

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 04/19/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50057</p> <p>Based on observation, interview and record review, the facility failed to follow standards of professional practice to maintain resident dignity by standing over four residents (R7, R22, R57, R91) during feeding assistance out of a sample of 26 total residents.</p> <p>Findings:</p> <p>On 04/17/24 at 8:54 AM, R57 was observed sitting in his wheelchair in his room. V29 (CNA) was observed standing next to wheel chair feeding R57 breakfast.</p> <p>On 4/18/2024 at 12:42 PM, V16 (CNA) was observed standing in the room of R57 with his lunch tray in front of R57 giving R57 liquid from a cup.</p> <p>On 04/16/24 at 12:35 PM, V16 (CNA) was observed standing over R22 while V16 assisted R22 with eating lunch.</p> <p>On 04/18/24 12:38 PM V29 (CNA) was observed standing over R91 feeding him lunch. When surveyor asked the resident's name, V29 provided the name and stated I'm helping him because he has trouble with his vision.</p> <p>Policy titled Resident Rights dated 12/2012 and revised 11/2013, 4/2014 and 4/2017 states in part:</p> <p>Policy Statement: Employees shall treat all residents with kindness, respect and dignity.</p> <p>Policy Interpretation and Implementation:</p> <p>1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right:</p> <p>b. To be treated with respect, kindness and dignity</p> <p>Policy titled Feeding Assistance dated 7/10/2011 and revised 8/5/2022 states in part:</p> <p>Policy:</p> <p>(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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3.For residents that require feeding assistance:</p> <p>Spoon food horizontally</p> <p>Place utensils to the center of the lips and mid portion of the tongue</p> <p>Check for pocketing</p> <p>47304</p> <p>The findings include:</p> <p>R7's health record documented admitted on 6/30/2023 with diagnoses not limited to Unilateral primary osteoarthritis left hip, Chronic obstructive pulmonary disease, Encounter for palliative care, Parkinson's disease without dyskinesia, Hyperlipidemia, Essential (primary) hypertension, Unspecified osteoarthritis, Syncope and collapse, Acute kidney failure, Unspecified glaucoma, Bipolar disorder, Schizophrenia, Anxiety disorder, Polyneuropathy, Pain in left leg.</p> <p>On 4/16/24 at 12:24pm Observed R7 sitting up on geri-chair in the dining room, alert and responsive with confusion. V17 (Certified Nursing Assistant/CNA) observed spoon feeding R7 in a standing position, not on eye level.</p> <p>On 4/17/24 at 2:44 PM V3 (Director of Nursing / DON) said if resident needs assistance at mealtime, staff is expected to assist or feed the resident with dignity by sitting down, maintain eye level while feeding the resident. She said resident should be treated with dignity.</p> <p>Minimum Data Set (MDS) dated [DATE] showed R7's cognition was impaired. He needed substantial/maximal assistance with eating, oral, toileting and personal hygiene, shower/bathe self, upper and lower body dressing, chair/bed, and toilet transfer.</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49486</p> <p>Based on observation, interview, and record review the facility failed to determine self-administration of medication was appropriate for three (R5, R57, R69) out of three residents observed with medication at bed side in a sample of 26.</p> <p>Findings Include:</p> <p>On 04/16/24 at 10:41 AM, surveyor entered R69's room and observed one medication in a medication cup on R69's bed side table. R69 stated the nurse left the medication on R69's table this morning, but R69 does not want to take the medication. At 10:45 AM, R69 triggered the call light, and V30 (Registered Nurse/RN) entered R69's room, V30 picked up the medication, V30 identified the medication as Colace 100 MG capsule administered at 9:00 AM. V30 stated V30 usually stay with R69 to ask if R69 wants the medication, but V30 did not ask R69 today because V30 went out of R69 to attend to other residents. V30 stated V30 should have stayed with R69 to take medication and that the medication should not have been left on R69's bed side table.</p> <p>R69's Minimum Data Set (MDS) dated [DATE] shows R69 to be cognitively intact. R69's Medication Administration Record (MAR) shows Colace oral capsule 100 MG was administered on 4/16/24 at 9 AM, and no physician order for medication self-administration was found.</p> <p>R69's Physician Order Sheet (POS) with active orders as of 4/16/24 shows an order for Colace oral capsule 100 MG, take one capsule daily for constipation. R69's clinical records had no documentation showing R69 is safe to administer R69's own medication. A review of R69's clinical records do not show a self-administration of medication assessment was completed.</p> <p>On 04/16/24 at 11:08 AM, surveyor entered R5's room and observed one inhaler and one patch on R5's bed side table. R5 stated R5 used the inhaler yesterday, R5 has been having the inhaler at R5's bed side for a long time since R5's Asthmatic attack about a month ago. R5 stated V36 (Licensed Practical Nurse/LPN) gave R5 the patch around 5:00 AM today. R5 told V36 that R5 would apply the patch to R5's lower back after R5 has taken a shower. At 11:14 AM, R5 triggered the call light, and V30 (Registered Nurse/RN) entered R5's room, V30 identified the medications as Albuterol Sulfate Inhaler 90 MCG/ACT and Lidocaine External Patch five percent. V30 stated V30 did not administer the two medications. V30 stated nurses should not leave any medications at residents' bed side. V30 stated that the medications should not have been left on R5's bed side table but should be locked up in the medication cart for safety.</p> <p>On 4/17/24 at 1:00 PM, V4 (Assistant Director of Nursing/ADON) stated V4 expects nurses to stay with resident when administering medication to ensure medication is taken, and to prevent other resident from taking the medication. V4 stated leaving medication at bed side could lead to undermedication or overmedication, nurses should not leave medication at R5's or R69 bed side table.</p> <p>(continued on next page)</p>

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/18/24 at 10:35 AM, V36 (LPN) stated V36 administered lidocaine patch to R5 around 5am and 6am on 4/16/24, V36 stated V36 did not leave the lidocaine patch at R5's bed side table and V36 could not remember leaving inhaler and the patch at R5's bed side table. V36 stated nurses should not leave any medications at bed side when there is no physician order. V36 stated another resident can take any medications left at bed side.</p> <p>On 4/18/24 at 11:12 AM, observed Albuterol Sulfate Inhaler 90 MCG/ACT and Lidocaine External Patch five percent on R5's bed side table. R5 stated R5 uses the inhaler everyday as needed for shortness of breath, and R5's Lidocaine patch daily for R5's low back pain. R5 stated R5's pain now is at a level of eight over ten pain scale. V30 stated nurse supposed to get an order for the resident to self-administer medicine. V30 and surveyor reviewed the medical record, V30 stated that R5 did not have an order to self-administer prescribed medications. V30 provided education to R5, V30 will call R5's physician to obtain order for self-administration.</p> <p>R5's Minimum Data Set (MDS) dated [DATE] shows R5 to be cognitively intact. R5's Medication Administration Record (MAR) as of 4/16/24 shows Lidocaine External Patch five percent, apply topically to lower back topically one time a day for mild pain of one to three, and Albuterol Sulfate Inhalation Aerosol Powder breath activated 108 (90 base MCG/ACT) inhale 2 puffs orally every six hours as needed for shortness of breath. No physician order for self-administration of medications was found.</p> <p>R5's Physician Order Sheet (POS) with active orders as of 4/16/24 shows Lidocaine External Patch five percent, apply topically to lower back, and Albuterol Sulfate Inhalation Aerosol Powder breath activated 108 (90 base MCG/ACT).</p> <p>R5's clinical records had no documentation showing R5 is safe to administer R5's own medication. A review of R5's clinical records do not show a self-administration of medication assessment was completed.</p> <p>The facility policy for Administering Medication dated 3/2014, revised 11/2020, read in part; Residents may self-administer their own medications only if the attending physician, in conjunction with interdisciplinary care planning team has determined that they have the decision-making capacity to do so safely. A review of self-administration of medications policy revised 4/2017 read in part: Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents.</p> <p>50057</p> <p>On 04/18/24 at 12:42 PM, V16 (CNA) was observed exiting the room of R57 carrying a lunch tray. As V16 began to walk to the soiled tray return cart, a medicine cup was noted on the tray. It was observed to contain a yellow substance with pink flecks. A tongue depressor was observed in the substance. V16 was asked what the substance was in the medicine cup. V16 stated that she did not know. As V16 walked to the tray return cart, surveyor and V16 stopped at the nurses station. V38 (LPN) was asked what the substance was. V38 responded I don't leave medication at the bedside. V34 (LPN) was asked what the substance was. V34 replied It's applesauce. When asked what the pink flecks were in the medicine cup, V34 again said applesauce. When asked again about the pink flecks, V34 stated that it was Depakote. V34 stated He's allowed to take it with food. When asked if the Depakote had been signed off as administered, V34 accessed the electronic health record and stated that the time of administration was 12:28 PM. V34 then stated Is it wrong?</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R57's Order Summary Report included in part: Diagnoses: Depression, Unspecified , Schizophrenia, Electrocutation, Subsequent Encounter</p> <p>Pharmacy Order: Divalproex Sodium Oral Tablet Delayed Release 500 mg - Give 1500 mg by mouth one time a day related to schizophrenia, unspecified (F20.9).</p> <p>R57's , Minimum Data Set (MDS) Section C- Cognitive Patterns BIMS Summary Score was 2, meaning R57 is not cognitively intact.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>40061</p> <p>Based on observations, interviews, and record reviews, the facility failed to place a resident's (R410) call light in a position that allowed the resident to utilize it for one out of a total sample of 26 residents reviewed for call lights.</p> <p>Findings include:</p> <p>R410's comprehensive care plan documents in part that R410 has Activities of Daily Living (ADL) self-care performance deficit due to paraplegia (paralysis of the lower body) and multiple diagnoses (initiated 04/25/2023). R410's care plan also documents in part that R410 is at risk for falls related to multiple diagnoses (initiated 07/17/2023). Interventions initiated 07/17/2023 documents in part: Call light in reach and answer in a timely fashion.