STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009757	A. BUILDING: _____ B. WING _____	C 09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION OF SOUTH SHORE	7750 SOUTH SHORE DRIVE CHICAGO, IL 60649

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S 000	Initial Comments FRI of 8/14/2024/IL177888	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6 300.3210(t) 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 plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999		

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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:

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.

Section 300.3210 General

t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

These Requirements were NOT MET as evidenced by:

Based on interview and record review the facility failed to develop and implement appropriate measures to ensure that adequate supervision is provided to two of three residents (R1 and R2) reviewed for supervision. This failure affected R1 and R2 who had an altercation that resulted in R1 having a human bite. R1 had to get a tetanus shot and was treated with antibiotics as a prophylactic for infection. this has the potential to affect all 41-resident residing on the 2nd floor.

Findings include:

R1's medical record admission record showed that R1 was admitted to the facility on 07/31/2023

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with diagnosis that includes but not limited to unspecified viral hepatitis C without hepatic coma, Acute posthemorrhagic anemia, weakness, pain right lower leg, pain left lower leg, open wound of right arm and other disorders of veins.
R2's medical record admission record showed that R2 was admitted to the facility on 06/30/2023 with diagnosis that includes but not limited to Aphasia following cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia following cerebral infarction and chronic ischemic heart disease unspecified.
R1's assessment tool used in assessing facility residents MDS (Minimum Data Set) dated 08/02/24 section C scored R1's BIMS (Brief Interview for Mental Status) as 14 indicating cognitively intact.
R2's assessment tool used in assessing facility residents MDS (Minimum Data Set) dated 06/27/24 section C scored R2's BIMS (Brief Interview for Mental Status) as 7 indicating that R2 has a severe impairment cognitively.

On 09/18/24 at 10:25am, R2 observed in bed. R2 was unable to recollect what happened on 08/14/24. R1 stated I'm fine.
At 10:28am, R1 stated that on (08/14/24) (R2) was in the room stealing from R1 and R3 drawer. R1 stated I (R1) was out of the room for a minute and when I came back, I (R1) saw R2 taking my stuff, food from my drawer and from R3's drawer who was at the hospital at the time. R1 stated when I (R1) asked R2 to put the things back, R2 attacked me (R1). R2 tried to hit me with a walker pointing to the walker in the room. R1 stated so I tried to defend myself and R2 bit me on my fingers and I had to take tetanus shot and I was in pain for couple of days and take antibiotics. R1

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stated R2 has been moved from the room but (R2) is still on this floor down the hall. I (R1) do notice that my food (Snacks) was missing but I will never think R2 was the one stealing them. R1 stated I (R1) was calling, and no one (referring to the facility staff) came for a while.

According to the facility presented investigation interview with the staff on duty on 08/14/24, interview statement showed that V17, V7, V12 assigned to the floor were not present on the floor at the time of incident.
Surveyor's interview with staff assigned to the floor on 08/14/24 also showed that both licensed nurses assigned to the floor V17 (RN) and V8 (LPN) and two of the CNAs V7 were not present on the floor leaving only one staff V12 (CNA) to supervise all the residents.

At 11:38am V12 CNA (Certified Nurse's Aide) stated that I was on the floor attending to other resident when I had the noise, I did not really see them (Referring to R1 and R2) fight but I heard it. V12 stated by the time I got to the room the fight was over the nurse was trying to calm them down.

On 09/18/24 at 2:00pm, V7 CNA (Certified Nurse's Aide) assigned to R1 and R2 stated that on 08/14 24 she worked with R1 and R2. V7 stated that I came in at the end of the incident. I went on lunch and was coming back to the floor and one of the CNAs told me both residents got into an altercation. It was a surprise to me because they never argue or fight before that day. The surveyor asked V7 did you ask the residents R1 and R2 or the roommates what happened or what they saw. V7 stated, no, I did not ask because I came in at the end of the altercation.

