STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145712	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion on Main Street, The	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 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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a bed rail was maintained in a safe manner for 1 of 3 residents (R1) reviewed for resident injury in the sample of 9. This failure resulted in R1 receiving an injury to her right lateral leg, being sent to a local hospital where she received stitches for her injury.The findings include:R1's admission Record, printed by the facility on 9/16/2025, showed she had diagnoses including, but not limited to, displaced comminuted fracture of shaft of humerus left arm (5/6/25), moderate protein-calorie malnutrition, difficulty in walking, reduced mobility, lack of coordination, pain in left should and left elbow, disorders of muscle, dysphagia, unsteadiness on feet, need for assist with personal care, age-related osteoporosis , repeated falls, hypertension, muscle spasm, history of healed stress fracture, dementia, glaucoma, weakness, abnormal gait and mobility, and malignant neoplasm of skin. R1's facility assessment dated [DATE] showed she had severe cognitive impairment. The assessment showed R1 had no verbal behaviors or physical behaviors (i.e., hitting, kicking, pushing, or grabbing others) towards others during the look back period of the assessment. The assessment also showed R1 required substantial to maximal assist for toileting, bathing, upper and lower body dressing, putting shoes on/off, personal hygiene, rolling side to side in bed, going from lying to sitting position, and sitting to lying position. The assessment showed R1 was dependent on staff for all transfers.On 9/16/2025 at 8:55 AM, R1 was sitting at a table with three other females after the breakfast meal. R1 was alert and smiling at staff. On 9/16/2025 at 9:20 AM, V4 (Registered Nurse-RN) said he was working the day R1 was sent out to the hospital (9/2/2025). V4 said the 9/2/2025 incident was the second time R1 went out recently to the hospital for stitches on her legs. V4 said the first incident happened in August 2025. V4 said R1 had a wound on her left leg time, was sent to the hospital and got 11 stitches to her left leg. V4 said he does not know what caused the injury to R1's left leg. He said interventions were to reinforce 2 staff assist with care and transfers and put protective sleeves on her to protect her arms. V4 said the most recent incident on 9/2/2025, R1 got a wound to her right leg. The CNA was V5 and the nurse on duty when it occurred was V6 (LPN-agency nurse). V4 said he was just starting his shift. He went down to see R1's leg on 9/2/25 before the ambulance arrived. V4 said V6 had already wrapped it, so he removed the bandage to see the wound. On 9/16/2025 at 9:31 AM, V5 (CNA) said she had just come back from a long medical leave and had only worked a few days since returning to work. V5 said it was her first time taking care of R1. V5 said R1 is fearful. V5 said, She is afraid she is going to fall. She was holding onto the side rail real tight. I was going to get her up and clean her up while she was on the toilet. I took her boots off. I came around to the right side of R1. I put the 1/2 side rail up. I was putting her gait belt on her, and she waved her hand and said, Leave me alone. She was scared. I put one arm behind her and one under her legs. I turned her to sit her up on the side of her bed. When I got her sat up on the side of the bed, she stopped, looked at me and said, My leg hurts. I looked down and there was a lot of blood. I informed the agency nurse (V6). The nurse wrapped R1's wound and called an ambulance to have R1 sent out. V5 said after they looked at the side rail it did not have the little stoppers on the ends. V5 said, They had to pad the rails. Without the stoppers it is sharp. She was a little combative and did not want to get up, but I don't recall saying she was kicking. She moved one arm to say leave me alone and the other hand was holding onto the railing. It was literally only a couple minutes. At 9:48 AM, this surveyor went with V5 to look at R1's bed. V5 demonstrated how after she put a gait belt on R1, she put one hand behind her and put the other hand under her legs to turn R1. V5 said as soon as she brought R1's legs around to the side of the bed, R1 stopped talking, looked at V5 and said, My leg hurts. V5 said she looked down and saw a puddle of blood on the floor, so she laid R1 back down, placed her leg on a pillow, grabbed something to wipe the floor really quick so no one slipped on it, and then hurried to get the nurse. V5 said maintenance padded the rail and the bed frame after the incident. On 9/16/2025 at 9:51 AM, V8 (Maintenance Director) was on the hall R1 resides looking down at a sheet of paper. V8 said he was looking at the list showing rooms had side rails with no end caps on them when they did a building wide sweep to check all the side rails. V8 said there were several siderails didn't have the caps on. Eight on the 2nd floor and 15 on the 1st floor were missing the end caps on the side rails. V8 said he was double- checking all of them and would provide the list when done. V8 was asked to come to R1's room to remove the tape and pool noodle so this surveyor could see the end of side rail. Observed the end cap on the side rail at time. The metal bars on the end of the side rail were rough where the caps met the metal. V8 said he put end caps on after R1's incident and padded the rail and bed