</p> <p>On 04/16/2024 at 10:37 AM, R410 was alert and oriented to person, place, and year. R410 laid in bed which was the furthest from the hallway. R410 was laying towards right side with a pillow under right forearm. R410 had contracted hands. R410 stated I'm burning up and asked the surveyor to remove R410's blankets. R410 stated uses call light to call staff but cannot reach it. Call light cord was tucked under the pillow under R410's right arm. R410 stated my arms are all sorts of messed up. I can't use it like that. R410 stated facility usually straps the call light to R410's wrist for R410 to hit the button with other wrist but staff forgot to do so this morning. R410 had on a black wrist strap with fasteners - call light was not attached.</p> <p>At 10:49 AM, surveyor was in the hallway. R410 called out hey nurse. R410 called out hey nurse multiple times including at 10:51 AM, 10:52 AM, 10:53 AM, 10:54 AM, 10:55 AM, 10:56 AM, 10:57 AM, 10:58 AM.</p> <p>At 11:00 AM, V23 (Nurse) entered R410's room. R410 stated feeling like burning up. V23 stated will take R410's vitals and left the room to retrieve equipment.</p> <p>At 11:03 AM, V23 returned to the room. V23 and V24 (Certified Nurse Aide) repositioned R410. Observed V23 pull out R410's call light from under the pillow and attach it to R410's right wrist strap.</p> <p>At 11:16 AM, V23 stated staff must make sure R410's call light is strapped to R410's wrist for R410 to use it.</p> <p>Facility's Call Lights policy (date 08/14/2021) documents in part: PURPOSE: 1. To respond promptly to resident's call for assistance. When providing care to residents, position the call light conveniently for the resident's use. Be sure call lights are placed within resident reach at all times, never on the floor or bedside stand.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46342</p> <p>Based on observation, interview and record review the facility failed to follow facility policy by not providing residents going to dialysis during mealtimes with a sack lunch for four (R29, R40, R45, R101) out of four residents reviewed for dialysis services in a sample of 26.</p> <p>Findings include:</p> <p>On 04/16/24 at 11:30 AM, R45 stated R45 goes out to dialysis three times a week on Monday-Wednesday-Friday. R45 stated they don't send me to dialysis with a meal or snack. R45 stated R45 usually leaves the facility at 10:00 AM and returns between 4:30-5:00 PM. R45 stated on dialysis days R45 eats breakfast and dinner at the facility. R45 stated R45 does not eat lunch or anything in between breakfast and dinner on dialysis days because the facility does not send him to dialysis with a sack lunch or snacks. R45 stated by the time R45 returns to the facility after dialysis it is time for dinner. R45 complains about being hungry on dialysis days because R45 eats breakfast around 8:00 AM and then does not consume anything else until 5:00 PM when dinner is served. R45 stated they hold R45's lunch but that by the time R45 returns to the facility it is already time for dinner. R45 stated R45's dialysis center allows people to eat before or after dialysis because R45 sees other people eating food there. R45 stated if the facility sent him to dialysis with food that would be good.</p> <p>On 04/16/24 at 12:01 PM, V11 (Licensed Practical Nurse) stated R45 eats breakfast before R45 leaves for dialysis and that R45 is not sent to dialysis with any sack lunch or snacks.</p> <p>On 04/17/24 at 9:25 AM, observed R29 sitting in a wheelchair waiting by the nursing station on the 1st floor. R29 stated R29 is waiting for R29's transportation to dialysis. R29 stated R29 is usually out of the facility on dialysis days between 9:00 AM and 3:00-4:00 PM depending on the transportation schedule. R29 stated the facility does not give R29 a lunch or any snacks to take to dialysis. R29 stated it is a long time to go without eating anything because on dialysis days R29 is away from the facility for so long. R29 said, I get hungry.</p> <p>On 4/17/24 at 9:28 AM, observed R40 sitting in a wheelchair waiting by the nursing station on the 1st floor. R40 stated R40 is waiting for R40's transportation to take R40 to dialysis. R40 stated on dialysis R40 usually leaves between 9:00-9:30 AM and returns between 3:30-4:00 PM. R40 stated R40 is not given any food to take with R40 to dialysis. R40 stated sometimes R40 gets hungry, and no one has ever asked R40 if R40 wanted a snack to take with R40 to dialysis. R40 stated, I'd like that.</p> <p>On 04/17/24 at 9:31 AM, R101 stated R101 receives dialysis Tuesday-Thursday-Saturday and usually leaves the building between 9:30 AM-10:00 AM and returns around 4:00 PM. R101 stated R101 eats breakfast before R101 leaves for dialysis and then eats dinner when R101 returns. R101 stated if the facility sent R101 with food to dialysis R101 would eat it because R101 gets hungry. R101 said, they never offered any food to me, so I didn't know that was possible.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/17/24 at 12:29 PM, V26 (Consulting Registered Dietitian) stated the menus provide approximately 2000-2200 calories, and 6 ounces of protein per day and that this is based on residents receiving three meals per day. V26 stated sack lunches are available if a resident goes out to an appointment or dialysis depending on the timing. V26 stated the dialysis centers are requesting for us not to send sack lunches because they cannot eat the meal while they are on the dialysis machine, so the facility stopped sending sack lunches or snacks with residents going to dialysis. V26 stated residents eat breakfast at their regular time before leaving for dialysis and receive a late lunch when they return to the building. V26 stated the dinner is served at 5:00 PM so if a resident is returning from dialysis around 3:30-4:00 PM that is very close to the dinner meal. V26 stated when a resident is out of the building for dialysis, they are usually out of the building for approximately 6 hours. This includes the 4-5 hour run time for dialysis and transportation to/from which is variable. V26 stated dialysis residents are at higher nutritional risk for not getting enough calories, and protein. V26 stated their appetites can vary depending how they are feeling, and they are on restricted diets which limits their food options, so the focus is on just getting them to eat because residents receiving dialysis need more calories and protein. V26 stated if residents on dialysis are missing a meal the potential is that they may not be meeting their nutritional needs for the day.</p> <p>On 04/17/24 at 2:42 PM, V35 (Dialysis Registered Dietitian) stated via phone interview that residents on dialysis have compromised immune systems and are at higher nutritional risk. V35 stated residents on dialysis have unique needs because they have an entire organ that is not functioning and because their kidneys are not working, they have to be on restricted therapeutic diets, so the challenge is to make sure their nutritional needs are being met within those dietary restrictions. V35 stated the dialysis center strongly encourage the patients not to eat while they are receiving dialysis. V35 stated while they discourage patients from eating during their dialysis treatment it would be okay for residents to eat before or after receiving dialysis especially if they are complaining about being hungry. V35 stated oftentimes there is a lot of waiting around time whether that be when waiting for dialysis to start or when waiting for transportation which would give the residents time to eat something. V35 stated the dialysis center gives out supplements if a resident's albumin drops <3.5 and if this is the case, then they are eligible for protein bar supplement or liquid protein supplement. V35 stated R45's albumin level is 4.0.</p> <p>R45's diagnosis included but not limited to, End Stage Renal Disease, Dependence on Renal Dialysis, Secondary Hyperparathyroidism Of Renal Origin, Iron Deficiency Anemia, Generalized Muscle Weakness, Hypertension, Cardiac Tamponade, Malignant Neoplasm of Prostate.</p> <p>R45's Order Summary Report printed 04/18/24, 13:25 documents in part may go to dialysis 3x/week on days of the week (Monday, Wednesday, and Friday) ordered 01/12/24.</p> <p>R45s MDS (Minimum Data Set) dated 03/20/24 indicates moderately impaired cognition with BIMS (Brief Interview for Mental Status) 11/15.</p> <p>R45's MDS dated [DATE] section O (Special Treatments, Procedures and Programs) documents in part R45 receives dialysis.</p> <p>R45's nutrition progress note completed by V26 dated 04/17/24 documents in part residents PO intake fluctuates related to dialysis days but often eating 50% or more of most meals, and potential for alteration in nutrition related to increased calorie and protein needs as evidenced by End Staged Renal Disease with hemodialysis.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R45's Pre/Post Dialysis Evaluation Forms dated 04/17/24 documents in part R45 left the facility at 9:54 with no meal/snack sent with resident and last meal eaten breakfast and returned to facility at 16:05 with last meal eaten breakfast.</p> <p>R45's Pre/Post Dialysis Evaluation Forms dated 04/15/24 documents in part R45 left the facility at 8:31 with no meal/snack sent with resident and last meal eaten breakfast and returned to facility at 17:30 with last meal eaten breakfast.</p> <p>R45's Pre/Post Dialysis Evaluation Forms dated between 03/15/24 to 04/12/24 documents in part R45 left the facility with no meal/snack sent with resident and last meal eaten breakfast.</p> <p>R29 diagnosis included but not limited to, End Stage Renal Disease, Dependence on Renal Dialysis, Chronic Obstructive Pulmonary Disease, Hemiplegia and Hemiparesis Following Unspecified Cerebrovascular Disease Affecting Left Non-Dominant Side, Type 2 Diabetes Mellitus.</p> <p>R29's Order Summary Report printed 04/18/24, 13:24 documents in part (name of dialysis center) Monday-Wednesday-Friday 11 am chair time.</p> <p>R29s MDS (Minimum Data Set) dated 04/09/24 indicates moderately impaired cognition with BIMS (Brief Interview for Mental Status) 12/15.</p> <p>R29's MDS dated [DATE] section O (Special Treatments, Procedures and Programs) documents in part R29 receives dialysis.</p> <p>R29's nutrition progress note completed by V26 dated 04/17/24 documents in part potential for alteration in nutrition related to increased calorie and protein needs as evidenced by End Staged Renal Disease with hemodialysis.</p> <p>Facility policy titled Transportation for Dialysis dated 12/20/22 documents in part for residents requiring a meal, a sack lunch will be made available at the reception desk to take with to the dialysis center.</p> <p>Facility policy titled Sack Lunch dated 2021 documents in part sack lunches will be available as needed for any client who will be out of the healthcare community at mealtime to attend workshops or other events and sack lunches will be planned by the dietitian.</p> <p>39779</p> <p>R101 was admitted to the facility on [DATE] with diagnosis not limited to Acute Embolism and Thrombosis of Right Internal Jugular Vein, Dependence on Renal Dialysis, Hyperlipidemia, Iron Deficiency Anemia, Thrombocytopenia, Umbilical Hernia, Visual Hallucinations, ESRD (End Stage Renal Disease), Essential (Primary) Hypertension, Insomnia, Localized Enlarged Lymph Nodes, Psychosis, Charcot's Joint, Right Ankle and Foot, Type 2 Diabetes Mellitus with Hypoglycemia, Human Immunodeficiency Virus Disease, Enterocolitis and Long Term (Current) use of Anticoagulants. Focus: is receiving Hemodialysis treatments related to diagnosis of ESRD. Potential risk for complications.