

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 08/27/2025
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.

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>Based on observation, interview, and record review the facility failed to provide a homelike environment. This applies to 2 of 23 (R8, R85) reviewed for homelike environment in the sample of 23. Findings include:On 8/25/2025 at 9:44AM, R8 and R85 room was observed to have heavy gouging behind both residents' headboards and behind R85's recliner. The area with heavy drywall gouging and missing paint is approximately 2-3 feet by 2-3 feet tall behind the headboards and recliner.On 8/26/2025 at 12:00PM, V16 Director of Maintenance said work orders are put in the [app] by staff or by him when issues are reported to him. V16 said there is not a work order for that room. V16 said resident rooms should have no wall damage or holes.The facility provided Quality of Life - Homelike Environment dated 4/2014 states, . residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible.</p>

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on interview and record review the facility failed to ensure baths were provided as scheduled for 2 of 23 residents (R56 & R91) reviewed for Activities of Daily Living (ADL's) in the sample of 23. Findings include:1. R56's ADL care plan initiated on 1/12/24 shows she has an ADL self-care deficit and requires assistance from staff for bathing/showering.The first-floor shower schedule shows R56 should receive showers on Tuesday morning shift and Friday evening shift. R56's Bath and Shower Report Sheet shows she had showers on 8/8/25 and not again until 8/19/25. R56's Electronic Medical Record (EMR) tasks/shower documentation conflicts with R56's shower sheets and has checkmarks indicating that R56 had both a shower and a bed bath on 8/12/25 (Tuesday). On 8/27/25 at 9:40 AM, R56 said, A couple weeks ago it did happen it was on a Tuesday that I did not get my shower. I was told by staff there was too much going on and they would try to come back and do one, but no one ever did.A Concern/Compliment Form shows V22 (R56's) son filed a grievance on 8/17/25 that R56 did not receive her shower the week of 8/10/2025. The concern form is documented that it is substantiated and that showers were not given that evening due to it being an agency CNA (Certified Nursing Assistant). On 8/27/25 at 10:08 AM, V2 (Director of Nursing) said it was verified that R56 did miss her shower that day as indicated in the substantiated grievance. 2.) On 8/25/25 at 10:06 AM, R91 said, Actually I do have a concern here, last Saturday no one ever came to give me my bath.R91's ADL care plan initiated on 7/16/25 shows he has an ADL self- care deficit and requires assistance from staff for his ADL's.The first-floor shower schedule shows R91 should receive showers on Wednesday morning and Saturday evening.R91's Bath and Skin Report Sheet has documented on Saturday 8/23/25 that R91 Refused his shower. There is no documented reason or name of who documented that refusal, why the shower was refused and there was no nurse signature on that shower documentation. On 8/26/25 at 11:16 AM, V14 (CNA) said residents should receive showers twice a week and document it on shower sheets, and if anyone refuses, they let the nurse know and she should sign off on the sheet. V14 said they should also re attempt to get the resident a shower later that day or the next day. On 8/27/25 at 9:35 AM, R91 was asked again when he missed his shower and if he refused to take one. R91 smirked and stated, I definitely did not refuse any shower. I wait for my showers. The facility provided Showers policy revised on 6/22 shows showers should be given a minimum of twice a week and if a resident does refuse a shower a nurse should be informed and document that refusal after speaking with the resident.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on observation, interview and record review the facility failed to follow physician's orders for a dermatology consult for a resident with a persistent body rash, ongoing since July 2025. This applies to 1 of 23 residents reviewed for quality of care in a sample of 23. Findings include: On 8/25/2025 at 12:30 PM R64 was in his room sitting in his wheelchair. R64 had a red, scabby rash covering his arms and abdomen. R64 stated it has been going on for a while and the facility recently tried a new cream on him. R64 stated, They used the whole tube. R64 stated he was treated for scabies in July, which he thinks it is, but the rash still continues. R64 stated he continues to be very itchy. R64 stated the rash is also on