

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PAVILION OF LOGAN SQUARE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2242 NORTH KEDZIE CHICAGO, IL 60647
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Survey: 2384822/IL160828, 2385070/IL161116 & FRt of 4/19/2023/IL160085	S 000		
S9999	Final Observations Statement of Licensure Findings 1 of 2 Violations 300.610a) 300.690a) 300.690b) 300.690c) 300.1210b) 300.1210d)6 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident	S9999		

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PAVILION OF LOGAN SQUARE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2242 NORTH KEDZIE CHICAGO, IL 60647
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 1</p> <p>affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.</p> <p>b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.</p> <p>c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2023
NAME OF PROVIDER OR SUPPLIER PAVILION OF LOGAN SQUARE, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 2242 NORTH KEDZIE CHICAGO, IL 60647		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2 d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Requirements were not met as evidenced by: A. Based upon interview and record review the facility failed to follow the fall management policy, failed to implement appropriate fall prevention interventions and failed to provide supervision to one of three residents (R1) reviewed for falls. These failures resulted in R1's (4/2/23) fall with laceration(s) to right side of eyebrow requiring two (2) stitches above right eyebrow and six (6) stitches below. R1's (4/19/23) fall with laceration to left side of head requiring two (2) staples. R1's (4/23/23) fall with right forehead contusion and bleeding injury which required sutures. R1's (4/30/23) fall with laceration to upper lip and hematoma to forehead. R1's (6/7/23) fall with laceration to right side of eyebrow requiring seven (7) sutures. Findings include: R1's diagnoses include dementia, generalized muscle weakness, difficulty in walking and history of falling. The (April-June 2023) facility fall log affirms R1	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2023
--	--	--	---

NAME OF PROVIDER OR SUPPLIER PAVILION OF LOGAN SQUARE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2242 NORTH KEDZIE CHICAGO, IL 60647
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 3</p> <p>fell on 4/2/23, 4/19/23, 4/23/23, 4/30/23 and 6/7/23.</p> <p>On 6/17/23, R1 was transferred to the hospital (due to change in condition) and was not in the facility during this survey.</p> <p>R1's (5/25/23) BIMS (Brief Interview Mental Status) affirms cognitive skills for daily decision making are severely impaired.</p> <p>R1's (5/25/23) functional assessment affirms (1 person) physical assist is required for transfer, walking and locomotion off unit. Mobility devices: wheelchair.</p> <p>R1's (5/30/23) cognition care plan states resident scored 3/15 (severe cognitive impairment) on the BIMS assessment.</p> <p>R1's (4/2/23) incident report states staff called for help at dining room. Writer observed resident lying on the floor. Resident noted with two (2) lacerations at right side of the eyebrow. Resident unable to describe occurrence. No witnesses found. R1's (4/2/23) initial reportable incident states resident returned from the hospital (4/3/23) with 2 stitches above right eyebrow and 6 stitches below.</p> <p>R1's (4/19/23) incident report states CNA (Certified Nursing Assistant) called writer for help. Writer observed resident sitting on floor mattress. Laceration observed at the left side of the head. Resident confused unable to describe occurrence. No witnesses found. Incident location: resident's room. R1's (4/19/23) initial reportable incident states resident fell while attempting to walk without the wheelchair. Resident returned from the hospital (4/20/23) with</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/27/2023
NAME OF PROVIDER OR SUPPLIER PAVILION OF LOGAN SQUARE, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 2242 NORTH KEDZIE CHICAGO, IL 60647		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 4</p> <p>2 staples on the left side of the head.</p> <p>R1's (4/23/23) incident report states CNA notify that resident has a little bump on right side of forehead with little bleeding. When I go to his room, resident is seated on floor mat noted with "fresh injury" to forehead. CNA said she noted resident came out from the toilet, he gets up with unsteady gait and poor balance. Resident unable to report how he hit his head. No witnesses found. Incident location: resident's room. R1's (4/23/23) CT (Computed Tomography) includes indication: fall/frontal contusion.