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R101 Order Summary Report document in part: Renal/LCS (Low Concentrated Sweet) diet Regular texture, thin consistency, Double portions order date 02/09/24. Dialysis chair time T-T-S (Tuesday-Thursday-Saturday).</p> <p>Care Plan document in part: Focus: R101 is receiving a Renal/LCS (Low Concentrated Sweet) diet (with)/double portions, Regular texture with thin liquids related to diagnosis of End Stage Renal Disease, Diabetes. Interventions: Provide, serve diet as ordered. Monitor intake and record q (every) meal. Explain and reinforce to the resident the importance of maintaining the diet ordered. Encourage the resident to comply. Explain consequences of refusal, obesity/malnutrition risk factors.</p> <p>Progress note dated 02/24/24 15:19 document in part: Pre/Post Dialysis Evaluation Treatment Information: Post-Dialysis Evaluation. Time back in facility: 02/24/24 3:00 PM Treatment performed off-site. Transported via non-emergent transport. Last meal eaten: breakfast. No meal/snack was sent with the Resident.</p> <p>Progress note dated 02/29/24 04:08 Pre/Post Dialysis Evaluation Treatment Information: Post-Dialysis Evaluation. Time back in facility: 02/29/24 4:00 PM Treatment performed off-site. Transported via non-emergent transport. Last meal eaten: breakfast. No meal/snack was sent with the resident.</p> <p>Progress note dated 03/05/24 16:40 document in part: Pre/Post Dialysis Evaluation Treatment Information: Post-Dialysis Evaluation. Time back in facility: 03/05/24 4:35 PM Treatment performed off-site. Transported via private car. Last meal eaten: breakfast. No meal/snack was sent with the resident.</p> <p>Progress note dated 03/07/24 15:21 document in part: Pre/Post Dialysis Evaluation Treatment Information: Pre-Dialysis Evaluation. Time out of the facility: 03/07/24 9:21 AM Treatment performed off-site. Transported by facility transport. Last meal eaten: breakfast. No meal/snack was sent with the resident.</p> <p>Progress note dated 03/09/24 17:45 document in part: Pre/Post Dialysis Evaluation Treatment Information: Post-Dialysis Evaluation. Time back in facility: 03/09/24 4:35 PM Treatment performed off-site. Transported via non-emergent transport. Last meal eaten: breakfast. No meal/snack was sent with the resident.</p> <p>Progress note dated 03/14/24 12:10 document in part: Pre/Post Dialysis Evaluation Treatment Information: Pre-Dialysis Evaluation. Time out of the facility: 03/14/24 9:10 AM Treatment performed off-site. Transported by facility transport. Last meal eaten: breakfast. No meal/snack was sent with the resident.</p> <p>Progress note dated 3/21/24 15:24 document in part: Pre/Post Dialysis Evaluation Treatment Information: Pre-Dialysis Evaluation. Time out of the facility: 03/21/24 9:24 AM Treatment performed off-site. Transported by facility transport. Last meal eaten: breakfast. No meal/snack was sent with the resident.</p> <p>Progress note dated 03/23/24 15:51 document in part: Pre/Post Dialysis Evaluation Treatment Information: Post-Dialysis Evaluation. Time back in facility: 03/23/24 3:51 PM Treatment performed off-site. Transported via non-emergent transport. Last meal eaten: breakfast. No meal/snack was sent with the resident.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Progress note dated 03/28/24 15:59 document in part: Pre/Post Dialysis Evaluation Treatment Information: Post-Dialysis Evaluation. Time back in facility: 03/28/24 3:45 PM Treatment performed off-site. Transported via non-emergent transport. Last meal eaten: breakfast. No meal/snack was sent with the resident.</p> <p>Progress note dated 03/30/24 19:17 document in part: Pre/Post Dialysis Evaluation Treatment Information: Post-Dialysis Evaluation. Treatment performed off-site. Transported via non-emergent transport. Last meal eaten: breakfast. No meal/snack was sent with the resident.</p> <p>Progress note dated 04/02/24 15:55 document in part: Pre/Post Dialysis Evaluation Treatment Information: Post-Dialysis Evaluation. Time back in facility: 04/02/24 3:45 PM Treatment performed off-site. Transported via non-emergent transport. Last meal eaten: breakfast. No meal/snack was sent with the resident.</p> <p>Progress note dated 04/06/24 16:19 document in part: Pre/Post Dialysis Evaluation Treatment Information: Post-Dialysis Evaluation. Time back in facility: 04/06/2024 3:20 PM Treatment performed off-site. Transported via non-emergent transport. Last meal eaten: breakfast. No meal/snack was sent with the resident.</p> <p>Progress note dated 04/11/24 16:00 document in part: Pre/Post Dialysis Evaluation Treatment Information: Post-Dialysis Evaluation. Time back in facility: 04/11/24 3:20 PM Treatment performed off-site. Transported via non-emergent transport. Last meal eaten: breakfast. No meal/snack was sent with the resident.</p> <p>Progress note dated 04/16/24 14:44 document in part: Pre/Post Dialysis Evaluation Treatment Information: Post-Dialysis Evaluation. Time back in facility: 04/16/24 2:46 PM Treatment performed off-site. Transported by facility transport. Last meal eaten: breakfast. No meal/snack was sent with the resident.</p> <p>Progress not dated 04/17/24 13:36 document in part: *Nutrition/Dietary Note Text: RD (Registered Dietitian) dialysis note. Resident attends out-patient HD (Hemodialysis) 3x/week. Receives a Liberal Renal, LCS, Regular diet with thin liquids with double portions. Potential for alteration in nutrition related to increased calorie and protein needs as evidence by ESRD with HD.</p> <p>On 04/17/24 at 09:55 AM R101 was observed sitting in a wheelchair at bedside. R101 stated I only get breakfast and dinner on the days that I go to dialysis. I don't get back in time for lunch and I be hungry. I leave the facility at 09:45 AM on Tuesday - Thursday - Saturday for dialysis. The dialysis center will probably just give me a Nutra bar and that's it. The facility does not give a bagged lunch to me. The facility has never sent anything with me to dialysis to eat.</p> <p>Policy:</p> <p>Titled Policy and Procedure Community Hemodialysis dated 01/12/11 document in part: Purpose: To ensure coordination of care for residents requiring hemodialysis in the community. 3. Special consideration will be given to residents going to dialysis to coordinate therapy, medication administration and meals. A sack lunch will be provided to residents that are going to dialysis during mealtimes following the special dietary orders of the resident.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Titled Long Term Care Facility Outpatient Dialysis Services Care Coordination Agreement dated 03/10/24 document in part: 3. Preparation of Residents: Long Term Care Facility shall ensure that each Resident is prepared to spend an extended length of time at Dialysis Facility, as necessary for the administration of Resident's prescribed treatment, and has received proper nourishment and any necessary medications before arriving at Dialysis Facility.</p> <p>Titled Long Term Care Facility Outpatient Dialysis Services Coordination Agreement dated 04/18/24 document in part: 4. Preparation of ESRD (End Stage Renal Disease) Residents: The Long Term Care Facility shall ensure that ESRD Residents are prepared to spend an extended length of time at the ESRD Dialysis unit and have received proper nourishment and any medications prescribed for reasons other than the treatment of ESRD, as appropriate, before coming to the ESRD Dialysis Unit.</p> <p>49486</p> <p>On 4/16/24 at 11:30 AM, received R40 up in wheelchair in the activity room, R40 stated R40 goes to dialysis three times a week, Monday, Wednesday, and Friday. R40 eats breakfast before going for dialysis around 10:00 AM, R40 returns to the facility after 4 PM to eat a late lunch.</p> <p>On 4/17/24 at 9:00 AM, R40 stated R40 did not receive a lunch bag yesterday or on dialysis day. R40 stated R40 do get hungry, and R40 would like to take a lunch bag to dialysis.</p> <p>R40's Minimum Data Set (MDS) dated [DATE] shows R40 is cognitively intact and shows R40 is on dialysis while a resident.</p> <p>R40's Physician Order Sheet (POS) with active orders as of 4/18/24 shows R40 has an order for dialysis.</p> <p>R40's progress notes by registered dietitian dated 4/12/24 documents in part: R40 attends Hemodialysis at Fresenius Kidney Care three times a week.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47304</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure the low air loss mattress was available for 1 (R74) resident with Stage IV pressure ulcer and failed to ensure the low air loss mattress was in the correct setting for 1 (R56) resident. These failures affected 2 (R56 and R74) of 2 residents reviewed for pressure ulcer in a sample of 26.</p> <p>The findings include:</p> <p>R74's health record documented admitted on 9/8/2021 with diagnoses not limited to Multiple sclerosis, Pressure ulcer of sacral region stage 4, Dementia in other diseases classified elsewhere, Bipolar disorder, Cannabis abuse, Other psychoactive substance abuse, Strange and inexplicable behavior, Major depressive disorder, Delusional disorders, Insomnia, Anemia.</p> <p>On 4/16/24 at 12:41pm Observed R74 sitting on the side of the bed, alert and verbally responsive. R74 stated he has wound on his bottom and not sure how he got it. He said he has a wound when he was admitted to the facility. R74 had no air mattress in place.</p> <p>On 4/17/24 at 11:05am Wound care observation conducted with V27 (Wound Care Nurse), observed wound dressing on R74's sacral area. She said wound identified as stage IV pressure ulcer present on admission. Observed V27 removed wound dressing on sacral area. Observed sacral wound bed is pinkish, dry, with scar tissue, no signs and symptoms of wound infection. No air loss mattress in place. V27 said air mattress was removed because it was malfunctioning. She said maybe it was removed on 4/15/24.</p> <p>At 2:44 PM V3 (Director of Nursing / DON) said air loss mattress should be provided to resident with pressure ulcer. She said air loss mattress helps in distributing pressure in the body and could help with wound healing.</p> <p>Minimum Data Set (MDS) dated [DATE] showed R74's cognition was moderately impaired. He needed partial/moderate assistance with oral, toileting and personal hygiene, shower/bathe self, lower body dressing; Supervision/touching assistance with upper body dressing, chair/bed and toilet transfer. MDS showed R74 was occasionally incontinent of bowel and bladder. MDS indicated 1 Stage IV pressure ulcer that was present on admission.</p> <p>R74's Wound assessment report dated 4/16/24 documented in part: Sacrum - Stage IV - present on admission. Date identified: 11/7/21. Measurement (Length x Width x Depth): 0.6 x 0.3 x 0.5 cm (centimeter).</p> <p>R74's POS (physician order sheet) dated 4/17/24 with active order not limited to:</p> <ul style="list-style-type: none"> - Low air loss mattress - Sacrum: Cleanse with NSS or wound cleanser. Skin prep periwound. Loosely pack with Iodoform strip and cover with dry dressing every day shift and PRN if dressing is soiled/saturated. <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Care plan dated 1/10/24 documented in part: R74 admitted with a stage 4 pressure injury to sacrum. R74 has multiple comorbidities. Care plan interventions included but not limited to Continue low air loss therapy mattress.