STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145792	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2025

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** 49666 Based on interview and record review the facility failed to implement fall prevention interventions for one (R1) of three residents reviewed for falls. This failure resulted in R1 falling on 02/08/2025 and R1 is hospitalized at the time of this survey. Findings include: R1's face sheet dated 09/15/2024, documents that R1 is a [AGE] year-old resident with diagnoses not limited to: unspecified intellectual disabilities, down syndrome, unspecified, type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema, nontraumatic subarachnoid hemorrhage, unspecified, traumatic subdural hemorrhage without loss of consciousness. R1's MDS/Minimum Data Set, dated dated dated [DATE] documents that R1 has a BIMS/Brief Interview for Mental Status score of 04/15, indicating that R1 has severely impaired cognition. On 02/08/25, 10:37 AM, V3 (Registered Nurse) states that R1 fell this morning at approximately 9:50 AM. V3 continues to state my CNA (certified nursing assistant) was in the room with her. R1 was walking barefoot. The CNA (V4) told her to go back and get your shoes.When she turned, she lost balance and she fell . V3 reports that V4 called V3 and V3 states that she went to the room and found R1 sitting on the floor, on her bottom. V3 states that V4 reported to her that R1 did not lose consciousness. V3 states that R1 didn't report anything, of what happened. She denied pain and had no visible injuries. V3 adds that V4 did inform V3 that R1 did hit her head on the door. V3 states that she is familiar with R1's care and is usually R1's regular nurse in the morning shifts. V3 reports that R1 has down syndrome, she is ambulatory, but lately she has been more confused, and we must redirect her more. Lately she has become a feeder. We present her with the tray, set her up, and encourage her to eat. She will say yes, but then not eat. So now she is a feeder. V3 reports that staff try to monitor R1 and do try to get her in the day room. We have someone in the day room and have yellow tape which means they are fall risk, by her name. V3 reports that R1 does not use any assistive devices. V3 states that R1's gait is steady, sometimes she gets distracted very easily. If she is walking and if you call her, she can turn fast. Lately she has been going into other residents' rooms. She usually doesn't go, but lately she has been presenting with these behaviors. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145792	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2025

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

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/08/25, 11:05 AM, V4 (Certified Nursing Assistant) states that she reads the residents' electronic medical record to know the residents' needs. V4 continues I ask the nurses that know the residents and ask them how I can help them. In the POC, there is person information that tells you the basic needs that they need assistance with. V4 reports that R1 needs help with showering, going to the toilet because she cannot clean herself. V4 states that R1 needs help with eating, sometimes she can eat by herself and sometimes she is in her own world and needs assistance. V4 stated that when R1 fell , V4 was in the middle of picking up breakfast trays. V4 states that when I went to her room, I just saw her without shoes. I told her put your shoes on, and she turned and fell . I went to go help her. V4 reports that R1 fell in her room, next to the bathroom door. She was just standing. V4 states that when R1 turned, she lost her balance and fell . She tried to grab the wall and did touch it, but her hand slid down the wall. R1 still fell . V4 reports that R1 landed on her bottom and bumped her head on the door of the bathroom. V4 continues sometimes R1 is a fall risk because V4 states R1 can walk and can lose her balance. On 02/10/25, at 1:09 PM, via telephone V9 (Primary Physician) states that some generalized complications from falls are head injuries, bleeding, and broken bones. V9 states we need to prevent falls; it is hard to prevent at times. V9 states that R1 needs to be monitored more closely. This surveyor asked V9 if a resident's individualized fall prevention care plan interventions are not implemented, does it place a resident at a higher risk to have an avoidable fall. V9 states yes, that is correct, if they are not implemented then it can place the resident at risk for an avoidable fall. R1's MDS section GG dated 12/11/2024, documents R1 requires supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity). Assistance may be provided throughout the activity or intermittently for putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility. R1's MDS section GG dated 12/11/2024, documents R1 requires supervision or touching assistance for walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns. R1's MDS section GG dated 01/07/2025, documents R1 requires supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently for putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility. R1's MDS section GG dated 01/07/2025, documents R1 requires supervision or touching assistance for walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns. R1's current care plan documents in part R1 is at risk of falls d/t (due to) H/O (history of) falls, intellectual disabilities, down syndrome, medication regimen, traumatic subdural hemorrhage w/o loss of consciousness, nontraumatic subarachnoid hemorrhage, syncope and collapse, goal is R1 will be free of injury. interventions document in part: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Pavilion of Logan Square, The		STREET ADDRESS, CITY, STATE, ZIP CODE: 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	-Encourage the resident to participate in supervised activities date Initiated: 06/11/2019 revision on: 02/15/2024. -Assist and encourage resident to day room for lunch date Initiated: 01/08/2025. -Ensure that appropriate footwear is in place when ambulating date Initiated: 06/11/2019. R1's nurse's note dated 02/08/202, 9:26 AM, documents in part CNA on duty call this writer (V3) to resident's room. Noted resident sitting in the floor by the door of the bathroom. Per CNA report resident was walking barefoot when she encouraged to have her shoes. Resident turned, lost her balance, and fell backwards hitting her head. Per CNA report resident did not lose consciousness. R1's nurse note dated 02/02/2025, 10:11 AM, documents in part, writer (V3) fed resident breakfast today. Writer encouraged the resident to eat on her own, but the resident kept the spoon with food without putting spoon to her mouth. Writer talked to the resident encouraging her to eat the food that she has in her plate. Resident agreed to writer, but she did not put the spoon in her mouth. R1 was assisted for morning care in the shower room and to get dressed. R1's nurse's note dated 02/08/2025, 4:22 PM, documents in part writer follow up regarding information provided to nurse on duty in regards to her Dx (diagnosis) of Right side subdural Hematoma. Per information given unable to provide if findings are acute, after reviewing previous hospital report, resident already with a diagnosis of right subdural hematoma and right frontal SAH (subarachnoid hemorrhage). Facility document dated 11/2013, titled falling star program policy documents in part to ensure that all residents determined to be at risk for falls or who have fallen are properly monitored the facility may initiate the falling star protocol. Individualized care plan will be initiated, and immediate intervention will be put into place. Facility document dated 5/25/2015, titled Accidents and Incidents: Supervision, Investigating and Reporting documents in part the facility provides an environment that is free from accident hazards over which the facility has control. The facility provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes identifying hazard and risk, evaluating and analyzing hazard and risk, implementing interventions to reduce hazard and risk, monitoring for effectiveness, and modifying interventions when necessary. Avoidable Accident means that an accident occurred because the facility failed to identify an environmental hazard or individual risk or the need for supervision and/or evaluate/analyze the hazard and risk and/or implement interventions consistent with the resident's needs, goals, plan of care and current standards of practice in order to reduce the risk of an accident and/or monitor the effectiveness of the interventions and modify the interventions as necessary in accordance with the current standards of practice. Facility document dated 04/2017, titled Care Plans, Comprehensive Person-Centered documents in part a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The Interdisciplinary Team (IDT), in conjunction with the resident and, resident representative or family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.