STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145792	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion of Logan Square, The	2242 North Kedzie Chicago, IL 60647

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 32819 Based upon observation, interview, and record review the facility failed to follow policy procedures, failed to timely document a skin integrity impairment, failed to document an accurate skin integrity impairment, and failed to follow physician orders for one of four residents (R3) reviewed for incidents/accidents. Findings include: R3's (3/1/24) BIMS (Brief Interview Mental Status) determined a score of 12 (cognition intact). R3's (5/24/24) physician orders include left knee: cover with foam silicon dressing for skin protection. Change every 3 days and as needed. On 5/28/24 at 1:32pm, R3 was observed lying in bed (in high position). Surveyor inquired about the current height of R3's bed V6 (Restorative CNA/Certified Nursing Assistant) stated in part It's kind of high right now and proceeded to lower the bed. As V6 lowered R3's bed, the over bed table (above R3's knees) fell and hit the side rail. Surveyor inquired about R3's (malfunctioning) over bed table V6 responded The tray table got caught underneath there. R3 replied Down in room (prior room number) that happened 3 times and caught this knee (pointing to the right knee). A week after that, it cut the left knee open. The scab is not healed yet. Surveyor inquired how R3's left knee was injured R3 stated She (staff) rolled it (over bed table) to my bed, I said stop. She (staff) hit the release button and it (over bed table) went boom on my knee. On 5/28/24 at 1:48pm, surveyor inquired about R3's left knee injury (which was covered with a large dressing) V7 (Registered Nurse) removed the dressing and replied, This is like a trauma, like a bump on a knee or something then placed the (soiled) dressing back on. A large, scabbed abrasion was observed on R3's left knee and sero-sanguineous drainage was on the dressing at this time. On 5/30/24 at 12:19pm, surveyor inquired about R3's left knee injury V2 (DON/Director of Nursing) stated That left knee is being followed by the Wound Nurse (V14) since 2/26/24. Her (V14) last assessment is 3/12/24 and it says intact skin she (V14) healed it (2.5 months ago). Surveyor inquired about R3's left knee treatment orders (received 6 days ago) V2 responded There's an order (5/24/24) for left knee cover with foam silicone dressing for skin protection and change every 3 days as needed and affirmed R3's left knee dressing administration was last documented today. Surveyor inquired why orders were received for R3's left knee if the wound was healed V2 was unsure. Surveyor requested that R3's left knee be assessed at this time. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145792	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion of Logan Square, The	2242 North Kedzie Chicago, IL 60647

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's (May 2024) TAR (Treatment Administration Record) affirms the left knee dressing was changed 3/24/24, 3/27/24 and 3/30/24 therefore (three times) before a wound assessment was documented. R3's TAR also affirms that the left knee dressing was changed 2 days after V7's (5/28/24) assessment therefore not as needed per physician's order. R3's (5/30/24) left knee wound assessment was documented at 2:06pm (after surveyor request) includes classification: blister. Source: present on admission. Status: closed. Date identified: 5/30/24. Tissue Type: deep maroon 100%. Outcome: healed (incongruent with attached picture). Size: 3.0 x 3.0 x 0.0cm (centimeters). Exudate: none. Pain Scale: 0. Maroon area with skin discoloration, well defined borders, tender to touch (incongruent with 0 pain rating), skin is fragile, dry, scaly. On Thursday (5/30/24) at 2:30pm, surveyor inquired when V14 (Wound Care Nurse) was made aware of R3's left knee injury V14 stated A very few days ago I cannot say for sure. Surveyor inquired if R3's left knee wound assessment was documented a few days ago V14 responded No it wasn't because it was not open. Surveyor inquired why V14 obtained treatment orders for R3's left knee if it wasn't open. V14 replied The resident (R3) said it was bothering him and said he (R3) wanted it covered because he doesn't want it to touch his sheets or clothes. Surveyor inquired about R3's left knee assessment on today's date V14 stated Its discolored area, not an open wound (the 5/30/24 picture on R3's assessment affirms otherwise). There's no drainage there, the skin is just very dry and scaly. Surveyor inquired how R3 injured the left knee V14 responded I don't know that. Surveyor inquired about the classification/outcome of R3's left knee wound (blister/healed) V14 replied There is no open wound there. Surveyor inquired if R3 sustained a left knee wound that's currently healed V14 stated I'm not saying it's healed, I'm saying it's not an open wound (R3's 5/30/24 assessment states blister healed). Surveyor inquired why R3's left knee wound was classified as a blister V14 responded There's no other way to classify it in the wound rounds. The way it looked it is not a blister but that's the only one that I picked (affirming R3 did not sustain a blister as documented). Surveyor inquired why V14 selected blister if R3's skin integrity impairment was clearly not a blister as stated V14 replied You cannot edit, you just have to choose from the choices that they give you. Surveyor inquired what other choices were available to select V14 stated Inflammation, infection, I'm not sure. Surveyor requested a description of what R3's wound currently looks like V14 responded I would say traumatic but maybe abrasion. Surveyor inquired if abrasion is a selection for documenting wounds V14 replied There is a selection yeah, but again I don't know how to describe the wound. Surveyor inquired (again) how R3 sustained the left knee injury V14 stated He (R3) said that he probably scratched it over the bed side table (incongruent with initial response). On 5/30/24 at 2:41pm, surveyor inquired about appearance of R3's (5/30/24) left knee photo V2 (DON) stated It looks like a bruise, and some discoloration and scaly skin. Surveyor inquired if the borders of R3's wound appear well-defined (as documented) V2 responded Well, it looks like all over therefore not well-defined. Surveyor inquired if R2's wound appears healed V2 replied I don't see that would be healed, it looks like there's blood there inside and there's bruising. It's a bruise, this is all scabbed or scale to me. There should have been a risk assessment and it needed to be put in wound rounds. Surveyor inquired when R3's left knee wound assessment should have been documented if R3 reported he probably scratched it over the bed side table, a few days ago (per V14) V2 replied On the day that he (R3) said that, there should have been risk management done for that. It should have been on the 24th as the order. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145792	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion of Logan Square, The	2242 North Kedzie Chicago, IL 60647