</p> <p>R1's (4/30/23) incident report states CNA called for help to resident room. Upon arriving observed resident lying on the floor on his back. Observed resident with small laceration at upper lip. No witnesses found. Transferred resident to hospital for medical evaluation. R1's (4/30/23) history & physical states "He does have a small hematoma to his forehead."</p> <p>R1's (6/7/23) incident report states resident noted sitting on the floor, noted laceration to side of right eyebrow. No witnesses found. Incident location: resident's room. R1's (6/7/23) initial reportable incident states resident admitted to hospital for 24-hour observation with seven (7) sutures on his right-side forehead.</p> <p>R1's (2/24/23) care plan includes risk for falls. Intervention: (4/3/23) PT (Physical Therapy) evaluation and treatment. Remove footrest. (4/19/23) Environment rearranged. (4/23/23) Helmet. (4/30/23) Psychological evaluation and medication review. (6/7/23) Anti-roll back mechanism for wheelchair and non-skid socks when ambulating or mobilizing in wheelchair however frequent rounds, supervision and/or</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/27/2023
NAME OF PROVIDER OR SUPPLIER PAVILION OF LOGAN SQUARE, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 2242 NORTH KEDZIE CHICAGO, IL 60647		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 5</p> <p>room change closer to nursing station are excluded (R1's falls were unwitnessed).</p> <p>V7 (LPN/Licensed Practical Nurse) documented R1's 4/2/23, 4/19/23, and 4/30/23 incident reports.</p> <p>On 6/21/23 at 11:29am, surveyor inquired about R1's cognitive status. V7 (LPN) stated, "He's (R1) confused, definitely there's confusion but he's able to let you know if he's okay with short words. He (R1) just says yes or no." Surveyor inquired about R1's fall prevention interventions. V7 responded, "He (R1) has a low bed, he has a mat to the side of the bed, he has a soft helmet and as soon as he wake up, we put him close to the nurses station to be supervised by staff. We also make rounds continuously." Surveyor inquired how R1 fell four (4) times (in the room) if staff put him close to the Nurse's station as soon as he woke up. V7 refrained from response. Surveyor inquired about R1's (4/2/23) injury .V7 reviewed the documentation and replied, "Staff was telling me that this was open and immediately we had to send him to the hospital because there were 2 cuts on the (right) forehead. He come back from the hospital with stitches. Surveyor inquired about R1's (4/19/23) injury. V7 stated, "That one has the laceration from the left side on the head. He (R1) had 2 staples to the left side." Surveyor inquired about R1's (4/30/23) injury. V7 responded, "The injury was for small laceration on the upper lip." Surveyor inquired if it was appropriate for R1 to reside at the facility. V7 replied, "We have been put all the interventions in place and the precaution to put him close to us but really sometimes when you working they fall."</p> <p>On 6/21/23 at 12:03pm, surveyor inquired about appropriate fall prevention interventions for R1 if</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/27/2023
NAME OF PROVIDER OR SUPPLIER PAVILION OF LOGAN SQUARE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 2242 NORTH KEDZIE CHICAGO, IL 60647		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S9999	Continued From page 6 his falls were unwitnessed. V2 (Director of Nursing) stated, "In the room, there was no supervision when he (R1) fell. We try to keep him (R1) monitored or at least do more frequent rounds with him when he's in the room." Surveyor inquired if R1's fall care plan includes moving resident closer to the nurse's station, frequent rounds and/or supervision. V2 affirmed, it does not. Surveyor inquired about R1's (4/23/23) injury. V2 responded, "Resident (R1) has a laceration on the right forehead. I believe he (R1) came back with sutures." Surveyor inquired about R1's (6/7/23) injury. V2 replied, "I saw that he had a small laceration on the right eyebrow, it opened again. They put sutures on that one." Surveyor inquired how R1 sustained (6/7/23) laceration (requiring 7 sutures) if a helmet was supposed to be implemented on or about 4/23/23. V2 stated, "It's literally up to here (pointing at mid forehead) but every time that he (R1) fall (pause) he is tall, the body fall on the mattress, but the head hit the floor." Surveyor inquired if it's appropriate for R1 to reside in the facility. V2 stated, "When it comes to his diagnosis yes, he does have dementia and he does have seizures he just gets very confused. We will have to review if social services should be looking for a place for him that could do more with him or maybe have a dementia unit." On 6/26/23 at 3:04pm, surveyor inquired about potential harm to R1 (or other residents) post sustaining multiple unwitnessed falls. V13 (Medical Director) stated, "It's not good when they (residents) keep falling but the thing is the patient (R1) is not very cooperative and he (R1) has a low bed. It can be some harm definitely, hopefully they (residents) are being watched all the time so we (staff) can prevent injury." Surveyor inquired about potential injury post falls.	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/27/2023
