

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145426	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER Pavilion of Ottawa		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure food was prepared, stored, and served in a manner to prevent cross-contamination. This failure has the potential to affect all 124 residents in the facility. The findings include: The CMS (Centers for Medicare and Medicaid Services) form 671 dated 8/26/2025 showed 124 residents resided in the facility. On 8/27/2025 at 8:20 AM, V2 (Director of Nursing) said the facility did not have any residents with a feeding tube. On 8/26/2025 between 9:45-10:15 AM, while doing the initial Kitchen observation, a scoop was left inside of the large container of thick-it (a powder used in food preparation to thicken food consistency). The scoop was directly on the powder mixture. The handle was touching the powder. On 8/26/2025 at 11:09 AM V11 (Cook) prepared the pureed foods (hamburger patties) for the lunch meal, then separated the pureed meat into several small pans for the different halls they were to be served on. V11 picked up half of the pans and held them against her clothing when she was taking them to put in the hot box until the lunch meal. V11 then picked up the remaining pans to put in the hot box and held them against her body while taking them to the hot box. During that same time, V12 (Dietary Aide) was making barbecue sauce in a large metal bowl. After making the barbecue sauce, V12 picked up the bottles of condiments used to make the sauce and held them against her clothing while taking them to put in the refrigerator. On 8/26/2025 at 12:47 PM, V13 (Dietary Aide) obtained the temperature of the foods in the steam table on the 200-hall kitchenette. V13 left the same gloves on for the lunch service. V13 placed both gloved hands on the steam table, touched the meal tickets, the Styrofoam plates, the handle to the door of the refrigerator, the handles on the utensils in the individual food items, reached into the bag of buns, grabbed a bun with the gloved hand, then used both gloved hands to separate a slice of cheese from the stack, and placed the cheese on the burger. V13 repeated these steps of touching the meal tickets, the Styrofoam plates, the handles on the utensils in the food items, reaching into the bag to grab a bun, and grabbing a slice of cheese with her gloved hands. V13 did not remove the gloves and wash her hands or change gloves during the lunch observation. On 8/26/2025 at 12:55 PM, V14 (Cook) was in the kitchenette on the 800-hall serving food to the residents. V14 touched the steam table, the meal tickets, the handles to the utensils in the food items on the steam table, reached into a bag, grabbing a bun with the same gloves, then grabbing a slice of cheese and placing it on the burger. V14 repeated the same process of touching the meal tickets, Styrofoam plates, handles to the utensils, then using the same gloves to grab a bun and a slice of cheese when plating the food for the residents on the 800-hall. V14 did not remove the gloves and wash her hands or change gloves during the lunch observation. On 8/26/2025 at 3:45 PM, V10 (Dietary Manager-DM) said dietary staff should not be touching door handles to the refrigerator, placing their gloved hands on the steam table, touching the handles of the utensils, then touching ready-to-eat items like buns or cheese, that is cross-contamination. V10 said tongs should be used to grab the buns and ready-to-eat food items. V10 said the scoops should not be in the dried food containers because that is cross contamination. The scoops should be put in a bag and placed on the top of the container. On 8/28/2025 at 9:03 AM, V10 (DM) said dietary staff should not be holding pans of food or condiments against their clothing, that is cross-contamination. V10 said he has talked to (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145426
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	V12 about that several times. On 8/28/2025 the facility provided their 2021 policy and procedure titled Food and Nutrition Services Sanitation and Food Safety Handwashing. The policy showed Food and nutrition services employees will practice safe food handling to prevent foodborne illness. The policy showed food and nutrition services employees will thoroughly wash their hands and exposed areas of their arms with soap and water in the designated hand-washing sink at the following times.After handling soiled equipment and utensils.The facility's 2017 policy and procedure titled Food and Nutrition Services Sanitation and Food Safety-Service showed Dishes and utensils are handled in a way which does not contaminate the surface the food touches. Care is taken to observe the following steps.Avoid touching the eating surface of the dish or bowl. The facility was not able to provide a policy and procedure addressing safe food handling to prevent cross-contamination during meal preparation or meal service regarding glove use, touching ready-to-eat foods, or not allowing clothes to touch items during food preparation prior to exiting the facility.