STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145426	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion of Ottawa	704 East Glover Street Ottawa, IL 61350

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 30678 Based on observation, interview, and record review the facility failed to identify fall risks and follow policy and procedures to prevent falls for two (R1 and R2) of three residents reviewed for falls in the sample of three. These failures resulted in R1 falling from wheelchair to the floor, bleeding, pain, bruising, and hospital visit with a diagnosis of nasal fracture and receiving sutures. These failures also resulted in repeat falls for R2. Findings include: The facility's undated Fall Management policy and procedure documents: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The responsibility to respect a resident's choices is balanced by considering the potential impact of these choices on other residents and the facility's obligation to protect the residents from harm. The facility will educate the resident and his or her family and staff regarding significant risks related to a resident's choice. Incorporating a resident's choices into the care plan, along with the family's and staff's input can help balance the interventions to reduce the risk of an accident, while honoring the resident's autonomy. This policy documents staff, family, roommate, and any other witness statements and Statements will be utilized as part of the root cause analysis. The facility's Accidents and Incidents policy and procedure, dated 5/2015, documents The facility provides an environment that is free from accident hazards over which the facility has control. The facility provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes identifying hazard and risk, evaluating and analyzing hazard and risk, implementing interventions to reduce hazard and risk, monitoring for effectiveness and modifying interventions when necessary. Avoidable Accident means that an accident occurred because the facility failed to identify an environmental hazard or individual risk or the need for supervision and/or evaluate/analyze the hazard and risk and/or implement interventions consistent with the resident's needs, goals, plan of care and current standards of practice in order to reduce the risk of an accident and/or monitor the effectiveness of the interventions and modify the interventions as necessary in accordance with the current standards of practice. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility's Resident Transfers and Safety Devices policy and procedures, dated 10/2017, documents All residents are assessed at time of admission for transfer ability. Residents who are unable to transfer themselves independently or with minimum assistance shall be transferred following the principles of this policy to allow for maximum safety during resident transfer. Transfers shall always be conducted following the principles of proper body mechanics, and safely. Each C.N.A. (Certified Nursing Assistant) must wear a (transfer) belt when transferring a resident. All resident falls and/or injuries occurring during resident transfer shall be reported to nurse. The incident will be reviewed and analyzed to determine the potential cause and corrective action. Assure (transfer) belt is in position on resident and Use the (transfer) belt on the resident, as with any transfer when transferring a Resident. The facility's (Transfer) Belts policy and procedure, dated 3/2014, documents A (transfer) belt is a required part of a CNA, nurse and therapist uniform. The CNA, nurse, or therapist shall place his/her (transfer) belt around his/her waist or in their pocket where it will be readily available for use when transferring or ambulating residents. If the CNA, nurse or therapist does not use the ambulation/(transfer) belt and a fall or injury occurs to him/her or the resident, it shall result in disciplinary action. The facility's Incident Log documents the following: R1 had a witnessed fall on 2/26/25 at 10:10 am; and R2 was lowered to the floor on 3/2/25 at 7:35 am and on 3/8/25 at 7:55 pm. 1. The Face Sheet for R1, documents R1 was admitted to the facility with the following diagnoses: Hemiplegia (paralysis) and Hemiparesis (weakness) following Cerebral Infarction (stroke) affecting right dominant side, Vascular Dementia, Epilepsy, Cerebral Infarction due to Embolism of Left Cerebellar Artery, Oral Phase Dysphagia, Slurred Speech, History of Transient Ischemic Attack (TIA-small strokes) and Cerebral Infarction. The Quarterly MDS (minimum data set) Assessment for R1, dated 3/21/25, documents R1 is cognitively intact, is moderately hard of hearing and usually understands others, and has no documented behaviors. R1 has functional limitations in range of motion to both upper and lower extremities on one side, uses a wheelchair and walker for mobility. R1 requires moderate to maximum assist with activities of daily living, transfers, and walking. The current Care Plan for R1 documents R1 is at a high risk for falls due to weakness and hemiplegia of right side. