

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S 000	Initial Comments Complaint Investigation: 2482762/IL171696 Investigation of Facility Reported Incident of 02-22-2024-IL171753 Investigation of Facility Reported Incident of 03-20-2024-IL171755 Investigation of Facility Reported Incident of 04-01-2024-IL171779	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 3 300.610a) 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or	S9999		

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 05/08/24
--	-------	---------------------------

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 1</p> <p>misappropriation of property.</p> <p>These regulations were not met as evidenced by:</p> <p>Based on interviews and records review, the facility failed to keep one resident (R4) free from abuse in a sample of three reviewed. This deficiency resulted in R4 being hit by R5 with a walker, and R4 sustained a laceration to the forehead requiring five sutures.</p> <p>Findings include:</p> <p>Facility Reported Incident Report (FRI) dated 3/20/2024 documents: -Physical abuse and documents R4 stated R5 picked up walker and pushed it towards his face. Investigations stated R4 sustained 5 sutures to right eyebrow, right hand skin tear and mid back abrasion.</p> <p>Hospital records dated 3/20/2024 document: -R4 assaulted by another resident with a walker. Patient c/o (complaining) of mild headache. Sustained laceration to forehead and skin tear to right hand. R4 is alert and oriented X4 (Person Place, time, situation). -R4 has two inches laceration superior right eyebrow, 5 cm in length, and 2 cm in depth. Laceration repaired with 5 sutures.</p> <p>R4's current face sheet documents R4 is a 94-year-old individual last admitted to the facility on 2/6/2024 and discharged on 4/9/2024. R4's medical conditions include but not limited to: Cerebral infarction, unspecified, syncope and collapse, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/19/2024
NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 2</p> <p>anxiety.</p> <p>R4's MDS (Minimum Data Set) section C -Cognitive Patterns documents R4's Brief Interview for Mental Status (BIMS) dated Feb 9, 2024, as 14/15, indicating R4 has intact cognitive funtion, and R4's MDS section GG - Functional Abilities and Goals dated Feb 22, 2024, document R4 needs partial/moderate assistance with showering/toileting, eats independently, and uses a manual wheelchair.</p> <p>R5 is a 72-year-old individual admitted to the facility on 3/13/2024 and discharged on 3/20/2024. R5's current face sheet documents R5's medical conditions to include but not limited to: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R5's Brief Interview for Mental Status (BIMS) dated Mar 23, 2024, document R5 has a BIMS score of 11/15, indicating R4 has moderate cognitive impairment. Section GG - Functional Abilities and Goals dated March 20, 2024, document R5 needs partial/moderate assistance with showering/toileting, eats independently, and R5 uses a walker for mobility.</p> <p>On 04/18/2024 V30 (Psychiatric Nurse Practitioner) said R4 was alert and oriented to person, place and sometimes to time, because R4 sometimes would forget where he was. V30 said R4 was not violent, and R4 mentioned to V30 that R5 threw a walker at him, and V30 observed a bruise on R4's forehead. V30 said R4 told her that he was not happy at being in the facility and he wanted to leave and go home especially after he was hit by R5, and he was disturbed that R5 hit him, and he did not understand why this could happen to him while he was at the facility. V30 said R5 was moved to</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 3</p> <p>another room and R4 felt safe but wanted to go home after the incident.</p> <p>On 4/16/2024 at 2:47 pm, V8 (Certified Nursing Assistant-CNA) said she was in another resident's room, when V10(Licensed Practical Nurse-LPN) asked her to go to R4's room and assist her. V8 said R4 and R5 were fighting, and R5 hit R4 with a walker. V8 further said when she last checked on R4 and R5 at about 2:40am, they were both in bed watching TV. V8 said she asked R4 what happened, and R4 said R5 threw something at him, and he threw it back at him. V8 said she saw R4 with gash between his forehead and nose, and he was bleeding. V8 said she assisted V9 and V10(LPNs) to clean R4. V8 said residents are not supposed to hit each other, and that's a form of abuse.</p> <p>On 4/16/2024, at 3:00pm, V9(Licensed Practical Nurse-LPN) she as she was coming out of another resident's room when she saw R4 in the hallway with V10(LPN). V9 said she went to find out what was happening and to assist because R4 was her resident that night. V9 said she saw R4 has a gash on his forehead and was bleeding, and R4 kept saying a resident (R5) hit him, pointing to his roommate (R5). V9 stated she started cleaning R4 up and put pressure on the gash, then called V12(ADON) who was in the building, called the physician, family and 911, and orders were given to send R4 to the nearby hospital. V8 stated hitting is not allowed in the facility and this is a form of abuse.