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide assistance with shaving facial hair for 3 female residents (R48, R57, R65) and failed to provide assistance with grooming, shaving and denture care for 1 resident (R131). This failure affected 4 of 4 residents (R48, R57, R65, R131) reviewed for activities of daily living in the sample size of 49. The findings include: 1. On 08/26/2025 at 11:56 AM observed R48 seated in a wheelchair at the nurse's station on the 800 unit and noted facial hair to chin area that appeared thick and course and was approximately 4-5 milliliters in length. R48 indicated that the girls help me with her chin hair. No aides were observed present on unit at this time. On 08/27/2025 at 12:14 PM, observed R8 seated at the dining room table on the 800 unit and noted facial hair to her chin area that appeared thick and course that was approximately 2-3 milliliters in length at this time. R48's face sheet showed an admission date of 05/14/2025 with a past medical history not limited to morbid obesity, dementia, muscle weakness, and need for assistance with personal care. R48's care plan with last completion date of 08/25/2025 reads in part: has a deficit in activities of daily living (ADL) abilities and requires staff assistance initiated on 05/14/2025. Interventions included but not limited to: daily morning and bedtime (AM/HS) care, assist with dressing and grooming tasks, oral care twice daily and as needed, and shower/bed bath per schedule. R48's Minimum Data Set (MDS) Section GG-functional abilities dated 08/13/2025 indicated that R48 requires setup or clean-up assistance with personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene). Review of R48's progress notes for last 30 days showed no documentation regarding any refusals of care. 2. On 08/26/2025 at 12:04 PM, observed R57 near room with visible facial hair to her top lip and her bottom lip above chin area that was approximately 3-5 milliliters in length. R57 was not aware that she had any visible facial hair. On 08/27/2025 at 12:33 PM, R57 was observed in the dining room on the 800 unit with a small amount of facial hair visible to her lower lip area above chin area that was approximately 1-3 milliliters in length at this time. R57's face sheet showed an admission date of 08/12/2023 with a past medical history not limited to Alzheimer's disease, dementia, and muscle weakness. R57's care plan with last completion date of 07/24/2025 reads in part: has impaired cognitive function and impaired thought processes; is at risk of possible abuse/neglect related to relying on others for care needs; has a deficit in ADL abilities and requires staff assistance, has impaired mobility and weakness. Interventions included: AM/HS care daily, assist with dressing and grooming tasks, oral care twice daily and as needed, provide resident with equipment in order for her to perform oral care, facial washing, and upper body grooming with minimal assistance from staff. Encourage her to do as much as possible. Encourage her also to select clothing to wear each day and donning/doffing upper body attire. Assist as needed; shower/bed bath per schedule, initiated 08/13/2023. R57's MDS Section GG-functional abilities dated 07/17/2025 indicated that R57 requires supervision or touching assistance with personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene). Review of R57's progress notes for last 30 days showed no documentation regarding any refusals of care. 3. On 08/26/2025 at 10:16 am and 08/27/2025 at 10:43 AM, observed R65 seated in her wheelchair in her room and noted facial hair to her chin area, hair appeared uncombed, and had an overall disheveled appearance. R65 was dressed in clothes and indicated on both days that she was ready for the day. R65's face sheet showed an admission date of 05/12/2020 with a past medical history not limited to dementia, morbid obesity, muscle weakness, and anxiety disorder. R65's care plan with last completion date of 06/05/2025 reads in part: bathing/hygiene deficit related to diagnosis of gout, anxiety, irritable bowel syndrome, dementia. She has weakness in her bilateral lower extremities; at risk of possible abuse/neglect related to residing in a nursing home and relying on others for care; is dependent on staff for meeting emotional, intellectual, physical, and social needs; (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	has a deficit in ADL abilities and requires staff assistance related to weakness, history of falls, osteoarthritis to bilateral knees, gout, anxiety, dementia and type 2 diabetes. Interventions included but not limited to: AM/HS care daily; assist with dressing and grooming tasks, provide resident with equipment in order for her to perform oral care, facialwashing, and upper body grooming with minimal assistance from staff, encourage her to do as much as possible; encourage her also to select clothing to wear each day and donning/doffing upper body attire, assist as needed; shower/bed bath per schedule.R65's MDS dated [DATE] indicated that R65 requires partial/moderate assistance with personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene). Review of behavior progress notes for last 30 days showed one documented incident for refusal of care dated 07/29/2025 that documented an agency staff entered the room to assist R65. Resident told agency staff, I do not want you to help me your skin is a different color then the regular staff. No other refusal of care notes were noted. 