his inner thighs. R64 stated his son was supposed to be taking him to the dermatologist soon. On 8/26/25, during the Resident Meeting, R64 was observed scratching and picking at scabs on his arms. R64's Physician's Order Sheet shows he was treated with Permethrin Cream on 7/9/25 for the same rash. R64's Progress Notes dated 8/7/25 state, Refer to dermatology for rash. and This writer spoke with POA about referral and is in agreement. On 8/26/2025 at 11:15 AM V17 (Scheduler) stated, I was not aware of the need for the appointment. I have not made him an appointment yet. At the end of the day on 8/26/25 a document was presented to this Surveyor showing an appointment had been made with dermatology on 12/3/25 for R64.</p>		

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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)		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview and record review the facility failed to safely handle a resident to prevent multiple skin tears. This failure resulted in R92 being transferred to the emergency room (ER) after a transfer which contributed to R92 sustaining a large skin tear requiring 11 stitches/sutures. This applies to 1 of 23 residents (R92) reviewed for safety in the sample of 23. Findings include: R92's progress notes dated 8/23/25 shows, Resident noted with a skin injury to the left lower leg. The incident occurred during transfer from the wheelchair to the bed, the CNA (certified nursing assistant) reported. MD (V21 R92's medical doctor (MD)) is informed with order to transfer resident to ER. R92's skin tear report dated 8/23/25 shows, Informed by the CNA (V20) that while providing care noted blood stain on sock and when sock was removed noted wound to left lower leg. Blood was new. R92's progress note dated 8/24/25 shows, Resident returned from ER at approximately 00:15 (12:15 AM) with daughter (V19) and EMS (emergency medical system). Resident received 11 sutures (stitches) to left lower leg. Bandage clean, dry and intact. Resident leg elevated on pillow. Vitals stable upon return, no pain upon arrival, but will give Tylenol as scheduled. New order for Clindamycin (antibiotic) 300mg (milligram) capsule 3 times per day for 7 days. Bacitracin (antibiotic) twice a day to left leg laceration. 10-14 days for suture (stitches) removal. R92's emergency room after visit summary dated 8/23/25 shows, Reason for visit: wound check, Diagnosis: laceration of shin. On 8/26/25 at 3:16 PM, V19 R92's daughter stated, V21 Registered Nurse (RN) called her over the weekend and said, V20 CNA was putting her to bed and bumped her leg. V19 said, Looked like more than a bump to me. It required 11 stitches. They called it a skin tear. She has had a lot of skin tears since she has been at the facility but this one required stitches. V19 said she rode with her to the ER. V19 was worried about her mom and what the facility was going to do to prevent these skin tears from happening. V19 said, They need to be more gentle with her (R92). On 8/26/25 at 2:18 PM, V18 RN stated, he told V20 CNA to put R92 to bed and then V20 CNA came back and told V18 that R92 had a skin tear. V18 said he went to the room and saw the wound on R92's leg. V18 asked V20 CNA what happened. V20 CNA told V18 RN that V20 transferred R92 to bed and tried to undress her when he noticed the wound. The blood was fresh, and he believed it happened during the transfer. V18 called V21, R92's medical doctor (MD) and reported what happened. V21 R92's MD sent R92 to the hospital for stitches/sutures. On 8/26/25 at 3:07 PM, V20 CNA stated, V20 transferred R92 to bed on 8/23/25. V20 noticed her socks had a red splotch on it. V20 pulled the sock down and saw the wound. V20 said, once he saw the wound he got the nurse. V20 said he didn't know what happened. On 8/27/25 at 10:48 AM, V21 R92's MD stated R92 sustained an injury during transfer. V21 felt it was a pretty significant skin tear and sent R92 to the ER. On 8/26/25 at 2:17 PM, V3 wound care nurse was changing R92's dressing to her left shin/leg. There was a red/purple baseball (approximately) size wound that had approximately 10 (some appeared to be double) stitches. V3 stated she received the wound during a transfer over the weekend. R92's wound assessment details report dated 8/25/25 shows, active skin tear type 2: partial flap loss, facility acquired, measuring 5.00 cm (centimeters) X 1.50 cm X 0.10 cm. R92's skin tear report dated 6/18/25 shows, This writer was notified by CNA that the resident had obtained a skin tear to the right elbow while assisting the resident with a boost in her wheelchair. R92's skin tear report dated 6/24/25 