</p> <p>Facility's prevention of pressure ulcers/injuries policy dated 1/2019 documented in part:</p> <p>- Utilize preventive equipment based on plan of care and need of resident.</p> <p>39779</p> <p>R56 has diagnosis not limited to Protein-Calorie Malnutrition, Arteriovenous Malformation of Digestive System Vessel, Type 2 Diabetes Mellitus, Essential (Primary) Hypertension, Schizoaffective Disorder, Bipolar Type, Major Depressive Disorder, Anxiety Disorder, Iron Deficiency Anemia, Dysphagia, Oral Phase, Tremor, History of Falling, Restlessness and Agitation, Hyperlipidemia, Retention of Urine, Syncope and Collapse, Glaucoma and First-Degree Hemorrhoids.</p> <p>Care Plan document in part: Focus: R56 has potential impairment to skin integrity r/t (related/to) Urinary retention, restlessness, agitation, iron deficiency, hyperlipidemia, Type 2 Diabetes Mellitus, Major Depressive disorder, Anxiety Disorder, Glaucoma, HTN (Hypertension), h/o (history of) hemorrhoids, dysphagia, tremors, difficulty walking, unsteadiness feet, syncope and collapse, h/o falling, bowel and bladder incontinence. Interventions: Interventions: R56 needs pressure relieving/reducing mattress to protect the skin while in bed. Focus: R56 has an ADL (Activities of Daily Living) self-care performance deficit. Interventions: Bed Mobility: R56 requires extensive assistance by X1 staff to turn and reposition in bed every shift and as necessary.</p> <p>Most Recent Risk assessment dated [DATE] document in part: Braden Score 12 (High Risk), Inactive Wounds (Healed) Wound site: Sacrum, Date Identified 09/07/23, Type: Pressure, Status: Healed, Clinical Stage: Stage 3.</p> <p>R56 weight dated 04/12/24 99.8 Lbs. (pounds).</p> <p>On 04/16/24 at 11:24 AM upon entering R56 room R56 was observed lying in bed on a low air mattress with the upper body appearing to be sunken into the mattress. The low air loss mattress knob was set between 180 and 210 pounds.</p> <p>On 04/16/24 at 02:36 PM surveyor entered R56 room with V11 (Licensed Practical Nurse). Surveyor asked V11 the setting on R56 low air loss mattress. V11 responded, it is set on 160. The top part of R56 body is sunken into the mattress. Something has to be going on with that. V11 proceeded to turn off the low air loss mattress, detach then reattach a cord then turn the low air loss mattress back on with no change noted with the mattress inflation.</p> <p>On 04/17/24 at 09:53 AM upon entering R56 room R56 was observed on a low air loss mattress set at 120 lying on her left side, facing door.</p> <p>On 04/17/24 at 10:28 AM surveyor entered R56 room with V10 (Licensed Practical Nurse). Surveyor asked V10 the setting on R56 low air loss mattress. V10 responded, the low air loss mattress is set at 120. I let V27 (Wound Care Nurse/Licensed Practical Nurse) know that R56 weight is 99.8 pounds and V27 said that 120 is the correct setting.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/17/24 at 10:30 AM V27 (Wound Care Nurse/Licensed Practical Nurse) stated V27 low air loss mattress is set at 120. R56 weighs 100 pounds, and we go up to the next weight setting on the low air loss mattress. The first selection is 90 and the next selection is 120. The low air loss mattress is set based on the resident weight. R56 has no wounds but she has had a sacral wound. The low air loss mattress is used for preventative measure based on R56 weight, age, comorbidities, because R56 had a wound and is at risk for skin breakdown. The low air loss mattress should not have been set between 180 -210 that was an incorrect setting. I did not see it set at the 180 - 210. Yesterday (04/16/24) the low air loss mattress was beeping and malfunctioning. I was messing with the low air loss mattress because I was trying to get it to inflate. When I went in there the bed appeared to be deflated and I tried to get it inflated, that is why we got R56 up. We changed R56 low air loss mattress yesterday and switched it out.</p> <p>On 04/17/24 at 10:47 AM V10 (Licensed Practical Nurse) stated something was wrong with R56 bed all day yesterday (04/16/24).</p> <p>On 04/18/24 at 10:00 AM V3 (Director of Nursing) stated If there is a person that we deem need a low air loss mattress, the purpose is for preventive measures if the resident is at risk for wounds or if there is a wound already. If the low air loss mattress malfunctions there is no air or distribution of weight. The resident will be sunken in the mattress, that can create another issue and we need to reorder a low air loss mattress.</p> <p>Policy:</p> <p>Titled Pressure Ulcer/Injury Risk Assessment Tool & Documentation dated 01/19 document in part: The purpose of this procedure is to provide guidelines for the structured assessment and identification of residents at risk of developing pressure ulcers/injuries and related documentation. 2. Risk factors that increase a resident's susceptibility to develop or to not heal PU/PIs (pressure ulcer/pressure injuries) include, but are not limited to: c. The presence of previously healed pressure ulcer/injuries (Areas of healed Stage 3 or 4 PU/PIs are more likely to have recurrent breakdown).</p> <p>Titled Low Air Loss Mattress revised 08/21 document in part; Purpose: To provide features of a mattress support system that provides a flow of air to assist in managing heat and humidity (microclimate) of the skin. 3. The lo air loss mattress will be checked on a regular basis to ensure that all cells of the mattress are functioning appropriately. When the low-pressure alarm sounds, the pressure inside the air mattress body is abnormal. 6. Low air loss mattress pressure will be set to the resident's weight.</p> <p>Titled Braden Risk Prevention Measures revised 11/13 document in part: 7. If score is 10-12, the resident is considered high risk.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47304</p> <p>Based on observation, interview and record review the facility failed to ensure the left-hand splint and left AFO (Ankle Foot Orthosis) were in place. These failures affected 2 (R38 and R54) residents reviewed for limited range of motion in a sample of 26.</p> <p>The findings include:</p> <p>R38's health record documented admitted on 12/15/2020 with diagnoses not limited to Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, Aphasia following cerebral infarction, Personal history of covid-19, Chronic fatigue, Multiple and bilateral precerebral artery syndromes, Repeated falls, Rhabdomyolysis, Hereditary and idiopathic neuropathy, Ataxia, Major depressive disorder, Essential (primary) hypertension, Alcohol abuse, Cannabis use, Hyperlipidemia.</p> <p>R54's health record documented admitted on 12/15/2019 with diagnoses not limited to Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, Unspecified chronic bronchitis, Low back pain, Age-related osteoporosis without current pathological fracture, Unspecified osteoarthritis, Epilepsy, History of falling, Personal history of (healed) traumatic fracture, Schizophrenia, Age-related physical debility.</p> <p>On 4/16/24 at 10:41am Observed R54 resting in bed, alert and verbally responsive, left hand contracted with no splint / device. She said not sure where her splint is.</p> <p>At 11:30am to 1:30 observed R54 up on wheelchair in the day room, no splint on left hand, no left AFO (Ankle Foot Orthosis) in placed. Observed R38 sitting up on Geri chair, alert and verbally responsive, left hand contracted with no device or splint.</p> <p>On 4/17/24 at 11:01am - 1:10pm Observed R38 sitting up on Geri chair in the day room, no splint on left hand. R54 sitting up in wheelchair, no splint on left hand, no Left AFO in placed.</p> <p>Minimum Data Set (MDS) dated [DATE] showed R38's cognition was moderately impaired. He needed total assistance/dependent to staff with eating, oral, toileting and personal hygiene, shower/bathe self, upper and lower body dressing, chair/bed and toilet transfer.</p> <p>Care plan dated 3/27/24 documented in part: R38 wears splints daily to left hand for 4 hours or as tolerated. Care plan interventions included but not limited to Apply splint.</p> <p>MDS dated [DATE] showed R54's cognition was moderately impaired. She needed set up/clean-up assistance with eating; Supervision/touching assistance with oral hygiene; Partial/moderate assistance with toileting and personal hygiene, shower/bathe self, upper and lower body dressing, chair/bed and toilet transfer.</p> <p>R54's physician order sheet (POS) dated 4/18/24 with active order not limited to:</p> <p>- Left AFO: apply when resident is out of bed and remove when put back in bed.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- May apply Left hand splint - apply for 4 hours, then remove May apply Left AFO - apply when out of bed, remove when in bed.</p> <p>- left hand splint: Apply in in the am and remove in the pm.</p> <p>Care plan dated 12/28/2023 documented in part: R54 need to wear splints: left hand and left AFO. Apply splint to: left hand and left AFO when up in wheelchair.</p> <p>Reviewed R38 and R54's electronic health records no documentation found that both residents refused for left hand splint or left AFO on 4/16/24 and 4/17/24.</p> <p>On 4/18/24 at 11:45AM V39 (Restorative Nurse) said splints are applied 4 hours in the morning everyday between 8:30am -12:30pm and as tolerated. She said splint helps maintaining the contractures in the affected area or it will help improve the contractures / deformities. V39 said if device or splint is not applied deformities or contractures can worsen. She said Splint or device should have an order and care planned. V39 said R38 and R54 are using left hand splint that should be applied daily in the morning between 8:30am to 12:30pm. She said R54 has left AFO that should be applied when out of bed.</p> <p>Facility's range of motion exercises / splinting policy dated 10/2020 documented in part:</p> <p>- Review the resident's care plan to assess for any special needs of the resident.</p> <p>- The splint should be apply for time frame designated in physician order as tolerated.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>40061</p> <p>Based on observations, interview, and record reviews, the facility failed to ensure fall precautions were in place for a resident (R18) at risk for falls for one out of a total sample of 26 residents.</p> <p>Findings include:</p> <p>R18's Fall Risk Evaluation dated 02/06/2024 documents in part that R18 is at risk for falls.</p> <p>R18's comprehensive care plan documents in part that R18 is at risk for falls/accidents related to medical complexities, impaired mobility, and multiple medications (initiated 08/08/2023). R18 had an unwitnessed fall on 02/04/2024. Interventions to prevent further falls document in part: floor mats down while resident is in bed (initiated 02/05/2024) and Resident's bed at the lowest position at all times (initiated 02/05/2024).</p> <p>On 04/16/2024 at 10:13 AM, R18 was lying in bed. There were large, blue, floor mats to each side of the head of the bed. The one on the left side of R18 was folded in half and not laid flat. The one on the right side of R18 was folded in half and standing on its side-not laid flat on the floor next to R18's bed.</p> <p>On 04/17/2024 at 10:20 AM, V24 (Certified Nurse Aide) left R18's room post grooming and incontinence care for R18. R18's bed was not in its lowest position. The large, blue, floor mat to the right of R18 was not laid flat near R18's bed. It was folded in half and standing on its side.</p> <p>On 04/17/2024 at 1:04 PM, V30 (Nurse) stated R18's floor mats are for precautionary measure to prevent injury. V30 stated the floor mats should be laid flat down on the floor next to the bed while R18 is in bed.</p> <p>Facility's Fall Management policy, last revised 05/2015, documents in part: Staff will initiate falling prevention protocol. Fall prevention measures will be reviewed, adjusted and implemented as needed.</p> <p>Facility's Care Plans, Comprehensive Person-Centered policy, last revised 04/2017, 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.</p>