4. On 08/26/2025 at 10:33 AM and 08/27/2025 at 10:46 AM, R131 was observed lying in bed wearing a gown with facial hair to his cheeks, mouth and chin area that appeared thick and course. R131's dentures appeared unclean with visible food debris in between teeth and throughout the top denture. Resident said he has not been washed up yet and he has not taken out his dentures for a few days. R131's overall appearance on both days was disheveled and fingernails appeared long with visible debris beneath nails to both hands. On 08/27/2025 at 12:50 PM, observed R131 seated in a wheelchair next to the bed feeding himself lunch. R131 was wearing hospital gown and indicated that he doesn't recall if he had been washed up yet, then said that he has not had a shower since he admitted 1-2 weeks ago. R131 was unsure of when his shower days were then said an aide told him yesterday that she would shave him but then the aide never came back to do it. R131 indicated that he needed to be shaved and could probably shave himself with an electric razor if he was pushed up to a mirror. No aides were observed present on unit at this time.Review of R131's records on 08/26/2025 through 08/28/2025 documented an admission date of 08/19/2025. Care plan with last completion date of 08/26/2025 reads in part: has a deficit in ADL abilities and requires staff assistance due to infection of right knee prosthesis, impaired mobility, history of spinal fusion, arthritis, weakness. Interventions included: AM/HS care daily; assist with dressing and grooming tasks; oral care twice daily and as needed, provide resident with equipment in order for her to perform oral care, facial washing, and upper body grooming with minimal assistance from staff. Encourage her to do as much as possible. Encourage her also to select clothing to wear each day and donning/doffing upper body attire, assist as needed; shower/bed bath per schedule.R31's admission MDS indicated in progress, section GG-functional abilities was not completed. Review of R131's progress notes since admission showed no documentation regarding any refusals of care.On 08/28/2025 at 08:24 AM, V2 (Director of Nursing) said female residents should not have visible facial hair, then indicated that resident grooming is typically done on shower days, which includes shaving residents and trimming their fingernails when needed. V2 added that partial bed baths are done in between shower days, and all residents should receive oral/denture care daily. V2 (DON) also said that grooming and shaving should be performed unless a resident is combative, is resistive to being shaved, or is adamant about not having facial hair removed.On 08/28/2025, facility provided care plan report page 7 of 8 for R57 and highlighted the following, I am resistive to care related to refusing personal cares with date initiated 01/17/2025. Facility also provided care plan report for R65 and highlighted on page 5 of 11, I am resistive to care related to showering dated 06/03/2025; on page 2 of 8, highlighted I will decline and refuse care sometimes and I easily get upset or agitated with date initiated 03/11/2021; and on page 5 of 8 highlighted, I have my routine and I get upset if this disrupts that was undated. Facility did not provided any documentation for refusals of care upon exit for R57 or R65.Activities of Daily Living (ADL) care policy dated 11/2015 reads in part: to meet the grooming and hygiene needs of residents with dignity and privacy. To encourage residents to achieve independence while providing the assistance needed. The basics for ADL care should be implemented (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	whenever a procedure or task occurs. Basics for ADL care include .ask the resident for permission to assist with or preform ADL care. If given permission proceed.notify nurse of anything unusual.Denture Care includes to ask the resident to remove their dentures. If they cannot remove them, wearing gloves gently move the upper denture from side to side and pulldown. Place the dentures in an emesis basin or denture cup. Remove the lower denture by using an upward movement while rocking the denture from side to side. Place the denture in an emesis basin or denture cup. Take the dentures to the sink, rinse off any food particles, clean them with denture cleaner, rinse and cover with fresh water. Remove your gloves and wash your hands. When inserting dentures, wash your hands and put on gloves. Rinse the dentures with fresh water and take to residents' bedside. Offer the resident a drink of water first to moisten their mouth. Ask resident to place the dentures in their mouth if unable place the lower plate in the resident's mouth first. Special Oral Care: if resident is unable to tolerate teeth brushing or to wear dentures provide special oral care. Wash your hands and put on gloves. Place a towel under the resident's chin. Ask resident to open their mouth if they are unable to, gently open the resident's mouth by placing one hand on the chin and pressing down. With your free hand insert a moistened applicator in the mouth, use mouthwash or other oral cleanser to moisten the applicator. Wipe the roof of the mouth, the inside of the cheeks, the tongue and the teeth. Change applicators frequently during the process. If the resident is unable to turn their head assist them with positioning their head so you can reach both sides of their mouth. After cleaning their mouth, rinse mouth with fresh water moistened applicators. Dry residents face. Apply a water soluble lubricant to moistener lips, mouth and tongue. Discard the used applicators. Remove the towel and place in soiled linen container. Position residents head for comfort and proper alignment. Remove the gloves and wash your hands. Combing and Brushing Hair includes to brush and comb the resident's hair daily, after bath care, when getting up from bed and as needed. Gently brush and comb only small amounts of hair at a time. If the resident cannot sit up, ask them to turn their