk assessment however a score/conclusion (indicating risk) was excluded. Surveyor inquired if R3 is at risk for falls, V2 reviewed the (9/13/24) fall risk assessment and stated No, she is not a fall risk. Surveyor requested the Restorative Nurse conduct R3's fall risk assessment today to affirm actual risk.</p> <p>On 11/7/24 at 12:50pm, V16 (Restorative Nurse) presented R3's (11/7/24) fall risk assessment which determined a score of 12 (high risk). Surveyor inquired if R3 is at risk for falls, V16 stated She's (R3) been a fall risk since admission. She (R3) was hospitalized because she was found on the floor, I think that was like in September (prior to admission).</p> <p>R2's diagnoses include dementia and repeated falls.</p> <p>R2's (12/26/23) admission fall risk assessment determined a score of 15 (high risk).</p> <p>R2's (10/18/24) BIMS states resident is rarely/never understood and disorganized thinking is present.</p> <p>R2's (10/18/24) functional assessment affirms substantial/maximal assistance is required for chair/bed to chair transfer and walking was not attempted.</p> <p>R2's (7/27/24) care plan states resident is high risk for falls related to cognitive impairment, weakness, poor balance, decreased activity endurance and history of falls.</p> <p>R2's (9/22/24) incident report states at 1:35am upon rounds CNA observed resident on the floor. Writer observed resident sitting on the floor near bed [witnesses are excluded]. Pants were soiled with urine. Resident stated she was trying to go to the washroom. [R2's predisposing situation factors which include trying to stand without assist, unsafe transfer without assist, and/or toileting needs were not selected on the incident report. R2's predisposing physiological factors which include gait imbalance, cognitive impairment, and/or incontinent were also not selected].</p> <p>On 11/7/24 at 10:56am, surveyor inquired about R2's predisposing factors to the (9/22/24) fall V2 (Director of Nursing) reviewed the incident report and stated, The call light in reach and bed in lowest position. Surveyor inquired about the predisposing factors which likely contributed to R2's fall V2 responded I don't see any other one that they check off on here.</p> <p>On 11/6/24 at 2:57pm, V14 (CNA) affirmed that she's assigned to the unit where R2 resides. Surveyor inquired about R2's fall prevention interventions, V14 stated I just started here, so I don't know about her conditions.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The fall occurrence policy (revised 7/26/24) states 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. A fall risk assessment form will be completed by the Nurse of the Falls Coordinator upon admission, readmission, quarterly, significant change, and annually. Those identified as high risk for falls will be provided fall interventions. An incident report will be completed by the Nurse each time a resident fall. The Falls Coordinator will review the incident report and may conduct his/her own fall investigation to determine the reasonable cause of fall. The Falls Coordinator may change the interventions provided by the Nurse if the investigation identifies a more appropriate intervention for the individual fall. The interventions will be reevaluated and revised as necessary.</p>		