STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145621	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion of Waukegan	2217 Washington Street Waukegan, IL 60085

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 34117 Based on observation, interview, and record review the facility failed to ensure the bathroom was clean and homelike. This applies to 4 of 4 residents (R48, R50, R56, R60) in the sample of 18. The findings include: On 5/20/25 at 9:31 AM, during the resident council meeting, R48, R50, R56 and R60 said the first bathroom/shower room looks like there is mold on the ceiling, it's been like that for a while. There has been no maintenance staff over a month to fix repairs, the last one was fired. On 5/20/25 at 10:06 AM, in the bathroom/shower room on the first floor a brown/yellowish discoloration of dried water rings with pieces of peeled paint and drywall hanging from the ceiling above the toilet. On 5/21/25 at 10:55 AM, V1 (Administrator) said we don't have a maintenance staff right now, our permanent maintenance staff left in October 2024, since then we have hired a couple of new maintenance staff and they have not worked out. The bathroom ceiling does not have mold, there was a leaky toilet upstairs on the 2nd floor that caused the damage. We were waiting to repair the ceiling after we hired a new maintenance staff. The facility did not provide maintenance log for the last three months and did not provide a policy on maintenance repairs when requested.

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. 40085 Based on interview and record review the facility failed to ensure anti-psychotic psychotropic medications had a stop date of 14 days for 1 of 6 residents (R15) reviewed for unnecessary medications in the sample of 18. The findings include: R15's face sheet shows she has diagnoses including cerebral infarction, unspecified dementia with psychotic disturbance and hemiplegia and hemiparesis. R15's Electronic Medical Record (EMR) shows she entered hospice care on 1/28/25. A Hospice Interdisciplinary Plan of Care completed on 3/20/25 shows an order for R15 to receive Risperdal (risperidone) (Anti-psychotic medication) 1 milligram (mg.) every morning and to continue PRN (as needed) Risperdal 0.5 mg. every 8 hours for agitation. There is no stop date identified. R15's EMR shows the hospice order for the PRN Risperdal was entered into the Physicians Orders with the following statement added, Do not discontinue without discussing with Hospice. A facility provided a not dated Medication Regimen Review Prescriber Recommendations shows the pharmacy had notified the facility on this form of the following for R15, CMS guidelines limit all PRN use of antipsychotics to 14 days and require prescriber examination/evaluation every 14 days to renew orders. Report of the resident's condition from staff to the prescribing practitioner does not constitute an evaluation. R15's Medication Administration Summary shows R15 received 9 doses of the PRN Risperdal on the following dates between 3/20/2025 and 5/21/2025 (3/22/25, 4/14/25, 4/15/25, 4/18/25, 4/27/25, 5/2/25, 5/9/25, 5/14/25, and 5/16/25). On 5/21/25 at 11:23 AM, V2 (Director of Nursing) said R15's medications are being managed by the hospice physician and she had attempted to contact R15's hospice provider for documentation showing that R15 had been re-assessed after 14 days but was not able to obtain those documents. V2 said she found where R15 had changes to the scheduled doses of Risperdal but could not find any stop dates for the PRN Risperdal after 3/20/2025. R15's EMR shows she was being seen by the facility Nurse Practitioner and they did not add any stop dates for R15's PRN Risperdal either. The facility provided Use of Psychotropic Medication Policy implemented on 3/11/25 states, PRN orders for antipsychotic medications only, shall be limited to 14 days with no exceptions. If the attending physician or prescribing practitioner believes it is appropriate to write a new order for the PRN antipsychotic, they must first evaluate the resident to determine if the new order for the PRN antipsychotic is appropriate.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 22499 Based on observation, interview and record review the facility failed to ensure a resident's splint/palm protector was in place to her left hand for 1 of 4 residents (R36) reviewed for splints/restorative care in the sample of 18. The findings include: On 5/19/25 at 10:30 AM R36 was in bed, asleep with no splint on her left hand. Again on 5/20/25 at 9:00 AM at 12:49 PM R36 was in bed with no splint on her left hand. R36's left hand is contracted in a closed fist position with her fingers pressing into her palm. On 5/20/25 at 12:55 PM V9 (Agency Certified Nursing Assistant) was asked about R36's left hand splint. V9 stated she didn't know anything about it and proceeded to take R36 out of the room in her reclining wheelchair and placed her in the dining room. On 5/21/25 at 9:32 AM V8 (Restorative Nurse) stated, I didn't know she didn't have it. It is a palm protector to keep her fingers from pressing into her palm. She takes it off with her other hand. I don't know where is was, I asked night shift to find it for me. R36's current Physician's Order Sheet shows an order dated 9/10/24 for Splint: Palm Protector for left hand. On during AM cares, off during PM cares. Remove for Hygiene, bathing. Monitor for redness and discomfort. R36's current care plan states, Restorative cna/rna splint program: Application and removal of palm protector for left hand. On during AM cares, off during PM cares. Remove for hygiene, bathing. Monitor for redness and discomfort. The Interventions include: Monitor resident compliance to use of device. Document and report refusals and or unscheduled removal by resident.