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	05/21/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents are free from physical abuse for one of four residents (R2) reviewed for abuse in the sample of four.Findings include:Facility's final incident report documents, in part: on 5.13.2026, Administrator notified by V5 (LPN-Licensed Practical Nurse) that she responded to a commotion on the fourth floor. Staff observed (R3) standing at the bedside of his roommate, R2), holding (R2's) grabber with both hands gesturing back and forth in front of (R2). Residents immediately separated. (R3) on 1:1 supervision. V6 (Physician) notified and orders to be sent to hospital for further evaluation.R2's medical record (Face sheet) documents R2 is a[AGE] year-old male with diagnoses including but not limited to: Other Reduced Mobility, COPD, Dysphagia, Type 2 Diabetes Mellitus, Chronic Kidney Disease Stage 3, and Chronic Respiratory Failure. R2's MDS (Minimum Data Set of 3.6.2026) documents a BIMS (Brief Interview for Mental Status) of 13 denoting R2 is cognitively intact.R3's medical record (Face sheet) documents R3 is a 73- year -old male, with diagnoses including but not limited to: Encephalopathy, Delusional Disorders, Chronic Kidney Disease, Dementia, Psychotic Disorder, and Anxiety Disorder. R3's MDS (Minimum Data Set of 5.22.2026) documents a BIMS (Brief Interview for Mental Status) of 9 denoting R3 is moderately cognitively impaired.On 5.15.26, Administrator (V1) interviewed resident R3 and re-interviewed R3 on 5.19.26. R3 stated that his roommate is very old and he would never intentionally hurt an old man. He stated that his roommate was banging his reacher against the table and he didn't like the noise, so he went to his roommate and attempted to take the reacher from him.On 5.15.26, Administrator (V1) interviewed resident R2 and re-interviewed R2 on 5.19.26. R2 stated that his roommate had come over, they were struggling with the reacher, as his roommate was trying to take it away from him. R2 stated his roommate hit him. R2 was asked to explain what hit him meant. R2 kept motioning the motion of going back and forth with the reacher. R2 was shown an example of striking with the reacher and he stated no.On 5.14.2026 at 7:21 PM, V1 (Administrator) said, I only have one reportable incident for the past three months. I just sent that one in yesterday. R2 and R3 are roommates and have never had any issues. R2 has a behavior of banging things (remote, grabber/reacher tool). Apparently R2 was banging his grabber, R3 got up and tried to take it away from R2. The nurse heard a commotion, went to their room and saw R2 and R3 involved in a tug of war of sorts. Both residents were holding onto the grabber and pushing/pulling back and forth. R2 had a small reddish circle like area on his hand. R3 was petitioned out to (hospital) for psych eval and has not returned.On 5.14.2026 at 9:35 PM, R2 was observed awake, alert in bed. Head of bed was elevated approximately 30 degrees. Gauze wrap dressing to left palm appeared clean/dry/intact. Elevated side rails x2. Call light within reach. Surveyor asked R2 what happened to R2's hand, and R2, without hesitation, clearly said in English, my roommate hit me. He's gone now; he's at a mental hospital.On 5.15.2026 at 5:09 PM via telephone, V5 (LPN-Licensed Practical Nurse) said, it happened on 5.13. 2026. I was doing my med pass. Around 11:00 AM, I heard a commotion coming from R2 and R3's room. I walked in, R2 was lying in bed, R3 was at the bedside. Both were holding on to R2's grabber, like playing tug of war. I tried to redirect R3, but he wasn't being compliant. When V7 came (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	into the room, she said to R3, let go and escorted I R3 out of the room. R2 had an abrasion to his left palm. R3 was petitioned to the hospital for psychiatric evaluation and treatment.5.15.2026 at 7:17 PM, V7 (CNA-Certified Nursing Assistant) said, on that day I was in another room doing patient care. I heard R2 hollering and then V5 (LPN-Licensed Practical Nurse) going into R2's and R3's room and hollering don't do that, get off him. I stopped what I was doing and ran into their room, V5 was by the doorway still hollering at R3 to get