

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145939	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2026
NAME OF PROVIDER OR SUPPLIER Pavilion of South Shore		STREET ADDRESS, CITY, STATE, ZIP CODE 7750 South Shore Drive Chicago, IL 60649	
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)		
<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure physician-ordered laboratory tests were completed and followed up in a timely manner for one resident (R2) out of three residents reviewed for improper nursing care. Findings include:Record review of R2's face sheet reads medical diagnoses that included but are not limited to other seizures, vascular dementia, and liver disease. R2's care plan reads in part R2 presents with a diagnosis of seizures (date initiated 9/17/25). One intervention includes lab tests for therapeutic monitoring of medication levels per MD (Medical Doctor) orders. Notify MD of subtherapeutic or toxic levels.Record review of R2's hospital discharge instructions dated 12/10/25 shows R2 was hospitalized due to seizure disorder with instructions to obtain Valproic Acid level in one week.R2's Physician's orders printed on 3/10/26, document that R2 was admitted on [DATE] with the orders to receive Valproic Acid Oral Solution 20 milliliters (ml) two times a day related to seizures (order date 12/10/25). The Physician's orders also document that orders received on 12/10/25, 2/12/26, and 2/24/26 to obtain the Valproic Acid laboratory values. R2's medical records have no documentation of these laboratory values being obtained. R2's progress notes from 12/10/25 to 3/9/26 have no documentation of R2's refusals with blood draws or if V25 (Physician) was notified.On 3/10/26 at 1:17 PM, V2 (Director of Nursing) stated that R2 had no laboratory results on file since October 2025. V2 reported attempting to contact the laboratory to determine the status of R2's lab work. V2 further stated that the facility had no information confirming whether the laboratory tests were completed, as there was no documentation indicating that R2 refused the labs or explaining why the labs were not performed. V2 stated that the laboratory previously provided notification forms to nursing staff when a resident refused lab work so the nurse could notify the physician; however, no such documentation was available for R2.On 3/10/26 at 2:44 PM, a phone interview was conducted with V7 (Licensed Practical Nurse/LPN). V7 stated she followed up on the laboratory order in December, but she could not recall the exact date of the follow-up. V7 stated that staff informed her R2 was very combative, and staff were unable to obtain the blood specimen. V7 stated she notified V25 (Physician), who instructed staff to continue attempting to obtain the blood draw. V7 further stated that she had not followed up since then because lab technicians come early in the morning when she is not yet working in the facility.On 3/11/26 at 11:55 AM, a follow-up interview was conducted with V2. V2 stated that V25 (Physician) orders laboratory tests, which are entered into the physician order system. V2 reported that nursing staff contact the clinical laboratory, and laboratory draws are routinely scheduled on Mondays and Wednesdays in the facility, unless the order is STAT (immediately), in which case the specimen is collected the same day. V2 stated that once results are available, they are entered into the system, reviewed by nursing staff, and communicated to the physician. V2 further stated that if a resident refuses a laboratory draw, the nurse is expected to notify the physician and document the refusal. V2 stated they were still attempting to determine why R2's laboratory orders from December had not been completed and reported being informed that the resident refused the blood draws.The facility's Laboratory and Diagnostic Procedures policy and procedures (6/26/16) documents in part: To ensure that the resident's attending physician and representative is notified of abnormal lab values. To (continued on next page)</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 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>ensure that any labs that are to be completed immediately are relayed to the MD as soon as possible. Ensure that lab or diagnostics are completed per MD order.</p>		