

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145712	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2025
NAME OF PROVIDER OR SUPPLIER Pavilion on Main Street, The		STREET ADDRESS, CITY, STATE, ZIP CODE 515 North Main Sandwich, IL 60548	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. (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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to immediately isolate residents with a suspected infectious rash. The facility failed to ensure staff did not expose residents to a suspected infectious rash. The facility failed to ensure residents on isolation remained in their rooms to prevent the possible spread of infection. The facility failed to clean and disinfect resident rooms and linen in a manner to prevent the possible re-exposure of a skin infection. These failures have the potential to affect all 94 residents in the facility. The findings include: The Facility Data Sheet dated 7/23/25 showed a resident census of 94 residents. A facility isolation list dated 7/23/25 showed R1 was on contact isolation for a suspicious rash. R2, R3, and R7 were on contact isolation due to scabies. 1. R1's resident assessment dated [DATE] showed R1 was severely cognitively impaired and dependent on staff for all cares. R1's nurses note dated 7/19/25 showed R1 was found to have a petechial rash to legs, torso, chest and back. A physician order dated 7/22/25 showed R1 was placed on contact isolation (2 days after her rash was noted). On 7/23/25 at 8:28 AM, no contact isolation signage was noted on or around R1's doorway. No isolation cart with PPE (personal protective equipment) was noted by or around the entrance to R1's room. No bins for isolation garbage or linen were noted in R1's room. On 7/23/25 at 8:58 AM, a contact isolation sign was noted on R1's door. V8 Housekeeping Director was placing isolation garbage and linen bins by the entrance to R1's room. No PPE cart was noted by or around the entrance to R1's room. V8 stated V15 Licensed Practical Nurse (LPN)/Acting Infection Preventionist (IP) had placed the contact isolation sign on R1's door a few moments ago. R1 was in bed with a red, pinpoint rash noted to her left upper and lower abdomen. On 7/23/25 at 8:51 AM, V5 Certified Nursing Assistant (CNA) stated R1 was not put on contact isolation until this morning. V5 CNA stated although she knew R1 had a rash, R1 has been brought out of her room by staff, that morning, to eat breakfast in the dining room with the other residents. On 7/23/25 at 8:51 AM, V6 CNA also confirmed R1 had eaten her breakfast in the main dining room that morning despite staff knowing about R1's rash. 2. R2's nurses note dated 7/21/25 showed R2 was found to have a petechial rash to his left upper leg. The note showed, Clothes and linens washed. Room deep cleaned. R2's physician order and July 2025 Medication Administration Record (MAR), dated 7/22/25, showed R2 was placed on contact isolation for his rash (one day after the rash was noted). R2's MAR dated 7/21/25 showed R2 received his first treatment of Permethrin Cream 5% (cream to treat scabies) topically for his rash. On 7/23/25 at 8:36 AM, a contact isolation sign hung on the door to R2's room. A PPE cart was noted by R2's doorway. This surveyor donned PPE and entered R2's room. R2 was in bed with a red, pinpoint rash to his right upper arm, right elbow, right breast area, and right upper abdomen. R2 was actively scratching his right upper arm. R2 stated to this surveyor, No one has been wearing that stuff (PPE) you have on. You are the first. R2 stated he's had his rash for a couple of days now. R2 stated he was treated with a cream and then showered but no one had changed his bed linen or cleaned his room since the application of the cream and shower. On 7/23/25 at 10:21 AM, V8 Housekeeping Director stated R2's room should have been deep cleaned and his bed linen changed after R2's first Permethrin treatment and prior to him coming back to his room from his shower, but we are working on it. We haven't done it yet. 3. R3's nurses note dated 7/19/25 showed R3 was found to have a petechial rash to his right upper and lower leg. The note showed, Clothes and linens washed. Room deep cleaned. R3's MAR dated 7/21/25 showed R3 received his first treatment of Permethrin Cream 5% (cream to treat scabies) topically for his rash. R3's physician order dated 7/22/25 showed R3 was placed on contact isolation for his rash (3 days after his rash was noted). On 7/23/25 at 8:45 AM, a contact isolation sign hung on the door to R3's room. A PPE cart was noted by R3's doorway. This surveyor donned PPE and entered R3's room. R3 was seated in a wheelchair by his bed. A red, pinpoint rash was noted to R3's left breast area and left arm. R3 stated he also had the rash to his bilateral inner thigh areas. R3 stated the rash to his left breast was still itchy. R3 stated to this surveyor, This is the first time seeing anyone in that garb (PPE). R3 stated he was put on isolation that morning (7/23/25), after he had eaten breakfast in the main dining room with other residents. R3 stated he'd had his first Permethrin treatment and shower, but no one had cleaned his room or changed his bedding in the last few days. On 7/23/25 at 8:51 AM, V5 and V6 CNAs stated R3 did eat breakfast in the main dining room that morning (7/23/25) despite staff knowing about R3's rash. V5 and V6 CNA each stated R3 was not put on isolation until the morning of 7/23/25. On 7/23/25 at 10:21 AM, V8 Housekeeping Director stated R3's room had yet to be deep cleaned, and his bedding had not been</p>

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>Based on interview and record review the facility failed to employ an Infection Preventionist that had successfully tested and completed infection preventionist training and education. This failure has the potential to affect all 94 residents in the facility. The findings include: The Facility Data Sheet dated 7/23/25 showed a resident census of 94 residents. V15's Licensed Practical Nurse (LPN)/Acting Infection Preventionist (IP) Nursing Home Infection Preventionist Training Course records printed 7/23/25 showed V15 started the course on 9/30/2023 but had yet to successfully complete the test portion of the course and receive the certification. On 7/23/25 at 10:51 AM, V15 LPN/Acting IP stated she had been the facility's Infection Preventionist for over a year but had yet to successfully complete the test for the infection preventionist course and receive the certification. V15 stated she had been acting as the IP under the IP certification the previous Director of Nursing (DON) had but that DON no longer worked at the facility. On 7/23/25 at 11:57 AM, V1 Administrator stated the facility did not currently have a certified Infection Preventionist. The facility's Infection Preventionist job description (undated) showed the Infection Preventionist education and experience requirements included a certification in Infection Prevention.</p>		