</p> <p>On 4/16/2024 at 3:18pm, V10(Licensed Practical Nurse) said she was at the nursing station when she saw R4 at the nursing station with a gush on his head, V10 provided care and notified V9(LPN), who was R4's nurse that night. V10</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 4</p> <p>stated residents should not hit each other because that is a form of abuse.</p> <p>On 04/17/2024 at 12:16am, V2(Director of Nursing-DON) V2 said residents should not hit each other, because that's physical abuse, and the facility has to intervene and separate residents before the abuse happens. V2 stated what happened between R4 and R5 would be considered resident to resident physical altercation, which is a form of abuse.</p> <p>On 04/17/2024 at 12:32pm, V1(Administrator) she got a call in the middle of the night on 3/20/2024 by nursing staff letting her know there were two residents (R4, R5) appeared to have had a physical altercation, which is a form of physical abuse. V1 said residents should not hit each other. V1 stated R5 has dementia, and he was startled when R4 put on the rights in their room, which prompted R5 hit R4 with his walker.V1 said R4 was sent to the hospital and received a few sutures to the head.</p> <p>On 4/17/2024 at 1:36pm, V12 (Assistant Director of Nursing-ADON) said V8 & V9 (LPNs) called him to the unit and informed him that there had been an alteration with injuries between R4 and R5. V12 said upon entering the unit, he observed R4 by the nursing station near the North Hallway, and the V8 and V9 were attending to him. V12 said R4 had a laceration on his forehead which was bleeding, and the nurses were putting pressure on it. V12 said he called 911 immediately, because R4 has a wound on the head that was bleeding. V12 said R5 was in the room with a CNA (cannot remember the name of CNA). V12 said he then called V1(administrator) who is the abuse coordinator and notified her of the alteration between R4 and R5. V12 stated</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 5</p> <p>what happened between R4 and R5 was physical abuse. V12 said physical contact between residents is not allowed in the facility.</p> <p>Facility Policy Titled Abuse and Neglect, dated 07/14/2023 documents: Policy Statement: 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 the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These guidelines include compliance with the seven (7) federal components of prevention and investigation.</p> <p>Abuse: Abuse is willful infliction of mistreatment, injury, unreasonable confinement, intimidation, or punishment. Abuse assumes intent to harm, but inadvertent or careless behavior done deliberately that results in harm may be considered abuse.</p> <p>Physical: Physical abuse includes but 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.</p> <p>Police Report Number: JH194447.</p> <p>Statement of Licensure Violations:</p> <p>(A) 2 of 3 300.610a) 300.1010h) 300.1210b)</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 6 300.1210d)3)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.</p> <p>Section 300.1010 Medical Care Policies</p> <p>h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 7</p> <p>resident to meet the total nursing and personal care needs of the resident.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record</p> <p>These regulations were not met as evidenced by:</p> <p>Based on interview and record review the facility failed to recognize, monitor, and provide needed services for a resident who had been noted with swelling of right leg and decline in activity for one resident (R2) out of three residents reviewed for quality of care, causing R2 to continue with a swollen leg for several days. R2 sustained an acute right hip fracture and underwent surgery to fix the fracture. The facility also failed to ensure that a cognitively impaired resident's pain management regimen was followed in accordance with physician's orders as the resident was not assessed for pain consistently. This failure affects one (R2) resident out of three residents reviewed for pain management. As a result of this failure, R2's well-being was significantly affected.</p> <p>Findings includes:</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 8</p> <p>Facility reported incident/FRI dated 03/18/2024 documents that the facility reported an unwitnessed fall with injury. FRI documents that R2 sustained an acute right hip fracture. FRI documents 03/18/24 physician was notified with orders to send out R2 to hospital for further evaluation.</p> <p>R2's hospital record date 3/18/2024 8:57 PM documents in part: "Xr femur 2 or more views right final result Findings and impression: Complete transverse impacted fracture of the base of the Right femoral Neck/intertrochanteric region with varus deformity. No other Location. Osteopenia. Vascular calcifications. Degenerative changes Lower lumbar Spine."</p> <p>R2's face sheet dated 04/17/2024 documents that R2 is a 94-year-old female with diagnoses not limited to: nondisplaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, encounter for other orthopedic aftercare, muscle weakness, dementia, history of falling. pain in right knee.</p> <p>R2's MDS (Minimum Data Set), dated 03/27/2024, shows R2 is rarely/never understood and cognitively impaired.