STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007074	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION OF LOGAN SQUARE, THE	2242 NORTH KEDZIE CHICAGO, IL 60647

(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 Survey: 2389440/IL166616, 23810076/IL167390 & 2389823/IL167074	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 300.610a) 300.1210b) 300.1210d)2 300.1210d)3 300.1210d)5 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 300.1210 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	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007074	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION OF LOGAN SQUARE, THE	2242 NORTH KEDZIE CHICAGO, IL 60647

(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 1 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. 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: 2) All treatments and procedures shall be administered as ordered by the physician. 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. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These Requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to provide timely incontinence care to prevent MASD (Moisture Associated Skin Damage), failed to document	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007074	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION OF LOGAN SQUARE, THE	2242 NORTH KEDZIE CHICAGO, IL 60647

(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 2 skin integrity impairment, failed to obtain timely treatment orders, and failed to offload wounds for one of three residents (R2) reviewed for pressure ulcers. These failures resulted in R2 incurring (facility acquired) stage 4 sacrum pressure ulcer (with bone exposed), osteomyelitis secondary to infection, fractured S5 vertebra - in the setting of osteomyelitis, pain rated 5/10, and severe sepsis. The facility also failed to follow physician orders, failed to ensure that dressings were changed daily, failed to prevent MASD, and failed to offload wounds for R1. These failures resulted in R1 incurring a stage 4 sacrum wound with undermining (extensive damage beneath the skin surface). Findings include: On (11/27/23) IDPH (Illinois Department of Public Health) received allegations that R2 is being left in urine/feces contributing to wound development. R2 is not repositioned timely (> 2 hours). R2's dressing is not being changed on a consistent basis; on weekends the dressing is left soiled. R2 is complaining of back being broken. R2's diagnoses include dementia, mild protein-calorie malnutrition, type II diabetes mellitus, transient ischemic attack, and adult failure to thrive. R2's (11/2/23) BIMS (Brief Interview Mental Status) determined a score of 6 (severe impairment). R2's (11/2/23) functional assessment affirms 1 to 2 staff are required for toileting, turning and repositioning.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007074	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION OF LOGAN SQUARE, THE	2242 NORTH KEDZIE CHICAGO, IL 60647

(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 3 R2's (5/30/23) care plan states resident is at risk for pressure ulcer development related to impaired mobility, incontinence, and history of pressure ulcer. Intervention: Resident needs assistance to turn/reposition at least every 2 hours, more often as needed or requested. R2's (11/14/23) POS (Physician Order Sheets) include sacrum: clean with wound cleanser, apply medihoney, cover with foam dressing. Change daily and as needed. R2's progress notes include (11/13/23) dressing was changed, area above buttocks (exact location, wound description, wound stage, wound drainage, and/or wound measurements are excluded). (11/26/23) PRN (as needed) medication given 5/10 pain in buttocks. (11/29/23) Medical doctor ordered Levaquin (Antibiotic) 500 milligrams daily for 10 days due to elevated white blood cell count. (12/1/23) Resident's wound observed with a foul smell during dressing. Doctor ordered to send resident to hospital for wound evaluation. Resident admitted for sepsis at hospital. On 12/18/23, surveyor requested R2's initial wound assessment and the wound assessment prior to (12/1/23) hospital transfer. Surveyor received R2's (11/16/23) wound assessment which affirms (facility acquired) MASD. Classification: incontinence. Date identified: 11/16/23 however the (11/13/23) progress note affirms a wound was present 3 days prior. R2's (11/29/23) sacrum wound assessment affirms pressure ulceration (stage 4). Wound deteriorated, increased in size, undermining present. Peri wound with dark discoloration, mild odor present.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007074	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION OF LOGAN SQUARE, THE	2242 NORTH KEDZIE CHICAGO, IL 60647

(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 4	S9999		

R2's (November 2023) TAR (Treatment Administration Record) affirms sacrum treatments were documented 11/14/23 (2 days prior to initial wound assessment).