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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. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident's medications were available and administered as ordered for 1 of 3 residents (R4) reviewed for medications in the sample of 10.The findings include: On 9/17/2025 at 8:39 AM, V6 (R4's wife) said R4 did not get his medications for 3 days when he was first admitted to the facility. V6 said she was not sure what medications. V6 said R4 just told her he was not getting all his medications. V6 said the facility told them the hospital did not send them. V6 said, I could not go into the facility when he was first admitted because I had the flu. I told (R4) to say something about not getting all his medications. V6 said she knows she spoke to someone about the medications. V6 said, He is on a lot of medications. I was worried he was going to have withdrawal because he is on methadone. V6 could not identify who she spoke to at the facility regarding R4's medications. V6 said when R4 was discharged from the facility back to home, they did not give him a prescription for diuretics. Bumetanide. V6 said R4 was discharged on a Tuesday (9/9/2025). The home health nurse came on Thursday (9/11/2025), so he did not start taking the diuretic until Friday. V6 said R4 missed Wednesday and Thursday's diuretic.On 9/17/25 at 11:20 AM, V24 (Registered Nurse-RN) said she was the nurse on duty when R4 was admitted to the facility on [DATE]. V24 said she did some of R4's admission. Other nurses completed some of the assessments for his admission because it was near the end of her shift. V24 said there were medications that R4 missed due to the medications not being available. V24 said she marked in R4's medication administration record (MAR) on 8/12/2025 and 8/13/2025 that the methadone and Lyrica were not available. The methadone is used for pain. The Lyrica is also for pain. V24 said when a new resident is admitted to the facility, the nurse will fax a script (prescription) to the physician. The doctor signs the script and faxes it back to the facility, the nurse will fax it to the pharmacy, and the pharmacy will dispense it for delivery. V24 said it could take 24-48 hours on admit before we receive the medications. V24 said, We must have the script to dispense the medications. V24 said as soon as we fax the signed script to the pharmacy, we can request a code if we have that medication in the C-box medications. V24 said she was not sure if those are in the C-box. V24 said there were medications that the facility did not have available and R4 did miss some medications. At 11:38 AM, V24 said she was also the nurse that discharged R4 on 9/9/2025. V24 said, He discharged home with a multivitamin that he brought in and DuoNeb treatments. I asked (R4) if he needed any medications to take home, he said no just those two. Neither him, nor his wife (V6) asked for any prescriptions. I even offered to request scripts from the doctor, and he said no. (V6) was here when he was discharged . I went over the discharge instructions and showed them which medications we were sending with them. His wife asked me to write down when all his medications were last given and when they were due next.On 9/17/25 at 1:49 PM, V2 (Director of Nursing-DON) said the hospital did not send a script for methadone and Lyrica when R4 was admitted . V2 said, We were trying to find a doctor to get the script. V19 (R4's physician while in the facility, and the facility's Medical Director) was his physician on admission. (V19) ended up signing the script. Initially (V19) told the nurse to contact the hospital. The hospital would not sign the script, so (V19) ended up signing it. Methadone is used for pain, and R4 said he had been on it for 13 years. When I found out about his methadone not being available, I went to make sure he was not in withdrawal. He said he was not having any withdrawal symptoms but was concerned that he may start having them soon. That is when he told me he had been taking it for 13 years. At 2:36 PM, V2 said R4 was admitted on [DATE]. V2 said there was an order for methadone and Lyrica, but there were no signed scripts. V2 said if there is no script, the nurse should call the doctor, and the pharmacy. If there are problems getting a script, then the nurse should call me. V2 said she was told the nurses reached out to V19, and the hospital, and was told the hospital would not send one to the facility because he was basically our problem. V2 said, Within one hour of speaking with (R4's) daughter and finding out about the medications not being available, I had the signed script sent to the pharmacy. V2 said then the facility had to wait for the pharmacy to deliver it. On 9/18/2025 at 1:56 PM, V19 (R4's physician while in facility/facility's Medical Director) he said he is familiar with R4. V19 said R4 is a challenging individual. V19 said the hospital should have sent 2-3 days' worth of the methadone with R4 on admission or sent a valid script with him. V19 said unfortunately, this is an ongoing issue with hospitals. V19 said the facility notified him to request the e-script (electronic script). V19 was not in a location where he could look it up on a computer to see when the facility first notified him of the needed e-scripts. V19 said the facility is usually pretty good at letting him know when they need one. V19