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	04/23/2025

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 - Actual harm Residents Affected - Some	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** 45196 Based on observation, interview, and record review, the facility failed to ensure that a fall intervention was in place for one resident (R2) who is high risk for falls; and failed to provide adequate supervision for five residents (R2, R3, R4, R6 and R7) who are high risk for falls. These failures resulted in R2 sustaining a fall which required R2 to go to the local hospital due to sustaining a acute right femoral fracture; R3 sustaining a fall which required R3 to go to the local hospital due to sustaining a left femur intertrochanteric fracture; R4 sustaining a fall which required R4 to go to the local hospital due to sustaining an acute fracture of T12 vertebral body; R6 sustaining a fall in the bathroom which required R6 to go to the local hospital due to sustaining a T12 (Thoracic) superior endplate fracture and acute nasal septal fracture; and R7 sustaining a fall from the wheelchair which required R7 to go the local hospital due to sustaining a left eyebrow laceration with repair. Findings include: R2's Initial Reportable Incident to the state agency dated 01/07/25 at 2:20 pm, documents, in part: At approximately 3:20 PM nurse and CNA/Certified Nursing Assistant on duty heard a thud in room XXX and immediately responded. Observed resident lying on the floor on her right side in front of the room closet. Resident unable to relay what happened they're all body assessment conducted, observed with cut approximately 1 cm (centimeter) by .2 cm to the right side of eyebrow site cleanse with normal saline and applied pressure dressing. Resident grimaced and moan with the right arm movement. R2's Final Reportable Incident to the state agency dated 01/13/25 at 5:55 pm, documents, in part: On 01/07/25 obtain update from hospital that resident is admitted for acute right femoral fracture. R2's hospital records dated 01/09/25 documents in part: [AGE] year-old female with past medical history of dementia, thrombocytopenia, hypertension, heart failure per ejection fraction, prior to transient ischemic attack (TIA), atrial fibrillation on Eliquis depression who presents as a trauma activation following an unwitnessed fall around 2:30 pm. Was found down alert and oriented times one at baseline per nursing home unknown level of consciousness and blood thinners positive. Injuries acute committed fracture right proximal humeral neck 1.5 cm (centimeter) laceration right temporal with ecchymosis right cheek mild right parietal scalp contusion. R2's Brief Interview for Mental Status (BIMS) dated 01/06/25 does not show a score for R2 and indicates that R2 has memory problems. (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 - Actual harm Residents Affected - Some	R2's Minimum Data Set (MDS dated [DATE] shows that R2 requires supervision or touch assistance with putting on/taking off footwear, and walking 10 feet, 50 feet, and 150 feet. R2's Face sheet shows that R2 has diagnoses which include but not limited to other nondisplaced fracture of upper end of right humerus, subsequent encounter for fracture with nonunion, unsteadiness on feet, difficulty walking, other lack of coordination, unspecified dementia, and history of falling. R2's progress note date 01/06/25 at 3:20 pm and authored by V4 (Registered Nurse, RN), documents in part: Writer called into a room by staff and observed the patient on the floor next to the bed. When I asked resident what happened the resident seemed confused. Resident is assessed and laceration noted to right eye and right arm is injury to the right arm. Resident is assisted to the bed by staff and pressure dressing applied to right eye. MD (Medical Doctor) and public guardian office notified . emergency services is called to transport patient to hospital for evaluation. R2's fall assessment dated [DATE] shows that R2 has a score of 11 and indicates that R2 is high risk for falls. R2's care plan dated 10/28/24 documents, in part: Focus: R2 is at high risk for fall related to weakness, limited mobility, decrease activity endurance, cognitive impairments due to dementia Intervention: Purposeful rounds by staff (pain, positioning, potty, personal items, and parting). The facility's undated and titled document from third floor Certified Nursing Assistance (CNA) help book presented on 04/21/25 by V5 (RN) shows R2's fall intervention include but not limited to call light within reach and encourage to use it for assistance. The facility's document dated January 2025 through April 2025 titled Incident