Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **0057547**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/27/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION ON MAIN STREET, THE	**515 NORTH MAIN , SANDWICH, Illinois, 60548**

(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) COMPLETION DATE
S0000	Initial Comments Annual Licensure Health Survey	S0000		09/23/2025
S9999	Final Observations Statement of Licensure Violations (1 of 2): 300.610a) 300.1210b) 300.1210c) 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. 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.	S9999		09/23/2025

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

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S9999	Continued from page 1 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: Based on observation, interview and record review the facility failed to safely handle a resident to prevent multiple skin tears. This failure resulted in R92 being transferred to the emergency room (ER) after a transfer which contributed to R92 sustaining a large skin tear requiring 11 stitches/sutures. This applies to 1 of 23 residents (R92) reviewed for safety in the sample of 23. R92's progress notes dated 8/23/25 shows, "Resident noted with a skin injury to the left lower leg. The incident occurred during transfer from the wheelchair to the bed, the CNA (certified nursing assistant) reported…. MD (V21 R92's medical doctor (MD)) is informed with order to transfer resident to ER…." R92's skin tear report dated 8/23/25 shows, "Informed by the CNA (V20) that while providing care noted blood stain on sock and when sock was removed noted wound to left lower leg. Blood was new…." R92's progress note dated 8/24/25 shows, "Resident returned from ER at approximately 00:15 (12:15 AM) with daughter (V19) and EMS (emergency medical system). Resident received 11 sutures (stitches) to left lower leg. Bandage clean, dry and intact. Resident leg elevated on pillow. Vitals stable upon return, no pain upon arrival, but will give Tylenol as scheduled. New order for Clindamycin (antibiotic) 300mg (milligram) capsule 3 times per day for 7 days. Bacitracin (antibiotic) twice a day to left leg laceration. 10-14 days for suture (stitches) removal…."	S9999		

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S9999	Continued from page 2 R92's emergency room after visit summary dated 8/23/25 shows, "Reason for visit: wound check, Diagnosis: laceration of shin…." On 8/26/25 at 3/16 PM, V19 R92's daughter stated, V21 Registered Nurse (RN) called her over the weekend and said, V20 CNA was putting her to bed and bumped her leg. V19 said, "Looked like more than a bump to me. It required 11 stitches. They called it a skin tear. She has had a lot of skin tears since she has been at the facility but this one required stitches". V19 said she rode with her to the ER. V19 was worried about her mom and what the facility was going to do to prevent these skin tears from happening. V19 said, "They need to be more gentle with her (R92)". On 8/26/25 at 2:18 PM, V18 RN stated, he told V20 CNA to put R92 to bed and then V20 CNA came back and told V18 that R92 had a skin tear. V18 said he went to the room and saw the wound on R92's leg. V18 asked V20 CNA what happened. V20 CNA told V18 RN that V20 transferred R92 to bed and tried to undress her when he noticed the wound. The blood was fresh, and he believed it happened during the transfer. V18 called V21, R92's medical doctor (MD) and reported what happened. V21 R92's MD sent R92 to the hospital for stitches/sutures. On 8/26/25 at 3:07 PM, V20 CNA stated, V20 transferred R92 to bed on 8/23/25. V20 noticed her socks had a "red splotch" on it. V20 pulled the sock down and saw the wound. V20 said, once he saw the wound he got the nurse. V20 said he didn't know what happened. On 8/27/25 at 10:48 AM, V21 R92's MD stated R92 sustained an injury during transfer. V21 felt it was a pretty significant skin tear and sent R92 to the ER. On 8/26/25 at 2:17 PM, V3 wound care nurse was changing R92's dressing to her left shin/leg. There was a red/purple baseball (approximately) size wound that had approximately 10 (some appeared to be double) stitches. V3 stated she received the wound during a transfer over the weekend. R92's wound assessment details report dated 8/25/25 shows, active skin tear type 2: partial flap loss, facility acquired, measuring 5.00 cm (centimeters) X 1.50 cm X 0.10 cm. R92's skin tear report dated 6/18/25 shows, "This writer was notified by CNA that the resident had obtained a skin tear to the right elbow while assisting the resident with a boost in her wheelchair."	S9999		