off him (R2). When I got there, R3 was standing over (R2). Both R2 and R3 were holding onto the grabber, almost like tug of war, going back and forth. R3 was pushing towards R2 and R2 was pushing towards R3. To me it looked like R3 was trying to push it towards R2's neck. As I got into the room I said to R3, what are you doing? You need to stop. R3 stopped and went over to his bed and laid down. That's when three staff (Housekeeper, CNA and Nurse) came into the room. R2 was hollering, because his hand was hurt. R2 said, he hit me, he hit me. I did see his hand (R2) was bleeding between thumb and index fingers. I think R3 just got annoyed and angry with R2 and just wanted him to stop.On 5.21.2026 at 12:20 PM, R3 was observed awake, alert sitting in wheelchair at bedside, eating lunch and watching TV. R3 agreed to speak with surveyor. R3 said, R2 has a stick that R2 uses to beat on the counter when R2 wants the nurse. He was banging on the counter, he was annoying me, I tried to get the stick away from him. That's all there is to it. I'm getting tired of talking about it.On 5.13.2026 R2's Skin/Wound evaluation documents, in part: left hand (palm), new abrasion. Length: 2 centimeters, width: 1.5 centimeters, depth: 0.1 centimeters. Initial treatment applied after cleansing with saline. Will refer to wound specialist.Abuse and Retaliation Policy (Reviewed/Revised 1.29.2026) documents, in part: It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows federal guidelines dedicated to prevention of abuse and timely and thorough investigation of allegations. These guidelines include compliance with the seven (7) federal components of prevention and investigation. Types of Abuse and Examples 1. Physical: Physical abuse includes but is not limited to infliction of injury that occur other than by accidental means and requires medical attention. Examples: hitting, slapping, kicking, squeezing, grabbing, pinching, punching, poking, twisting, and roughly handling.

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F 0603 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents were kept free from involuntary seclusion when staff tethered a bedsheet from the resident's room door handle to a hallway handrail, physically trapping the resident inside the room. This deficient practice affected one of four residents (R1) reviewed for abuse. A reasonable person reviewing these actions would conclude that tying a door shut with a bedsheet is a punitive, non-therapeutic mechanism used to involuntarily confine a resident.A reasonably prudent caregiver would recognize that blocking an exit in this manner completely strips the resident of their freedom of movement, creates an immediate fire and entrapment hazard, and serves strictly as a measure of staff convenience to manage the resident's whereabouts.Findings include: R1's medical record (face sheet) documents R1 is an [AGE] year-old female with diagnoses including but not limited to: Polyneuropathy, unspecified, Bipolar disorder, current episode manic without psychotic features, severe, Unspecified protein- calorie malnutrition and Violent behavior. R1's MDS (Minimum Data Set of 3.6.2026) documents a BIMS (Brief Interview for Mental Status) as 8 denoting R1 is moderately cognitively impaired.On 5.14.2025 at 9:49 PM, R1 said, I don't recall them locking me in my room.On 5.15.2026 at 6:05 PM via telephone, V17 (NP-Nurse Practitioner) said, I was notified by nursing that (R1) was aggressive and violent towards staff and roommate. I was informed that resident was in her room alone. I didn't feel comfortable that R1 was in her room alone. I was concerned that R1 was not being monitored in her manic state, that something could happen to her, R1 could have fallen or hung herself. I was crucified by email for writing detained in my note. They (facility) wanted me to change my note, to say resident was monitored. They had a script they wanted me to follow. I didn't feel comfortable doing that. They harassed me so much that I added an addendum to my original note. On 5.16.2026 at 1:10 PM and 5.19.2026 at 3:26 PM via telephone, V8 (CNA-Certified Nursing Assistant) said, around 5:00 AM, I heard R1 saying lady, lady. I went to investigate, R1 said she was okay, R4 you could tell