NAME OF PROVIDER OR SUPPLIER PAVILION OF LOGAN SQUARE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 2242 NORTH KEDZIE CHICAGO, IL 60647		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S9999	<p>Continued From page 7</p> <p>V13 replied, "To my knowledge its mostly laceration."</p> <p>The fall management policy (revised 5/2015) states staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. As a fall occurs the Nurse on duty will initiate a new intervention to prevent further falls. The plan of care will be updated at this time. The revisions to the fall of care will be monitored for effectiveness and adjustments made as needed.</p> <p>B. Based upon record review and interview the facility failed to document a descriptive summary (post fall) including resident injury and/or repair in the progress notes and failed to report incident(s) resulting in serious injury to IDPH (Illinois Department of Public Health) for one of three residents (R1) reviewed for falls.</p> <p>Findings include:</p> <p>R1's (4/23/23) incident report states CNA (Certified Nursing Assistant) notify that resident has a little bump on right side of forehead with little bleeding. When I go to his room resident be seat over floor mat noted with "fresh injury" to forehead. R1's (4/23/23) CT (Computed Tomography) includes indication: fall/frontal contusion. [R1's progress notes exclude documentation of actual injury which was bleeding and/or repair of the injury].</p> <p>R1's (4/30/23) incident report states CNA called for help to resident room. Upon arriving observed resident lying on the floor on his back. Observed resident with small laceration at upper lip. R1's (4/30/23) history & physical states "He does have</p>	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2023
--	--	--	---

NAME OF PROVIDER OR SUPPLIER PAVILION OF LOGAN SQUARE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2242 NORTH KEDZIE CHICAGO, IL 60647
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 8</p> <p>a small hematoma to his forehead." [R1's progress notes exclude laceration repair and/or hematoma].</p> <p>R1's (4/23/23) and (4/30/23) incident investigations and transmittals to IDPH were requested however not received during this survey.</p> <p>On 6/21/23 at 11:29am, surveyor inquired about R1's (4/30/23) injury. V7 (Licensed Practical Nurse) responded, "The injury was for small laceration on the upper lip."</p> <p>On 6/21/23 at 12:03pm, surveyor inquired about the regulatory requirement for reportable incidents. V2 (Director of Nursing) stated, "If there's a fall that I'm reporting I have up to 24 hours to report if there's any injury to IDPH. I do an initial investigation and send the report. Within 5 days were sending a final report to IDPH with any outcomes." Surveyor inquired about the regulatory requirement for incident documentation. V2 responded, "We document the resident condition." Surveyor inquired about R1's (4/23/23) injury. V2 responded, "Resident (R1) has a laceration on the right forehead. I believe he (R1) came back with sutures." Surveyor inquired about R1's (4/23/23) reportable incident investigation and transmittals. V2 replied, "That one was done by the night shift supervisor and I'm still looking for that one." Surveyor inquired about R1's (4/30/23) reportable incident. V2 stated, "That one wasn't a reportable, for that one it was nothing. It wasn't actually a laceration it was that he bit his lip. I don't think that we have any reportable for 4/30." [V7's documentation and statement affirms R1 sustained a laceration].</p> <p>The falls management policy (revised 5/2015)</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2023
NAME OF PROVIDER OR SUPPLIER PAVILION OF LOGAN SQUARE, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 2242 NORTH KEDZIE CHICAGO, IL 60647		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 9 states the Illinois Department of Public Health must be notified of any accident/incident that results in physical harm or injury as soon as possible within 24 hours of the occurrence. A narrative summary of the reportable occurrence will be sent to the department within five (5) working days of the occurrence. Documentation will support the monitoring, findings and actions taken. (B) 2 of 2 Licensure Violations 300.1210b) 300.1210d)3 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PAVILION OF LOGAN SQUARE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2242 NORTH KEDZIE CHICAGO, IL 60647