head, if they cannot turn their head gently turn the residents head from side to side to comb all sides. Style the resident's hair according to his or her preference. Clean the brush and comb. Store them in the resident's bedside stand. If dryness, redness, flakes, skin irritation or sores are noted to the scalp notify the nurse. Shaving with safety razor: prior to shaving a resident check with the nurse to ensure they are not on blood thinners. Dampen the resident's beard with a warm washcloth to soften it. Apply shaving cream. Begin at sideburns and work down over the cheek and chin. Keep the skin tight as you shave this helps prevent nicks. Rinse the razor after each stroke. Have the resident tip their head back, if possible, use up-ward strokes under the chin and jaws. When finished shaving the resident rinse the extra soap off the face. Dry the skin and apply after shave. Discard the safety razor in the sharps container. If the resident is nicked or an unusual area is noted to the resident's skin notify the nurse. If the resident is a women shave only the areas with facial hair and apply facial moisturizer instead of aftershave. Shaving with electric razor: apply pre-shave if desired. Plug in razor and turn on. Shave cheeks first, then around the mouth and down the neck last. If possible, have resident tip their head back when shaving the neck. For a razor with a flat or flexible head use short up and down motion with the grain of the beard. For a razor with a circular head use small, circular motions. When shave is completed wipe extra pre-shave off face. Pat face dry. Apply after shave. Clean electric razor and store away.Fingernail Care: place a towel under hand or foot prior to providing nail care. Collect nail clipping in the towel. Discard the nails after each hand or foot. Nail care includes daily cleaning of nails and as needed, and nail trimming as needed. Clean hands. Gently remove dirt from around and under each nail with an orange stick. Trim nails on fingers in an oval shape. Trim toenails trim straight across. Do not trim nails below the skin line. Do not trim diabetic's toenails. Smooth trimmed nails with an emery board. If hand or nails are very soiled soak each hand in soapy water before nail care or if possible complete nail care after a shower or bath. When nail care is completed apply lotion to hands and feet. Place soiled towel in soiled linen bin. Partial Bath: if possible, take the resident to the bathroom to provide am care. After giving the resident time to void. Provide am care. A partial bath (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	consists of washing the residents face, the underarms, under breasts, and peri-area, or any other soiled area. Provide privacy and dignity for the resident by exposing only the area of the body that is being washed.Dressing: encourage resident to choose the clothes they will wear. Encourage resident to dress self as much as possible. If assistance is needed begin dressing the resident on their weak side. Assist as needed with putting on clean undergarments, socks and slacks. Next put on shirt, blouse or dress. Finish with putting on shoes. Assist with buttoning and zipping as needed.R131's face sheet, care plan and MDS were requested from V2 (Director of Nursing) on 08/28/2025 but were not provided upon exiting survey.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure multiple insulin pens and a vial of liquid morphine were properly labeled with an open and discard date in accordance with professional standards. This failure affected 6 of 6 residents (R5, R8, R41, R74, R82, R94) reviewed for medication storage in the sample size of 49. The findings include: On 8/27/2025 at 10:38 AM, R94's long-acting prefilled insulin pen had a yellow sticker with a spot to document Date Open, Date Exp (expired), and initials. The sticker was not filled out or initialed. The cap for the pen had a tamper resistant red tape which indicated the pen had been opened. V4 Licensed Practical Nurse (LPN) stated she had given R49's long-acting insulin that morning and the pen had already been previously opened and used prior to the morning of 8/27/25. On 08/27/2025, medication storage and labeling task was performed by this surveyor with V6 (Registered Nurse) on the 800 unit with the following findings. At 12:22 PM, observed two glargine insulin pens for R82 and one glargine (lantus) insulin pen for R5 with the red tamper-evident tape broken on each insulin pen that were visibly used and not labeled with either an open date or a discard date. Also observed a glargine (basaglar) insulin pen for R8 with the red tamper-evident tape broken that was visibly used and labeled with an open date of 08/22/2025 but no discard date or staff initials indicated. V6 then said that she will just add a discard date to R8's insulin pen and proceeded to use a spread sheet with insulin expiration dates to determine discard date. On 08/27/2025 at 12:24 PM, V6 (RN) indicated that R8 and R82 were both administered insulin in the morning, then indicated that she labels all insulin pens upon opening, with the date opened, the discard date and her initials. On 8/27/25 at 12:53 PM, the 500-unit medication cart was reviewed with V9 (Licensed Practical Nurse) present. The narcotic box had two multi-dose vials of liquid morphine in it. One vial was for R41, and the other vial was for R74. Neither vial was dated with an open date or expiration date. R41's corresponding count sheet for the morphine showed the first day of administration was 7/24/25. R74's