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>50057</p> <p>Based on observation, interview and record review, the facility failed to follow their policy to maintain acceptable parameters of nutritional status as evidenced by an unrecognized significant weight loss, failed to serve food desired by a resident and failed to care plan weight loss for one resident (R57) in a sample of 26 total residents. This failure resulted in R57 experiencing a 17% weight loss that was not recognized and addressed by the facility.</p> <p>Findings:</p> <p>On 04/16/24 at 12:30 PM, R57 was observed in his wheelchair in dining room. V16 (CNA) presented lunch and said that it was a cheeseburger. R57 looked at the meal and said I want a cheeseburger. Not this. V17 (CNA) stated It is a chicken patty. He wants two peanut butter and jelly sandwiches. That is what he likes.</p> <p>On 04/16/24 at 12:50 PM, R57 was observed in the dining room eating a sandwich with a second sandwich wrapped on the plate.</p> <p>On 04/17/24 at 8:46 AM R57 was observed in his wheelchair in the hallway. When asked if he had eaten breakfast, he responded No. I'm hungry. V29 (CNA) was asked if R57 had eaten breakfast. V29 responded that she was getting ready to feed him. On 04/17/24 at 8:54 AM V29 was observed returning R57 to his room where she fed him breakfast. R57 stated that he did not like eggs and hot cereal. V29 stated that never eats his eggs and that she would ask the nurse to ask the kitchen for cold cereal.</p> <p>On 4/18/2024 at 9:52 AM, V29 (CNA) and V34 (LPN) were asked if R57 ate breakfast. V29 stated Yes. He ate 75-100% of his breakfast. When R57 was asked by surveyor if he ate breakfast, he stated I want water. V34 stated that she would get him water.</p> <p>On 04/17/24 at 11:05 AM the weight record of R57 was reviewed in the electronic health record:</p> <p>Weight 4/12/2024 - 145.6 pounds</p> <p>Weight 3/20/2024 - 143 pounds (20.73% decrease since 11/7/2023 and a 10.18% decrease since 2/9/2024)</p> <p>Weight 3/13/2024 - 140.2 pounds (22.28% decrease since 11/7/2023 and an 11.93% decrease since 2/9/2024)</p> <p>Weight 3/7/2024 - 149 pounds (17.41% decrease since 11/7/2024 and a 6.71% decrease since 2/9/2024)</p> <p>Weight 2/28/2024 - 148.6 pounds</p> <p>Weight 2/9/2024 - 159.2 pounds (11.75% decrease since 11/7/2023)</p> <p>Weight 1/4/2024 - 157.6 pounds</p> <p>Weight 12/28/2023 - 155.2 pounds</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Weight 12/21/2023- 158.6 pounds</p> <p>Weight 12/14/2024 - 160.7 pounds</p> <p>Weight 12/7/2023 - 163.5 pounds (9.37% decrease since 11/7/2023)</p> <p>Weight 11/23/2023-166.2 pounds (7.87% decrease since 11/7/2023)</p> <p>Weight 11/23/2023-162.8 pounds (9.76% decrease since 11/7/2023)</p> <p>Weight 11/16/2023 - 171.6 pounds</p> <p>Weight 11/7/2023 - 180.4 pounds</p> <p>On 04/17/24 at 11:39 AM V26 (Registered Dietician) was interviewed. V26 stated that she has worked at the facility for 6 years. V26 works once a week / thirty-two hours a month. V26's process for evaluating residents includes seeing any high risk residents which V26 described as residents with tube feedings, TPN, bed sores and anyone that the staff ask V26 to see. V26 runs reports out of the electronic health record such as the diet report, enteral feeding report and wound rounding report. V26 meets weekly with the multidisciplinary team which V26 described as the restorative nurse, administrator, director of nursing, corporate nurse, corporate lawyer and corporate wound nurse. The multidisciplinary team meets virtually and usually on Friday of each week. V26 stated that nurses do not have specific criteria which would require a consult to V26. The dietary manager reviews weight loss and communicates to V26 any residents who triggered concern about weight loss. V26 described a weight loss concern as a five percent weight loss within one month or a ten percent weight loss within six months. V26 stated that if there was a weight loss, the actions would include an assessment and documentation in the electronic health record, discussion with the resident or resident representative to understand possible causes or concerns, and that the issue would be addressed at the multidisciplinary meeting on Friday. V26 would also speak with staff to understand the cause of the weight loss. V26 stated that V26 relies on staff to understand what is going on with the resident and what is triggering the weight loss. V26 reviewed the list of residents on the third floor who V26 had concerns about relative to weight loss. R57 was not on that list. When asked if each resident with weight loss would have a care plan specific to the weight loss, V26 stated that V26 is not involved in minimum data set documentation or care planning. When V26 was asked about R57, V26 stated that He pulled up on my report for this month. I had not seen him previously . Yes, he has a loss. She described R57's weight loss as 17% loss between November 2023 and March 2024. V26 stated Actions should have been taken. V26 reviewed the care plan and stated I see a care plan, but it has nothing to do anything .The dietary care plan only says his diet and that he has cardiovascular disease .When there was a 17% weight loss in March, he should have been seen by me to figure out what is going on.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During Interview with V3 (Director of Nursing) on 4/18/2024 at 8:57 AM, V3 stated that the restorative team takes residents' weights every month. The Restorative Nurse, Director of Nursing, Dietician, Wound Care Nurse, nurse consultant, corporate lawyer and wound care consultant meet weekly on Friday at 12:30 PM to discuss wounds and any resident changes, resident weights, or whether a resident would benefit from supplements. It is everyone's responsibility to identify a weight change. That means that the floor nurse will raise a concern if there is a change in a resident's eating. The restorative nurse will raise any concern about weight loss. V26 (Dietician) will then evaluate the situation and chart about any changes. If a weight changes, the physician is notified because the doctor may want to change something in the orders. The initial care plan begins upon admission. The Nurse doing the admission starts the care plan. The MDS Coordinator will then go an fix it, personalize it. Each department does their own care plan. MDS Coordinator does the nursing care plans. During a clinical meeting each morning care plans are discussed. If V3 does not see something in the care plan, she will notify the MDS coordinator. Social Services Department conducts a care plan meeting with the resident and family.</p> <p>During interview with V33 (Minimum Data Set (MDS) coordinator) on 4/18/2024 at 9:36 AM, V33 described the process of care planning and MDS documentation. When the resident is admitted , V33 looks at the paperwork from the transferring facility and puts the diagnoses into PCC. V33 introduces herself to the resident within 24-48 hours. V33 uses day eight as the admission assessment date and alerts all departments of the assessment reference date. V33 then starts the care plan process based on the diagnoses and documents from the sending facility. V33 develops the care plans, and the Social Services Department notifies the family to schedule a care plan meeting. All departments are involved in the care plan process including restorative, therapy, nursing, dietary, social services. V33 stated that she reviews information in PCC every day. V33 looks at every resident's twenty-four-hour report from nursing which includes any admissions, discharges, any changes in provider orders, antibiotic initiation, room changes or any change in condition. Weight change is not included in that report. V33 stated that she would be aware of a change in resident weight by getting ready for quarterly. V33 stated that she bases her MDS coding on progress notes or assessments. V33 would not code a weight change in MDS if the only documentation was the documented weight and there was no nursing note or dietician note in the electronic health record. V33 reviewed the MDS of R57 dated 3/5/2024. Section K stated no weight loss. V33 stated that if she had looked at R57's weight, she would have used the 2/28/2024 weight of 149.6 pounds to determine weight loss, but V33 would still have wanted to see a note from the Dietician or Dietary Manager before documenting a weight change in MDS. V33 stated that if she is not sure about coding, V33 can reach out to the Restorative Nurse. If V33 sees a weight that V33 is concerned about, V33 reaches out to the restorative nurse and asks for a reweight. If it is a big change in weight, V33 would suggest doing weekly weights. V33 stated that the Restorative Nurse is out sick and V33 is not sure who is covering for her while she is out.</p> <p>On 4/17/2024 at 3:27 PM, record review included a note from V26 dated 4/17/2024 at 14:11 which stated in part:</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Resident needs assistance from staff to complete meals. Resident often eats fifty percent or more of meals. Current weight on 4/12/2024 is recorded as 145.6 pounds. Weight at one month is 140.2 pounds (3.85% decrease) on 3/13/2024. Weight at three months is 157.6 pounds (7.6% decrease) on 1/4/2024. Significant weight loss over 3 months. Resident went to the hospital in February and there is a question if hospitalization is related to some of the weight loss. BMI is 25.0 and considered overweight. Goal is for weight maintenance. No edema noted. Skin intact. No new labs to report on. Medications were reviewed. Secondary to weight loss, will recommend to add HiCal 60ml 1x/day for additional kcals and protein. Goal at present time is for weight maintenance. Will follow as needed.</p> <p>On 4/18/2024 at 10 AM, the electronic medical record contained an order dated 4/18/2024 at 9 AM for house supplement H.Cal 60 ml once a day ordered by V26 (Dietician).</p> <p>On 4/18/2025 at 10 AM, review of R57's dietary care plan dated 11/7/2024 and revised on 2/28/2024 states in part: Goals (Date initiated: 11/7/2024, revised on 3/12/2024, target date 6/5/2024): The resident will maintain adequate nutritional and hydration status as evidenced by maintaining stable weight, no signs/symptoms of malnutrition, and consuming at least 75% of meals daily throughout the review date.