</p> <p>Facility reported incident/FRI dated 03/12/2024 documents that the facility reported an injury of unknown origin. FRI documents that V1 (administrator) was notified by V32 (director of</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 9</p> <p>guest relations) that V39 (R2's daughter/Power of Attorney) noticed discoloration on R2's right lower face cheek and R2 was unable to state what happened. FRI documents that nurse on duty performed skin check and discoloration noted to lower right cheek, right arm, and hand. FRI documents that R2's doctor was notified.</p> <p>On 04/16/2024 surveyor reviewed R2's health records and no documentation of R2's provider being notified/consulted of discoloration to R2' right lower cheek, right arm, and hand. No documentation in R2's health records of any thorough assessment or treatment done on or after 03/12/2024.</p> <p>On 04/17/24 at 11:35 AM V39 (R2's Power of Attorney/POA) states that she would inquire about R2's right leg swelling to the nurses on duty each day she was there, and the nurses would respond to her that R2 has arthritis. V39 states that R2 would be screaming "dolor" which means pain in Spanish and staff would not pay attention to her. V39 states that she noticed a decline and change with R2 since that morning that V39 noticed R2's discoloration to right side of face, right arm, right hand, and right leg swelling.</p> <p>04/18/24 at 9:51 AM V43 (Assistant Administrator) states that she investigated the injury of unknown origin. V43 states that R2 didn't know where she got it, initial investigation started on 03/12/24. V43 states that date 03/06/24 documented in the FRI is an error. V43 states that nursing is responsible to document assessments and documentation of notification to the residents' provider. V43 states that it is important for the resident's provider to know so if he wants to give new orders for in house treatment or send out to hospital for further</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 10</p> <p>evaluation. V43 states that no staff stated witnessing R2 falling.</p> <p>On 4/17/2024 at 12:29pm via telephone call, V22 (Registered Nurse) states that she cannot remember what happened to R2's face. V22 states that she remembers R2 being in pain. V22 does not remember the exact dates. V22 states that what was unusual, was R2 was rubbing part of her leg. V22 is not sure what part, but seemed like R2 was in pain. V22 states that she could not even touch R2 without everything hurting. V22 states that she notified the attending provider and there was an order for x-ray of her right knee. V22 states R2 was in a lot of pain and that was not her usual. V22 states that she had worked with her a week before that, and she was always wanting to stand up. V22 states that R2's daughter came up to V22 and said this is not like mom, she usually gets up. V22 states that she assessed R2's vital signs and documented in progress notes. V22 states that she is not sure exactly what she said to the provider over the phone. V22 states that she was trying to lift her leg and R2 was moaning and even if V22 lay her hand on her leg gently, R2 complained of pain.</p> <p>R2's change in condition form (03/10/2024) documents in part: right knee pain started on 03/08/24 ...unable to stand without pain ...R2 has pain to right knee when attempting to perform ROM (range of motion).</p> <p>R2's ADL (Activity of daily living) mobility task (03/06/2024) V38 documented R2 required partial/moderate assistance supervision/touch assistance with bed mobility, transfers between surfaces.</p> <p>R2 tasks that V36 documented (03/07/2024) R2</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 11</p> <p>required substantial/maximal assistance supervision/touch assistance with bed mobility, transfers between surfaces.</p> <p>R2 tasks that CNA documented (03/08/2024) R2 dependent for supervision/touch assistance with bed mobility, and for transfers between surfaces not applicable.</p> <p>R2 tasks that CNA documented (03/09/2024) R2 dependent for supervision/touch assistance with bed mobility, transfers between surfaces.</p> <p>No ADL (Activity of daily living) mobility documentation noted for dates 03/10/2024 and 03/11/2024.</p> <p>R2 tasks that V36 documented (03/12/2024) R2 required substantial/maximal assistance supervision/touch assistance with bed mobility, transfers between surfaces.</p> <p>R2 tasks that CNA documented (03/13/2024) R2 required substantial/maximal assistance supervision/touch assistance with bed mobility, and for transfers between surfaces not attempted due to medical condition or safety concerns.</p> <p>R2 tasks that CNA documented (03/14/2024 05:53 AM) R2 required partial/moderate assistance supervision/touch assistance with bed mobility, and for transfers between surfaces not attempted due to medical condition or safety concerns.</p> <p>R2 tasks that V36 documented (03/14/2024 8:03 PM) R2 required substantial/maximal assistance supervision/touch assistance with bed mobility, transfers between surfaces.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 12</p> <p>R2 tasks that CNA documented (03/14/2024 11:41 PM) R2 required dependent supervision/touch assistance with bed mobility, and for transfers between surfaces not applicable.