she looked agitated. Approximately 30-40 minutes later, R4 came out of the room. R4 said she (R1) woke me up. She had her hand in my face. I told R4 to have a seat at the nurse's station. It was crazy. Okay, so at this point, V10 comes out of restroom. I let her know what's going on. V10 told R1, you can't do that. R1 said something like who's house is that. R1 comes all the way to the med cart, saying stuff to her (V10), putting her hand in V10's face like she (R1) was going to hit V10. At this point I saw R1 grab the pill crusher. V10 grabbed R1's hands. Now R1 is fighting. I grabbed R1's wheelchair and sat her down in her wheelchair. R1 bit V10 before I was able to get R1 in the wheelchair. V10 was holding R1's hands to prevent her from hitting people, R1 was kicking at me. V10 pushed R1 in her room. At this point R1 is still trying to fight, still aggressive. V10 stated I called V9 (ADON-Assistant Director of Nursing). I (V10) told V9 that R1 was very aggressive at the moment, fighting with V10; V10 put R1 in R1's room. V9 asked me to speak with V10, I let V10 know. R1 ended up tied in her room so she wouldn't get out. The sheet was on the door, I'm guessing tied to the handrail in the hallway. I stood outside the door to monitor. R1 did end up calming down and lying down when R1 realized she couldn't get out of the room. I know it wasn't appropriate (to tie sheet to door handle and secure to hallway handrail). It's part of abuse, it's seclusion. On 5.16.2026 at 2:07 PM, V9 (ADON-Assistant Director of Nursing) said, the first call I received from V10 was at 5:59 AM on 5.2.2026. V10 told me, I got bit by R4, she bit me on the arm. V10 said R1 was bothering R4 I asked her what she (V10) did. V10 said, I removed R4 from the room and put her at the nurse's station. I tried to talk to R1, she came to my med cart, she grabbed the pill crusher and tried to hit me with it. I blocked her from hitting and that's when she bit my arm. V10 told me she brought R1 back to her room. We hung up so that V10 could go and check on R1. I called a third time, around 7:00 AM. V10 said, R1 is calm now. Earlier when she was having behavior, I put a towel or a sheet on the door, I tied the door. I told her to immediately remove (continued on next page)

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F 0603 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	it. That's abuse, involuntary seclusion. On 5.19.2026 at 12:34 PM, V11(CNA) said, well, I was standing at the nurse's station at approximately 7:10 AM looking to see who would be working with me that day. V15 (CNA) was coming down the hallway. He asked me, what's going on with R1's room. We both saw the sheet tied to the door and handrail, the door was completely closed. I heard her call help. I undid the sheet. I went into R1's room, she was alone in the room. When I was going to untie the door, the nurse (V10) said, you don't know what's going on, don't let her out. I said this is our morning shift. I'm unlocking the door. When we went in, R1 was standing by the door. R1 seemed upset, anxious. R1said, I had to fight for my life. Where were you at? I told R1 to calm down. The door shouldn't have been tied. I think it's abuse. I would panic if I were secluded in a room like that. On 5.19.2026 at 2:14 PM, V2 (DON-Director of Nursing) said, V10 said, In the moment I was flustered, I didn't want her (R1) to come out of the room again. I didn't want anyone to get hurt. V10 acknowledged what she did. She was suspended pending outcome of the investigation. She finally resigned. That's involuntary seclusion. That's a form of abuse. How would you feel? I would feel bad. I would be confused why I am being kept in the room. I would feel bad. When I spoke to administration no report had been sent in. It should have been reported. On 5.19.2026 at 3:02 PM, V14 (CNA-Certified Nursing Assistant) said, I did see the sheet tied to R1's room door handle and handrail. The door was closed, R1 was alone in her room. V10 should not have done that, I don't feel it was safe for R1. I would feel upset if someone did that to me. On 5.2.2026 at 5:30 AM, R1's Progress Note documents, in part: Resident was physically aggressive toward her roommate and staff. (R1) attempted to hurt her roommate. Roommate was immediately separated from (R1). (R1) came out to the nurse's station toward the nurse and grabbed the pill crusher machine to hit the nurse. The nurse tried to remove the machine from (R1). (R1) then bit the nurse in the Rt.