by Incident report shows that R2 sustained a fall with injury on 01/06/25 at the facility. On 04/16/25 at 2:06 pm, V9 (Certified Nursing Assistant, CNA) stated that V9 is familiar with R2 and that V9 was the CNA assigned to R2 on 01/06/25 and recalls R2's sustaining a fall on 01/06/25 at the facility. V9 stated that V9 heard a Boom loud noise like someone had fallen. V9 stated that V9 believes that V9 was down the hall charting when V9 heard the loud noise and that V9 went to R2's room because V9 felt that is where V9 heard the loud noise come from. V9 explained that R2 Sun Downs every evening, verbalizes that R2 is going to the Polish neighborhood, tries to obtain her R2's coat from R2's closet, and then attempts to leave the facility to go to the Polish neighborhood. V9 further explained that on 01/06/25 the day of R2's fall in question after it was after 3:00 pm when V9 heard a loud Boom went to R2's room and observed one of R2's arms underneath R2 and R2's head was bleeding above R2's eyebrow (V9 was unsure of which one of R2's eyebrows was bleeding). V9 stated that she observed R2 wearing only a night gown and no shoes. V9 stated that R2 frequently walked independently up and down the hallways by herself exit seeking the unit after 3:00 pm every day and that V9 believes this is what R2 was about to do prior to R2's fall. V9 explained that the last time V9 saw R2 prior to R2's fall on 01/06/25, R2 was walking independently in R2's room, throughout the unit independently. V9 explained that R2 would also go to the bathroom and toilet herself (R2) without staff assistance or supervision independently. V9 stated that after R2's fall on 01/06/25, R2 is now supervised by staff and R2 is placed in the dining room with staff. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	On 04/17/25 at 9:12 am, V4 (Registered Nurse, RN) stated that V4 is an agency nurse that works at the facility occasionally. V4 stated that V4 recalls R2 at the facility and that the day R2 had a fall on 01/06/25 V4 was at lunch when R2 fell . V4 stated that V4 believes that R2 was trying to walk in R2's room by herself and fell . V4 doesn't remember if R2 was a resident who cared for themselves or required supervision. V4 stated that V4 believes R2 used a walker to ambulate but doesn't recall if R2 had R2's walker when R2 fell . When V4 return from lunch V4 stated that the nurse that V4 was working with (V4 could not recall the nurses name) and V9 (CNA) had already assisted R2 off the floor from R2's fall. When V4 asked when was the last time V4 saw R2 prior to R2's fall V4 stated that V4 rounded on all of V4's residents prior to V4 going on break and that V4 believes that R2 was in the bed when V4 left the unit for lunch. When V4 was asked regarding how V4 knows what each resident's care requirement is at the facility, V4 stated that the previous nurse will give V4 report regarding the resident's care and that V4 also relies on the regular CNAs at the facility to let V4 know what kind of care each resident requires. On 04/17/25 at 10:10 am Surveyor attempted to reach V10 (Registered Nurse, RN) and was unsuccessful. On 04/21/25 at 8:35 am, R2 was in bed resting and R2's call light on the floor behind R2's bed not in reach. Surveyor brought this observation to V5 (Registered Nurse, RN, Falls Coordinator) and V5 stated the resident's call light should not be on the floor or behind the bed and should be in reach of the resident. When V5 was asked regarding the importance of residents call lights being within reach when the resident is in bed and V5 stated, So the resident can notify staff when they need something. The resident can soil themselves or try to get up without calling for help and fall. On 04/21/25 at 10:41 am, V27 (R2's Nurse Practitioner) stated that R2 is a resident who is a high risk for falls resident at the facility and requires supervision from staff due to R2's dementia and safety awareness. When V27 was asked regarding what could happen to R2 if R2 is in R2's room unsupervised and walking alone. V27 stated that R2's risk for falls will increase and that R2 could fall. V27 explained that R2 should be supervised by staff when R2 is walking for R2's safety. On 04/22/25 at 10:52 am, V2 (Director of Nursing, DON) stated that R2 is a resident who is high risk for falls and requires supervision from staff. V2 stated that the facility cannot provide R2 with one-to-one supervision at all times however when R2 is ambulating staff should be supervising R2 for R2's safety to prevent R2 from falling. When V2 was asked regarding fall interventions such as R2's call light V2 stated that R2's call light should be within R2's reach and accessible at all