STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145792	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion of Logan Square, The	2242 North Kedzie Chicago, IL 60647

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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 15301 Based on interviews and record reviews, facility failed to follow their policy to investigate an allegation of abuse for one of three residents (R2) reviewed for abuse in the sample of six. Findings include: 11/12/2024, at 11:31 AM via telephone, V3 (Emergency Department Physician) said R2 has a known fall risk history. Injury allegedly occurred during resident care at the facility; resident rolled out of bed onto floor. V3 said per facility, R2 was already in a low bed. V3 said R2's injuries were consistent with being punched in the face, not fall from low bed. V3 added R2's eyelid laceration was too complex (involved tear duct, resident crying bloody tears) to be treated at original hospital, R2 was transferred to another local hospital for laceration repair. 11/13/2024, at 11:02 AM, V5 (Certified Nursing Assistant) via telephone, said I helped V7 (Certified Nursing Assistant) transfer R2 from shower chair to bed using a gait belt. I asked V7 if she needed help with R2, V7 said no, I left the room. 11/13/2024, at 11:34 AM, V7 (Certified Nursing Assistant) said I gave R2 his shower the day he fell out of bed. V5 (Certified Nursing Assistant) helped me transfer R2 from the shower chair back to bed using a gait belt. We stood him up, turned him and someone grabbed his legs and we put him in bed, V5 left the room. V7 said I went to the window side of the bed, and rolled R2 towards me. Then, I reached over to pull the diaper out from under R2; R2 rolled towards me onto the floor, I think he hit his head on the nightstand. V7 said the bed was at working height for me, about waist high. V7 said R2 can't move from side to side. 11/13/2024, at 2:22 PM V1 (Administrator) said, V5 and V7 showered R2 the day he fell out of bed. V5 left the room, V7 was trying to put R2's brief on, he was on the floor so fast. V1 said I told her (V7) she had to go home so that I could complete an investigation, it's part of our protocol. V1 did not say what protocol was followed when asked. V1 said I spoke to V5, she said she helped V7 transfer R2 to his bed then left. V1 continued, I spoke with the nurse, she said he was on the floor on the mat near the window, lacerations to side of eye and above eyebrow. V1 said I interviewed staff on unit, they were not witnesses to the incident. V7 was alone in the room by herself. The bed was raised to provide care. I went over the incident with V7. We did the reportable (for fall with injury). We did not do a reportable for abuse, we knew it was a fall. V1 added, we brought her (V7) back, did some re-education about bed mobility. (continued on next page)

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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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V1's (Administrator) Witness Statement documents in part: 10/28/2024 Administrator spoke to (R2's) son and went over the interventions and how the incident happened. Also spoke about hospital('s) allegation of abuse. Facility's Abuse Prevention Program (10/2022) documents in part: Policy This Pavilion facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This will be done by implementing systems to promptly and aggressively investigate all reports and allegation of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making the necessary changes to prevent future occurrences. VII. Internal Investigation: Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of property will result in an investigation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15301 Based on interview and record review, the facility failed to: a. implement care plan interventions for one resident (R2) and b. failed to ensure staff follow their job description and Driver Safety Rules for two residents (R3, R6) for three of three residents reviewed for falls in the sample of six. These failures resulted in R2 sustaining facial lacerations and R3 sustaining neck fractures. Findings include: a.11/13/2024, at 11:02 AM, V5 (Certified Nursing Assistant) via telephone, said I helped V7 (Certified Nursing Assistant) transfer R2 from shower chair to bed using a gait belt. V7 said I left the room. 11/13/2024, at 11:34 AM, V7 (Certified Nursing Assistant) said I gave R2 his shower the day he fell out of bed. V5 (Certified