R2's (12/1/23) history & physical states patient presents to the emergency department for sacral wound evaluation from the nursing home. White blood cell count 12.1 (High). Patient appears to have infected sacral wound, concern for underlying osteomyelitis. Sacral wound with exposed muscle. Pelvis CT (Computed Tomography) with signs of acute osteomyelitis. Fracture at S5 vertebra cannot exclude pathologic fracture - in the setting of osteomyelitis. Sacral decubitus ulcer coursing to the coccyx and inferior most sacrum. Of note a portion of the skin ulceration tunnels within the subcutaneous fat approximately 3 centimeters superiorly posterior to the upper coccyx and lower sacrum. There are some thin fluids within the ulceration and adjacent edema/cellulitis. Diagnosis: Severe sepsis. Sacral ulcer acute. Sacral osteomyelitis acute.

On 12/18/23 at 11:17am, surveyor inquired about R2's (11/13/23) dressing change which was documented in the progress notes. V22 (Licensed Practical Nurse) stated, "The CNA (Certified Nursing Assistant) told me the dressing was coming off and asked me to change it. She (R2) had a wet to dry (dressing) already on, I just put a new bandage back on." Surveyor inquired if R2 had treatment orders (on 11/13/23). V22 responded, "We don't need orders for a wet to dry dressing." Surveyor inquired about the appearance of R2's (11/13/23) wound. V22 replied, "I don't remember."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007074	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION OF LOGAN SQUARE, THE	2242 NORTH KEDZIE CHICAGO, IL 60647

(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 5 On 12/18/23 at 12:24pm, surveyor inquired if physician orders are required for wound treatments. V15 (Wound Care Nurse) stated, "A physician order is always required for wound treatment, for all wound treatment we do require physician order." Surveyor inquired when R2's skin integrity impairment was identified. V15 reviewed the electronic records and responded, "On November 13 it was an area of moisture skin damage and then on the 16 it deteriorated and became stage 2 pressure sore. Before she was sent out (12/1/23) it was debrided by wound care doctor and stage 4." Surveyor inquired what causes MASD. V15 replied, "Contact with urine is moisture. She (R2) had a very fragile skin, and she is incontinent." Surveyor inquired what causes dark discoloration of the peri wound. V15 stated, "Pressure." Surveyor inquired what causes a stage 4 wound. V15 responded, "Pressure and moisture all together plus not just that also different factors; it's a process of repositioning and history of pressure ulcer that also contributing to stage 4." Surveyor inquired what causes undermining. V15 replied, "Pressure, in her (R2) case undermining was created when doctor debrided the wound. Pressure, plus moisture, plus the wound itself all together that's how her (R2) wound developed." Surveyor inquired what an odorous wound is indicative of. V15 stated, "Infection." Surveyor inquired what causes osteomyelitis. V15 responded, "Infection of the bone." Surveyor inquired about the appearance of R2's wound prior to 12/1/23 hospital transfer. V15 stated, "It was deep, it was all the way up to the bone after debridement." On 11/13/23, IDPH (Illinois Department of Public Health) received allegations that R1 is not provided appropriate wound care and bed sores	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007074	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION OF LOGAN SQUARE, THE	2242 NORTH KEDZIE CHICAGO, IL 60647

(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 6 are deteriorating. R1's diagnoses include dementia, type II diabetes mellitus, end stage renal disease, dependence on dialysis, and pressure ulcer. R1's (11/1/23) BIMS determined a score of 5 (severe impairment). R1's (11/1/23) functional assessment affirms resident requires maximal assistance with turning/repositioning and 1-2 person assist with toileting. Upper extremity impairment (one side) and lower extremity impairment (both sides) was also noted. R1's care plan includes (10/17/23) resident is at risk for pressure ulcer development related to immobility, incontinence, type II diabetes mellitus, and failure to thrive. (11/20/23) Readmitted with unstageable (coccyx/left buttock) pressure ulcers. R1's POS includes (11/20/23) skin check every shift. Turn and reposition in bed every 2 hours and as needed. Utilize foam wedges or pillow to offload pressure areas. Apply zinc oxide cream to buttocks, sacrum and perineal area every shift after incontinence care. (11/29/23) Sacrum: clean with wound cleanser, apply medihoney, pack open areas with calcium alginate, cover with foam dressing. Change daily and as needed. R1's (11/20/23) wound assessments include the following (present on admission) coccyx (unstageable) pressure ulceration. Tissue types: 40% epithelial, 15% bright pink, 45% slough loosely adherent. 4.5 x 2.5 x 0.2cm (centimeters). Left buttock (unstageable) pressure ulceration. Tissue type: slough loosely adherent 100%. 2.5 x 2.0 x 0.2cm.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007074	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION OF LOGAN SQUARE, THE	2242 NORTH KEDZIE CHICAGO, IL 60647