</p> <p>No ADL (Activity of daily living) mobility documentation noted for date 03/15/2024.</p> <p>R2 tasks that CNA documented (03/16/2024) R2 required substantial/maximal assistance supervision/touch assistance with bed mobility, transfers between surfaces.</p> <p>R2 tasks that CNA documented (03/17/2024) R2 required substantial/maximal assistance supervision/touch assistance with bed mobility, and for transfers between surfaces dependent.</p> <p>R2 tasks that CNA documented (03/18/2024) R2 required dependent supervision/touch assistance with bed mobility, transfers between surfaces.</p> <p>On 04/16/2024 at 3:31 PM V36 (CNA) V36 states she saw R2's leg was swollen. V36 states she reported it Saturday and the discolorations and swelling weren't there Friday, March 15, 2024. V36 (Certified Nursing Assistant) states that R2 wasn't always in pain.</p> <p>On 04/16/2024 at 12:59 PM V37 (CNA) states the importance of notifying the nurse when a resident has had a fall whether unwitnessed or witnessed, V37 states because resident could have broken something or could have hit their head. V37 states that staff will not know what is going on internally. V37 states that R2 says dolor, and V37 states that she reports it to the nurses. V37 states that she cannot recall the dates and times that she reported to the nurses about R2's pain.</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 13</p> <p>On 4/17/24 at 3:20 PM. V29 (CNA) states she is sure that R2 has had pain and V29 is more than likely sure she reported to the nurse. V29 does not remember which nurse she reported it to.</p> <p>On 04/18/24 at 11:42 AM V42 (Director of Rehabilitation) states that if a fracture occurred then you can assume that the patient will show a decline in activity.</p> <p>R2's physical therapy note, (03/06/24) documents in part: R2 had gait training.</p> <p>R2's physical therapy note, (03/08/24) documents in part: R2 had gait training.</p> <p>R2's physical therapy note, (03/11/24) no documentation that R2 had gait training.</p> <p>R2's physical therapy note, (03/13/24) documents in part: R2 refused gait training.</p> <p>R2's physical therapy note, (03/14/24) documents in part: R2 refused gait training.</p> <p>R2's physical therapy note, (03/15/24) documents in part: R2 low tolerance for standing. R2 refused gait training.</p> <p>On 04/16/2024 at 2:35PM, V17 (Nurse Practitioner) states R2 was having swelling. V17 states that she ordered the ultrasound doppler because if there is no sign of infection, no trauma or report of a fall and staff didn't tell V17 that R2 had any laceration, V17 states she will typically do a Doppler to rule out a blood clot because that is biggest thing that can harm. V17 states that she did not see R2 before V17 ordered the ultrasound doppler. V17 states that certainly a fall</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 14</p> <p>can cause a fracture.</p> <p>On 04/17/24 at 10:53 AM V40 (Licensed Practical Nurse/LPN) states that when R2's daughter informed her about R2's leg being swollen, V40 states that R2 was sitting on the wheelchair in front of the nurse's station. V40 states that she checked the lower part of the legs, just to see if it was swollen or not. V40 states that she escorted R2 to her room. V40 states that she pulled R2's pants down and noticed the right thigh was bigger than the other thigh. V40 states that she reported to V17, and she ordered ultrasound doppler only at that time. V40 states that when her leg was swollen, R2 still had fading bruises on her face and arm.</p> <p>R2's Health Status Note, 3/16/2024 15:29, documents in part: R2's daughter complained that R2's right leg is slightly bigger than her left leg ...V17 (Nurse Practitioner) order for venous doppler of right leg to rule out blood clot. No documentation of R2's assessment including pain assessment noted in R2's health record on 03/16/2024.</p> <p>R2's General Progress note, 03/16/2024 21:30, documents in part: V15 (Registered Nurse) was notified by CNA that while changing R2, noted to have swelling of right leg from hip down and complained of pain with movement ...attending physician was notified with orders to do x-ray of right thigh and hip.</p> <p>R2's right hip radiology results report documents examination date 03/18/2024 at 12:00 AM.</p> <p>Medical Professional Progress Note, 3/18/2024 12:09, documents in part: Per nursing staff R2 is reporting pain when transferring, and with</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 15</p> <p>changes R2 has had no behavioral changes besides continued fatigue ... swelling present in right leg, very limited ROM in right leg, R2 report pain with all movement of right extremity ...hip pain and swelling noted over the weekend x-ray of the right hip and doppler of the right lower leg ordered ...Right hip x-ray shows a complex right intro, chant, moral hip fracture, no dislocation or vascular necrosis diffuse osteopenia.