</p> <p>Review of policy titled Weight Assessment and Intervention dated March 2014 and revised October 2020 stated in part:</p> <p>Policy Statement: The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents.</p> <p>Policy Interpretation and Implementation</p> <p>3. Any weight change of 5% or more since the last weight assessment will be retaken for confirmation. If the weight is verified, nursing staff will immediately notify the Dietician. Verbal notification must be confirmed in writing.</p> <p>4. The Dietician will response within 24 hours of receipt of written notification.</p> <p>5. The Dietician will review the unit weight record monthly to follow individual weight trends over time. Negative trends will be evaluated by the treatment team whether or not the criteria for significant weight change has been met.</p> <p>6. The threshold for significant unplanned and undesired weight loss will be based on the following criteria (where percentage of body weight loss equals usual weight minus actual weight divided by usual weight times one hundred):</p> <p>a. One month - 5% weight loss is significant; greater than five percent is severe.</p> <p>b. Three months - 7.5% weight loss is significant; greater than 7.5% is severe.</p> <p>c. Six months - 10% weight loss is significant; greater than 10% is severe.</p> <p>Care Planning</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>1. Care planning for weight loss or impaired nutrition will be a multidisciplinary effort and will include the physician or licensed independent practitioner, nursing staff, the Dietician, the consultant Pharmacist, and the resident or resident's representative.</p> <p>Review of policy titled Care Plan, Comprehensive Person-Centered dated 11/2013 and revised 4/2017 stated in part:</p> <p>Policy statement: A comprehensive, person-centered care plan that includes measurable objectives and timelines to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.</p> <p>Policy Interpretation and Implementation:</p> <p>2. Care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.</p> <p>8. The comprehensive, person-centered care plan will:</p> <p>b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.</p> <p>g. Incorporate identified problem areas</p> <p>9. Areas of concern that are identified during resident assessment will be evaluated before interventions are added to the care plan.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46342</p> <p>Based on observation, interview and record review the facility failed to place oxygen cannula tubing in a bag when not in use for one (R103) resident of three residents reviewed for respiratory care in a sample of 26.</p> <p>Findings include:</p> <p>On 04/16/24 at 11:48 AM, observed in R103's room oxygen cannula tubing attached to R103's oxygen concentrator hanging across the top of the concentrator. Cannula oxygen tubing was not stored in a bag or covered in anyway. The oxygen concentrator was not turned on and R103 was not in R103's room at this time.</p> <p>On 4/16/24 at 11:57 AM, observed R103 sitting on R103's bed. Next to R103's bed was R103's wheelchair with a portable oxygen tank on the back with oxygen cannula tubing attached and draped over a pole coming from the portable oxygen tank. The oxygen cannula tubing attached to the portable oxygen tank was not stored in a bag or covered in anyway. Observed R103 wearing the oxygen cannula tubing attached to the oxygen concentrator which was infusing oxygen at two liters per minute.</p> <p>On 04/16/24 at 11:58 AM, V10 (Licensed Practical Nurse) observed oxygen cannula tubing attached to the portable oxygen tank uncovered and stated when oxygen tubing is not in use it should be stored in a plastic bag to keep it clean.</p> <p>On 04/16/24 at 11:59 AM, R103 stated R103 changes the tubing so often that the tubing doesn't have time to get dirty.</p> <p>On 04/17/24 at 1:34 PM, V3 (Director of Nursing) stated when oxygen cannula tubing is not in use it should be stored in a plastic bag and the tubing should not be uncovered hanging or touching other items for infection control reasons. V3 stated it is important to keep the oxygen cannula tubing clean and germ free because the oxygen cannula goes into the resident's nose which is a direct portal to the resident's inside. V3 stated R103 uses an oxygen concentrator when R103 is in R103's room and a portable oxygen tank stored on the back of R103's wheelchair when R103 is out of R103's room. V3 stated education was provided to R103 yesterday regarding oxygen tubing storage when not in use.</p> <p>R103's diagnosis included but not limited to Acute and Chronic Respiratory Failure with Hypoxia, Opioid Dependence, Psychoactive Substance Abuse, Drug-Induced Myopathy, Type 2 Diabetes Mellitus, Hypertension, Long Term Use of Anticoagulants.</p> <p>R103's Order Summary Report printed 04/17/24 documents in part oxygen per nasal cannula at 2 liters per minute continuous every shift for shortness of breath related to acute and chronic respiratory failure with hypoxia dated 02/29/24.</p> <p>R103s MDS (Minimum Data Set) dated 03/07/24 indicates intact cognition with BIMS (Brief Interview for Mental Status) 13/15.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R103's MDS dated [DATE] section O (Special Treatments, Procedures, and Programs) documents in part R103's use of oxygen therapy.</p> <p>R103's oxygen care plan documents in part R103 is at risk for altered respiratory status/difficulty in breathing related to diagnosis of acute/chronic respiratory failure with hypoxia, receives oxygen continuously and oxygen via nasal cannula.</p> <p>Facility provided policy titled Oxygen Care and Storage dated 12/2017 which documents in part oxygen tubing must be stored in a bag when not in use.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40061</p> <p>Based on interviews and record reviews the facility failed to obtain medication consents and care plan for the use of an antidepressant for R85, in a total sample of 26.</p> <p>Findings include:</p> <p>R85's face sheet documents in part an admitted [DATE].</p> <p>R85's physician order sheets (POS) documents in part an order for Nortriptyline HCl (hydrochloride) Capsule 10 MG (Milligram) Give 1 capsule by mouth at bedtime for depression.</p> <p>R85's progress notes and Medication Administration Records (MARs) document in part that R85 received the medication since admission. R85's January 2023 MAR documents in part that the first dose was on 01/21/2023. R85's November 2023 MAR documents in part that facility discontinued Nortriptyline on 11/22/2023 and reordered it on 11/29/2023. R85's March 2024 MAR documents in part that the medication was discontinued on 03/21/2024. R85's April 2024 MAR documents in part that it was reordered on 04/02/2024.</p> <p>Surveyor verbally requested R85's psychotropic consents multiple times on 04/18/2024 and via electronic mail on 04/18/2024 at 10:20 AM. Facility provided a consent dated 11/29/2023. Facility did not provide the initial consent for Nortriptyline from admission or for the reorder on 04/02/2024.</p> <p>Surveyor also reviewed R85's comprehensive care plan. Facility did not care plan for R85's Nortriptyline.</p> <p>Facility's Psychotropic Medication policy, dated 11/2013, documents in part: An informed consent must be obtained prior to starting the medication. An informed consent form signed by the resident or legal representative for the appropriate medication(s) and dose. A care plan will be developed and updated quarterly or more frequently as needed. The care plan will include resident goals, incorporate findings from the comprehensive assessment, non-pharmaceutical interventions, and potential adverse reactions.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45110</p> <p>Based on observations, interviews, and record review the facility [A] failed to label individual resident's insulin medications with an open date, [B] failed to dispose expired insulin, [C] failed to refrigerate unopened insulin in 3 of 5 medication carts reviewed for medication storage and labeling in a sample of 26.</p> <p>On 4/16/23 at 9:22 AM, V18 [Licensed Practical Nurse] and surveyor conducted inventory of the third-floor medication cart, observed the following:</p> <p>R72's [1] Open Novolog Flex Pen was opened and used, no open or expiration date. [2] Open Lantus insulin pen with an open date of 3/14/24, expiration date of 4/12/24, and [3] Open [NAME] pen with no open date.</p> <p>R72's physician orders:</p> <p>12/14/23-Novolog Solution 100 units/ml, inject 10units three times per day.</p> <p>9/6/22-Lantus Solution 100 unit/ml, inject 25 units at bedtime.</p> <p>R2's [1] Unopened Levemir Flex Insulin Pen read on the package Refrigerate Until Open. [2] Insulin Aspart Flex Insulin Pen with open date of 3/7/24, expiration date of 4/7/24.</p> <p>R2's physician orders:</p> <p>3/22/24- Detemir (Levemir) Solution 100 units/ml, inject 40 units at bedtime.</p> <p>1/4/24- Insulin Aspart Solution 100units/ml inject 15 units/ml.</p> <p>R16's Open Admelog Insulin with open date of 3/12/24, expiration date of 4/9/24, and [2] Open Admelog Insulin with no open date.</p> <p>R16's physician order:</p> <p>12/02/22- Admelog 100unit/ml, inject 10 units three times per day.</p> <p>On 4/16/24 V18 stated, I used some of the insulin in this cart, but I did not pay attention to the dates on the insulin pens. The night nurses are to make sure the cart is cleaned, remove the expired, open and undated insulin off the cart and reorder the resident's medication. If the insulin is expired or there is no open date, then the insulin will not work effectively for the resident.</p> <p>On 4/16/24 at 9:47 AM, V23 [Licensed Practical Nurse] and surveyor conducted inventory of the second-floor medication cart, observed the following:</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R97's open Insulin Lispro with no open date.</p> <p>R97's physician order:</p> <p>3/22/24- Insulin Lispro injection Solution 100unit/ml give per slide scale.</p> <p>On 4/16/24 at 10:00 AM, V23 stated, The insulin is to be dated for 28 days, then discarded. If the nurse used undated insulin, it could potential not be effective.</p> <p>On 4/16/24 at 10:22AM V10[Licensed Practical Nurse] and surveyor conducted inventory of the first-floor medication cart, observed the following:</p> <p>R49's Unopen Humulin R Solution 100units/ml, give insulin per slide scale. On the package read Refrigerate Until Open.</p> <p>R49's Physician order- 4/10/24, Humulin R Solution 100units/ml, give insulin per slide scale.</p> <p>On 4/16/24 at 10:40AM, V10 stated, The insulin should be refrigerated, until it's opened, and an open date placed on the insulin. Because if there is no date, and the insulin is not refrigerated, the time of effectiveness already started, but nursing staff don't know when the insulin was not in the refrigerator, the insulin is not effective.</p> <p>Policy document in part:</p> <p>Storage of Medications and Medical Supplies dated 12/2017</p> <ul style="list-style-type: none"> -Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurse's station. -Insulin pens should be dated when opened and with the adjusted expiration date. -Expired medications are to be disposed of. -Multiple dose vials such as insulin shall be dated the day they opened and with the expiration date. 		