(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 7 R1's (11/30/23) wound assessment states pressure ulcer at coccyx and left buttock are connected with undermining and therefore recalcified by wound care nurse practitioner as one wound with location at sacrum. R1's (12/7/23) sacrum wound assessment states (stage 4). Tissue types: bright beefy red 80%, slough loosely adherent 20%. 6.0 x 5.0 x 2.0cm (increased in size). On 12/12/23 at 2:07pm, R1 was lying in bed and on his back therefore the sacral wound was not off loaded. Surveyor inquired about R1's wounds. V5 (Licensed Practical Nurse) responded, "I know the wound care nurse (V15) just changed his dressings and his pouch (re: colostomy) about 10, 15 minutes ago." V16 (Family) at bedside also affirmed R1's dressing was just changed. V5 removed R1's incontinence brief (as requested) and his right hip was covered with a red rash. V5 stated, "He's got a rash and it's probably from the diaper, it's too tight or if it's not changed often." A (4 x 4) border dressing (dated 12/12) observed on R1's sacrum appeared clean, dry and intact. V5 removed R1's border dressing (as requested) the small open area (between the buttocks) had no treatments and/or dressing atop of the wound. The large open area on R1's right buttock appeared to be packed with a dressing however the dressing (outside the wound) had dried sangeunous drainage and was adhered to R1's skin. Surveyor inquired if the dressing packed in R1's wound appeared as if it was "just changed". V5 stated, "No, the dressing says 12/12 but it doesn't seem like it. It shouldn't be dry; it should be fresh. If it's open or tunneling (referring to the wounds) it should be honey or something like that and it looks dry." Surveyor inquired if a dry dressing promotes wound	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007074	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION OF LOGAN SQUARE, THE	2242 NORTH KEDZIE CHICAGO, IL 60647

(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 8	S9999		

healing. V5 stated, "No, it has no purpose."

On 12/12/23 at 2:20pm, surveyor inquired about R1's treatment orders. V15 (Wound Care Nurse) stated, "He has daily medihoney, calcium alginate and a dry dressing. Every morning calcium alginate and medihoney goes directly to the wound bed." Medihoney and/or zinc oxide were not present on R1's skin and or inside the border dressing. Surveyor requested to see R1's treatments. V15 responded, "We don't keep them separately; we have a house supply that we use." V15 opened the treatment cart and presented wound cleanser (with R1's name), border dressings and calcium alginate. Surveyor inquired where R1's medihoney was located. V15 replied, "Medihoney? I used the last, it was just a little bit left. So now I"m gonna open a new one" however medihoney was not available on the treatment cart at this time.

R1's (December 2023) TAR (Treatment Administration Record) affirms on Saturday (12/9/23) (daily) sacrum treatments were not documented.

On 12/14/23 at 2:34pm, surveyor relayed concerns regarding facility staff not following treatment orders and/or changing dressings daily as ordered. V21 (Medical Director) stated, "Nursing have to take care of the patients, they have to do a better job." Surveyor inquired about potential harm to resident wounds if treatments are not followed and/or not administered daily (as ordered). V21 responded, "It can get infected and make it worse."