</p> <p>On 04/18/24 at 10:42 am, V2 (Director of Nursing) states that she reported the unwitnessed fall with injury on March 18th. 2024, because V2 states that she was made aware of the x-ray, resulting as a positive acute fracture. V2 states when R2's x-ray results came in, V2 went to see R2 and there was swelling on the right leg, V2 states that she asked R2 if she was in "dolor" which means pain in Spanish. V2 states that R2 responded with face gesture in some way acknowledging it is discomfort. V2 states that she asked R2 if she had a fall, and R2 said yes to V2. V2 states that she asked R2 when her fall occurred and R2 responded like some 5 days or 3 days ago. Surveyor asked V2 (Director of Nursing) why no pain assessment is there done in R2's March 2024 MAR (Medication administration record). V2 states that she looked at R2's MAR and didn't see it either. V2 states that nurses are supposed to be assessing it every shift.</p> <p>R2's care plan (02/29/2024) documents in part: R2 is at risk for pain related to musculoskeletal issues: Right hip surgery, osteoporosis, on PRN (as needed Tylenol and Lidocaine patch ...observe for non-verbal signs of pain, evaluate efficacy of pain management, notify MD if inadequate pain relief, provide analgesic as ordered.</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/19/2024
NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 16</p> <p>R2 Physician Order Sheet dated 02/29/2024 documents: Pain Assessment: Numeric Scale (0= No Pain; 1 to 3=Mild Pain; 4 to 7 Moderate Pain; 8 to 10= Severe Pain) or PAINAD (Pain Assessment in Advanced Dementia) every shift for monitoring.</p> <p>R2's March 2024 MAR (medication administration record) shows no documentation administration for pain assessment every shift.</p> <p>Facility policy titled "Notification for Change of Condition" (12/27/2023) documents in part: The facility will provide care to residents and provide notification of resident change in status ... The facility must immediately inform the resident; consult with the resident's physician when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention.</p> <p>Facility policy titled "Pain" (07/28/2023) documents in part: It is the policy of the facility to ensure that all residents are assessed for pain in every situation where there is a potential for pain. For pain complaints and for situations/incidents that might result in pain (ex: fall incident, altercation, cuts, bruises, wound care, etc.), the nursing staff may document it in any part of the resident's medical record that includes nurses' notes, incident report, and medication administration record.</p> <p>(A)</p> <p>Statement of Licensure Violations: 3 of 3 300.610a) 300.1210b)</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 17</p> <p>300.1220b)3) 300.1220d)6)</p> <p>Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 18</p> <p>nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>These regulations were not met as evidenced by:</p> <p>Based on review of records and interviews the facility failures are as follows: Failed to maintain the right of every resident to be safe from accident and hazard. Failed to identify risks for prevention of fall. Failed to ensure adequate supervision and assistance were provided. Failed to place applicable patient centered and effective interventions to prevent fall for 2 out of 3 residents (R6 and R3) reviewed for hazards, incidents, and accidents.</p> <p>These failures resulted in 1 resident (R6) falling multiple times sustaining multiple injuries including right arm/shoulder (humerus) fracture, subdural hemorrhage, and subdural hematoma. And 1 resident (R3) fall resulted to closed fracture of the right wrist (distal radius).</p> <p>Findings include:</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 19</p> <p>R6 is 79 years old, initially admitted to skilled nursing facility on 2/7/2024 with medical diagnosis includes dementia (11/7/2019), orthostatic hypotension (2/15/2024), injury (2/6/2024), traumatic subdural hemorrhage (4/3/2024), fracture of shaft of humerus, right arm (4/3/2024). R6 was not present during review per resident record. R6 fall risk assessments dated 2/13/2024, 4/2/2024 and 4/16/2024 documents that R6 is at high risk for falls.</p> <p>Per facility reported incident dated 4/1/2024, documents: Approximately at 10:20 PM, R6 was observed laying on the floor and was assessed to have cut to right eyebrow, pain on her right upper extremity on the scale 10/10. R6 claimed that she attempted to get her wheelchair but slipped and fell. Per report, R6 sustained injury right humerus fracture and subdural hematoma.</p> <p>Per facility reported incident dated 4/16/2024, documents: On 4/15/2024 at around 8:15 PM R6 was observed laying on the floor in prone position or face down. R6 was transferred to the emergency room and sustained subdural hematoma.</p> <p>Progress Notes of R6 are as follows:</p> <p>Per V34 (Medical Doctor) dated 2/6/2024 during initial admission of R6 from assisted living to skilled nursing facility, documents that R6 was transferred from hospital to facility due to fall.</p> <p>Per V15 (Registered Nurse) dated 2/13/2024, documents that R6 was seen laying on the floor. R6 claimed that she hit her head. R6 was transferred to the hospital and was admitted for</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 20</p> <p>observation due to fall.