shows, During transfer from the w/c (wheelchair) to the bed, CNAs noted a blood on the pad. Resident is noted with skin tear to the left elbow. R92's skin tear report dated 7/17/25 shows, At the time of the incident, resident was being repositioned in her wheelchair. Resident stated she hit her leg. Notes: . Resident observed sliding while sitting in her chair. During repositioning, resident stated, I hit my leg on my wheelchair. Skin tear noted to the posterior (back) left leg. R92's care plan date initiated 6/3/25 shows, The resident has an actual impairment to skin integrity: 6/3/25-laceration to left elbow, 6/4/25- left lateral elbow, 6/11/25- abrasion to left mid-upper back, 6/18/25- rt (right) elbow skin tear, 6/24/25- left elbow skin tear, 6/25/25- right elbow skin tear, 7/17/25- left posterior skin tear, 8/1/25- bruise to right forearm, wrist ad hand, 8/12/25- skin tear right elbow. R92's care plan date initiated 8/25/25 shows, R92 has a laceration to her left lower leg. She is taking Clindamycin and bacitracin to prevent infection. Interventions: Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces. R92's care plan date initiated 5/7/25 shows, The resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) activity intolerance, dementia. Interventions: Sit to stand: dependent, 2 assist. The facility's resident transfers and safety devices policy dated 10/2017 shows, Policy: All residents are assessed at time of admission for transfer ability. Residents who are unable to transfer themselves independently or with</p>		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview and record review the facility failed to ensure dietary recommendations were implemented for residents with a history of significant weight loss. This failure resulted in R43 and R93 not receiving their therapeutic diets as ordered for their severe weight loss. This applies to 2 of 9 residents (R43, R93) reviewed for weight loss in the sample of 23. Findings include: On 8/25/25 at 10:32 AM, V5 Dietary Manager added 21 cooked, individual chicken nuggets into the facility's food processor. V5 stated, she was making puree for 11 residents. V5 stated, regular diets will get 5 chicken nuggets per person. (There should have been 55 nuggets pureed for 11 pureed diets but only pureed half of the amount she should have). The spreadsheet for the noon meal on 8/25/25 shows, regular diets should get 5 chicken nuggets to equal 2 ounces of protein per person. 1. R43's face sheet lists his diagnoses to include: toxic encephalopathy, dysphagia and dementia. R43's meal ticket shows, pureed diet with double portions on every tray. On 8/25/25 at 11:51 AM, R43 was eating the lunch. He was eating a regular pureed diet. He did not have double portions. On 8/26/25 at 8:28 AM, R43 was eating breakfast. He had a regular pureed diet. He did not have double portions. On 8/26/25 at 11:49 AM, R43 was eating lunch. He had a regular pureed diet. He did not have double portions. On 8/26/25 at 1:26 PM, V8 Registered Dietitian (RD) stated, R43 had a significant weight loss in one week when he went out to the hospital. R43 has continued to lose weight. V8 saw R43 last week and recommended larger portions. V8 clarified that meant double portions. V8 stated she put that on R43's meal ticket. V8 stated, They should be following the meal ticket and providing double portions. R43's progress notes from V8 RD dated 8/4/25 state, Nutrition note due to significant weight loss: Observed R43 during meal service this morning- he was feeding himself and appeared to be eating well. Noticed some coughing. He continues to receive a general/pureed diet with thin liq's (liquids). He feeds himself with set-up or requires assistance with meals. Supplements: House supplements- 120 ml (milliliters) TID (three times per day). PO (by mouth) intake has been 50-100% at meals since readmission per nsg (nursing) documentation. Weight 146.4 # (pounds)- decreased from 148# upon readmission from hospital and significantly by 9.6% in the past month from 162# on 7/1 (7/1/25). His weight has decreased by 11.8% in 3 months from 166# on 5/16 (5/16/25) and by 10.6% in 4 months from 163.8# on 4/23 (4/23/25). Current BMI (body mass index): 21.0- low for his age. He is not currently taking diuretics. Labs do not suggest hydration imbalance. Will arrange for him to receive larger portions to prevent further weight loss and monitor via nutrition at risk team. R43's care plan date initiated 8/5/25 shows, Focus: R43 has had a significant weight loss. Weight: 146.4# on 8/1-decreased from 148# upon readmission from hospital and significantly by 9.6% in the past month from 162# on 7/1. His