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S9999	Continued from page 3 R92's skin tear report dated 6/24/25 shows, "During transfer from the w/c (wheelchair) to the bed, CNAs noted a blood on the pad. Resident is noted with skin tear to the left elbow…." R92's skin tear report dated 7/17/25 shows, "At the time of the incident, resident was being repositioned in her wheelchair. Resident stated she hit her leg. Notes: …. Resident observed sliding while sitting in her chair. During repositioning, resident stated, "I hit my leg on my wheelchair". Skin tear noted to the posterior (back) left leg…" R92's care plan date initiated 6/3/25 shows, "The resident has an actual impairment to skin integrity: 6/3/25-laceration to left elbow, 6/4/25- left lateral elbow, 6/11/25- abrasion to left mid-upper back, 6/18/25- rt (right) elbow skin tear, 6/24/25- left elbow skin tear, 6/25/25- right elbow skin tear, 7/17/25- left posterior skin tear, 8/1/25- bruise to right forearm, wrist ad hand, 8/12/25- skin tear right elbow…." R92's care plan date initiated 8/25/25 shows, "R92 has a laceration to her left lower leg. She is taking Clindamycin and bacitracin to prevent infection. Interventions: Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces." R92's care plan date initiated 5/7/25 shows, "The resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) activity intolerance, dementia. Interventions: Sit to stand: dependent, 2 assist." The facility's resident transfers and safety devices policy dated 10/2017 shows, "Policy: All residents are assessed at time of admission for transfer ability. Residents who are unable to transfer themselves independently or with minimum assistance shall be transferred following the principles of this policy to allow for maximum safety during resident transfer. Transfers shall always be conducted following the principles of proper body mechanics, and safety…." (B) 2 of 2: 300.610a) 300.1210b)	S9999		

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S9999	Continued from page 4 300.1210c) 300.3210t) 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. 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to ensure dietary recommendations were implemented for residents with a history of significant	S9999		

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S9999	Continued from page 5 weight loss. This failure resulted in R43 and R93 not receiving their therapeutic diets as ordered for their severe weight loss. This applies to 2 of 9 residents (R43, R93) reviewed for weight loss in the sample of 23. On 8/25/25 at 10:32 AM, V5 Dietary Manager added 21 cooked, individual chicken nuggets into the facility's food processor. V5 stated, she was making puree for 11 residents. V5 stated, regular diets will get 5 chicken nuggets per person. (There should have been 55 nuggets pureed for 11 pureed diets but only pureed half of the amount she should have). The spreadsheet for the noon meal on 8/25/25 shows, regular diets should get 5 chicken nuggets to equal 2 ounces of protein per person. 1. R43's face sheet lists his diagnoses to include: toxic encephalopathy, dysphagia and dementia. R43's meal ticket shows, pureed diet with double portions on every tray. On 8/25/25 at 11:51 AM, R43 was eating the lunch. He was eating a regular pureed diet. He did not have double portions. On 8/26/25 at 8:28 AM, R43 was eating breakfast. He had a regular pureed diet. He did not have double portions. On 8/26/25 at 11:49 AM, R43 was eating lunch. He had a regular pureed diet. He did not have double portions. On 8/26/25 at 1:26 PM, V8 Registered Dietitian (RD) stated, R43 had a significant weight loss in one week when he went out to the hospital. R43 has continued to lose weight. V8 saw R43 last week and recommended larger portions. V8 clarified that meant double portions. V8 stated she put that on R43's meal ticket. V8 stated, "They should be following the meal ticket and providing double portions". R43's progress notes from V8 RD dated 8/4/25 state, "Nutrition note due to significant weight loss: Observed R43 during meal service this morning- he was feeding himself and appeared to be eating well. Noticed some coughing. He continues to receive a general/pureed diet with thin liq's (liquids). He feeds himself with set-up or requires assistance with meals. Supplements: House supplements- 120 ml (milliliters) TID (three times per day). PO (by mouth) intake has been 50-100% at meals since readmission per nsg (nursing) documentation. Weight 146.4 # (pounds)- decreased from	S9999		