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46342</p> <p>Based on observations, interviews, and record reviews, the facility failed to a.) ensure food items were labeled and dated per facility policy, b.) discard expired and/or rotten foods, c.) keep food storage areas clean, d.) conduct hand washing in between handling dirty and clean plateware/equipment. These failures have the potential to affect all 110 residents receiving food prepared in the facility's kitchen.</p> <p>Findings include:</p> <p>On [DATE] at 9:18 AM, during initial kitchen tour V5 (Dietary Manager) stated all food items need to be labeled with a in date or delivery date, an open or prepared date and a use by date or expiration date. Depending on what the food is determines its expiration or use by date. V5 pointed to a documented posted outside the walk-in cooler and stated that piece of paper has the use by dates on it organized by the item. V5 stated it is the responsibility of the staff member who puts the item in the cooler to label and date the item and it is V5's responsibility to monitor expiration dates and throw out any expired or items beyond the use by date. V5 stated it is important to monitor the expiration dates so we are not serving contaminated or spoiled food to the residents. People are in here because they are sick. We don't want to make them sicker.</p> <p>On [DATE] at 9:28 AM, observed cooling fan inside walk-in cooler. The plastic lid covering the cooling fan was covered in a black material. Also, viewed black material surrounding the base of the cooling fan and clumps of black material on the ceiling and plastic stripping near the doorway. V5 observed the black material on the cooling fan, ceiling and plastic stripping and stated the black material shouldn't be there because it could contaminate the food because some of the food boxes containing fresh produce are open.</p> <p>On [DATE] at 9:36 AM, observed the following items in the reach-in cooler:</p> <p>1.) Opened 1 gallon container of green relish. Not labeled with an open or use by date. V5 stated the container should have been labeled with an open and use by date so that staff would know if the item was safe to use and when it needs to be thrown out.</p> <p>2.) ,d+[DATE] case of fresh tomatoes felt very soft and swollen. V5 stated the tomatoes are like that because they are frozen and cannot be used anymore. V5 stated V5 is going to throw them out.</p> <p>On [DATE] at 9:40 AM, observed the following items on the metal cart containing dried condiments:</p> <p>1.) Opened bottle of ground ginger with printed manufacturer's best by date [DATE]. Delivery sticker on the side of the bottle very worn and not legible to read the delivery date.</p> <p>2.) Opened bottle of rosemary with printed manufacturer's best by date [DATE]. Delivery sticker on the rosemary indicate delivery date [DATE].</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>On [DATE] at 10:05 AM, observed V6 (Dietary Aide) working in the dish machine area by himself. V6 stated V6 been working at the facility for 6 years and usually works the dish machine by himself.</p> <p>On [DATE] at 10:09 AM, observed V6 putting dirty insulated coffee & plastic juice pitchers into the dish machine.</p> <p>On [DATE] at 10:12 AM. observed V6 removing cleaned insulated coffee pitcher and plastic juice pitchers from the dish machine and then remove each of the items from the racks and place them into storage area. V6 did not wash hands in between handling dirty items and cleaned items. Then observed V6 go to the dirty side of the dish machine and put a stack of dirty meal trays into a rack and then place the rack into the dish machine to wash.</p> <p>On [DATE] at 10:13 AM, observed V6 begin to break down the resident breakfast trays. V6 stacked dirty plate domes in a pile, meal trays and dishes in a separate stack and put bowls and silverware into a liquid to soak.</p> <p>On [DATE] at 10:16 AM, observed V6 push cleaned rack containing meal trays out of the dish washer and touch individual meal trays with hand and organize the meal trays in stacks according to size/color. V6 did not wash hands before touching cleaned meal trays.</p> <p>On [DATE] at 10:19 AM, observed V6 return to dirty side of the dish machine and picks up dirty trays and dome lids and place them into a rack and place them into the dish machine to be washed.</p> <p>On [DATE] at 10:20 AM, observed V6 go to the clean side of the dish machine and use V6's hand to remove the cleaned items from dish machine. V6 did not wash hands before handling cleaned items.</p> <p>On [DATE] at 10:25 AM, V6 stated I've been working here by myself for a while now and I put the dirty items in the dish machine and then pull out the cleaned items and then put them away. V6 stated V6 keeps his hands in soapy, bleach water which keeps them sanitized all the time. V6 said when I leave out of the kitchen and come back inside that's when I use the hand sink to wash my hands.</p> <p>On [DATE] at 10:33 AM, V5 stated V6 should be washing his hands in between handling the dirty and cleaned items and changing gloves in between touching dirty and clean items.</p> <p>On [DATE] at 10:37 AM, V9 (Maintenance Director) viewed black material collecting around the cooling fans, ceiling and on plastic stripping by the doorway in the walk-in cooler and V9 stated that the black material was accumulated dirt and that the dirt should not be there.</p> <p>On [DATE], facility provided list of diet orders for all residents in the facility printed [DATE] at 12:16 PM from the facility electronic health system. Diet order list indicates there was one resident receiving nothing by mouth (NPO).</p> <p>Facility provided policy titled Labeling and Dating Foods dated 2021 documents in part, to decrease the risk of food borne illness and to provide the highest quality, foods is labeled with the date received, the date opened and the date by which the item should be discarded and use by date recommendations for expiration date per manufacturer.</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>Facility provided policy titled Storage of Refrigerated Foods dated 2021 documents in part, refrigerated food is stored in a manner that ensures food safety and preservation of nutritive value and quality, food in the refrigerator is covered, labeled and dated with a use by date, and open products that have not been properly sealed and dated are discarded.</p> <p>Facility provided kitchen policy titled, Handwashing dated 2021 documents in part food and nutrition services employees will practice safe food handling to prevent foodborne illness and food and nutrition services employees will thoroughly wash their hands and exposed areas of their arms with soap and water in the designated hand-washing sink at the following times: after touching anything unsanitary (garbage, dirty dishes) and after handling soiled equipment and utensils.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40061</p> <p>Based on observations, interviews, and record reviews, the facility failed to follow their policies and procedures to (a) ensure there was signage outside of the resident's (R74) room indicating Enhanced Barrier Precaution (EBP); (b) provide readily available personal protective equipment (PPE) supplies outside of the resident's (R74) room; (c) use PPE in isolation rooms (R74, R28, R85, R410); (d) maintain infection control practices during medication administration (R4, R93, R105); (e) ensure a resident's (R85) urinary catheter bag remained off the floor; and (f) contain soiled linens in sealed bags during transport. This has the potential to affect 111 residents residing in the facility.</p> <p>Findings include:</p> <p>R85's physician order sheets (POS) documents in part: Single Room Strict Contact Isolation for (ESBL [Extended-spectrum beta-lactamases], Herpes) (ordered 04/09/2024), resident on enhance barrier precautions due to [history of] ESBL, [urinary] Catheter (ordered 04/05/2024), and [urinary] catheter care every shift for infection control and hygiene (ordered 04/03/2024).</p> <p>Facility's Urinary Catheter Care Policy and Procedure, dated 03/2014, documents in part: Place urinary bag in urinary bag holder.</p> <p>R85's comprehensive care plan documents in part that R85 requires strict contact isolation precautions related to diagnosis of ESBL in the urine and carbapenem-resistant Acinetobacter baumannii (CRAB) infection. Intervention, initiated 01/30/2024, documents in part: Strict Contact Isolation precautions as ordered.</p> <p>On 04/16/2024 at 10:19 AM, surveyor observed two postage signage on R85's door indicating that R85 was on Enhanced Barrier Precautions (EBP) and Contact Precautions. Contact Precautions signage documents in part that providers and staff must put on gloves and gown before room entry. V31 (Companion Care) sat beside R85's bed without any PPE.</p> <p>On 04/16/2024 at 10:23 AM, R85 was oriented to person, place, and year. R85 stated [R85] was on isolation due to a urinary tract infection. R85 stated some staff do not wear gowns. During interview, surveyor observed a catheter privacy bag hanging off the bed frame to R85's right side but R85's urinary catheter bag was laying flat on the floor.</p> <p>On 04/16/2024 at 10:33 AM, V31 stated [V31] was employed by an outside company to provide emotional support to some residents. V31 stated staff do not gown up when entering the room so V31 assumed [V31] didn't have to do so also. V31 stated facility did not provide verbal instruction or redirection when in R85's room.</p> <p>On 04/16/2024 at 10:44 AM, R76 entered R85's room. R76 did not perform hand hygiene or wear PPE. Both R76 and V31 were in R85's room without PPE. At 10:59 AM, V23 (Nurse) took R76 out of the room stating R76 was not supposed to be in R85's room and that R76 needed hand sanitizer.</p> <p>R410's comprehensive care plan documents in part that R410 has a history of ESBL and requires enhanced barrier precautions and is at risk for complications (initiated 02/20/2024).