</p> <p>Per V14 (Registered Nurse) dated 4/2/2024, documents that around 10:10 PM R6 was found laying on her left side on the floor with bleeding on her head. Per documentation by V14, R6 stated that she wants to get her wheelchair and slipped and fell. V35 (Registered Nurse) documents that R6 was admitted with broken right shoulder in the hospital.</p> <p>Per V27 (Registered Nurse) dated 4/16/2024, documents that R6 was found on the floor bleeding on the left side of her face.</p> <p>On 4/16/2024 at 2:37 PM, V17 (Nurse Practitioner) stated that R6 was very impulsive and has dementia. R6 cannot remember that she cannot get up and because of that R6 falls are mostly due to not remembering her capacity to transfer and gets up and falls. At times V17 saw R6 trying to get up, but partly her fall was related due to dementia. V17 stated that staff needs more engagement with R6 because R6 likes to have conversations. When asked about preventive measures during nighttime while resident is in bed, V17 stated, "It is hard to say."</p> <p>On 4/17/2024 at 10:09 AM, with V2 (Director of Nursing) and V3 (Psychotropic and Fall / Registered Nurse). V3 stated that R6 requires extensive assistance in all transfers. V2 stated that R6 had a fall when originally admitted on 2/6/2024 from assisted living to the skilled floor, R6 has impairment on right shoulder upper extremity. On 4/1/2024, R6 fell and sustained right arm fracture and subdural hematoma. On 4/15/2024, R6 fell again close to the bathroom and sustained hematoma on her head and was brought to the hospital. Both falls happened</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 21</p> <p>during nighttime while resident was already placed in bed. After review of R6's progress notes, V3 stated, "Yes, she (R6) also fell on 2/12/2024 around 10:00 PM." Plan of care of R6 were reviewed by V2 and V3 for fall intervention(s) related to fall during nighttime after R6 was placed in bed and fell on 2/13/2024, 4/1/2024 and 4/15/2024. V2 stated, "The only one I can see was to use call light." Both V2 and V3 were asked since R6 is diagnosed with Alzheimer and Dementia what is the guarantee that she will remember to use the call light during nighttime? V2 stated, "I understand, we can use bed alarm or toilet R6 before putting her to bed at night."</p> <p>On 4/18/2024 at 8:06 AM, V27 (Registered Nurse) stated she was the nurse when R6 fell on Monday 4/15/2024. V27 stated that R6 fell around 8:15 PM after R6 was placed on bed. R6 was found near the entrance door near the toilet. R6 position was face down, when she (V27) tried to move R6's head up there was blood on the floor. V27 stated that she does not know how R6 was able to get from the bed to the door, and the hospital informed her (V27) that R6 sustained subdural hematoma. V27 stated that R6 trying to get out of the bed is her usual behavior or baseline, and R6 needs help during transfers because R6 is unstable. V26 said, "Everyone knows that R6 is a huge fall risk, and she has no bed alarm. If they only put bed alarm, we can respond every time it sounds and alert us."</p> <p>On 4/18/2024 at 10:22 AM, V14 (Registered Nurse) stated that she was the nurse when R6 fell on 4/1/2024. V14 described the fall stating that R6 hit her head resulted to laceration and dislocation of her right arm or shoulder. R6 cannot be moved because of pain on her right arm. V14 stated that R6 was found near the</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 22</p> <p>window which was located left side of R6's bed. V14 stated that R6 tried to get her wheelchair that was located in between R6's bed and the window. V14 stated that she always instructs R6 to use her call light, and sometimes R6 uses her call light. V14 said that R6 is oriented but forgetful. V14 stated that R6 is forgetful, and that sometimes she needs to cut R6's pill into half so that if R6 insist that she did not get her pill V14 gives the other half. V16 did not respond when asked how can R6 remember to use her call light if she cannot remember that she just taken her pill?</p> <p>On 4/18/2024 at 11:23 AM, V30 (Psychiatric Nurse Practitioner) stated that R6 is her patient and was seen, R6 has dementia that is getting worse. Per V30's assessment, R6 was becoming more forgetful and increased depression. V30 stated that staff told her that R6 wants to leave the facility, and R6 was started with hydroxyzine an anti-anxiety medication as needed because R6 tends to be anxious. V30 stated that part of her dementia is R6 forgets about her ability that she cannot go to the bathroom, and forgets to use the call light.</p> <p>Food and Drug Administration (FDA) and Pfizer Drug Information on VISTARIL- hydroxyzine pamoate capsule, reads:</p> <p>Under Geriatric Use, hydroxyzine is a sedating drug that may cause confusion and over sedation in the elderly; elderly patients generally should be started on low doses of VISTARIL and observed closely.