times to R2 to call for staff when R2 needs help. When V2 was asked regarding what could happen if R2's call light is not within reach and V2 stated, If the call light is not accessible then staff won't be able to know that the resident needs anything. When V2 was asked regarding what could happen if a resident who is at risk or high risk for falls is not being supervised by staff and V2 stated that it could be a risk for the resident to get out of bed, fall or other situations can happen if the resident is not being monitored. R3's Initial Reportable Incident to the state agency dated 01/11/25 at 1:45 pm, documents, in part: Unwitnessed fall with injury . on 01/11/25 approximately responded. Observed resident lying on the floor on her right side between bed and closet in R3's room. Resident unable to relay what happened head to toe assessment done, no apparent injury. Resident sent out to local hospital for further evaluation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	R3's Final Reportable Incident to the state agency dated 01/17/2025 at 6:45 pm, on 01/20/2025 at 4:00 PM obtain update from hospital that resident is admitted for left femur intertrochanteric fracture and further evaluation. R3's hospital records dated 01/13/25 documents in part: The patient is a [AGE] year-old female with history of hypertension, hyperlipidemia, and remote history of breast cancer status post lumpectomy who presents complaining of left hip pain after an accidental fall. The patient states that she felt like there might have been some soap on the floor, and she stepped into an area and slipped landing on her left hip. She (R3) then had left hip pain, so she (R3) was brought to the emergency department. She (R3) did not hit her head or lose consciousness. X-ray femur two or more views left clinical indication trauma pain findings impression displaced and angulated intertrochanteric fracture proximal left femur. R3's Brief Interview for Mental Status (BIMS) dated 01/16/25 shows that R3 has a BIMS score of 7 which indicates that R3 has some cognitive impairments. R3's Minimum Data Set (MDS dated [DATE] shows that R3 required supervision or touch assistance with toilet transfer, and walking 10 feet, 50 feet, and 150 feet. R3's Face sheet shows that R3 has diagnoses which include but not limited to displaced intertrochanteric fracture of left femur, history of falling, difficulty in walking, other symptoms and signs involving the musculoskeletal system, and need for assistance with personal care. When surveyor requested R3's progress notes regarding R3's fall on 01/11/25 V5 (RN) stated, We don't do progress notes. Its all-risk management. I did an incident report about the fall (referring to R3's fall on 01/11/25). R3's progress notes dated 01/11/25 at 4:26 pm and authored by V5 (RN) documents, in part: Nurse on duty spoke with local hospital and resident admitted for further evaluation. R3's fall assessment dated [DATE] shows that R3 has a score of 17 which indicated that R3 is high risk for falls. R3's care plan initiated 03/03/24 documents, in part: Focus: R3 is at a high risk for falls related to unsteady gait, disease process, anxiety, hypertension, and anemia, cataract at left and right eye . Intervention: Provide safe environment clutter free from spills. The facility's document for R3's tilted Falls Without Injury Report shows that on 01/11/25 9:00 am, documents, in part: Resident noted during rounding by CNA at approximately 8:30 am, on side of bed with breakfast tray resident clean and dry resident noted with nonskid shoes on feet. Resident bed noted in lowest position and call light within reach. At approximately 8:45 am, resident noted on the floor lying on the right side at 15 angle at the foot of bed. Resident glasses on floor. Resident with 1 shoe snugly with the other off her foot in lying next to her on the floor. The facility's document dated January 2025 through April 2025 and titled Incident by Incident report shows that R2 sustained a fall with injury on 01/11/25 and 01/17/25 at the facility. