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	03/29/2026

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	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** Based on interviews and records reviewed the facility failed to complete an accurate fall risk assessment to identify a newly admitted resident (R2), with a history of falls, unsteady gait, and Dementia with confusion was at high risk for falls and provide 1 person assistance for safe transfers and ambulation. This failure affected 1 of 3 residents reviewed for falls.R2's diagnoses include but are not limited to Polyneuropathy, Peripheral Vascular Disease, Hypertension, Dementia, Osteomyelitis of the Left Ankle and Foot, and Cellulitis of the Left Lower Limb. According to admission assessment R2, [AGE] year-olds, was admitted to the facility on [DATE] at approximately 2:21PM. According to Incident Report dated 2/25/25 at approximately 3:10AM R2 fell in the hallway. R2 was transferred on 3/25/25 to the hospital for evaluation and did not return to the facility. R2's medication includes a daily blood thinner, Xarelto.On 3/28/26 at 12:34PM V11, CNA (certified nursing assistant), listed as assigned to R2 on 3/25/26 at 3:00AM said I don't remember R2. V11 said I work on all floors. V11 said contact guard assist (CGA) means I would assist the person with transfer or walking to the next location by placing my hand on them. V11 said I would use a gait belt.On 3/27/26 at 1:30PM V16, Fall Coordinator, said to be a fall risk, we need to know of any previous falls, if a family tells us there is a history of falls, then the resident is at risk. We have an assessment for fall risk. Interventions used will depend on the person and situation, we can use floor mats or alarms.On 3/28/26 at 11:55AM V8, Restorative Aide, said CNAs are issued a gait belt at the time of hire and everyone is trained on use of gait belts. V8 said we have extra gait belts at the nurses' stations for the staff to use. V8 said for new admissions, we wait for therapy to assess them before we give them a walker. V8 said Restorative aids do not assess new admissions for transfers, that would come from therapy.On 3/28/26 at 9:52am V12, RN (registered nurse), said I was given report from the day shift on that day (3/24/26). V12 said I was told R2 was alert and oriented times 2-3 and he used a walker. V12 said I can't recall when I first saw R2 on that shift. V12 said I had assisted R2 with toileting about an hour before the fall. V12 said I was in the hall and saw R2 walking alone to the bathroom and I went in to help him. V12 said I helped him because he was still new at the time. V12 said R2 had a steady gait up until the fall. V12 said R2's room was about halfway down the hall from the nurses' station. V12 said when the fall occurred, R2 had come out of his room and was walking towards the nurses' station with a walker, he was in a gown and had non-skid socks on. V12 said I was walking towards him, and he was asking about breakfast, I offered to help him with returning to his room. V12 said he went to turn around, lifted his walker, I was near him and tried to catch him, but he then fell onto his buttock and backwards hitting his head. V12 said R2 was on blood thinners, he hit his head, so I sent him to the hospital. V12 said when they gave me report at the start of the shift, they told me he was a fall risk. V12 said interventions for residents at risk includes monitor them, keep the bed low, all needed items are near the bedside, call light is in reach, and we do frequent rounds. V12 said I can't remember who the CNAs were that shift. V12 said after the fall, we left R2 on the floor for paramedics to pick him up. V12 said when I went to make the phone calls, someone stayed with R2, but I can't remember which CNA. V12 said R2 was a new admission, and he did not use the call light either time I (continued on next page)

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	assisted him, that shift. V12 said R2 was getting up a lot during the shift, it was a new environment for him, and he had some confusion.On 3/28/26 at 11:44am V7, CNA, said I was on the opposite side of the hall doing rounds and saw R2 walking to nurses' station. V7 said R2 was coming to the nurse where she was with her cart. V7 said I saw the nurse with R2 and my back was turned to both of them. V7 said R2 had a walker and was dressed in street clothes. V7 said R2 had gotten himself up, he had been in his bed. V7 said I think he heard the noise in the hall of us doing rounds and it prompted him to see what was going on. V7 said when I heard the noise, I saw he had fallen, then I went to help. V7 said R2 was on the floor. V7 said V11, CNA, (the other CNA assigned to the floor) was not in the area during the time of the fall.On 3/28/26 at 1:03PM V13, R2's wife, said my husband fell several times prior to his admission to the facility. V13 said R2 fell off the toilet at home trying to get up. V13 said R2's last fall was just before he was hospitalized on [DATE], I think his last fall was in January 2026. V13 said while R2 was in the hospital he had a chair and bed alarm. V13 said we have a full time care giver for R2 and he told a group of staff at the desk R2 was at risk for falls and had alarms in the hospital. V13 said the staff said we can't do that until he gets assessed the next day. V13 said R2 does not have a good sense of where he is, he is elderly, has dementia, and was weak from the IV therapy he was undergoing. V13 said the facility placed him in a room far from the nurses' station, about 4 rooms away from the desk. V13 said no one ever called me from the facility for a history or to ask any questions about him during the admission. V13 said I think they were going off of what R2 said to them.On 3/27/26 2:29 V10, Director of Nursing, said I expect the Fall Risk Assessment for a new admission to be completed within 4 hours of admission to have a baseline for the plan of care. V10 said I did not meet R2. R2 had just been admitted . V10 said after the fall, I spoke to the nurse, V12 (RN), about it. V10 said I was told around 2:00am R2 was observed ambulating to the bathroom, he was steady with a walker, and the nurse assisted him. V10 said later, R2 was observed in the hallway with a walker, steady gait, anti-skid socks, and he was looking for breakfast. V10 said when the nurse saw him she was redirecting him. He was lifting his walker while turning. V10 said it was a witnessed fall, he then fell to the floor. V10 said R2 landed on his buttock and hit his head, then we sent him out 911. V10 said V12 saw R2 hit his head on the floor; he sustained an abrasion and reported back pain. V10 said based on R2's fall risk assessment he was at low risk for falls. V10 reviewed R2's admission skin assessment and said he was noted to have wounds on the left ankle and had an amputated toe (healed). V10 said R2 went to the hospital, and he did not return. V10 said I didn't speak to his family regarding R2.On 3/28/26 at 12:28pm V10 said contact guard assist (CGA) for ambulation means staff is touching the person, uses a gait belt, and walks with the person.On 3/28/26 at 1:33pm V10 said when gathering information on admission it comes from nurse-to-nurse verbal communication from the hospital. V10 said the hospital will report what equipment is needed, IVs used, or any restrictions. The admitting nurse looks at assessments, medical records sent from the hospital and note any appointments. V10 said for questions, if the patient can answer they use that, but the answers need to correlate with the medical record. V10 said social services will do cognition assessments. V10 said the nurse is expected to review the medical record, if the family is here, we can discuss care with them. V10 said after, we may place a courtesy call to let the family know the have arrived to the facility. V10 said some residents can be responsible for themselves. V10 was asked if a resident fell in January and is admitted to the facility in February, are they a fall risk? V10 replied hypothetically, in that situation yeah then they are a fall risk. V10 said if the family is present with the resident and making a request, such as siderails or alarms, then we should look at the request. V10 said we would not tell the person that they will have to wait until the next day, we should not say that. V10 said no one reported to me that the care giver was present and requesting an alarm for R2 on the day of admission. V10 reviewed R2's fall risk assessment with the surveyor. V10 said the fall assessment was accurate based on the history that R2 had a fall in the past. V10 said I don't know where the walker R2 was using when he fell came from, it was not from us. On 3/27/26 at 3:02PM V9, Administrator, said we used the hospital paperwork to determine R2's ambulation status (continued on next page)

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