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Witnessed Fall investigation for R1, dated 2/26/25 at 10:10 am, documents (R1) was being wheeled down the hallway for an appointment and put his feet down causing him to fall out of the wheelchair onto his face. R1 was assessed with laceration to R1's nose between nostrils and bridge of nose and complained of pain to nose. This Investigation documents Predisposing Factors as Range of Motion Deficits and Hemiplegia (partial or total paralysis)/Hemiparesis (weakness on one side of body). V7 CNA's (Certified Nursing Assistants) statement is documented as: I asked the resident if he wanted his footrests on and he said no. I was pushing him down the hallway to the front to leave for an appointment and he put his feet down and fell forward out the wheelchair onto the floor. R1's statement documents I put my feet down and I shouldn't have. R1 was observed lying on the floor with laceration to nasal septum. Heavy amount of blood present. Laceration is full thickness. Skin tear to bridge of nose observed. Skin tear is partial thickness total flap loss. R1 was transported to a local hospital with bruise, laceration, and skin tear to his face. R1 returned to the facility with diagnosis of nasal fracture and received two sutures to nose laceration. This investigation documents Foot dropped during transport as the root cause analysis. The Wound Assessment Details Report for R1, dated 2/28/25, documents photos of R1's wounds and the following documentation as: Nasal Septum laceration, Bridge of Nose skin tear, and Facial bruising are all facility - acquired and caused by trauma sustained by a fall and identified on 2/26/25. R1's Nasal Septum laceration measured 1.0cm (centimeters) by 0.2cm by 0.1cm with two sutures in place and dried scab forming. Swelling to nose present. The photo shows swelling to nose and sutured split at septum. R1's Bridge of Nose skin tear measured 0.8cm by 0.3cm by 0.1cm with partial thickness total flap loss and scant amount of serosanguineous (thin watery fluid) drainage present. The photo shows swelling to R1's nose and pink/red open wound. R1's Facial bruising measured 4.0cm by 4.0cm with deep purple/red coloring. The hospital Imaging Results for R1, dated 2/26/25, documents maxillofacial CT (computed tomography) was completed for R1 due to Facial trauma, blunt, fall. The Impression documents the following: 1. Comminuted fractures of the nasal bone, with overlying soft tissue swelling; 2. Acute fracture of the anterior nasal septum; 3. Hematocrit levels in the left maxillary sinus and sphenoid sinus. Bubbly secretions likely representing blood products within the nasal cavity. On 3/28/25 at 2:18 pm, R1 was sitting up in a wheelchair in his room without leg/footrests on his wheelchair. Two leg/footrests were resting on the floor in R1's closet. Scarring noted to R1's nasal septum area and to the bridge of R1's nose. R1 was unable to move his right arm and hand but able to raise right foot and leg off the floor. R1 demonstrated how he moves his wheelchair independently by lifting both of his legs as if walking his wheelchair. R1 stated he doesn't like to use the leg rests in the facility because he can't propel his wheelchair with them on. R1 stated he can propel his own wheelchair slowly and for short distances to and from the dining room with rest periods at times. R1 stated (2/26/25) he was in his wheelchair going out for a doctor appointment and V7 CNA was going fast, because you have to in order to get up the ramp (incline in hallway). R1 stated my foot got caught and it stopped the wheelchair from going and I fell right out of my chair. My face made contact with the cement floor. Broke my nose and cut my face up. They (hospital) put stitches on the bottom part of my nose. I was a mess. The worst fall I've had in my life. It was terribly painful. R1 stated he uses the leg rests now if he goes out for appointments. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/28/25 at 12:30 pm, V1 Administrator stated in February (2/26/25) R1 had a fall from his wheelchair. V7 CNA was pushing R1's wheelchair, R1's foot hit the floor and R1 went forward out of his wheelchair. R1 did get a nasal fracture and now uses pedals if he is being pushed. R1 cannot always propel his own wheelchair but can move short distances with his feet but not enough to get around due to his stroke. On 3/28/25 at 3:20 pm, V5 RN (Registered Nurse) stated V7 CNA pushed R1 up the inclined hallway, turned onto the 500 hallway, and V5 RN was right behind them. When V5 RN got to the 500 hallway R1 fell from his wheelchair onto the floor just past the fire doors. V8 CNA witnessed it as well. V5 RN stated If (R1) would have had his leg rests on it wouldn't have happened. On 3/28/25 at 3:28 pm, V8 CNA stated she was standing at the charting station on the 500 hall and saw V5 CNA pushing R1's wheelchair down the hall. V8 CNA stated she heard V5 CNA telling R1 she was going to go get R1's leg rests because it wasn't safe, and that R1's feet were scuffing coming up the inclined hallway. V8 CNA stated about that time R1 dropped his feet down on the floor and went forward out of his wheelchair on to the floor. On 4/1/25 at 11:23 am V2 DON (Director of Nursing) and V4 LPN (Licensed Practical Nurse)/Restorative Nurse stated R1 was being pushed in his wheelchair by V7 CNA and R1 dropped his foot causing R1 to fall forward out of his wheelchair. V4 LPN stated R1 probably held his foot up so long going up the inclined hallway, got tired, and dropped his leg. R1 didn't ask for a rest period. V2 DON and V4 LPN/Restorative Nurse stated V7 CNA should have alerted the Nurse if R1 was refusing his leg rests. On 4/1/25 at 2:00 pm, V7 CNA stated she was R1's CNA on 2/26/25. V7 CNA stated she was pushing R1 in his wheelchair to the front of the facility for a doctor's appointment. R1's feet buckled, and he put his feet down. I didn't realize he had put them down, and (R1) went right out (of the chair) on his face. V7 CNA stated R1 was bleeding, R1's nose split, and R1 was complaining of pain to his face and nose. V7 CNA stated, I should have been more adamant about using R1's leg rests. 