</p> <p>After the fall on 4/1/2024 that resulted in R6 right arm fracture and traumatic subdural hemorrhage, hospital records documents that R6 was receiving</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 23</p> <p>levetiracetam / Keppra via intravenous infusion. During R6 re-admission to the facility dated 4/3/2024, R6 was ordered by physician to receive 500 MG of levetiracetam / Keppra Food and Drug Administration (FDA) drug information is an anti-seizure or antiepileptic drug /medication. After reviewing no seizure assessment or plan of care related to seizure were documented on R6 clinical records. V1 (Administrator) and V2 (Director of Nursing) were made aware. R6 fell on 4/15/2024 sustaining subdural hematoma on Keppra medication from 4/4/2024 to 4/10/2024.</p> <p>Fall Occurrence Policy, dated 7/17/2023 reads:</p> <p>It is the policy of the facility to ensure that residents are assessed for risk of fall, that interventions are put in place, and interventions are reevaluated and revised as necessary. Those identified as high risk for falls will be provided fall interventions. Ultimately, the Falls Coordinator may change the intervention to address falls in the unit, even prior to the Fall's Coordinator's investigation. The Falls Coordinator will add the intervention in the resident's care plan. The interventions will be reevaluated and revised as necessary.</p> <p>Findings Include:</p> <p>R3's current face sheet documents in part, R3 is a 92-year-old individual, admitted to the facility on 02/20/2024, and his medical diagnosis include but not limited to: Dementia severity without behaviors disturbance, spinal stenosis, history of falls, low back pain, essential hypertension, cerebral infarction and hyperlipidemia.</p> <p>R3's (Minimum Data Set) MDS 3.0 Section C - Cognitive Patterns document resident is</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 24</p> <p>rarely/never understood. No BIMS score recorded.</p> <p>C1000. Cognitive Skills for Daily Decision Making-severely impaired.</p> <p>MDS 3.0 Section GG - Functional Abilities and Goals document R3 requires,</p> <p>A. Self-Care: Code the resident's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.</p> <p>B. Indoor Mobility (Ambulation): Code the resident's need for assistance with walking from room to room (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.</p> <p>R3's Care Plan dated initiated 2/20/2024 documents in part,</p> <p>R3 is at high risk for falls related to impaired Safety awareness, impaired balance and impaired mobility associated with the disease processes/conditions of: Cerebral infarction, Dementia, Essential hypertension, Pneumonia, spinal stenosis, chronic hepatitis C, lower back pain, wedge compression fracture first lumbar vertebra as evidenced by a recent fall prior to admitting to the skilled care facility and an actual fall as resident of the skilled care facility.</p> <p>FOCUS: R3 attempted to get out of bed to use bathroom and slid out of bed. Resident fell to the floor.</p> <p>FOCUS: R3 chose to be independent and attempted to walk without assistive device and fell on the floor.</p> <p>On 4/17/2024 at 11:00AM V13 states I am the POA for R3. She was discharged from the hospital on 2/20/2024 and sent to the nursing home and was there only three days. R3 ended</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 25</p> <p>up in the emergency room three times for falls within three days. The first hospitalization was 2/21/2024. I Left her that evening on the 2/20/2024 when R3 was admitted to that facility. I got a call around six o'clock in the morning from the hospital informing me that R3 had a fall at the nursing home. The nursing home did not make me aware and that was a red flag. They found R3 on the floor between the bed and the hallway. R3 cannot ambulate and if she tries it would take her a while. The hospital ran diagnostic testing and R3 was clear of injuries. R3 was sent back to the facility, there was no reason to admit her. I went back with R3 to get her settled in bed. I came back the next day to talk to the administrator to see how R3 fell. I couldn't speak with him; however, I was notified by staff at that time that R3 had another fall. They informed me that R3 fell around one o'clock in the morning. I had no idea R3 was taken to the emergency room for the second time. Later that day while visiting after she returned, I noticed R3 right wrist was bothering her. R3 has dementia and she can't explain her needs at times. R3 was trying to wrap a sheet around her wrist when I was visiting her. I wasn't thinking about her wrist being affected because the hospital did do more x-rays of her elbow. I left the facility immediately started looking for other nursing homes.</p> <p>V13 states on 2/23/2024 I went to work that Friday and had my daughter to go and check on R3. My daughter called me and informed me that R3 right wrist was with swelling, redness and felt warm and looked painful. My daughter informed me that the nurse gave R3 pain medication and ordered the in- house Xray. I went to the facility and demanded them to send R3 to the emergency room. When I arrived at the hospital, I found out R3 had a fracture to her right wrist. I</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 26</p> <p>asked the hospital to keep her overnight and they admitted R3. I refuse to let them discharge her back to that facility. I felt like I could no longer trust them with R3.They didn't do anything to prevent her from falling. R3 was only at the facility for three days and it ended up falling and obtaining another fracture.