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S9999	Continued from page 6 148# upon readmission from hospital and significantly by 9.6% in the past month from 162# on 7/1 (7/1/25). His weight has decreased by 11.8% in 3 months form 166# on 5/16 (5/16/25) and by 10.6% in 4 months from 163.8# on 4/23 (4/23/25). Current BMI (body mass index): 21.0- low for his age. He is not currently taking diuretics…. Labs do not suggest hydration imbalance. Will arrange for him to receive larger portions to prevent further weight loss and monitor via nutrition at risk team." R43's care plan date initiated 8/5/25 shows, "Focus: R43 has had a significant weight loss. Weight: 146.4# on 8/1-decreased from 148# upon readmission from hospital and significantly by 9.6% in the past month from 162# on 7/1. His weight has decreased by 11.8% in 3 months from 166# on 5/16 and by 10.6% in 4 months from 163.8# on 4/23. He continues to receive a general/pureed diet with thin liq's. He feeds himself with set-up or requires assistance with meals. Interventions: 8/4/25 Increase portions for him at meals to prevent further weight loss…." 2. R93's face sheet lists his diagnoses to include: major depressive disorder, complete loss of teeth, alcohol use & gastro-esophageal reflux disease. R93's meal ticket shows, pureed diet with super cereal X2 in the morning, double portions of all food and ice cream for lunch and dinner. On 8/25/25 at 11:51 AM, R93 was eating lunch. He had a general pureed diet. He did not have double portions or ice cream. On 8/26/25 at 9:29 AM, R93 was eating breakfast. He did not have 2 bowls of super cereal or double portions. On 8/26/25 at 11:49 AM, R93 was eating lunch. He did not have double portions or ice cream. On 8/26/25 at 1:15 PM, V8 RD stated, interventions they have in place for R93's weight loss is double portions at every meal, 2 bowls of super cereal at breakfast and ice cream. V8 stated, "They need to be following the recommendations to meet the nutritional needs of the residents". R93's progress notes from V8 RD dated 8/4/25 shows, "Nutrition noted due to significant weight loss: Saw R93 this morning during meal rounds and he had eaten 100% of this meal (double portions). R93's weight decreased significantly by 11.2% in 6 mo from 114# on 2/3 to 101.2# on 8/2. Current BMI: 14.9- severely underweight. He continued to receive a general/pureed	S9999		

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S9999	Continued from page 7 diet with double portions and thin liquids. He feeds himself with supervision and set-up. Supplements: super cereal with breakfast and 120 ml supplements with every meal. PO intake has been 76-100% at most meals recently per nsg documentation…. Family has been notified of significant weight loss and have decline when TF (tube feeding) was discussed. Will continue to monitor nutritional parameters follow up as needed." R93's care plan date initiated 3/18/2024 shows, "Focus: R93's weight decreased significantly by 11.2% in 6 mo. from 114# on 2/3 to 101.2# on 8/2. He continues to receive a general/pureed diet with double portions and thin liquids. He feeds himself with supervision and set-up. Supplements: super cereal with breakfast and 120 ml supplements with every meal. Interventions: Give resident supplements as ordered…." The facility's weight management policy dated 9/2019 shows, "Policy: It is a policy of this facility that each resident will be provided with sufficient food intake to maintain proper nutrition and health…. Procedure: …Significant weight changes are defined as a gain or loss of: 5% in one month, 7.5% in 3 months, 10% in 6 months, gradual or insidious unwanted weight loss/gain. These residents shall be referred to the registered dietitian/diet tech for assessment of nutritional status. Appropriate dietary recommendations shall be made as indicated…." (B)	S9999		