The prevention of pressure ulcer policy (revised 1/2019) states; assess the resident on admission (within 8 hours) for existing pressure ulcer/injury

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007074	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION OF LOGAN SQUARE, THE	2242 NORTH KEDZIE CHICAGO, IL 60647

(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 9 risk factors. Repeat the risk assessment weekly for the first 4 weeks, then quarterly and upon any changes in condition. CNA's will inspect the skin on a daily basis when performing or assisting with personal care or ADL's. Select appropriate pressure reducing support surfaces based on resident's mobility, continence, skin moisture and perfusion, body size, weight, and overall risk factors. Evaluate, report and document potential changes in the skin. If the resident refused the care, document the reason why and notify the supervisor. (B) 2 of 2 Licensure Violations 300.610a) 300.1210b) 300.1210d)2 300.1210d)3 300.1210d)6 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 300.1210 General Requirements for	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007074	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION OF LOGAN SQUARE, THE	2242 NORTH KEDZIE CHICAGO, IL 60647

(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 10 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. 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: 2) All treatments and procedures shall be administered as ordered by the physician. 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. 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. These Requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to ensure (R3's)	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007074	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION OF LOGAN SQUARE, THE	2242 NORTH KEDZIE CHICAGO, IL 60647

(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 11 functional assessment was accurate, failed to ensure staff use proper and/or appropriate transfer techniques, failed to implement and/or revise fall care plan interventions, failed to provide supervision, and failed to obtain a timely x-ray for one of three residents (R3) reviewed for falls/IOUO (Injuries of Unknown Origin). These failures resulted in R3 sustaining acute fractures of the left lateral 7th through 9th ribs (identified 12/2/23) and pain rated 3/10. The facility also failed to implement the falls management policy, failed to document (R4's) fall, failed to notify (R4's) family/physician immediately and failed to conduct daily skin assessments. These failures resulted in R4 sustaining a large bruise to the right arm (identified 12/11/23 - by the State surveyor). Findings include: R3's diagnoses include dementia, abnormal posture, difficulty walking, transient ischemic attack, and generalized muscle weakness. The fall log affirms R3 fell on 7/27/23 and 11/12/23. R3's (11/12/23) incident report states informed by CNA (Certified Nursing Assistant) that resident was on the floor. Resident observed lying on the floor next to his bed with feces and urine. Resident has right side weakness due to previous stroke. No witnesses found. [R3's November 2023 pain assessments affirm pain level was rated "0" post fall]. R3's progress notes state (11/30/23) staff reported resident was unable to get up this morning due to painful area on his abdomen and chest on left side. Nurse Practitioner made	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007074	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION OF LOGAN SQUARE, THE	2242 NORTH KEDZIE CHICAGO, IL 60647

(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 12	S9999		

aware, order chest x-ray. [Nothing was documented 11/23/23 through 11/29/23]. (12/2/23) Writer received call from hospital, resident has left lateral acute fracture on ribs 7, 8, and 9. (12/3/23) Resident noted with facial grimacing when care was being provided. PRN (as needed) medication was provided. (12/5/23) Resident noted with facial grimacing when care was being provided. PRN medication was provided.

R3's (December 2023) pain assessments affirm pain level was rated "2-3."

R3's (12/2/23) history & physical states patient presents to the emergency department for evaluation of a possible fall. Per EMS (Emergency Medical Service) as well as by patient, patient fell about a week ago last Saturday (11/25/23) when he was walking, lost his balance, fell towards the side and hit a table, landing over the table with his (left) side rib cage. Patient has more pain over the left side when he moves. Mild tenderness over the right lower rib cage. Worst tenderness over the left mid clavicular line lower ribcage as well as mid-axillary line. Tenderness over torso. He had too much pain with doing x-rays, given Fentanyl (Schedule II Narcotic) afterwards.

On 12/13/23 at 9:51am, surveyor inquired about R3's rib fractures (identified 12/2/23). V1 (Administrator) stated, "I believe he might have had an unwitnessed fall and maybe fell on the table."