corresponding count sheet for the morphine showed the first day of administration was 6/13/25. V9 (LPN) stated both vials should be dated to show when they were opened. Nurses need to know that so we can follow how long it is good for. V9 said expired medications have the potential to be less effective. V9 stated both R41 and R74 are residents on hospice and the morphine is needed to treat their pain or shortness of breath. R5's face sheet showed an admission date of 11/08/2024 with a past medical history not limited to type 2 diabetes mellitus. Review of R5's records active orders revealed no current order for insulin glargine (lantus). Review of R5's discontinued orders showed an order to inject 10 units of insulin glargine 100 unit/ml solution with pen-injector subcutaneously at bedtime related to type 2 diabetes mellitus was discontinued on 06/30/2025. Review of R5's June 2025 eMAR also showed the insulin glargine was discontinued on 06/30/2025 at 12:38 PM and was last administered to R5 on 06/29/2025 at 08:00 PM (2000). (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R94's Face Sheet showed an admission date of 7/3/24 with a diagnosis of type 2 diabetes. R94's Order Summary Report showed an order for 20 units of long-acting insulin to be given daily in the morning. R8's face sheet showed a last admission date of 07/29/2024 with a past medical history not limited to type 2 diabetes mellitus. Review of R8's active orders showed an order to inject 25 units of insulin glargine (basaglar) 100 unit/ml solution with pen-injector subcutaneously in the morning, and 15 units at bedtime related to type 2 diabetes mellitus with a start date of 06/12/2025. Review of R8's eMAR for August 2025 documented that insulin glargine is scheduled to be administered at 08:00 AM and 08:00 PM and documented that V6 (RN) administered the 08:00 AM dose to R8 on 08/27/2025. Record also documented that R8 has received this insulin glargine daily throughout the month. R82's face sheet showed a last admission date of 11/14/2024 with a past medical history not limited to type 2 diabetes mellitus. Review of R82's active orders showed but not limited to inject 40 units of insulin glargine 100 unit/ml (milliliter) solution with pen-injector subcutaneously every morning and at bedtime related to type 2 diabetes mellitus with a start date of 07/28/2025. Review of R82's electronic medication administration record (eMAR) for August 2025 documented that insulin glargine is scheduled to be administered at 09:00 AM and 09:00 PM (2100) and documented that V6 (RN) administered the 09:00 am dose to R82 on 08/27/2025. Record also documented that R82 has received this insulin glargine daily throughout the month. On 8/27/2025 at 1:13 PM, V2 (Director of Nursing) stated that insulin pens should be dated with the date opened, the expiration date, then initialed by the nurse. V2 added that nurses have a spread sheet used to determine the 30 day expiration date after opening the insulin and should not be used past thirty days because there is a risk that the medication is not as effective and the risk for contamination is increased. V2 then said that nurses should be checking the label on the pen prior to use, pen should be returned to pharmacy if the label is blank, and if the seal is broken, that indicates that the pen had been used. On 08/28/2025 at 08:24 AM, V2 (DON) said insulin pens should be labeled with the date opened and the discard date because the potency is not effective after recommended discard date. V2 then said that any discontinued insulins should be discarded and should be removed the med cart. Labeling of Medication Containers policy (MM 05/01/09) reads in part: all medications maintained in the facility shall be properly labeled in accordance with current state and federal regulations. Labels for individual drug containers shall include all necessary information, such as, the resident's name; prescribing physician's name; name, address, and telephone number of the issuing pharmacy; name, strength, and quantity of the drug; prescription number (if applicable); date that the medication was dispensed; appropriate accessory and cautionary statements; expiration date when applicable; and directions for use. In addition to the above information, multi-dose vials must be dated and initialed the time they are opened. Multi-dose vials are to be discarded after 28 days of being opened. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility provided pharmacy documentation (undated) showing the morphine medication expires one year from the dispense date or manufacturer's expiration date, whichever is sooner. The facility's Labeling of Medication Containers policy dated 5/1/09 states under the multi-dose vials dating section: 6.multi- dose vials must be dated and initialed at the time they are opened.