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 10</p> <p>further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Requirements were not met as evidenced by:</p> <p>Based upon observation, interview and record review the facility failed to provide nursing care to (R6), failed to follow the abuse prevention program and failed to ensure that one of six residents (R3) in the sample remained free from abuse. R3 sustained (6/18/23) dislocated shoulder and affirmed that staff caused the injury.</p> <p>Findings include:</p> <p>On (6/20/23) IDPH (Illinois Department of Public Health) received allegations that on 6/18/23, R3's shoulder was dislocated by an unknown staff.</p> <p>R3's diagnoses include dementia without behavioral disturbance.</p> <p>R3's (5/8/23) BIMS (Brief Interview Mental Status) determined a score of 6 (severe impairment).</p> <p>R3's (5/8/23) functional assessment affirms (1 person) physical assist is required for bed mobility/locomotion. (2 persons) physical assist is required for transfers.</p> <p>On 6/20/23 at 1:26pm, surveyor inquired about R3's dislocated shoulder. V4 (Family) stated, "I</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2023
NAME OF PROVIDER OR SUPPLIER PAVILION OF LOGAN SQUARE, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 2242 NORTH KEDZIE CHICAGO, IL 60647	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
S9999	<p>Continued From page 11</p> <p>went to see him (R3) last Sunday (6/18/23) and as soon as I (V4) got off the elevator, I heard him (R3) yelling. When I (V4) went to the room there were 2 staff members in there, my dad (R3) said they hurt me and pointed at one of them (staff). I (V4) asked the guy (staff) did you do something to him (R3)? He (staff) said, I didn't touch him. My dad (R3) tells me, I can't even move my arm it hurts so bad. He (R3) was yelling, he was hurting when the guy (staff) moved his (R3) arm. I told the Nurse and all she did was give him (R3) Tylenol. He (R3) fell asleep, and I (V4) left. My brother (V11) went there (facility) a few hours later and said it doesn't even look like his (R3) shoulder was even, so he (V11) asked for him (R3) to be sent to the hospital. I called the facility, and they (staff) told me his (R3) shoulder was dislocated."</p> <p>R3's progress notes include (6/18/23) 5:00pm, resident visited by son (V11) with POA (Power of Attorney) on the phone, stated, the resident's (R3) right shoulder seemed injured and requested that the resident be sent to ER (Emergency Room) for further evaluation. AROM (Active Range of Motion) assessed, resident incapable to move RUE (Right Upper Extremity). (6/19/23) Resident shoulder was dislocated and was placed back in hospital.</p> <p>On 6/20/23 at 2:08pm, R3 affirmed he speaks Spanish, therefore V5 (Certified Nursing Assistant) translated the conversation for R3. R3 responded appropriately during interview. Surveyor inquired about R3's dislocated shoulder. V5 stated, "He (R3) says, somebody (staff) dislocated it, the black man. He (R3) says, he (staff) just held him from the arm and twisted it to one side."</p>	S9999	

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2023
NAME OF PROVIDER OR SUPPLIER PAVILION OF LOGAN SQUARE, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 2242 NORTH KEDZIE CHICAGO, IL 60647		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 12 On 6/20/23 at 2:29pm, surveyor inquired about R3's dislocated shoulder. V2 (DON/Director of Nursing) stated, "He (R3) did have a fall a week and a half, almost two weeks ago. When he (R3) did have the fall we sent him to the hospital, but he was not complaining about increased pain on the shoulder, they (hospital) only check if he hit his head or whatever. They (staff) sent him (to the hospital) Sunday night (6/18/23) because of increase pain in the shoulder." Surveyor advised, R3 stated staff dislocated his shoulder. V2 responded, "This is my first time I (V2) heard this. Yesterday (6/19/23) that was not the case when I (V2) assess him (R3). He (R3) tries to get up on his own and tried to do things on his own" then alleged that R3's dislocated shoulder was likely related to 6/6/23 fall (which occurred 12 days prior to injury) because he was taking pain medication. On 6/21/23 at 2:45pm, surveyor inquired about R3's (6/18/23) injury. V1 (Administrator) stated, "We contributed it to his previous fall. When you (surveyor) interviewed him (R3) he was saying that someone twisted his arm." Surveyor inquired if staff were suspended. V2 responded, "(V10 CNA/Certified Nursing Assistant) who was the CNA on Sunday was suspended yesterday (2 