| 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 09/18/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PAVILION ON MAIN STREET, THE | 515 NORTH MAIN , SANDWICH, Illinois, 60548 |

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| S0000 | Initial Comments<br><br>Facility Reported Incident of 9/2/25 - 2610280 | S0000 | | 09/26/2025 |
| S9999 | Final Observations<br><br>Statement of Licensure Violation:<br><br>300.610a)<br><br>300.1210b)<br><br>300.1210d)6)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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.<br><br>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be | S9999 | | 09/26/2025 |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| S9999 | Continued from page 1<br>practiced on a 24-hour, seven-day-a-week basis:<br><br>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.<br><br>These requirements were not met as evidenced by:<br><br>Based on observation, interview, and record review, the facility failed to ensure a bed rail was maintained in a safe manner for 1 of 3 residents (R1) reviewed for resident injury in the sample of 9. This failure resulted in R1 receiving an injury to her right lateral leg, being sent to a local hospital where she received stitches for her injury.<br><br>The findings include:<br><br>R1's Admission Record, printed by the facility on 9/16/2025, showed she had diagnoses including, but not limited to, displaced comminuted fracture of shaft of humerus left arm (5/6/25), moderate protein-calorie malnutrition, difficulty in walking, reduced mobility, lack of coordination, pain in left should and left elbow, disorders of muscle, dysphagia, unsteadiness on feet, need for assist with personal care, age-related osteoporosis , repeated falls, hypertension, muscle spasm, history of healed stress fracture, dementia, glaucoma, weakness, abnormal gait and mobility, and malignant neoplasm of skin.<br><br>R1's facility assessment dated 8/12/2025 showed she had severe cognitive impairment. The assessment showed R1 had no verbal behaviors or physical behaviors (i.e., hitting, kicking, pushing, or grabbing others) towards others during the look back period of the assessment. The assessment also showed R1 required substantial to maximal assist for toileting, bathing, upper and lower body dressing, putting shoes on/off, personal hygiene, rolling side to side in bed, going from lying to sitting position, and sitting to lying position. The assessment showed R1 was dependent on staff for all transfers.<br><br>On 9/16/2025 at 8:55 AM, R1 was sitting at a table with three other females after the breakfast meal. R1 was alert and smiling at staff. | S9999 | | |

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| S9999 | Continued from page 2<br>On 9/16/2025 at 9:20 AM, V4 (Registered Nurse-RN) said he was working the day R1 was sent out to the hospital (9/2/2025). V4 said the 9/2/2025 incident was the second time R1 went out recently to the hospital for stitches on her legs. V4 said the first incident happened in August 2025. V4 said R1 had a wound on her left leg time, was sent to the hospital and got 11 stitches to her left leg. V4 said he does not know what caused the injury to R1's left leg. He said interventions were to reinforce 2 staff assist with care and transfers and put protective sleeves on her to protect her arms. V4 said the most recent incident on 9/2/2025, R1 got a wound to her right leg. The CNA was V5 and the nurse on duty when it occurred was V6 (LPN-agency nurse). V4 said he was just starting his shift. He went down to see R1's leg on 9/2/25 before the ambulance arrived. V4 said V6 had already wrapped it, so he removed the bandage to see the wound.<br><br>On 9/16/2025 at 9:31 AM, V5 (CNA) said she had just come back from a long medical leave and had only worked a few days since returning to work. V5 said it was her first time taking care of R1. V5 said R1 is fearful. V5 said, "She is afraid she is going to fall. She was holding onto the side rail real tight. I was going to get her up and clean her up while she was on the toilet. I took her boots off. I came around to the right side of R1. I put the ½ side rail up. I was putting her gait belt on her, and she waved her hand and said, "Leave me alone". She was scared. I put one arm behind her and one under her legs. I turned her to sit her up on the side of her bed. When I got her sat up on the side of the bed, she stopped, looked at me and said, "My leg hurts". I looked down and there was a lot of blood. I informed the agency nurse (V6). The nurse wrapped R1's wound and called an ambulance to have R1 sent out". V5 said after they looked at the side rail it did not have the little stoppers on the ends. V5 said, "They had to pad the rails. Without the stoppers it is sharp. She was a little combative and did not want to get up, but I don't recall saying she was kicking. She moved one arm to say leave me alone and the other hand was holding onto the railing. It was literally only a couple minutes". At 9:48 AM, this surveyor went with V5 to look at R1's bed. V5 demonstrated how after she put a gait belt on R1, she put one hand behind her and put the other hand under her legs to turn R1. V5 said as soon as she brought R1's legs around to the side of the bed, R1 stopped talking, looked at V5 and said, "My leg hurts." V5 said she looked down and saw a puddle of blood on the floor, so she laid R1 back down, placed her leg on a pillow, grabbed something to wipe the floor really quick so no one slipped on it, and then hurried to get the nurse. | S9999 | | |