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure the device used to check residents' blood sugar levels (a glucometer) was disinfected according to the manufacturer's instructions, to prevent cross-contamination for 9 of 9 residents (R3, R10, R13, R20, R34, R40, R75, R107, and R127) reviewed for glucose checks in the sample of 49. The findings include: On 8/26/2025 at 12:13 PM, V15 (Licensed Practical Nurse-LPN) performed a blood glucose test on R127 prior to the lunch meal. After checking R127's blood sugar level, V15 used a micro-kill disinfectant wipe to clean the glucometer. V15 did one swipe across the glucometer, then place the glucometer on a tissue that was on the medication cart. At 12:26 PM, V15 used the same glucometer to check R3's blood sugar level prior to the lunch meal. After obtaining the blood sample, V15 placed the glucometer on the windowsill in R3's room. V15 picked up the glucometer, informed R3 of the results and went out of the room. At 12:28 PM, V15 used the micro-kill wipes again on the glucometer, wiping the glucometer for 5 seconds before placing the glucometer on the same tissue that was used after checking R127's blood sugar level. V15 put the glucometer in the 200-hall medication cart a minute later when it was dried. On 8/27/2025 at 2:18 PM, V16 (LPN/Infection Prevention Nurse) and V17 (Assistant Director of Nursing-ADON) identified the residents on the 200-hall that receive blood glucose level checks. V17 (ADON) said the nurses should disinfect the glucometers with the Clorox wipes that are in the medication carts. V16 (LPN/IP nurse) said the glucometer should be kept wet with the Clorox wipe for at least 3 minutes to disinfect the glucometer. V16 said if the nurse is doing another glucose check, there should be another glucometer ready to go. V16 and V17 said the nurse should make sure the glucometer is cleaned according to the manufacturer's instructions to make sure it is sanitized and does not cross-contaminate to another resident. V17 provided the list of residents on the 200-hall that get blood glucose checks. The list identified R3, R10, R13, R20, R34, R40, R75, R107, and R127 as the residents receiving blood glucose checks on the 200-hall. On 8/27/2025 at 3:19 PM, V17 (ADON) said she looked at the instructions on the micro-kill wipes and the nurse must keep the glucometer wet with the wipe for 3 minutes to disinfect the glucometer. On 8/28/2025 at 12:41 PM, V2 (Director of Nursing) brought this surveyor a copy of the label on the micro-kill wipes. V2 said it is hard to read the copy, but the label showed the nurses need to keep the glucometer wet for 3 minutes with the micro-kill wipes to disinfect the glucometer. On 8/28/2025 the facility provided R3, R10, R13, R20, R34, R40, R75, R107, and R127's admission Records and Order Summary Reports. The admission records showed R3, R10, R13, R20, R34, R40, R75, R107, and R127 all had a diagnosis of diabetes mellitus. The Order Summary reports showed all these residents had an order for accu checks (blood glucose monitoring). The facility's midnight census report, printed on 8/27/2025, showed all of the previously listed residents reside on the 200-hall of the facility. The facility's policy and procedure titled Cleaning and Disinfecting Resident Care Items and Equipment, with a revision date of June 2022, showed Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard. The following categories are used to distinguish the levels of sterilization/disinfection necessary for items used in resident care. Semi-Critical items consist of items that may come in contact with mucous membranes or non-intact skin (e.g. respiratory therapy equipment). Such devices should be free from all microorganisms, although small numbers of bacterial spores are permissible. The facility's policy and procedure titled Cleaning and Disinfecting Blood Glucose Meters, with a revision date of January 2014, showed, It is the policy of the facility to clean and disinfect blood glucose meters that are shared between residents. Indirect contact transmission - Patient-care devices (e.g., electronic thermometers, glucose monitoring devices) may transmit pathogens if devices contaminated with blood or body fluids are shared between patients without cleaning and disinfecting between patients. The procedure showed. 4. Use gloves to obtain droplet of blood on to glucose test strip. 5. Dispose of used finger stick devices and lancets at the point of use (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in an approved sharps container. Never reuse needles, syringes, or lancets. 6. Remove gloves and wash hands. 7. Apply new gloves. 8. Thoroughly clean all visible soil or organic material (e.g., blood) from glucometer prior to disinfection. 9. Using gloves as indicated wash vigorously with disinfectant and allow for drying time as indicated per manufacturer. 10. Perform hand hygiene (i.e., hand washing with soap and water or use of an alcohol-based hand rub) immediately after removal of gloves and before touching other medical supplies intended for use on other residents. 11. Follow manufacturer's guidelines for cleaning and disinfecting of glucose meters. Specific guidelines for glucose meters may vary with the manufacturer. Consult with manufacturer to determine which cleaning procedures, specific to glucose meter sharing, should be adhered to. 12. In the absence of manufacturer's recommendations, the glucometer is considered a semi-critical device, follow policy for cleaning semi-critical devices. Use of disinfectants, antiseptics, and germicides are in accordance with manufacturers' instructions and EPA or FDA label specifications to avoid harm to staff, residents and visitors and to ensure effectiveness . All personnel who perform these tasks are trained with regard to proper procedure, protective equipment required (if any), and safety precautions . All products and processes used for cleaning, disinfection and sterilization are approved by Infection Control Committee/Infection Preventionist. The policy and procedure showed Note: When selecting a disinfecting cleaning product, you will want to look at contact time. In other words, you want to be aware of the length of time the disinfectant must be in contact with the item being cleaned for the germ/bacterial to be considered killed. Some product item may be as short as one minute, another product it may be ten (10) minutes. On 8/28/2025 at 9:28 AM, V1 (Administrator) provided instructions via email for micro-kill germicidal bleach wipes. The instructions showed 4. Ensure contact time: Wipe the surface to ensure it remains visibly wet for the entire contact time required by the product's label. The necessary contact time varies depending on the organism (e.g., 30 seconds for many bacteria and viruses, but 3 minutes for Clostridium difficile spores).		