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 40085 Based on observation, interview, and record review the facility failed to ensure dietary supplements were provided for 1 of 6 residents (R22) reviewed for weight loss in the sample of 18. The findings include: R22's face sheet shows she has diagnoses including dementia. R22's Weight Summary shows she weighed 116.4 pounds (lbs.) on 4/1/24 and she weighed 108.3 lbs. on 3/3/25 a 8.1 lb. 7.75% weight loss in 1 year. R22's 3/12/24 Dietary Note completed by V12 (Dietician) shows that R22 has had some weight fluctuations possibly due to dementia. The Dietary Note shows that supplements to promote higher protein and calorie consumption had been added prior to the weight change including yogurt 6 ounces with meals, skim milk three times a day with meals, double eggs at breakfast, and a new dietary supplement of peanut butter and jelly sandwiches with meals was added. On 5/19/25 the noon meal service on the 1st floor was observed. At 1:20 PM R22's meal tray was brought out to her, and staff assisted R22 to start eating and sat at the table with her. On R22's meal tray was a copy of her meal ticket that said 6 ounces of yogurt should be given (if available) with her lunch. There was no yogurt on R22's meal tray and at no time did facility staff go to get one for R22. On 5/20/25 at 12:44 PM during meal service R22 again did not have yogurt on her meal tray. V14 (Certified Nursing Assistant) was sitting at the table R22 was eating at. V14 said they must encourage R22 to wake up and eat but she will eat it just takes her a while. R22's current Weight Loss care plan shows that supplements should be given as ordered. R22's Physician Order Summary shows R22 should receive calorie and protein supplements per dietician recommendation. On 5/20/25 at 1:12 PM, V10 (Director of Culinary Services) said the facility does have yogurt available and if a resident has an order for yogurt with meals it should come out from the kitchen on the meal tray. On 5/21/25 at 7:35 AM, V12 (Dietician) said R22 did trigger for a significant weight loss at one point but they questioned the validity of that earlier weight because it was high for R22. V12 said she did see R22 in March for weight loss and added another supplement. V12 said R22 has been on the yogurt for increased protein and calorie, and she expects the facility to offer the supplement to R22 with her meals because if R22 does eat the yogurt it is good for her.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37232 Based on interview and record review the facility failed to document a numerical value for a peripherally inserted central catheter (PICC) measurements for 1 of 1 resident (R61) reviewed for intravenous (IV) access in the sample of 18. The findings include: R61's face sheet printed on 5/19/25 showed he was a [AGE] year-old male that had the diagnosis of osteomyelitis (bone infection). A facility assessment done on 4/10/25 showed R61's mental status was intact. On 5/19/25 at 12:19 PM, R61 said he was getting IV antibiotics for a bone infection through a PICC that had been removed. R61 said staff did not measure the catheter length or the circumference of his arm. R61's Medication Administration Records (MAR) for April 2025 and May 2025 showed an order to measure the catheter length of the PICC weekly from the insertion site to the tip of the cap and to call the doctor if the length changed more than 2 centimeters. Also, to measure the arm circumference weekly. The measurements were to be done on the following dates: 5/14/25, 5/7/25, 4/30/25, 4/23/25, 4/16/25, and 4/9/25. The MARs had a check mark documented with no numerical value recorded for the measurements. R61's Progress Notes for 5/14/25, 5/7/25, 4/30/25, 4/23/25, 4/16/25, and 4/9/25 did not have a documented numerical value for the measurements of the PICC length or arm circumference. On 5/20/25 at 1:11 PM, V7 (Registered Nurse) said PICC measurements are documented in the MAR or sometimes in the progress notes. V7 said measurements are done to see if the PICC line was pulled out or if the resident has arm swelling by comparing the measurements with a previous measurement. V7 added there should be a number documented for the measurements. The facility's Care and Maintenance of Central Venous Catheter policy dated 1/1/25 showed central lines will be placed after careful considerations of the risk and benefits of use. Risks associated with central line use include infection, deep vein thrombosis, and dislodgement.