weight has decreased by 11.8% in 3 months from 166# on 5/16 and by 10.6% in 4 months from 163.8# on 4/23. He continues to receive a general/pureed diet with thin liq's. He feeds himself with set-up or requires assistance with meals. Interventions: 8/4/25 Increase portions for him at meals to prevent further weight loss. 2. R93's face sheet lists his diagnoses to include: major depressive disorder, complete loss of teeth, alcohol use & gastro-esophageal reflux disease. R93's meal ticket shows, pureed diet with super cereal X2 in the morning, double portions of all food and ice cream for lunch and dinner. On 8/25/25 at 11:51 AM, R93 was eating lunch. He had a general pureed diet. He did not have double portions or ice cream. On 8/26/25 at 9:29 AM, R93 was eating breakfast. He did not have 2 bowls of super cereal or double portions. On 8/26/25 at 11:49 AM, R93 was eating lunch. He did not have double portions or ice cream. On 8/26/25 at 1:15 PM, V8 RD stated, interventions they have in place for R93's weight loss is double portions at every meal, 2 bowls of super cereal at breakfast and ice cream. V8 stated, They need to be following the recommendations to meet the nutritional needs of the residents. R93's progress notes from V8 RD dated 8/4/25 shows, Nutrition noted due to significant weight loss: Saw R93 this morning during meal rounds and he had eaten 100% of this meal (double portions). R93's weight decreased significantly by 11.2% in 6 mo from 114# on 2/3 to 101.2# on 8/2. Current BMI: 14.9- severely underweight. He continued to receive a general/pureed diet with double portions and thin liquids. He feeds himself with supervision and set-up. Supplements: super cereal with breakfast and 120 ml supplements with every meal. PO intake has been 76-100% at most meals recently per nsg documentation. Family has been notified of significant weight loss and have decline when TF (tube feeding) was discussed. Will continue to monitor nutritional parameters follow up as needed. R93's care plan date initiated 3/18/2024 shows, Focus: R93's weight decreased significantly by 11.2% in 6 mo. from 114# on 2/3 to 101.2# on 8/2. He continues to receive a general/pureed diet with double portions and thin liquids. He feeds himself with supervision and set-up. Supplements: super</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observation interview and record review the facility failed to administer medication as ordered. There were 30 opportunities with 2 errors resulting in a 6.67% error rate. This applies to 2 of 4 residents (R51, R35) reviewed for medication administration in a sample of 23.</p> <p>Findings include:1. On 8/26/2025 at 8:45AM V15(RN) took a new needle from the medication cart drawer and applied it to the Insulin Degludec (Long-Acting Insulin) pen. V15 then dialed the pen to 20 units and administered the medication to R51. V15 did not prime the needle prior to administration of the insulin. When questioned, V15 stated, We only have to prime the needle with the first dose from the pen.</p> <p>The Manufacturer's Guidelines for the administration of the insulin state, Instructions for use Priming your (Insulin) pen: Turn the dose selector to select 2 units, Hold the pen with the needle pointing up. Tap the top of the pen gently a few times to let any air bubbles rise to the top, Hold the pen with the needle pointing up. Press and hold in the dose button until the dose counter shows 0. The 0 must line up with the dose pointer, A drop of insulin should be seen at the needle tip.</p> <p>2. On 8/26/25 at 8:19, V18 Registered Nurse (RN) was passing R35's morning medications. He gave 1 tablet of Bumex (water pill) instead of 2 tablets. Before giving the medications to R35, V18 verified a total of 6 pills in the cup. (Should have been 7). R35's medication administration record (MAR) for August 2025 shows, bumetanide (Bumex) oral tablet 1 mg, give 2 tablets by mouth one time a day related to essential primary hypertension (high blood pressure). The same MAR shows, he should have received 7 pills total for the morning medication pass. On 8/27/25 at 11:51 AM, V18 RN stated, the Bumex tablets are 2 mg (milligram) tablets, so he only gave 1 tablet. R35's Bumex card was verified and shows, they are 1 mg tablets and to give 2 tablets in morning as prescribed by the physician.</p> <p>The facility's administering medications dated 11/2020 shows, Policy statement: Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: .4. Medications are administered according to physician's orders unless otherwise specified (for example, before and after meals orders) .