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure wheelchair foot rests were in place for a resident during transport and failed to ensure a resident's medication was secured. This applies to 2 of 9 residents (R77, R74) in the sample of 49. The findings include: 1. R77's admission Record (Face Sheet) showed an admission date of 7/7/23 with diagnoses to include Alzheimer's (dementia), muscle weakness, osteoarthritis, history of falling, osteoporosis, and weakness. R77's Care Plan showed she was a mechanical lift transfer. R77's 6/11/25 Minimum Data Set (MDS) showed she required Partial/Moderate assistance for wheelchair transports of 50 feet and she was totally dependent upon staff for transport of 150 feet. On 8/26/2025 at 12:12 PM, R77 was in the central common area of the locked memory care unit. R77 was in her wheelchair. V3 Agency Certified Nursing Assistant (CNA) transported R77 to the dining area. As V3 pushed R77 in her wheelchair, R77's right foot was dragging and skipping along the floor (R77's other foot was supported on a footrest). The distance V3 pushed R77 was at least 60 feet. On 8/27/2025 at 1:26 PM, V2 Director of Nursing (DON) stated residents who are able to keep their legs elevated and are only being transported a short distance, may be moved without a wheelchair footrest; however, V2 stated since R77's foot was dragging on the ground a footrest should have been used. V2 said residents can fall out of wheelchairs or sustain broken bones when wheelchair footrest is not used appropriately. The facilities Equipment- Self Propel Wheelchair policy (Effective 11/2013) showed Any resident who is being transported in the wheelchair off their assigned unit should have footrests.2. R74' face sheet dated 8/28/25 showed diagnoses including but not limited to dementia, heart disease, kidney disease, anxiety disorder, and cataracts. 2. R74's facility assessment dated [DATE] showed moderate cognitive impairment. The same assessment showed staff setup assistance for eating and staff supervision for oral hygiene. R74's physician order report dated 8/28/25 showed an order for Fluticasone propionate nasal suspension, one spray in each nostril in the morning for allergies, itchy eyes/nose (start dated 5/5/25). On 8/26/25 at 10:37 AM, R74 was lying in bed sleeping and the bedside table was over his waist. The table had a bottle of fluticasone nasal spray sitting on it which was directly within reach. There was no nursing staff in the room or immediate area. On 8/27/25 at 9:05 AM, R74 was seated in a wheelchair in his room. R74 stated he did not know how to take his medications. The nurses give him all medications and they tell him when to do it. R74 said he had no idea when or what type of medications he was prescribed. On 8/27/25 at 12:53 PM, V9 (Licensed Practical Nurse) stated R74 is somewhat alert and oriented but (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he is not able to take his medications on his own. V9 said the nasal sprays are not something R74 can do by himself. He definitely needs help with those. On 8/28/25 at 9:01 AM, V2 (Director of Nurses) stated it is not common for the residents to self-administer medication here. There is no way to safely lock medications in resident rooms. An assessment would first need to be done to determine if a resident can safely take them alone. Nurses should never leave medications in the room. There is the potential for the resident to take it incorrectly or not take it at all. All medications, including over the counter ones, should be stored properly. That means locked in a medication cart or medication room. V2 verified there was no assessment for R74 to self-administer medications. V2 stated there are no residents in the building that take medications on their own. The facility's Administering Medications policy revision dated 11/2020 states: Medications shall be administered in a safe and timely manner, and as prescribed. The same policy states: Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely, and resident has successfully completed a competency for self-administration.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to keep a resident's urinary catheter off of the floor; failed to keep catheter tubing below the level of the resident's bladder, and failed to have orders or diagnoses in place for an indwelling catheter. This applies to 2 of 3 residents (R43, R128) reviewed for urinary catheters in the sample of 49. The findings include: 1. R43's Face Sheet showed an admission date of 11/10/24 with diagnoses to include dementia, interstitial cystitis (bladder pain and/or urgency), and urinary retention. R43' Care Plan showed [R43] has a UTI (urinary tract infection) and is at risk for recurrent UTI's.