</p> <p>On 4/16/2024 at 11:00AM V3(Fall Nurse/Registered Nurse) state we should follow our policy regarding any fall. Every admission should have a fall risk assessment completed. If the resident is admitted with previous fall or high risk, then it's not required we just follow the protocol. When a resident fall staff should assess them notify provider for further instructions and notify the family. If the resident is on blood thinners or it is unwitnessed, we should send them out to the hospital for further evaluation. After a fall we should re-evaluate the interventions in place or immediately start interventions and add or update the interventions to the care plan.</p> <p>On 4/17/2024 at 1:30PM V12(Assistant Director of Nursing) states we follow regulation and policy when we send residents out for falls. If they are on blood thinners or if the fall is unwitnessed, hit their head, spine or hip we call 911 and send them out immediately. After any fall staff should be completing fall risk assessment, pain assessment, neuro checks if unwitnessed and a post seventy-two hour follow -up. Fall coordinator and myself investigate the falls we should also be updating interventions or putting something else in place.</p> <p>Nurse note dated 2/21/2024 01:58 Change of Condition (SBAR) Situation: 1. The change in condition, symptoms,</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/19/2024
NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 27</p> <p>or signs observed and evaluated is/are: Patient noted sitting on the floor in the hallway. Patient very anxious with no visible signs of injury noted. Patient is on heparin and Plavix. 911 local emergency services notified to transport resident to local hospital for further evaluation due to blood thinning medications.</p> <p>Nurse note dated document in part, on 2/22/2024 00:44 Change of Condition (SBAR) Situation: 1. The change in condition, symptoms, or signs observed and evaluated is/are: Fall.</p> <p>Nurse note dated 2/23/2024 08:02 Health Status Note document, Note Text: Resident is c/o right wrist pain this morning. Area is red and she is protecting it. Administered prn oxycodone and placed ice pack. Also place her lidocaine patch to the RFA. Checked resident records from both ER visits yesterday. There is no record of right wrist x-ray.</p> <p>2/23/2024 15:06 General Progress Note Note Text: Resident c/o right wrist pain this morning. Noted area is red and she is protecting it. Administered prn oxycodone and placed an ice pack. Notified NP with an order to have an x-ray of right wrist. Placed x-ray order at All-Stat, spoke to technician will come anytime today. Notified Perry(daughter) by Pan coordinator and informed of patient's current condition. Around 1:00 pm the patient's daughter came into the facility, was informed that she cannot wait for the x-ray technician to come and wants the patient to transfer to the ER as soon as possible. Informed NP of daughter's request, order to transfer patient to AIMMC-ER. Report given to emergency command center and lifeline ambulance with 2 paramedics picked-up patient at 1:40pm to AIMMC-ER. Will follow-up.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 28</p> <p>2/23/2024 18:33 General Progress Note Note Text: Follow up at AIMMC-ER, patient admitted Dx: Right Radius fracture.</p> <p>Emergency department provider noted dated 2/23/2024 documents in part, ED Provider Note Patient presents with oWrist Swelling 92-year-old female with a history of chronic hepatitis dementia, TIA, GERD, gout, and hyperlipidemia presents from the nursing home for evaluation of a fall. Patient was just here on the 21st for fall and had some x-rays and CT. patient also is grimacing at the right tib-fib and has an abrasion over the tib-fib area. Patient is nonverbal, no other visible injuries are noted, no evidence of respiratory distress, no other complaints reported by the nursing home. Patient is currently being treated for UTI.</p> <p>Hospital medical records dated 2/23/2024 confirmed R3 diagnosis of closed right wrist fracture of distal end of right radius.</p> <p>Reviewed facility reported incident/FRI dated 2/23/2024 reported R3 was sent to hospital for pain and swelling of right wrist. Hospital reported right wrist fracture to facility. Resident did have a fall incident day prior.</p> <p>No updated care plan or updated interventions dated after fall 2/21/2024. No updated care plan or updated interventions dated after fall 2/22/2024.</p> <p>Facility document dated 08/03/2016, titled "Fall Occurrence" documents in part, "Policy statement: It is the policy of the facility to ensure</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/19/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVANTARA LINCOLN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 WEST FULLERTON AVENUE CHICAGO, IL 60614
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	Continued From page 29 that the residents are assessed for risk for falls, that interventions are put in place, and interventions are reevaluated and revised as necessary. (A)	S9999		
-------	---	-------	--	--