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The wound assessment policy (revised 5/2022) states an abrasion is an area on the skin that has been damaged by friction, scraping, rubbing or trauma. Document assessment of wound in (Electronic Medical Records) or Wound Rounds. When an abrasion/skin tear/bruise is discovered, complete a Risk Management.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145792	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion of Logan Square, The	2242 North Kedzie Chicago, IL 60647

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 - 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** 32819 Based upon observation, interview, and record review the facility failed to follow policy procedures, failed to implement fall prevention interventions and/or failed to provide supervision for one of four residents (R1) in the sample. Findings include: R1 was admitted [DATE] and discharged [DATE]. R1's diagnoses include but not limited to encephalopathy and (5/12/24) wedge compression fracture of first lumbar vertebra. R1's (3/31/24) BIMS determined a score of 11 (moderate impairment). R1's (3/31/24) functional assessment affirms supervision or touching assistance is required for chair/bed to chair transfer and walking. Partial/moderate assistance is required for toileting. R1's (4/12/24) fall risk assessment determined a score of 11 (at risk). The facility fall log affirms R1 fell on [DATE] and 5/12/24. R1's (5/6/24) incident report states patient verbalized she was walking towards the door lost balance and fell . Sent to hospital for evaluation. No witnesses found. R1's (5/7/24) progress notes state returned to facility. Complained of lower back pain. R1's (5/12/24) incident report states CNA (Certified Nursing Assistant) called writer for help in resident's room. Writer observed resident lying on the floor (on her back) next to the bed. Resident stated, I wanted to go to the bathroom, and I fell . No witnesses found. Resident taken to hospital. R1's (5/13/24) progress notes state resident returned to facility in fair condition. Lumbar spine x-ray, there is age-indeterminate compression fracture involving the anterior superior endplate of L1. R1's (5/15/24) history & physical includes clinical history/indication for exam: head/neck pain status post fall. (5/12/24) lumbar spine x-ray impression: there is age-indeterminate compression fracture involving the anterior superior endplate of L1. R1's (2/6/24) care plan states resident is at risk for falls related to opioid dependence, encephalopathy, syncope, and collapse. Interventions: (5/6/24) Patient educated and redirected to rise slowly from a seated or supine position and await assistance as appropriate. Medication review. Wheelchair provided. (5/12/24) Assist to bathroom before dinner [supervision is excluded]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145792	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion of Logan Square, The	2242 North Kedzie Chicago, IL 60647

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 - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/24 at 12:38pm, surveyor inquired about R1's cognitive and functional status V2 (DON) stated She's (R1) alert and oriented x3 and she's ambulatory but she has impulsive behaviors and gets up on her own. Surveyor inquired about R1's (5/6/24) fall V2 responded She (R1) said that she was walking by the door, she lost her balance and fell (in her room). It was not a witnessed fall. Surveyor inquired about R1's fall prevention interventions post (5/6/24) fall V2 replied We (staff) were mostly re-directing her (R1) and encouraging her to use the call light. Surveyor inquired about R1's (5/12/24) fall V2 stated On the 2nd fall, she (R1) was also in her room and this time she was trying to go to the washroom [R1 requires partial/moderate assistance for toileting] it was unwitnessed fall. Surveyor inquired about R1's fall prevention interventions post (5/12/24) fall V2 responded Assist to the bathroom after dinner. Surveyor inquired if R1's fall prevention interventions include supervision or frequent monitoring due to unwitnessed fall(s) V2 reviewed R1's electronic medical records and replied I'm trying to look here but I don't see it. No, I don't see frequent monitoring here. Surveyor inquired why supervision or frequent monitoring was excluded from R1's care plan knowing multiple falls were unwitnessed V2 stated What I can say about supervision is that they need to be checking on the patient all the time. For patients at high risk, we (staff) always put them in the dining room and monitoring them. That's why we have supervision at all times in the dining room. Surveyor inquired about staff requirements for dining room supervision V2 responded To be in the dining room at all times, for someone to be there so there's some type of supervision there. On 6/5/24 at 12:58pm, surveyor inquired about potential harm to a resident that falls V15 (Medical Director) stated We always educate for prevention of fall, that's our main goal. As much as we (staff) can we always try to prevent a fall. It could be a serious issue if they (residents) fall, it could be a bleed, it could be a fracture anything can happen. The fall management policy (revised 5/2015) states all residents shall be screened for the potential for falls, using the Fall Risk Screening Tool. Staff will initiate falling prevention protocol. As a fall occurs the Nurse on duty will initiate a new intervention to prevent further falls. The plan of care will be updated at this time. The revisions to the fall of care will be monitored for effectiveness and adjustments made as needed. The fall meeting will review the reports and communicate to facility staff any changes that need to be made to the resident's plan of care.