(11/18/24) On 08/26/2025 at 11:50 AM, R43 was sitting in her wheelchair in the common area on the locked memory care unit. R43's catheter tubing exited her lower pant leg and discharged into a catheter bag suspended under the seat of her wheelchair. At least 18 inches of R43's catheter tubing was laying on the floor. In the middle of the tubing was a clip. On 8/26/2025 at 12:09 PM, V4 Licensed Practical Nurse (LPN) moved R43, in her wheelchair, to the dining room; over 60 feet away. During the transport, R43's wheelchair wheel rolled over R43's tubing, twice, and the tubing dragged along the floor. On 8/27/2025 at 1:21 PM, V2 Director of Nursing stated catheter tubing should not be on the floor, should not be dragged along the floor, and should not be run over with a wheelchair. V2 stated this is to prevent UTI's. The facility's Urinary Catheter Care policy (3/2014) showed, The primary purpose for giving daily urinary catheter care is to prevent infection. Maintain aseptic technique at all times when handling and caring for the urinary catheter. When moving, transferring, or positioning the resident, make sure that all tubes are positioned in such a manner that they will not be pulled out or cause injury to the resident. When the resident is in a wheelchair, the urine tubing is placed over the cross-bars under the seat and is not kinked or curled. The bag is then place in the urinary bag holder. 2. R128's admission record shows she was admitted to the facility on [DATE]. The 8/27/25 order summary reports show R128 had orders to change a urinary drainage bag and monitor urinary output and an order to be placed on enhanced barrier protection due to indwelling urinary catheter. The orders did not show a diagnosis for R128 to have the catheter or size of the urinary catheter. R128s care plan for urinary catheter does not list any reason or diagnosis for her to have the catheter. On 8/27/25 at 1:25 PM, R128 was sitting in her wheelchair by the bed and her urinary catheter bag was in a dignity bag under the wheelchair. V5 certified nursing aide (CNA) placed a gait belt around R128s waist. V5 removed the urinary drainage bag from under the wheelchair and held the bag well above the level of R128s bladder, hooking the bag to her pants. V5 continued to transfer R128 from the wheelchair to the bed. On 8/28/25 at 11:00 AM, V2 said when a resident is admitted with an indwelling urinary catheter, the orders should include when to change the catheter, the size, and a diagnosis is required. She said all (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the information should be in in the physician orders. V2 said we were not clear as to why R128 had the catheter, we reached out to her son as well and he did not know. She said there should have been a diagnosis. V2 said the urinary drainage bag should always remain below the level of the bladder, so the urine does not back up in the tubing. The facility's 3/2014 policy for urinary catheter care documents the primary purpose for giving daily urinary catheter care is to prevent infection. Infection control measure: the (drainage) bag must be held lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure oxygen was administered at the physician prescribed rate for 1 of 1 resident (R9) reviewed for oxygen in the sample of 49. The findings include: R9's face sheet dated 8/28/25 showed diagnoses including but not limited to chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure with hypoxia, emphysema, cerebral atherosclerosis, and dependence of supplemental oxygen. R9's facility assessment dated [DATE] showed severe cognitive impairment. R9's order summary report dated 8/28/25 showed an order for oxygen at three liters via nasal cannula every shift for dyspnea (difficulty or shortness of breath), start dated 7/22/25. R9's care plan showed a focus area for the risk of acute exacerbation of COPD and the use of oxygen at two liters per nasal cannula (initiated 5/13/25). The same care plan showed to administer the oxygen at two liters per continuous nasal cannula per physician orders. On 8/27/25 at 10:05 AM, R9 was seated in a high back wheelchair in her room. R9 had an oxygen tank on the back of her wheelchair and the tubing was in her nose via nasal cannula. The oxygen tank setting showed the needle in the red (empty) zone. The setting was at three, but no oxygen was being administered. R9 removed the nasal cannula and said she did not feel any air coming through the tubing. At 10:13 AM, V8 (Certified Nurse Aide) was called into the room and observed the tank. V8 said R9 needs her oxygen every day, 24/7. R9 exited the room and notified the floor nurse. V7 (Registered Nurse) entered the room and verified the oxygen tank was empty. V7 said R9 needs it running continually due to her COPD. V7 said R9 could get shortness of breath or trouble breathing if it is not running as ordered. The oxygen saturation levels could plummet. On 8/28/25 at 9:05 AM, V2 (Director of Nurses) stated nurses should always be following physician orders. Residents run the risk of hypoxia and shortness of breath if oxygen is not given as ordered. All staff should be looking at the oxygen supplies during cares to ensure everything is running correctly. On 8/28/25 at 10:20 AM, V18 (Registered Nurse) stated resident care plans should match what the physician has ordered. We always follow the physician order but the care plan also directs the plan of care. The facility's Oxygen Administration policy last revision dated 3/20 states under the preparation section: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan for any special needs of the resident. The same policy states under the steps in the procedure section: 9. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered.		