(right) arm.On 5.2.2026 at 7:37 AM, R1's (Telehealth) Progress Note documents, in part: Notified by nursing this morning that patient has been extremely violent and aggressive towards staff and her roommate. Patient is currently detained in her room alone. Patient has been biting staff physically, assaulted her roommate and grabbed the pill crusher machine to attempt to throw at the nursing staff. Review of R1's care plan and physician orders revealed no clinical rationale, behavior management protocol, or orders permitting the restriction of the resident's exit.In-service sign in sheet dated 5.4.2026 documents a 1:1 was given over the phone to V10. The topics were Abuse Policy (Prevention, Identification & Reporting). Crisis Management, documentation and thorough communication/communication of events to MD/medical doctor, family, Nurse Practitioner. Abuse and Retaliation Policy (Reviewed/Revised 1.29.2026) documents, in part: It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows federal guidelines dedicated to prevention of abuse and timely and thorough investigation of allegations. These guidelines include compliance with the seven (7) federal components of prevention and investigation. Types of Abuse and Examples 4. Involuntary Seclusion: Isolation of a resident against his/her will (involuntary, imposed seclusion). This is different from placing the resident in a room for emergency reason to protect resident form himself or protect other residents in emergency situations. Examples: statements to threaten or secluding, isolating or locking a resident in their room or a room or area by themselves.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to follow their abuse policy by failing to ensure that one of four residents (R1) was protected by failing to immediately report an allegation of involuntary seclusion to the State Survey Agency within the required two-hour timeframe for one of four (R1) residents reviewed for abuse in the sample of four.Findings include:On 5.14.2026 at 7:21 PM and 5.15.2026 at 9:17 PM, V1 (Administrator) said I only have one reportable incident for the past three months. I just sent that one in yesterday. I did not send an incident report to IDPH (Illinois Department of Public Health) for R1. I should have; it was a missed opportunity. There was a moment when V10 (LPN-Licensed Practical Nurse) called V9 (ADON-Assistant Director of Nursing). V10 told V9 that V10 had placed a bedsheet on R1's door handle and tied it to the hallway handrail. V9 told V10 to immediately remove the sheet.On 5.16.2026 at 2:07 PM, V9 (ADON-Assistant Director of Nursing) said, the first call I received from V10 was at 5:59 AM on 5.2.2026. V10 told me, I got bit by R4, she bit me on the arm. V10 said R1 was bothering R4 I asked her what she (V10) did. V10 said, I removed R4 from the room and put her at the nurse's station. I tried to talk to R1, she came to my med cart, she grabbed the pill crusher and tried to hit me with it. I blocked her from hitting and that's when she bit my arm. V10 told me she brought R1 back to her room. We hung up so that V10 could go and check on R1. I called a third time, around 7:00 AM. V10 said, R1 is calm now. Earlier when she was having behavior, I put a towel or a sheet on the door, I tied the door. I told her to immediately remove it. That's abuse, involuntary seclusion. It should have been reported to IDPH.Abuse and Retaliation Policy (Reviewed/Revised 1.29.2026) documents, in part: It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows federal guidelines dedicated to prevention of abuse and timely and thorough investigation of allegations. These guidelines include compliance with the seven (7) federal components of prevention and investigation. VII. Reporting/Response. All allegations and/or suspicions of abuse and retaliation must be reported to the Administrator immediately. All allegations of abuse and retaliation must be reported to IDPH immediately not exceeding 2 hours after the initial allegation is received.