</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>(continued on next page)</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on observation, interview and record review the facility failed to prepare pureed foods in a manner to maintain its nutritive value. The facility failed to serve mechanical soft foods to residents that required a mechanical soft diet. The facility failed to serve foods according to their daily menu. These failures apply to all 97 residents in the facility. Findings include: 1. A facility list dated 8/25/25 showed 11 residents required a pureed diet. Chicken nuggets, cooked carrots, potatoes, bread, and melon were the food items listed on the facility's lunch menu/spreadsheet dated 8/25/25. The menu/spreadsheet showed each resident was to receive a total of 5 chicken nuggets, for a total of 2 ounces of protein, at lunch. The facility's pureed chicken nugget recipe printed 8/25/25 showed each resident on a pureed diet was to be served the pureed equivalent of 5 chicken nuggets for lunch. The recipe showed facility kitchen staff were to add 3 tablespoons of chicken broth to each 2 ounce portion of chicken nuggets to make the puree. Staff were to add thickener as needed to make the puree. On 8/25/25 at 10:32 AM, V5 Dietary Manager added 21 cooked, individual chicken nuggets into the facility's food processor. V5 stated she was making puree for 11 residents. V5 then added an unmeasured amount of hot water and bread crumbs into the food processor with the chicken and began to puree the mixture. V5 stopped the processor and again added an unknown amount of hot water and bread crumbs to the pureed chicken nugget mixture. V5 pureed the mixture. At 10:41 AM, V5 poured the chicken nugget puree into a tin pan and placed it in a warmer. At no time during the puree prep, did V5 Dietary Manager refer to or follow a puree recipe for chicken nuggets. V5 Dietary Manager did not puree any bread for lunch. On 8/25/25 at 11:40 AM-12:10 PM, V5 Dietary Manager plated lunch for residents, from the steam table, which included the pureed chicken nuggets. No pureed bread or slices of bread were served to any residents. On 8/25/25 at 2:00 PM, V5 stated, Each puree was supposed to have gotten 5 pureed nuggets. I don't puree enough. I only pureed 21 nuggets for 11 people. I should have used 55 nuggets. They only got 2-3 nuggets a piece. V5 stated she added water to the chicken instead of broth because broth can be too salty. When asked why she used bread crumbs instead of thickener to make the lunch puree, V5 stated, The residents don't like the thickener. V5 stated she did not refer to the facility's pureed chicken nugget recipe prior to or while making the puree. V5 stated residents did not receive a slice of bread or pureed bread for lunch because she forgot it was on the menu. On 8/26/25 at 1:15 PM, V8 Dietician stated the facility cooks are to follow the facility's recipes when making pureed foods to ensure residents on pureed diets are receiving adequate nutrition and accurate serving sizes. V8 stated water should not be added to purees unless the recipe calls for it to ensure the nutritive and calorie content are preserved. V8 stated bread crumbs are not to be used in purees to thicken the mixture unless the puree recipe calls for it. 2. A facility list dated 8/25/25 showed R81 and R92 each required a mechanical soft diet. Chicken nuggets, cooked carrots, potatoes, bread, and melon were the food items listed on the facility's lunch menu/spreadsheet dated 8/25/25. The facility's mechanical soft chicken nugget recipe printed 8/25/25 showed chicken nuggets where to be ground, with gravy added to the ground nuggets. to achieve a mechanical soft texture. On 8/25/25 at 11:40 AM-12:10 PM, V5 Dietary Manager served and plated lunch to residents on the second floor. No mechanical soft chicken nuggets were noted on the steam table to serve to residents. On 8/25/25 at 11:45 AM, R81 was served 5 individual chicken nuggets, carrots and potatoes for lunch. On 8/25/25 at 11:51 AM, R92 was served 5 individual chicken nuggets, carrots and potatoes for lunch. On 8/26/25 at 1:15 PM, V8 Dietician state kitchen staff should follow the facility's recipes/spreadsheets when preparing mechanical soft foods. V8 stated if the recipe/spreadsheet shows the food/meat should be ground, it should be ground. The facility's Cycle Menu Food and Nutrition Services policy (undated) showed, Cycle menus are planned to meet the nutritional needs of the clients in accordance with the Dietary Reference Intakes of the Food and Nutrition Board of the Institute of Medicine, National Academy of Sciences and with additional guidance from My Plate for Older Adults and the USDA Dietary Guidelines for Americans Key Recommendations.</p>		