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	On 04/16/25 at 10:18 am, R3 was observed in bed, awake, predominately Spanish speaking and unable to answer surveyor's questions. On 04/16/25 at 1:18 pm, V5 (Registered Nurse, RN, Falls Coordinator) stated that V5 has been the Falls Coordinator at the facility since March 2025. V5 stated that V5 was R3's floor nurse on 01/11/25 when R3 sustained a fall at the facility. V5 stated that after R3 had been served her (R3's) breakfast on 01/06/25, V5 was alerted to R3's room by V8 (Certified Nursing Assistant, CNA). V5 explained that V8 stated The resident is on the ground. V5 then explained that V5 and V8 went into R3's room and observed R3 laying on her right side between the pathway from bed to R3's bathroom. V5 explained during the time of R3's fall, R3 ambulated without assistance, did not require supervision for walking, R3 walked by herself and was independent with ambulation. V5 stated when V5 went into R3's room, R3 was screaming and moaning out in pain and that R3 was trying to get herself off the ground and attempting to get up on her own. V5 further explained that V5 and V8 assisted R3 to taking a 1/2 step from the floor to bed and laid R3 down on her (R3's) left side. V5 then stated that V5 assessed R3 in bed and observed R3 guarding the injured side but was able to move all other limbs. V5 explained that R3 was sent to the local hospital for evaluation. V5 then explained that V5 spoke with R3's son who was with R3 at the local hospital and that R3's son stated that R3 informed her (R3's) son that she (R3) was trying to go to the bathroom and fell . V5 then reiterated that at the time of R3's fall on 01/06/25 R3 was independent with R3's care and it wasn't unusual for R3 to take R3 to the bathroom without staff. When V5 was asked regarding what can happen if a resident who requires assistance from staff for ambulating and toileting does not receive assistance from staff and V5 stated that the resident can soil themselves, they can get confused and not know where to go or they can be physically harmed if they encounter obstructions. On 04/16/25 at 1:40 pm, V8 (Certified Nursing assistant, CNA) stated that V8 vaguely recalls R3 having a fall on 01/11/25. V8 stated that V8 gave R3 her breakfast and R3 sat on the side of the bed and that V8 left out of R3's room. V8 stated that when V8 returned to R3's room to give R3's roommate their breakfast tray V8 observed R3 on the floor near the bathroom and R3's closet area. When V8 was asked regarding if V8 performed any Activities of Daily Living (ADL) care for R3's on the day of R3's fall (01/11/25), V8 stated that V8 don't recall given R3 ADL care or assistance on the day of R3's fall. V8 stated it was around 8 am and that V8 only provided ADL care before breakfast to the residents who ask for ADL care prior to breakfast. V8 stated that V8 didn't recall if R3 was a resident who was able to communicate her (R3's) needs. V8 stated when V8 saw R3 on the floor, V8 yelled out for the nurse and V5 (RN) assisted R3 to bed, assessed R3, called the ambulance, and had R3 transport to the local hospital. On 04/22/25 at 10:41 am, V27 (R3's Nurse Practitioner) stated that R3 is a resident who is a high risk for falls resident at the facility and requires supervision from staff due to R3's safety awareness. When V27 was asked regarding what could happen to R3 if R3 is in R3's room unsupervised and walking alone and V27 stated that R3's risk for falls will increase and that R3 should be supervised by staff when R3 is walking for R3's safety. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	On 04/22/25 at 10:52 am, V2 (Director of Nursing, DON) stated that R3 is a resident who is high risk for falls and requires supervision from staff. V2 stated that the facility cannot provide R3 with one-to-one supervision at all times however when R3 is ambulating staff should be supervision R3 for R3's safety and to prevent R3 from falling. When V2 was asked regarding what could happen if a resident who is at risk or high risk for falls is not being supervised by staff and V2 stated that it could be a risk for the resident to get out of bed, fall or other situations can happen if the resident is not being monitored. R4's Initial Reportable Incident to the state agency dated 01/26/25 documents, in part: at approximately 6:50 PM nurse heard a loud thud on 3 north hallway and immediately responded. Observed resident sitting on the hallway across room XXX door. Resident unable to relay what happened. A visitor of another resident told nurse that R4 was walking in hallway, fell and hit her head against the wall. Head to toe assessment done, no visible injury. Resident nonverbal no grimaces no sign of pain. Physician and family informed. Residents sent to local emergency room for further evaluation. R4's Final Reportable Incident to the state agency dated. 