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On 09/19/24 at 11:42am, V8 LPN (Licensed Practical Nurse) stated that I was coming off (returning from) lunch break, when V17 RN (Registered Nurse) told me that R1 and R2 got into a fight. V8 stated I called V2 and V3, while V17 was holding R1, and I was holding R2. I did not witness the fight I was on break; the fight was over when I got to the floor. When asked what the residents caused the physical altercation V8 stated I did not ask because I was not on the floor when it happened, and it is not in my place to ask this question.

At 12:00pm, V3 stated that I (V3) was called to the room by staff that there was an altercation between (R1) and R2, when I got there (referring to the room). I (V3) immediately separated R1 and R2. I (V3) took R2 downstairs. The surveyor asked whether V3 asked the residents about the cause of the physical altercation. V3 stated that she cannot remember what R1 said. R1 just said R2 came to his side of the room, R2 was unable to recall the cause of the altercation, R1 reside in the room on bed one across from R2's bed. V3 stated that R1 had a bite mark and I (V3) asked V17 (RN) to clean up the wound and we got an order from the physician to give tetanus shot. V3 stated that she did not document the incident stating that V2 (DON) did all the charting after she was made aware of all that happened.

On 09/19/24 1:50pm, V2 stated that the expectation from the staff on the floor is to arrange the lunch time and break times to accommodate the resident mealtime for lunch time the staff are to take their lunch time and break time between 10:30am and 11:30am because the lunch time is between 12:00pm and 1:00pm. The incident happened around 1pm. I was not aware that V17 (RN) was not on the floor

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because V8 (LPN) told me she was the nurse on break. V2 stated both nurses should not be on lunch break at the same time leaving the residents unsupervised, two CNAs should at least be present on the floor with the nurse. V2 stated that on (08/14/24) V17 did not document the incident, and I (V2) did the documentation.

According to the facility presented investigation interview with the staff on duty on 08/14/24, interview statement showed that V17, V7, V12 assigned to the floor were not present on the floor at the time of incident.
Surveyor's interview with staff assigned to the floor on 08/14/24 also showed that both licensed nurses assigned to the floor V17 (RN) and V8 (LPN) and two of the CNAs V7 were not present on the floor leaving only one staff V12 (CNA) to supervise all the residents.

On 09/25/24 at 12:53pm, V18 (Physician) stated that he is familiar with both R1 and R2. Because they are his patients. When asked about the incident of 08/14/24. V18 stated that the only thing I (V18) can remember is that one of the residents (R2) bite another resident (R1) on the finger. V18 stated that R2 is aphasic due to stroke, R2 have problem with communication and can be irritable, R1 is in the same room with R2. V18 stated that the nurse called that they both (Referring to R1 and R2) had altercation between themselves. I (V18) asked for them to be separated, petition R2 to be sent to the hospital for psyche-evaluation. The one with the human bite (R2) to be treated with antibiotics and follow up. V18 stated that all human bites are to be treated with antibiotics as a prophylactic for infection. there are so many bacteria in the mouth that can cause infection.

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S9999	Continued From page 6 On 09/25/24 at 4:00pm, V1 stated that the staff have the right to go on their breaks. Then the surveyors asked whether they should all take a lunch break at the same time. V1 did not answer the question. V3 then stated that her office is on the second floor, but she was not on the floor to supervise but they (Staff) can easily call her to help in supervising the floor because they all know not to go out on lunch at the same time. The facility Accidents and Incident policy presented with revision date 5/2015 under supervision indicated that monitoring there is sufficient staff based on residents' needs which can vary. Such needs could include behaviors and behaviors leading to altercations with others. Facility job description for both LPN (Licensed Practical Nurse) and RN (Registered Nurse) presented documented in part that the primary purpose of a RN position is to provide each of the residents with routine daily nursing care and services in accordance with each resident's assessments and care plan. Essential duties and responsibility include but not limited to delivering nursing care to patients/residents requiring long-term or rehabilitative care, directs and supervises care given by other nursing personnel. (B)	S9999		