On 12/13/23 at 12:03pm, surveyor inquired about R3's (11/30/23) change in condition. V17 (Licensed Practical Nurse) stated, "Staff reported to me that he was uncomfortable and then I went

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007074	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION OF LOGAN SQUARE, THE	2242 NORTH KEDZIE CHICAGO, IL 60647

(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 13 to see him (R3). I asked him (R3) you in pain? He said I don't know but he look uncomfortable and maybe were in pain. At that moment the Nurse Practitioner was there, and I can see he (R3) was no good and did not want to get up. He (Nurse Practitioner) order x-ray for the abdomen, chest and hip. I (V17) placed the order that day but I think it was the next day that they come and do the x-ray." Surveyor inquired if the x-rays were ordered STAT (on 11/30/23). V17 responded, "Yes." Surveyor inquired about STAT turnaround time. V17 replied, "Normally we call and say to the technician this is stat and they (technician) say we will be there as soon as possible they don't give the hour or anything like that. I remember I was calling to the x-ray and they don't answer two times." Surveyor inquired how R3 incurred an injury. V17 stated, "He didn't tell me any because he doesn't look like he want to answer me." Surveyor inquired about R3's functional status. V17 responded, "That day he was in a (Brand Name wheelchair) when I went to see him. They (Staff) told me he (R3) is not too stable they use a 2 or 3 people to get in the (Brand Name wheelchair)." On 12/14/23 at 2:27pm, surveyor inquired about potential harm to a resident that has an unwitnessed fall. V21 (Medical Director) stated, "To my knowledge we (facility staff) always report any fall and for any unwitnessed fall. We always send the patient to the emergency room for evaluation. They (residents) can have a broken bone, or they can have a bleeding in the head (a hematoma) so we always send them out." R3's (12/2/23) x-ray (obtained 2 days after pain was noted) affirms acute fractures of the left lateral 7th through 9th ribs.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007074	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION OF LOGAN SQUARE, THE	2242 NORTH KEDZIE CHICAGO, IL 60647

(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 14 R3's (9/20/23) BIMS (Brief Interview Mental Status) determined a score of 7 (severe impairment). R3's (9/20/23) functional assessment states (1 person) physical assist is required for bed mobility and transfers however observation and interviews were incongruent with this assessment. R3's (12/15/22) care plan states resident is at risk of falls related to dementia, weakness, and history of falling. Interventions: one side rail placed for bed mobility and transfers. Educate on safe transfer technique, assist to bathroom as needed. Resident is able to toilet himself with one person assist. Monitor/report any changes (re: declines in function). On 12/11/23 at 12:05pm, R3 was observed (in the dining room) seated in a wheelchair, leaning towards the left side, and appeared uncomfortable. On 12/11/23 at 12:10pm, surveyor inquired when R3 was placed in the wheelchair. V8 (CNA) stated, "We got him up like at 7:30(am), it took four of us (staff) to transfer him to the chair." Surveyor requested to inspect R3's incontinence brief. V7 (CNA) and V8 placed a gait belt on R3 (R3 has fractured ribs) and instructed him to stand however he (R3) was unable to do so. R3 was lifted from the chair and stated, "Don't let me slip" as his feet were sliding sideways on the floor. V7 and V8 proceeded to transfer R3 (instead of placing him back in the chair) and almost dropped him on the floor however his butt landed on the mattress (near the floor). R3 has a low bed made of PVC pipes which is unable to be raised and/or lowered to accommodate	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007074	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION OF LOGAN SQUARE, THE	2242 NORTH KEDZIE CHICAGO, IL 60647

(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 15	S9999		

resident and/or staff during transfer. [R3's bed did not have side rails for bed mobility and/or transfers as stated on the care plan]. Surveyor inquired if R3 can walk. V8 stated, "When I first started around 6 or 7 months ago but not now. You see we have difficulty at him holding up." Surveyor inquired if R3 is able to stand. V8 stated, "No." Surveyor inquired if R3 is able to turn and/or reposition himself. V8 stated, "No, he's totally care." V8 removed R3's brief which was moderately saturated with urine and contained a large bowel movement. V8 stated, "He's wet and dirty."