01/31/25 documents, in part: On 1/26/25 at 4:00 AM obtain update from local hospital that resident is admitted for acute fracture of T12 vertebral body. R4's hospital record dated 01/27/25 documents, in part: [AGE] year-old female with a past medical history of diabetes, falls, seizures, severe dementia sent here for a fall unable to obtain review of systems giving her severe dementia . Fall T12 fracture states acute on CT (Computed Tomography) scan. R4's Brief Interview for Mental Status (BIMS) dated 02/02/25 shows that R4 does not have a BIMS score and indicates that R4 has memory problems. R4's Minimum Data Set (MDS) dated [DATE] shows that R4 requires supervision or touching assistance with walking 10 feet, 50 feet, and 150 feet. R4's Face sheet shows that R4 has diagnoses which include but not limited to wedge compression fracture of T11-T12 (Thoracic) vertebra, difficulty in walking, other lack of coordination, syncope, and collapse, need for assistance with personal care, history of falling, and unspecified dementia unspecified severity, dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R4's progress note dated 01/25/25 at 7:44 pm, and authored by V6 (LPN, Agency) documents, in part: Resident observed sitting on the floor in hallway near her room, visiting witness stated that resident observed falling and hitting the back of her head on wall. Resident transferred to local hospital for medical evaluation to rule out head injury. 911 call for transfer, Power of Attorney (POA) notified of transfer, nursing manager informed of this incident. The facility's undated document titled Post Fall Investigation/RCA (Root Cause Analysis) Investigation documents, in part Activity at the time of Incident: Ambulating independently R4's fall assessment dated [DATE] documents R4 has a score of 13 and which indicates that R4 is high risk for falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	R4's care plan dated 01/21/25 documents, in part: Focus: R4 is at high risk for falls related to muscle weakness, activity intolerance, and cognitive impairment due to Dementia. The facility's document titled Incident by Incident report shows that R4 sustained a fall at the facility on 01/25/25, 02/02/25, 02/06/25, 02/16/25, 03/14/25, 02/26/25 03/20/25. On 04/16/25 at 10:04 am, R4 was observed sitting in the third-floor dining room. R4 was not able to answer surveyor's questions. On 04/17/25 at 10:11 am, V11 (Certified Nursing Assistant, CNA) stated that V11 works part time at the facility. V11 stated that V11 recalls caring for R4 at the facility. V11 stated, R4 requires a lot of attention because R4 is a wanderer who will fall if you are not watching her (R4). If she (R4) is not supervised she will also put things into her mouth. She requires a lot of redirection. V11 stated that R4 requires minimal assistance from staff for ambulation and that if R4 is not kept entertained she will wander off. V11 also stated that the facility's activities only keep R4's attention for a minute and then V11 will wander off throughout the unit ambulating alone. When V11 was asked regarding R4's fall on 01/25/25, V11 stated that V11 was not assigned to R4 the day of R4's fall and that V11 came back the next day to work and was told that R4 had a fallen. V11 stated that V11 does not recall caring for R4 on 01/25/25 or ever caring for R4 on a day that R4 has fallen. V11 stated that V11 was never R4's CNA when R4 sustained a fall at the facility. The facility's document dated Saturday January 25, 2025, shows that V11 (CNA) worked on 01/25/25 during the 3:00 pm, - 11:00 pm shift on the 3rd floor unit. On 04/17/25 at 11:16 am, surveyor attempted to reach V6 (Licensed Practical Nurse, LPN, Agency) and was unsuccessful. On 04/17/25 at 11:22 am, attempted to reach V17 (CNA) and was unsuccessful. On 04/17/25 at 11:24 am, V18 (CNA) stated that V18 is familiar and has cared for R4 at the facility. When V18 was asked regarding R4 sustaining a fall at the facility V18 stated, I don't recall caring for R4 at the facility when R4 had a fall. I (V18) never cared for R4 when R4 had a fall. V18 stated that R4 is a resident who walks all day and requires constant redirection and will get right back up after staff seats R4. V18 also explained that R4 wanders in the hallways alone at times when staff walks away from R4. V18 explained that R4 walked constantly alone throughout the facility and was given activities to do however R4 would still walk throughout the unit when staff would leave R4. On 04/22/25 at 10:14 am, V26 (R4's Nurse Practitioner, NP) stated that R4 is a resident who has dementia and wanders throughout the unit at the facility and is a high risk for falls. V26 also stated that R4 will sometimes walk backwards really increasing R4's risk for falls due to R4's safety awareness. V26 stated that R4 requires supervision from staff at all times due to R4's safety awareness. V26 also explained that R4 has sustained falls at the facility and staff was unaware that R4 had fallen until staff observed R4 on the unit on the ground. When V26 was asked regarding what could happen if R4 who is at risk or high risk for falls is not supervised by staff and V26 stated that R4 could fall, and staff not be aware for a while. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	On 04/22/25 at 10:52 am, V2 (Director of Nursing, DON) stated that R4 is a resident who is high risk for falls and requires supervision from staff. V2 stated that the facility cannot provide R4 with one-to-one supervision at all times however when R4 is ambulating staff should be supervising R4 for R4's safety and to prevent R4 from falling. When V2 was asked regarding fall interventions for R4 V2 stated that staff will take R4 to activities however R4 will often leave activities and wander throughout the unit. When V2 was asked regarding what could happen if a resident who is at risk or high risk for falls is not being supervised by staff and V2 stated that it could be a risk for the resident to get out of bed, fall or other situations can happen if the resident is not being monitored. On 04/22/25 at 11:24 am, surveyor attempted to reach V6 (Licensed Practical Nurse, LPN, Agency) and was unsuccessful. On 04/17/25 surveyor requested a Resident Supervision Policy and V1 (Administrator) stated that the facility does not have a policy regarding supervising the residents at the facility. On 04/22/25 at 9:45 am, V1 (Administrator) stated that the facility identified the increased falls from January and that the facility has undergone a lot of changes regarding staffing to improve supervision and fall occurrences. The facility's document dated 07/26/24 and tilted Fall Occurrence documents, in part: Policy Statement: 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 . 2. Those identified as high risk for falls will be provided fall interventions. The facility's document dated 05/20/2022 and titled Certified Nursing Assistant documents, in part: summary objective in keeping with our organization's goal of improving the lives of the guests we serve, the certified nursing assistant (C.N.A.) plays a role in providing superior customer service in nursing care to all guests. The CNA safeguards the health, safety, and welfare of all guests under their care by following applicable laws, regulations, and establish nursing policies and procedures . 4. Attends to individual needs of all guests in regard to incontinent care, transferring, ambulation, range of motion, communication, and other needs . 7. Must be knowledgeable of individual care plans and support the care planning process by providing supervisors the specific information and observations of the guests needs, preferences and report any behavioral changes. The facility's document dated 12/1/2019 and titled LPN (Licensed Practical Nurse) Floor Nurse documents, in part: Summary/Objective and keeping with our organization's goals of improving the lives of the guests we serve the licensed practical nurse LPN plays a critical role in providing superior customer service and nursing care to all Guests and guests. The L. P. N. provides supervision of staff and will safeguard the health, safety, and welfare of all Guests/guests yes under their care by following applicable laws, regulations, and established nursing policy and procedures . 14. Must be knowledgeable of individual care plans and support the care plan process by reporting specific information observation of guest needs, preferences and report any behavioral changes. (continued on next page)

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	04/23/2025

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 - Actual harm Residents Affected - Some	The facility's document dated 12/1/2019 and titled RN (Registered Nurse) Floor Nurse documents, in part: Summary/Objective and keeping with our organization's goals of improving the lives of the guests we serve the licensed practical nurse RN plays a critical role in providing superior customer service and nursing care to all Guests and guests. The R.N. provides supervision of staff and will safeguard the health, safety, and welfare of all Guests/guests yes under their care by following applicable laws, regulations, and established nursing policy and procedures . 14. Must be knowledgeable of individual care plans and support the care plan process by reporting specific information observation of guest needs, preferences and report any behavioral changes. 