| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145510 | A. Building<br>B. Wing | 09/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avantara Lincoln Park | 1366 West Fullerton Avenue<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility [A] failed to provide adequate supervision for 1 cognitive impaired resident (R1) who is a high fall risk with a history of falls, and [B] failed to follow their fall prevention policy to ensure fall interventions were put into place for each fall, and failed to implement the interventions that were in place, for one [R1] of two residents reviewed for falls. Findings Include:R1's clinical record indicates the following in part: R1 with medical diagnoses of hydrocephalus, repeated falls, type II diabetes, dementia, history of falling, and essential hypertension. Minimum data set [MDS] Brief Interview Mental Status Score Indicates R1 is cognitively impaired. R1's Clinical Electronic Record indicates:R1 sustained 11 falls on: 3/31/25, 4/10/25, 5/12/25, 5/16/25, 5/30/25, 6/28/25, 7/15/25, 7/17/25, 8/4/25, 8/15/25, and 8/27/25.R1's Care plan in part:3/14/25, R1 is a high fall risk related to dementia.Interventions:Keep all needed items like water pitcher, tissue box, urinal within reach [3/14/25],Provide a safe environment, and a working and reachable call light [3/14/25]Engage R1 in activities that interest him during the day [5/12/25]R1 to assisted in putting on appropriate footwear when out of bed in the morning [5/12/25]Family will provide well-fitting nonskid shoes [6/28/25]Bed alarm [7/17/25][Missing fall interventions for 3/31/25, 4/10/25, 5/16/25, 5/30/25, 8/4/25, 8/15/25, and 8/27/25]8/28/25 R1 has osteoarthritis of bilateral hips and chronic pain due to cervicalgia. Interventions: Educate care givers on safety measures that need to be taken in order to reduce risk of falls.R1's Progress notes in part:8/15/25 Nurse Note at 11:30 PM:R1 is awake. He got out of his bed sitting on the floor.V5 [Registered Nurse]8/21/2025 9:30 PM Behavior Note Behavior: CNA [Certified Nurse Assistant] staff observed R1 slowly lowering self to the floor. Resident able to stand up by himself, no assistance. R1 given a chair to sit on. Non-Pharmacological Interventions: Redirected to sit in the chair. Pharmacological Interventions: Night medication administered. List education provided: Summary/Outcomes: R1 sat on the floor witnessed by the CNA, resident then stood up by himself with no assistance needed. Resident currently on the chair near the nurse's station.8/22/25 V7 [Licensed Practical] Nurse Note:R1 observed to have yellowish purple bruise to top of right shoulder. V6 [Nurse Practitioner] notified, new orders to transfer R1 to emergency room for evaluation.8/23/25 at 12:42 AM Nurse Note:R1 admitted to hospital diagnosis: Fall. X-rays and CT scan was negative.8/27/25 at 1:09 PM Nurse note:R1 returned to facility. Nurse practitioner and family made aware.8/27/25 at 2:42 PM V7 [Licensed Practical Nurse] Nurse Note:Change in Condition: R1 witness fall, unresponsive verbally for approximately five minutes. Primary physician gave order to send to emergency room.8/31/25 at 9:25 PM Psych Note:Chart review, R1 was recently hospitalized from [DATE] to 8/27/25 for an unwitnessed fall. CT scan of head no acute findings. After R1 returned to the facility, R1 had a witnessed mechanical fall, evaluated at emergency room, EKG negative, pelvis and bilateral hips x-rays no acute findings. R1 returned in stable condition.Interviews:On 9/6/25 at 12:05 PM, V14 [Licensed Practical Nurse] and surveyor observed R1 sitting on the edge of his bed eating lunch alone, wearing socks. R1's call light was tangled on the floor underneath the head of bed. Water pitcher, tissue box or urinal was not in reach. R1 stood up and walked around in the room the bed alarm did not sound off. V14 stated, I am an agency nurse and work here often. I am familiar with R1. He [R1] is a high fall risk and a frequent fall resident. Nursing staff provides R1 with frequent monitoring and supervision. R1 needs stay in his room because he has a cough. R1 is negative for Covid and influenza, but in nurse-to-nurse report, R1 needs to stay in his room. R1 is not on isolation. R1's call light in tangled up on the floor, its supposed to be in reach at all times. I think the bed alarm is not on, because it did not sound when R1 stood up off the bed. I did not turn the bed alarm off, but the alarm needs to be on. R1 does not have any bruises now, but he had some face and shoulder bruises about a month ago from a fall.On 9/6/25 at 12:22 PM, V16 [Activity Assistant] stated, I am familiar with R1. He has not participated in activities for a couple of days because he must stay in his room due to coughing. R1 enjoys sensory, touching, music, exercise, and coloring. Typically, when is resident is on isolation I would go and complete one-to-one activities in their room. R1 has not had one-to-one activity in his room, but I can start today.On 9/6/25 at 2:33 PM, V7 [Licensed Practical Nurse] stated, R1 is alert but very confused, and requires constant supervision and monitoring due to wandering and frequent falls. On 8/22/25, R1's family member [V4] requested R1 to be sent out to the hospital due to bruising on his forehead and shoulder from a previous fall. All test results were negative for fractures. On 8/27/25 R1 returned back to the facility around 1:00 PM. Later around 3PM, R1 was in the dining room, I guess he tried to sit on another resident's lap, but he missed the chair and fell on |