Nursing Assistant) helped me transfer R2 from the shower chair back to bed using a gait belt. We stood him up, turned him and someone grabbed his legs and we put him in bed.V5 left the room. V7 said I went to the window side of the bed, and rolled R2 towards me. Then, I reached over to pull the diaper out from under R2. R2 rolled towards me onto the floor. I think he hit his head on the nightstand. V7 said the bed was at working height for me, about waist high. V7 said R2 can't move from side to side. 11/13/2024, at 1:24 PM, V2 (Director of Nursing) said, staff had given R2 a shower and transferred him from shower chair to bed via mechanical lift with two persons assist. V2 said R2 can turn, so when he turned in bed, he rolled onto the floor hitting his head on the nightstand and probably the wall with the side of his face. He got some small lacerations there. V2 said now he's going to be a two person assist so that this doesn't happen again. 11/13/2024, at 2:22 PM V1 (Administrator) said, V5 and V7 showered R2 the day he fell out of bed. V5 left the room, V7 was trying to put R2's brief on, he was on the floor so fast. V1 said I told her (V7) she had to go home so that I could complete an investigation, it's part of our protocol. I spoke to V5, she said she helped V7 transfer R2 to his bed then left. V2 said I spoke with the nurse, she said he was on the floor on the mat near the window; lacerations to side of eye and above his eyebrow. V2 said I interviewed staff on unit, they were not witnesses to the incident. V7 was alone in the room by herself. The bed was raised to provide care. I went over the incident with V7. We did the reportable. We brought her back, did some re-education about bed mobility. R2's MDS (Minimum Data Set of 8/26/2024) Section GG documents (Functional Abilities and Goals) documents roll left and right as 2 or substantial/maximal assistance. R2's ADL (Activities of Daily Living) self-care performance care plan (initiated 3/19/2019) documents: Bed Mobility: The resident requires substantial/maximal assistance x2 staff for repositioning and turning in bed and as necessary. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	10/25/2024, 10:30 AM, Incident Note Late Entry documents in part: CNA (Certified Nursing Assistant) called this writer for help to resident room. Upon arriving observed resident lying on the floor matt facing the window wall. Resident unable to describe occurrence. Writer assessed resident head to toe, ROM (Range of Motion) completed to all extremities, no observed injuries or discomfort. Observed abrasion on bilateral eyebrows and a small open skin bellow his right eye, and a laceration on his right index finger. Paramedics took resident to (local hospital) to be evaluated. 10/25/2024, at 10:57 AM, R2's hospital record documents in part: [AGE] year-old male presents from nursing home per (local fire department) for fall. Patient has multiple lacerations on his face and injury to his right hand inconsistent with reported history. 10/26/2024. at 7:06 AM, documents in part: patient reported as fall, but his injuries are severe and do not fit with mechanism and description by EMS (Emergency Medical Services). Patient's eyelid lacerations are technically complex and cannot be repaired by (V3). They require ophthalmology namely oculoplastic (eye doctor that specializes in treatment of conditions affecting structures that surround the eye including eyelids, eye socket, and tear drainage system) not available at this hospital. 10/25/2024, at 11:34 AM, Head CT documents in part: right periorbital (around the eye) soft tissue swelling and laceration. b. 11/12/2024, at 11:57 AM, V4 (R3's granddaughter) said R3 has a history of falls, three of them involve the facility van. V4 said per her grandmother, the facility's van driver does not properly secure R3 in the van, resulting in R3 falling two times. V4 said R3's last fall occurred on 10/28/2024, but is unclear if resident fell in van or inside hospital where resident had an appointment. V4 continued stating that someone from (local hospital) told her R3 had a fall but did not say where or when fall occurred. R3 was transferred to (local hospital) due to a neck fracture related to fall. R3 was admitted to ICU (Intensive Care Unit) at (local hospital) where he later developed pneumonia. V4 added the van driver was terminated because of other incidents. 