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 04/16/2024 at 11:04 AM, surveyor observed Enhanced Barrier Precautions signage on R410's door. V23 (Nurse) did not wear gloves or gown when doing R410's vitals. V23 and V24 (Certified Nurse Aide) did not wear gowns when repositioning R410. V23 did not wear a gown when cleansing R410's arms and face with a wet towel.</p> <p>R28's POS documents in part: Strict Contact Isolation for CRE (Carbapenem-resistant Enterobacterales) of Urine every shift (ordered 02/13/2024)</p> <p>R28's comprehensive care plan documents in part that R28 requires strict isolation precautions related to diagnosis of CRE. Intervention, initiated 02/14/2024, documents in part: Initiate and maintain strict isolation.</p> <p>On 04/16/2024 at 11:27 AM, surveyor observed Contact Precautions signage on R28's door. R28 pressed the call light at 11:29 AM, V23 came in shortly after to answer the call light. V23 did not wear gloves or a gown prior to entering R28's room and turning off the call light. R28 requested water. V23 left the room and came back a few minutes after with a cup of water. V23 did not wear gloves or a gown prior to entering R28's room. V23 elevated R28's head of the bed and assisted R28 to drink water.</p> <p>On 04/17/2024 at 12:08 PM V21 (Infection Preventionist) stated residents are placed on Enhanced Barrier Precautions (EBP) to protect them and the staff so there is no transmission of any infectious organism. If staff are doing any type of high-contact care such as taking vitals and repositioning, the staff need to perform hand hygiene and wear gloves and a gown. When staff and visitors enter contact isolation rooms, they are to perform hand hygiene and wear gloves and a gown prior to entering the room.</p> <p>Facility's Enhanced Barrier Protection policy, dated 05/2022, documents in part: Healthcare providers must don a gown and gloves prior to entering a room and doff after leaving the room for high contact resident care activities. High contact activities include providing hygiene.</p> <p>Facility's Contact Precautions policy, last revised 05/2022, documents in part: In addition to Standard Precautions, use Contact Precautions to prevent nosocomial spread of organisms that can be transmitted by direct resident contact (hand or skin-to-skin contact that occurs when performing resident-care) or by indirect contact (touching) of environmental surfaces or contaminated resident care equipment. Contact Precautions require the use of gown and gloves on every entry into a resident's room.</p> <p>On 04/16/2024 at 12:16 PM, surveyor toured the laundry area with V22 (Laundry Attendant). There was a plastic bin under the laundry chute in the washer side of the laundry room. The bin had unwrapped/loose hand towels, body towels, incontinence pads, and other pieces of linen from the laundry chute. V22 stated the staff are supposed to send the linens in sealed plastic bags down the laundry chute. V22 stated the staff sometimes do not do that as is the case with the loose linens in the plastic bin.</p> <p>Facility's Linen and Laundry policy, last revised 05/2022, documents in part: If linen chutes are used, it is recommended that they are designed and maintained to as to minimize dispersion of aerosols from the contaminated laundry. (e.g. No loose items in the chute and bags are closed before tossing into the chute).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>47304</p> <p>R74's health record documented admitted on 9/8/2021 with diagnoses not limited to Multiple sclerosis, Pressure ulcer of sacral region stage 4, Dementia in other diseases classified elsewhere, Bipolar disorder, Cannabis abuse, Other psychoactive substance abuse, Strange and inexplicable behavior, Major depressive disorder, Delusional disorders, Insomnia, Anemia.</p> <p>On 4/17/24 at 11:05am Observed R74 up and about, ambulatory with steady gait. Wound care observation conducted with V27 (wound care nurse), observed wound dressing on R74's sacral area. She said wound identified as stage IV pressure ulcer present on admission. Observed V27 removed wound dressing on sacral area and provided wound treatment without wearing proper PPEs. V27 wore gloves but not gown. No signage posted on the door or wall outside of R74's room indicating Enhanced Barrier Precaution (EBP). No PPE supplies were made available outside of R74's room.</p> <p>At 1:28 PM V21 (Infection Preventionist / IP nurse) said resident with pressure ulcer should be on enhance barrier precautions. Staff is expected to wear proper PPE such gown and gloves when providing wound care. Door signage should be posted on resident's room to inform staff what to do upon entering the room. Proper PPE should be worn when providing high care activities to prevent any transmission of infection. If there is no door signage, staff will not be able to know what to do and will not be informed what kind of PPE will be worn when providing care.</p> <p>At 2:44 PM V3 (Director of Nursing / DON) stated resident with pressure ulcer should be placed under enhanced barrier precautions. Staff are expected to wear proper PPE including gloves and gown when providing high care activities like wound care to prevent cross contamination. She said door signage for EBP should be posted by resident's door entrance to alert the staff what they are going to do when going into the room. If there is no signage - staff won't be able to know.</p> <p>Minimum Data Set (MDS) dated [DATE] showed R74's cognition was moderately impaired. He needed partial/moderate assistance with oral, toileting and personal hygiene, shower/bathe self, lower body dressing; Supervision/touching assistance with upper body dressing, chair/bed and toilet transfer. MDS showed R74 was occasionally incontinent of bowel and bladder. MDS indicated 1 Stage IV pressure ulcer that was present on admission.</p> <p>R74's Wound assessment report dated 4/16/24 documented in part: Sacrum - Stage IV - present on admission. Date identified: 11/7/21.</p> <p>R74's POS (physician order sheet) dated 4/17/24 with active order not limited to: Sacrum: Cleanse with NSS or wound cleanser. Skin prep peri wound. Loosely pack with Iodoform strip and cover with dry dressing everyday shifts and PRN if dressing is soiled/saturated.</p> <p>Care plan dated 1/10/24 documented in part: R74 admitted with a stage 4 pressure injury to sacrum.</p> <p>Facility's enhanced barrier protection policy dated 5/2022 documented in part:</p> <ul style="list-style-type: none"> - Health care providers must don a gown and gloves prior to entering a room and doff after leaving the room for high contact resident care activities. - High contact activities include Wound care and any skin opening requiring a dressing. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<ul style="list-style-type: none"> - Post clear signage on the door or wall outside of the resident room indicating the type of precautions and required PPE (e.g gown and gloves). - For Enhanced Barrier Precautions, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves. - Make PPE including gowns and gloves available outside of the resident room. <p>49486</p> <p>On 04/16/24 at 09:38 AM, observed V30 (Registered Nurse/RN) administering Lactulose Encephalopathy oral solution 10MG/5ML to R105. V30 picked up a new bottle of Lactulose, V30 did not perform hand hygiene, V30 did not wear clean gloves, V30 dipped right thumb into the new bottle to open the sealed liquid medication. When V30 was asked why V30 opened the sealed container without hand hygiene. V30 stated V30 should not have dipped V30's dirty thumb inside the liquid medication, V30 should have performed hand hygiene and put on clean gloves. V30 stated opening the medication with V30 dirty finger could result to contamination that could infect the resident.</p> <p>On 4/16/24 at 10:10 AM, observed V30 (RN) administering Buprenorphine HCL-Naloxone HCL 4MG-1MG Sublingual film to R93. V30 cut the sealed packet with V30's key without hand hygiene. V30 stated V30 should not have used V30's key, V30 should have put on clean gloves and use a clean scissor. V30 stated, V30 using a dirty (unsanitized) key could have introduced germs into the medication and contaminate the medication.</p> <p>On 04/17/24 at 08:47 AM, observed V11 (Licensed Practical Nurse/LPN) administering MiraLax Packet 17 GM (Polyethylene Glycol 3350) by mouth to R4. V11 picked a new bottle of Miralax powder, V11 did not perform hand hygiene and did not wear clean gloves, V11 dipped right thumb to open the sealed medication. V11 stated opening the medication with a dirty finger (unsanitized) could lead to bacterial infection. V1 stated, V11 should have performed hand hygiene to prevent infection.</p> <p>On 4/17/24 at 12:56 PM, V4 (Assistant Director of Nursing/ADON) stated nurses should not use dirty finger (unsanitized) or object to open a sealed medication. V4 stated as a form of infection control, V4 expects nurses to perform hand hygiene, put on a pair of clean gloves to cut the packet or pull up the tab at the edge of the imprinted seal to open any sealed medication.</p> <p>On 4/18/24 at 8:52 AM, V21 (Infection Preventionist/IP) stated V21 expects nurses to perform hand hygiene before administering care to the resident to reduce the spread of germs. V21 stated when nurses need to get a medication from the packet and to open a sealed medication, V21 expects nurses to perform hand hygiene either by washing with soap and water or by using hand sanitizer and put on a pair of clean gloves to avoid contamination and infection.</p> <p>V21 stated It is absolutely wrong for nurses to use a key to cut a packet or use dirty finger to open a sealed medication.</p> <p>The facility's policy for Administering Medications dated 3/2014, revised 11/2020 read in part: Staff shall follow established facility infection control procedures; handwashing, antiseptic technique, gloves, isolation precautions for the administration of medications as applicable.</p>		