2. The Face Sheet for R2 documents R2 was admitted to the facility with the following diagnoses: displaced Fracture of Lower Epiphysis (separation) of Right Femur, Morbid Obesity, Spinal Stenosis of Lumbar Region with Neurogenic Claudication, Intervertebral Disc Degeneration of Lumbar Region, Wedge Compression Fracture of Fourth Lumbar Vertebra, Right Artificial Knee Joint, and History of Falling. The Quarterly MDS (minimum data set) Assessment for R2, dated 2/17/25 documents R2 is cognitively intact with no documented behaviors. R2 has no range of motion impairments to her upper and lower extremities and uses a wheelchair for mobility. R2 requires moderate assistance for oral hygiene, personal hygiene and rolling side to side in bed and maximum assist for remaining activities of daily living, all transfers, positioning, and wheelchair mobility. R2 did not have any falls prior to this assessment. The current Care Plan for R1 documents R2 is at high risk for falls due to weakness and a history of falls in the community and was lowered to the floor by facility staff on 3/2/25 and 3/8/25. This Care Plan documents interventions as: 3/2/25 Resident current illness and to be assessed by physician; and 3/8/25 Resume restorative programs in therapy gym. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Lowered to the Floor investigation for R2, dated 3/8/25, documents Staff informed (V6 RN/Registered Nurse) that (R2) was lowered to the floor. Upon entering room (R2) was observed on knees facing the bed. R2 stated My knees just gave out. I felt my right ankle twist a little. R2 complained of pain when right ankle was moved. At the time of the incident there were no visible injuries. Bruising to anterior right knee was reported post incident. Predisposing Factors included: History of falls, Gait imbalance, Prone to bruising, Recent illness, and occurred during transfer. V9 CNA's (Certified Nursing Assistant's) statement documents V9 CNA informed V6 RN that R2 was lowered to the floor. R2's statement documents R2 stated My knees just gave out. I felt my right ankle twist a little. The Notes section documents X-ray results are negative, and resident continues to have weakness due to illness and is unable to participate in restorative programs in therapy gym and for Restorative programs to resume. This investigation documents the root cause analysis as: recent illness, weakness, prone to bruising/lowered to floor. On 3/28/25 at 2:30 pm, R2 was sitting in a wheelchair with a mechanical lift sling underneath her. R2 had visible light discoloration to her right knee. R2 stated she had a fall on 3/2/25 and the facility changed her from one assist to two assist. R2 stated on 3/8/25 she was in her room and one CNA (V9) was helping her get out of her wheelchair to go to bed. R2 stated I'm inpatient and head strong. Thought I could do it. R2 stated the CNA did not use the lifting belt, and she slid down the bed and hurt her knees. R2 stated I probably wouldn't have fallen if there had been two staff. R2 stated the facility did get x-rays and she did not break anything. R2 stated the pain is much better now but since her last fall the staff use the mechanical lift for transfers and I don't like it and feel like I am not getting any stronger by using it. On 4/1/25 at 6:15 pm, V6 RN stated V9 CNA reported to V6 that (R2) had to be lowered to the floor. V6 RN stated when she got to R2's room, R2 was on her knees facing her bed and was complaining of ankle pain and after assessing R2 V6 RN called and got an order to x-ray R2's ankle. V6 RN stated the next day she saw bruising to R2's right knee and got an order to x-ray R2's knee and all the x-rays came back negative for fractures. V6 RN stated V9 CNA told V6 RN that he had transferred R2 by himself without a transfer belt and R2 was supposed to be transferred with the assistance of two staff and a transfer belt and R2 reported this same information. On 4/1/25 at 3:55 pm, V9 CNA stated he transferred R2 on 3/8/25 from her wheelchair to bed by himself and did not use a transfer belt. V9 CNA stated prior to this time, R2 was able to stand, transfer, turn, and take a few steps. This time (R2) said she couldn't move her left leg. R2 was facing the bed and just went down onto her knees. V9 CNA stated he was given a written warning because he didn't use a transfer belt during the transfer and (R2) was supposed to be two assist and I did it by myself and should not have. On 4/1/25 at 11:23 am, V2 DON (Director of Nursing) and V4 LPN (Licensed Practical Nurse)/Restorative Nurse stated after R2's fall on 3/2/25 she was changed to a two assist for transfers and the staff were all educated, and it was added to her profile in the computer system and over R2's bed. On 3/8/25 V9 CNA transferred R2 by himself and was reprimanded at that time. V2 DON and V4 LPN/Restorative Nurse confirmed a transfer belt is to be used for all resident transfers.