11/13/2024, at 11:02 AM, V5 (Certified Nursing Assistant) via telephone, said I was asked to escort R3 to the hospital for a scheduled procedure. R3 was transferred in his wheelchair to the facility van by V6 (Former Bus Driver). I did not watch V6 place R3 into the van or secure R3. I did not check if R3 was secured, I assumed he was. I sat in passenger's seat in the front of the van. After V6 was done, we proceeded to the hospital. V5 continued, we got to a stop sign, V6 stopped. I heard something fall. I turned around and I saw R3 on the floor. He did not have his seatbelt on. R3 fell out of his wheelchair. V6 got R3 back into R3's wheelchair. I asked R3 if he was okay. R3 complained that his head was hurting. We proceeded to the hospital. When we got to the hospital, I registered R3 for his appointment, then told someone at the front desk about his fall in the van. I told the doctor what happened. They ordered x-rays and a CT scan. They told me R3 had a neck fracture, they were going to transfer R3 to another hospital. I was suspended for 3 days to find out what really happened. 11/13/2024, at 12:12 PM, V6 (Former Bus Driver) via telephone, said I rolled R3 into the van and secured the wheelchair with hooks that are attached to the van's floor. I did not fasten R3's seatbelt. He was sitting on a cushion and sitting towards the edge of the wheelchair. I should have repositioned him. He fell out of his wheelchair onto his butt. We (V6 and V5) got him off the floor, placed R3 back into the wheelchair. R3 was complaining of shoulder pain; that wasn't new. R3 was also complaining of back pain. After we got him back into the wheelchair, we proceeded to the hospital for R3's appointment. I told V5 to let hospital staff know about R3's fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	11/13/2024, at 1:24 PM, V2 (Director of Nursing) said, the nurse from the hospital called to inform us that R3 was being evaluated in the emergency room because R3 had a fall in the van on the way to the hospital; V5 said R3 was complaining of neck and knee pain. V2 said R3 had fractures to C6-C7 (neck bone fractures). R3 was transferred to another hospital for treatment. V2 added we did an investigation. V5 told us V6 came to stop and R3 fell out of his wheelchair. V6 told us he could not remember if he fastened R3's seatbelt. V2 said, we know that R3's seatbelt was not secured. 11/13/2024, at 2:22 PM, V1 (Administrator) said, R3 was in facility van on the way to the hospital when R3 fell from his wheelchair in the van. V1 said R3 complained of shoulder pain that was not new. V1 said x-rays were done in the emergency room ; R3 had a neck fracture and was transferred to another hospital for treatment. V1 said she was not aware of any previous incidents of falls in the van. 10/28/2024, at 11:00 AM, R3's Nurses Note documents in part: Writer received a called from (local hospital) ER nurse in regards of a fall incident that happened when patient was being transfer(ed) to his appointment this morning. ER nurse mentioned patient was complaining of pain on his neck & right shoulder. 10/28/2024, 2:18 PM, R3's Nurses Note documents in part: Writer received a call from (local hospital) in regards of patient status after a fall, intensive care unit nurse mentioned patient will be transfer(ed) to (local hospital) in reference to a neck fracture for further treatment. ICU (Intensive Care Unit) nurse verbalized resident has a fracture between C6 to C7. Driver Safety Rules (signed by V6 on 7/31/2023) documents in part: Pull seatbelt to make sure resident is secure. Position: Bus Driver (signed by V6 on 7/28/2023) documents in part: Follows established safety policies and procedures. 11/14/22024, at 2:27 PM, V11 (Registered Nurse) said V6 told me R6 slid from wheelchair in van onto van floor; incident occurred on the way back to facility. 11/14/2024, at 3:38 PM, R6 said, I was in my wheelchair in the back of the van, my seatbelt was not fastened. R6 continued, the driver slammed on the breaks, I fell on my a**. 10/9/2024, 1:23 PM, R6's Nurses Note documents in part: Driver from facility van come to this writer to report that resident slide down from his wheelchair during the driving returning from an appointment. Resident is assessed in his room. Resident states that he slid down from the wheelchair stating: I am okay, I am bullet prof (proof), everything hurts not because I fell , because all my body hurts, except my penis. 10/9/2024, 4:45 PM, Nurse Practitioner Progress Note Late Entry documents in part: Seen for a fall. Per nurse, resident slid out of his wheelchair while driving to his appointment. The facility did not produce evidence (for past noncompliance) until later.