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 37232 Based on observation, interview, and record review the facility failed to ensure a resident consumed their medications when administering medications for 1 of 18 residents (R42) reviewed for pharmacy services in the sample of 18. The findings include: R42's Care Plan with an initiated date of 4/24/24 showed R42's memory is or may be impaired. Consequently, the resident has problems with decision-making, insight, logic, calculation, reasoning, planning, and judgement. On 5/19/25 at 9:37 AM, R42 was in bed. On the bedside table was a clear medication cup with 4 pills (one white, one yellow, and two brown). R42 said he had not received his morning medications. R42 was asked about the pills on his bedside table. R42 said he was not aware there were pills sitting on his bedside table. R42 added sometimes staff will leave his medication on the bedside table for him to take later. On 5/19/25 at 10:21 AM, the pills remained on R42's bedside table. On 5/19/25 at 10:50 AM, the pills were no longer on R42's bedside table. On 5/19/25 at 11:09 AM, V5 (Registered Nurse) said he noticed the pills sitting on R42's bedside table. V5 said the pills were not from his shift and he disposed of the pills. V5 said sometimes R42 will ask staff to leave his medications at his bedside. V5 added staff should not leave medications at the bedside. They should stay with the resident to ensure the resident takes the medication. R42's Care Plan and Order Summary Report printed on 5/19/25 did not indicate R42 could self-administer medications. The facility's Medication Administration policy (undated) showed when administering medications staff were to observe residents consume the medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 40085 Based on observation, interview, and record review the facility failed to ensure insulin pens were properly stored and labeled for 2 of 18 residents (R60, R78) reviewed for medication storage in the sample of 18. The findings include: On 5/20/25 at 12:17 PM, the first-floor medication cart was reviewed with V15 (Registered Nurse). Inside the medication cart in the top drawer there was a 1/4 full (Lantus) insulin pen that had no resident name or open date on it and a Humalog Kwik pen belonging to R78. The pen was not opened and the packaging the pen was in was clearly labeled Refrigerate. V15 verified the Humalog was a new unopened insulin pen and should be kept in the refrigerator until it is open for use. V15 also was unable to verify whose (Lantus) insulin pen was inside the cart that was not labeled and said all insulin pens should be clearly labeled with who it belongs to and the open date. On 5/21/25 at 7:30 AM, V2 (Director of Nursing) said that the insulin pens should clearly be labeled and dated when opened and any insulin pen that is new should be kept refrigerated until it is used. A list of residents receiving Lantus insulin on the 1st floor was provided from the facility and it shows R60 and R78 both received the insulin, and the unlabeled pen could have belonged to either one of them. R60's and R78's Physician Order Summaries both show they have current orders for Lantus insulin pens and R78 also has an active order for Humalog (lispro) insulin. The facility provided Insulin Pen policy shows that the pens must be clearly labeled with the resident's name and the date opened, and any unopened insulin pens should be stored in the refrigerator.

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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. 47552 Based on observation, interview, and record review the facility failed to ensure safe food handling practices were followed to prevent cross-contamination. This has the potential to affect all residents that receive food and nourishments from the kitchen. The findings include: Centers for Medicare and Medicaid form 671 dated 5/19/25, shows there are 88 residents that reside in the facility. On 5/21/25 at 10:40 AM, V10 (Director of Culinary Services) said at this time, all residents residing in the facility receive food, beverage, or nourishment from the kitchen at this time; even those receiving a tube feeding because they are ordered pleasure feeding. 1. On 5/19/25 at 11:25 AM, V11 (Cook) dropped a white cleaning towel onto the floor. V11 picked up the towel and continued to wipe down the food prep counter next to the oven, wipe down and clean a thermometer, clean down the prep counter that attaches in front of the steam table, and then placed the towel by the three-compartment sink. On 5/19/25 at 11:36 AM, V10 began the mechanical soft chicken process and used a green handle scoop to scoop portions of chicken into the food processor. When finished, V10 placed the scoop back into the food service pan of chicken with the food contact surface touching the chicken and the handle outside of the food. When V10 returned to the food service pan of chicken to remove portions for the puree chicken, V10 placed the scoop rim side down onto the prep counter that attaches in the front of the steam table, the same place that V11 cleaned with the towel that touched the floor. There was no additional cleaning of the