days after the injury). (R3) keeps going in his room and they (staff) try to keep him (R3) out of the room because he falls. I talked to (V10) to see if he (V10) touched R3 or he held him back with any type of force when transferring him. He (V10) said many times he (V10) would just put his arms out to like help him (R3) do a pivot transfer [R3 requires 2 persons assist with transfers] and he didn't complain of pain. He (V10) put the brakes on his (R3) chair, so he (R3) was holding on to the bed, and held onto it. I (V10) left him (R3) because he (R3) just keeps screaming and I	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PAVILION OF LOGAN SQUARE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2242 NORTH KEDZIE CHICAGO, IL 60647
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 13</p> <p>(V10) don't want to have any concerns with him (R3)." Surveyor inquired why R3's injury (of unknown origin) was not considered abuse. V1 replied, "First we didn't know it was a dislocation, when I talked with (V2) she thought he (R3) fell recently and maybe it occurred at that time because he was requesting pain medication."</p> <p>R3's (6/6/23) incident report states resident was noted in the bathroom sitting on his buttock. Head to toe assessment perform with no visual injuries. Level of pain is blank.</p> <p>R3's (June 2023) Medication Administration Record affirms Tylenol was only documented on 6/9/23 for pain rated "3." R3's pain level was rated "0" (6/14/23 through 6/17/23) however on (6/18/23) R3's pain was rated "7" therefore likely not related to (6/6/23) fall.</p> <p>On 6/26/23 at 3:07pm, surveyor inquired about potential harm to other residents if an injury of unknown origin (allegedly caused by staff) is not addressed immediately. V1 replied, "I seriously doubt that staff are hurting any resident. They (staff) should notify the attending and find out what they (physician) want to do and what course they want to take. The DON and the Nurses they always watch the patient and what's going on. If somebody's hurting residents let em go. We definitely need to do more watching just to see if anything of that nature happens so we can take action."</p> <p>R6's diagnoses include dementia and encounter for palliative care.</p> <p>R6's (5/3/23) BIMS affirms resident is rarely/never understood.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2023
NAME OF PROVIDER OR SUPPLIER PAVILION OF LOGAN SQUARE, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 2242 NORTH KEDZIE CHICAGO, IL 60647		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 14</p> <p>R6's (5/10/23) care plan states resident has potential for abuse or neglect related to poor communication. Intervention: treat with dignity and respect.</p> <p>On 6/20/23 at approximately 2:15pm, R6 stated "I don't feel well" while surveyor was interviewing R3 (roommate). Surveyor immediately approached the Nurse's station and reported to V6 (Registered Nurse) that R6 was not feeling well. V6 subsequently entered R6's room and advised that R6's Nurse was currently off the floor. V6 then exited the room without inquiring why R6 was not feeling well, obtaining vital signs and/or offering any intervention.</p> <p>On 6/20/23 at 2:28pm, V2 (Director of Nursing) entered R6's room (as requested). Surveyor stated, R6 was not feeling well and V6 was made aware, however V6 neglected to address R6's concern. V2 advised she would look into it however also neglected to assess R6 at this time.</p> <p>R6's progress notes exclude (6/20/23) documentation.</p> <p>R6's physician order sheets exclude (6/20/23) orders.</p> <p>R6's (6/20/23) medication administration record affirms PRN (as needed) medications (Bisacodyl suppository, Lorazepam, Morphine, and/or Tylenol) were not administered.</p> <p>The (10/2022) abuse prevention program states in part this facility affirms the right of our residents to be free from abuse, neglect, deprivation of goods and services by staff or mistreatment. This will be done by: identifying occurrences and patterns of potential mistreatment. Identifying</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/27/2023
NAME OF PROVIDER OR SUPPLIER PAVILION OF LOGAN SQUARE, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 2242 NORTH KEDZIE CHICAGO, IL 60647		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 15 concerns of residents' allegation of deprivation of goods and services by staff. Immediately protecting residents involved in identified reports of possible abuse, neglect, and mistreatment The facility will take steps to prevent potential abuse while the investigation is underway. Employees of this facility who have been accused of abuse, neglect or mistreatment of resident will be removed from resident contact immediately. (B)	S9999		