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| S9999 | Continued from page 3<br>V5 said maintenance padded the rail and the bed frame after the incident.<br><br>On 9/16/2025 at 9:51 AM, V8 (Maintenance Director) was on the hall R1 resides looking down at a sheet of paper. V8 said he was looking at the list showing rooms had side rails with no end caps on them when they did a building wide sweep to check all the side rails. V8 said there were several siderails didn't have the caps on. Eight on the 2nd floor and 15 on the 1st floor were missing the end caps on the side rails. V8 said he was double- checking all of them and would provide the list when done. V8 was asked to come to R1's room to remove the tape and pool noodle so this surveyor could see the end of side rail. Observed the end cap on the side rail at time. The metal bars on the end of the side rail were rough where the caps met the metal. V8 said he put end caps on after R1's incident and padded the rail and bed frame.<br><br>On 9/16/2025 at 10:28 AM, V7 (Licensed Practical Nurse-LPN) said R1 can be very verbal at times with staff. Her skin is like paper. V7 said R1 had a history of skin tears.<br><br>On 9/16/2025 at 11:06 AM, R1 was taken to her room for wound care. R1 said she does not remember how her injury happened. R1 said she thinks it is getting better. R1 was transferred from her wheelchair to her bed by V22 (certified occupational therapist-COTA) and V23 (Certified Nursing Assistant-CNA). R1 complained of back pain after sitting down on the side of the bed. Staff said they would let the nurse know. R1's right leg was right by the end of the railing where it was now padded and covered with black tape. V9 (Wound Nurse) did the dressing changes for R1. V9 said R1's staples were removed last week. V9 said we steri-stripped it, and it looks really good. R1 had an area on her right lateral leg was secured with multiple steri-strips. The area was curved (u-shaped). After completing the right leg dressing change. V9 removed the dressing from the left lower leg (shin area). R1 had a large, reddened area on the left leg with an opened area inside the red area. V9 said R1 had a laceration on area prior to getting the laceration on the right leg. V9 said the day before R1 got the laceration to her right leg, she was started on an antibiotic due to an infection in the left leg wound. During the wound care resident was alert and pleasant. No resistance to care observed. After wound care, resident was transferred back to her wheelchair and taken back to the dining room/activity area.<br><br>On 9/16/2025 4:02 PM, V6 (Agency staff-LPN) said she | S9999 | | |

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| S9999 | Continued from page 4<br>worked 9/1/2025 on the overnight shift. V6 said at the end of her shift, the morning of 9/2/2025 an aide came to her and said she needed me to come with to R1's room. The aide said R1 had fluid coming from her leg. V6 said, "I asked the aide what kind of fluid. She said blood". V6 said R1 was in her bed when she got to her room. Blood was on the sheet and a pillow. V6 said, "The laceration was deep. I asked what happened and the aide said she did not know. It was a big gash". V6 said she told V4 (RN) oncoming nurse R1 needs to be sent out. He said call the doctor, family, and 911. R1 was sent to the hospital. V6 said V5 (CNA) did not say anything about R1 kicking or being resistant. V6 said, "When I went in the resident did not seem upset or resistive". V6 said V5 said she was getting R1 up and noticed fluid coming out of leg.<br><br>On 9/17/2025 at 2:10 PM, V5 CNA said V1 (Administrator) and V3 (Regional VP of Clinical Operations) met with her right after she talked with this surveyor the previous day. V5 said they asked her what this surveyor was talking with her about, then they handed her a paper and said we forgot to have you sign the statement about what happened with R1's incident. V5 said she started reading it and was told to just sign it. V5 said she told them she was going to read it first. V5 said she told them she did not recall saying anything about R1 kicking. V5 said V1 and V3 said "You did, just sign it." V5 said she told them R1 was not kicking, she just waved her hand and told me to go away because she did not want to get up. V5 said she felt pressured into signing the form and just signed it. V5 said as soon as she did, she regretted it, and wished she had not signed the statement.<br><br>On 9/17/2025 at 2:57 PM, V2 (Director of Nursing-DON) said they determined something happened with the metal on the bed caused R1's injury. V2 said that is why her bed got padded. V2 said she expects staff to report any equipment might cause a safety issue for residents, and to take the equipment out of service until it can be repaired.<br><br>On 9/18/2025 at 12:56 PM, V19 (R1's Physician/facility's Medical Director) said R1 is a very fragile individual. V19 said, "She (R1) doesn't just get skin tears; she has skin explosions". V19 said there were not many days between the 9/2/2025 incident, and the one before. V19 said he would expect the facility staff to make sure the equipment used is smooth with no rough edges.<br><br>The facility's investigation and QAPI plan for R1's 9/2/2025 incident showed R1 was sent to the hospital | S9999 | | |

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| S9999 | Continued from page 5<br>for a laceration to her right leg occurred while sitting the resident up on the side of her bed. R1 returned to the facility with 20 sutures. The list V8 had been going over showing side rails in which there were no end caps, or the end caps needed to be replaced showed over 20 side rails either did not have end caps, or they needed to be replaced. The facility's investigation file had staff interviews in it. V5's interview statement showed V5 said R1 was resistant and kicking her legs. V5's statement had a date up at the top of the form dated 9/2/2025. (These interviews were not provided to this surveyor until after V5 was interviewed by this surveyor).<br><br>The facility's list of residents with wounds, provided on 9/16/2025 showed R1 has had 7 skin tears in the last three months.<br><br>The facility's 9/16/2025 Wound Report for non-pressure wounds showed R1 had two active wounds as of 9/16/2025. One to her left lower leg in the front, from a previous incident on 8/25/2025 (facility was cited for this on annual survey), and one to her right lateral lower extremity measured 4.5 centimeters (cm) in length x 6.5 cm width.<br><br>R1's Wound Assessment Details Report dated 9/11/2025 showed R1 sustained a laceration and was sent to the emergency room (ER). Staples dry and intact to site Resident with mild episodic pain to site.<br><br>R1's 9/2/2025 notes from a local hospital showed "New laceration of right lower extremity status post suture repair today.<br><br>The facility's undated policy and procedure titled Supplies and Equipment, Environmental Services showed Equipment shall be monitored for good working condition or any needed repairs. (B) | S9999 | | |