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 08/27/2025
NAME OF PROVIDER OR SUPPLIER Pavilion on Main Street, The		STREET ADDRESS, CITY, STATE, ZIP CODE 515 North Main Sandwich, IL 60548	
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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, interview and record review the facility failed to ensure residents receiving pureed diets were served appetizing and flavorful meals for 4 of 4 residents (R73, R43, R93 & R6) reviewed for palatability in the sample of 23. Findings include: On 8/25/25 at 9:13 AM, R73 was in his room eating his morning breakfast tray. R73 said he must have his food pureed and the food here just sucks, and I can't eat most of it. R73's tray was noted to still have a full bowl of hot breakfast cereal, and what he reported to be pureed pancakes. R73 said he was not sure what the other meal item on the tray was, but he was done and could not eat it. R73's morning meal ticket shows he should have pureed pancakes, cream of rice, and pureed scrambled eggs. On 8/25/25 at 12:33 AM, R73 was in his room eating his lunch. R73's meal ticket showed he should have on his meal tray pureed chicken nuggets, carrots, fruit and bread. R73 said the chicken nuggets were terrible and he could not eat them. The chicken nuggets were in a ball on the tray and looked like a big ball of stuffing. On 8/25/25 at 12:50 AM, after the lunch service was finished, a test tray of the pureed meal was sampled by this surveyor and 2 additional surveyors. The chicken nuggets and carrots were very thick and would stick to the roof of your mouth as you tried to swallow them. On 8/26/25 at 8:35 AM, during the morning breakfast service the pureed eggs were sampled by this surveyor and one additional surveyor. The eggs were a milky white color with the consistency of a thin pudding. The taste of the eggs were a mixture of water and powder and very unpleasant to eat. On 8/26/25 at 8:40 AM, V1 (Administrator) sampled the pureed eggs in front of the surveyors and said to him it tasted like a pudding with no sugar. On 8/26/25 at 9:20 AM, R73 was again in his room eating the morning meal tray. R73 pointed to the eggs which were still on his tray and said, I can't even tell you what that tasted like. R73 pointed to a ball of food and said, and I am not sure what that is but it's awful I think it maybe bread. On 8/26/25 at 2:03 PM, V8 (Dietician) said the staff cooking the food should follow the recipes in the kitchen. When it was described by this surveyor to V8 how the pureed eggs looked and tasted V8 replied, Oh my. The facility provided pureed diet list shows in total 11 residents receive a pureed diet including: R73, R93, R43, and R6. R93, R43 and R6 Electronic Medical Records show they all have cognitive impairments and were not able to be interviewed. The facility provided Food Palatability-Hot Food Temperature Guidelines dated 2018 shows that food should be prepared and served that are both safe and appetizing.</p>		

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NAME OF PROVIDER OR SUPPLIER Pavilion on Main Street, The		STREET ADDRESS, CITY, STATE, ZIP CODE 515 North Main Sandwich, IL 60548	

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on observation, interview and record review the facility failed to ensure kitchen utensils were stored in a sanitary manner. The facility failed to ensure food was prepared in a manner to prevent cross contamination. The facility failed to ensure kitchen staff covered facial hair to prevent cross contamination. The facility failed to maintain the kitchen in a sanitary manner. These failures have the potential to affect all 97 residents in the facility. Findings include: The facility's Long-Term Application for Medicare and Medicaid form date 8/25/25 showed a resident census of 97. On 8/25/25 from 9:11 AM-9:25 AM, the following observations were noted during the initial tour of the facility's basement kitchen: The garbage container located under the handwashing sink was overflowing with garbage. The kitchen floor, by the oven and the food prep table, was sticky. Food and liquid debris were noted on the floor in these areas. Dried liquid and food debris were noted on the sides and front of the oven. A sticky substance was noted to the sides and front of a food processor. Multiple large spoons and metal scoops were noted on a black, plastic drainage mat located on top of a prep table. Food debris and a sticky white liquid were noted scattered across the black mat, under the spoons and scoops. V5 Dietary Manager pointed to the scoops