R3's (12/7/23) care plan states resident has fracture of multiple ribs of left side however supervision and/or additional fall prevention interventions (re: mechanical lift) are excluded.

The accidents and incidents policy (revised 5/2015) states adequate supervision is defined by the type and frequency of supervision, based on the individual residents assessed needs and identified hazards in the resident environment. A systematic approach has been put in place to promote resident safety and reduce accident/incidents. This approach includes identification of hazards, implementation of interventions, and supervision.

R4's diagnoses include dementia, lack of coordination, abnormalities of gait/mobility, and need for assistance with personal care.

R4's (10/30.23) functional assessment affirms moderate assistance is required for dressing and maximal assistance is required for toileting.

R4's (10/25/23) care plan states resident is at risk for falls related to history of falls, restlessness,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007074	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION OF LOGAN SQUARE, THE	2242 NORTH KEDZIE CHICAGO, IL 60647

(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 16	S9999		

and agitation. Interventions: be sure resident's call light is within reach. Ensure that resident is wearing appropriate footwear when ambulating.

On 12/11/23 at 11:55am, R4 was lying in bed however the call light was on the floor and out of reach. Surveyor inquired about the location of R4's call light. V6 (CNA) stated, "It's by the bed on the floor." Surveyor inquired if R4 could reach the call light. V6 responded, "Not from this angle he couldn't." Surveyor observed a large bruise on R4's right arm and requested the assigned Nurse. V6 left the room (without assisting R4) and did not return. R4 sat up, put a pull-up on and walked (with slow, shuffled, unsteady gait) to the doorway (without socks and/or shoes).

On 12/11/23 at 12:02pm, V4 (LPN/Licensed Practical Nurse) entered the room and assisted R4 to the bathroom. Surveyor inquired about the bruise on R4's arm. V4 responded, "With the shoulder? He (R4) has a bruise over there, let me see" and assessed the resident. Surveyor inquired how R4 sustained the bruise. V4 replied, "I just came back from vacation" and affirmed she was unsure. V4 accessed R4's EMR (Electronic Medical Records) and stated, "There is no incident there, I don't see any incident put in risk management if we saw something like this (referring to R4's bruise). Nobody reported that he (R4) has a bruise."

On 12/11/23, at 12:16pm, V4 (LPN) inquired how R4 sustained the bruise (R4 responded in Spanish). V4 affirmed "A few days before, he (R4) remember a fall, that's what he tell me."

On 12/14/23 at 12:40pm, surveyor inquired about R4's bruise. V1 (Administrator) stated, he (R4) told me that he fell and hit the wall with his arm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007074	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION OF LOGAN SQUARE, THE	2242 NORTH KEDZIE CHICAGO, IL 60647

(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 17	S9999		

when the CNA was taking care of the roommate. A a male Nurse had also gone into the room. We traced back to see who was working. The CNA (V20) stated, he (R4) was walking around the room bumped into the wall and slid down to the ground, she said he didn't fall. I asked the Nurse (V3) about the incident. He (V3) said, the CNA called me, I (V3) asked did he (R4) fall. She (V20) said, "No." I (V1) said if he (R4) was on the floor and fell you (staff) have to do risk management. I had to educate them (V3, V20), if they (residents) crawl to the floor, you lower them to the floor, or they slide to the floor, you have to report it timely. Whoever witness the fall needs to report it to the nurse supervisor regardless of whether they witness it. The nurse needs to assess the resident, communicate with the doctor, and take orders if they (residents) need pain management or further evaluation. They (staff) have to document the incident report on the risk management on the computer.

V20's (12/11/23) statement affirms R4 fell on 12/6/23 (5 days prior to IOUO investigation).

The fall management policy (revised 5/2015) states any time a resident sustains a fall, a report of that occurrence is to be completed by the licensed nurse. The family and doctor will be notified of the occurrence. Documentation will support the monitoring, findings and actions taken. A separate accident/incident/unusual occurrence report is to be completed.

(A)