45644 A facility incident report to IDPH (Illinois Department of Public Health) initial report dated 2/2/25, documents in part, on January 31,2025, R6 was observed laying on her left side in the washroom in R6's room, with a nosebleed and cut to left forehead. On 2/2/25 received an update from hospital that R6 was being admitted for an acute T12 (Thoracic) superior endplate fracture and acute nasal septal fracture. R6's admission record diagnoses include but not limited to cerebral infarction, hypertension, heart disease, difficulty in walking, unsteadiness on feet, lack of coordination, need for assistance with personal care, history of falls, fracture of nasal bone, wedge compression fracture of T11-T12 vertebra, and dementia. R6's (2/6/25) Brief Interview of Mental Status (BIMS) score is 10, which indicates R6 has moderate cognitive impairment. R6's Functional abilities for chair/bed to chair transfer is coded a 2 that requires substantial/maximal assistance. R6's 1/31/25 hospital records documents in part, CT (Computed Tomography) of head: acute nasal septal fractures as well as suspected nondisplaced depressed fracture of the anterior nasal arch. Small forehead contusion with laceration. CT of C/A/P (Chest/Abdomen/ Pelvis) impression: acute T12 superior endplate compression fracture or dislocation. diagnoses T12 compression fracture and nasal septal fracture. On 4/17/25 at 2:20 pm, V24 CNA (Certified Nursing Assistant) stated, I (V24) had just left out of R6's room. I was in the room assisting R6's roommate. I heard a boom like something falling from the hallway. It was her (R6) falling in the bathroom. I went into the bathroom she was laying on the floor. I called for the nurse and the nurse came in and assessed her. When we (staff) lifted her head up, we saw blood coming from her face, and 911 was called. Sometimes she (R6) doesn't use her call light, and we'll see her standing. Her gait is not steady. At that point she did not have a bed alarm on. She needs assistance, but sometimes do not always wait for it. She is not safe being alone. She needs to be supervised because she thinks she can do things on her own. She is a 1:1 assist. She can walk just need someone on her side because of her unsteady gait. On 4/22/25 at 10:29 am, Surveyor inquired about R6's falls in the facility? V27 (Nurse Practitioner) stated, I (V27) am aware of R6 having a history of falls. She (R6) is a high risk for falls. She does require supervision and is a 1 person assist because she is wheelchair bound. She is cognitive sometimes she has poor insight on her medical condition is why she requires supervision. She should not be walking without supervisor. If she walks without supervisor she will fall. (continued on next page)

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	04/23/2025

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

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(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 - Actual harm Residents Affected - Some	On 4/22/25 at 10:52 am, V2 DON (Director of Nursing) stated that R6 is a high risk for falls, that require supervision. If a resident that requires supervision is not supervised, they can fall. Surveyor asked V2, why no injury was observed at time of incident, on R6's fall injury report when R6 was bleeding from her nose and head? V2 stated, The nurse documented wrong, the injuries should have been on the report. Surveyor inquired about a bed alarm for R6? V2 stated, Bed alarms are used for residents who get up on their own. We try not to use bed alarm because the alarm startles the resident. Facility's fall with injury report for R6 dated 1/31/25 documents in part, Injury Observed at Time of Incident: No injuries observed at time of incident. R6's Post Fall Investigation /RCA (Root Cause Analysis) Investigation dated 2/2/25, documents in part unwitnessed fall with injury, ambulating independently, alert oriented x/times 2, and poor safety awareness. R6 is a fall risk and has a history of falls. Facility's fall list reviewed from January 2025 to April 2025. R6 had a fall on 1/12/25 and 1/31/25 in the facility. R6's (1/12/25) fall risk evaluation documents in part, fall risk score is 13 which indicates high risk. R6's (1/31/25) fall risk evaluation documents fall risk is 11 which indicates high risk. R6's (7/2/24) care plan documents in part, Focus: R6 is at high risk for falls related for current medication use, poor safety awareness, unsteady gait, diminished perception/sensations of urge to void, impaired mobility. A facility incident report to IDPH (Illinois Department of Public Health) initial report dated 2/2/25, documents in part, CNA (Certified Nursing assistant) reported to nurse that R7 abruptly leaned forward in her wheelchair and fell face forward on the floor. Observed cut to forehead with moderate bleeding observed. Final report dated 4/7/25 documents Laceration and age indeterminate anterior right 3rd rib fracture. R7's admission record diagnoses include but not limited to fracture of right-side rib, lac[TRUNCATED]