and spoons and stated, That's where we store our clean scoops. It looks like they need to be cleaned again. That mat is dirty. When asked when the kitchen floor was last mopped or cleaned, V5 stated, Probably the last time I worked, which was over a week ago. Scattered frozen green beans, a bag of flour tortillas, and a bag of potatoes wedges were noted on the floor of the walk-in freezer. Packets of sugar, crackers, and salt were scattered across the floor of the dry storage room. Food debris and multiple opened cardboard boxes were noted on the floor of the room. At 9:23 AM, V6 and V7 Dietary Aides were noted in the kitchen performing different tasks. V6 and V7 each had full beards. Neither V6 nor V7 wore facial coverings over their beards. On 8/25/25 at 9:27 AM, during the initial tour of the facility's first floor kitchenette, the following observations were noted: The coffee machine appeared dirty with dried coffee and food debris noted on the sides of the machine. A soiled spoon, wet washcloth, a cup and an empty pitcher sat in the sink of the kitchenette. Food debris, including scrambled eggs, were noted on the bottom of the sink. Flies were noted crawling in the sink. The floor of the kitchenette was sticky to walk on. Multiple areas of food debris were noted across the floor. The steam table was empty however areas of spilled oatmeal and eggs were noted on the table. Flies were noted crawling on the food on the table. On 8/25/25 at 10:32 AM, V5 Dietary Manager removed a metal tin, containing cooked chicken nuggets, from a warmer and placed the tin on a prep table. Behind the prep table, a large black garbage bag was noted sitting on the floor, 3/4 full of garbage. At 10:34 AM, V5 removed the foil covering off the tin, with her bare hands. V5 turned and grabbed the garbage bag with her bare hands and threw away the foil. Without washing her hands, V5 immediately began preparing the pureed chicken to be served for lunch. On 8/25/25 at 10:42 AM, V5 Dietary Manager stated beards and facial hair are to be covered when in the kitchen and/or when serving food to prevent hair from falling into the food. V5 stated she was unsure when the kitchen had last been cleaned. V5 stated, They are supposed to clean it daily, but I have been off for over a week, so I don't know if it was ever done. It needs to be cleaned. If I am not here, I am not sure it gets done. The facility's Food and Nutrition Services Hair Restraints/Jewelry/Nail Polish policy dated 2017 showed, Food and nutrition services employees shall wear hair restraints and beard guards. Hairnets will be worn at all times in the kitchen. [NAME] guards or masks will be worn as indicated. The facility's Food and Nutrition Services Cleaning Schedule policy dated 2018 showed, The healthcare community stores, prepares, distributes and serves food in a sanitary manner to prevent foodborne illness. A daily cleaning schedule will be posted in the kitchen with specific cleaning assignments to include both routine cleaning/sanitizing tasks along with deep cleaning tasks. Director of food and nutrition services or someone designated as person in charge will review the cleaning schedule each day to assure the tasks have been completed in a satisfactory manner.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview and record review the facility failed to ensure the glucose monitoring machine was cleaned after each resident use. This applies to 2 of 23 residents (R21 and R23) reviewed for infection control in the sample of 23. Findings include: On 8/26/2025 at 8:30 AM V15 (RN) used the blood glucose monitoring machine to check R21's blood sugar. After getting the result V15 returned to the medication cart, took a new test strip from the bottle and a new lancet from the drawer and without cleaning the machine proceeded to go to R23's room and checked her blood sugar. V15 then returned to the medication cart in the hallway again and put the blood glucose machine into the top drawer of the cart. V15 was asked if/when the facility cleans the blood glucose monitoring machines. V15 stated, We clean the machine after each shift with the purple wipes. R21's Physician's Order Sheet dated 8/26/25 shows R21 has an order for Insulin Aspart (Fast acting insulin) per sliding scale before meals and at bedtime. Within this order there is a place to enter R21's blood sugar results. R23's Physician's Order Sheet dated 8/26/25 shows R23 has an order for Blood Glucose Monitoring before meals and at bedtime. The facility policy entitled Cleaning and Disinfecting Blood Glucose Meters dated 6/2022 states, 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.</p>		