prep counter after being wiped with the towel that touched the floor. On 5/19/25 at 11:49 AM, V10 started the puree process and used a gray handle scoop to scoop portions of rice into the food processor. When finished, V10 placed the scoop back into the food service pan of rice with the food contact surface touching the rice and the handle outside of the food. On 5/19/25 at 11:57 AM, V11 started to place lids on top of the steam table pans and removed all the scoops that were being stored in the food and placed them on top of the lids, uncovered. On 5/19/25 at 12:02 PM, V10 removed all the steam table lids and placed the scoops that were stored on top of the food service lids back into their respective food items. No new scoops for the rice or chicken were used before starting to serve. On 5/21/25 at 8:59 AM, V10 said after V11 dropped the rag, V11 should have immediately brought the rag to the disposal bin underneath the hand sink, washed V11's hands, then grabbed a new towel before cleaning again. V10 also said scoops that have already been used to serve or retrieve food from bins should be left with the food contact surface inside of the food until service has ended to prevent cross-contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. On 5/19/25 at 11:26 AM, V10 began pureeing creamed corn for lunch. During the process, V10 reached into the bulk bin of food thickener, grabbed the scoop, and scooped out a portion of food thickener to add to the creamed corn. When V10 lifted the food processor lid to pour the food thickener into the product, drops of creamed corn fell on to the scoop. V10 then used the same scoop and scooped out another portion of food thickener to add to the creamed corn. When finished, V10 returned the scoop to the bulk bin and hung it on the storage hook inside of the bin. On 5/19/25 at 11:42 AM, V10 began pureeing chicken for lunch. During the process, V10 reached back into the bulk bin of food thickener and grabbed the scoop that was used during the creamed corn process, with the creamed corn still on the scoop, and scooped out a portion of food thickener to add to the creamed corn. When V10 lifted the food processor lid to pour the food thickener into the product, drops of pureed chicken fell on to the scoop. On 5/21/25 at 8:59 AM, V10 said during the puree process, V10 did not see the food drop onto the scoop. If V10 saw the food drop onto the scoop, V10 would have either washed and sanitized the scoop before using it again or V10 would have grabbed a new, clean, and sanitized scoop to prevent cross-contamination.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37232 Based on observation, interview, and record review the facility failed to ensure staff wore the required personal protective equipment (PPE) when providing high contact care activities for 2 of 18 residents (R7 and R36) reviewed for infection control in the sample of 18. The findings include: 1. R7's Face Sheet printed on 5/19/25 showed R7 had a gastrostomy (tube feeding). R7's Order Summary Report printed on 5/19/25 showed an order for enhanced barrier precautions related to an indwelling medical device of a tube feeding. On 5/19/25 at 9:50 AM, on R7's door was a sign that indicated R7 was on enhanced barrier precautions. The sign indicated staff were to wear gloves and gown for high contact care such as device care or use of a feeding tube. On 5/19/25 at 9:50 AM, R7 was in bed. V5 (Registered Nurse) was holding R7's tube feeding tubing while connecting a syringe that contained fluid to R7's tube feeding. V5 had on gloves. V5 did not have on an isolation gown. On 5/20/25 at 12:41 PM, V6 (Wound Care Nurse) said staff should put on gloves and gown when providing care or touching an indwelling urinary catheter or tube feeding tubing. R7's Care Plan (undated) showed R7 was on enhanced barrier precautions because of a tube feeding. Listed under interventions was apply personal protective equipment per facility policy. Staff to wear gloves and gown when providing direct nursing care. The facility's Enhanced Barrier Precautions policy dated 2/25/25 showed enhanced barrier precautions refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. PPE for enhanced barrier precautions is only necessary when preforming high-contact care activities. High-contact resident care activities include device care. 22499 2. On 5/20/25 at 12:39 PM V9 (Agency Certified Nursing Assistant) was providing care for R36. R36 has a gastrostomy tube and an indwelling urinary catheter. There was no sign for Enhanced Barrier Precautions (EBP) on R36's door. V10 dressed R36 and then emptied R36's foley catheter. V10 was not wearing a protective gown while providing care for R36. On 5/20/25 at 11:07 AM V3 (Assistant Director of Nursing/Infection Preventionist) stated, We in-service all the staff and they have to wear PPE, gown and gloves when providing direct care (for resident's on EBP). They should have signs on the resident doors (showing EBP). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R36's current Physician's Order Sheet shows and order for Enhanced Barrier Precautions related to indwelling device (urinary catheter and feeding tube).