STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145246	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Hinsdale, The	600 West Ogden Avenue Hinsdale, IL 60521

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 Based on observation, interview, and record review, the facility failed to provide LVAD (Left Ventricular Assist Device) dressing changes as ordered by the physician. This applies to 3 of 4 residents (R1, R2, and R3) reviewed for improper nursing care in the sample of 4. The findings include: 1. The EMR (Electronic Medical Record) shows R1 was admitted to the facility on [DATE]. R1 was sent to the local hospital on November 25, 2024, admitted to the hospital with shortness of breath, and returned to the facility on [DATE]. The EMR continues to show R1 was sent to the local hospital on December 12, 2024 and did not return to the facility during this investigation. R1 had multiple diagnoses including acute on chronic combined systolic and diastolic congestive heart failure, chronic kidney disease, shortness of breath, klebsiella pneumoniae, difficulty walking, acute and chronic respiratory failure, cardiogenic shock, diabetes, chronic atrial fibrillation, pleural effusions, presence of automatic implantable cardiac defibrillator, long-term use of anticoagulants, and presence of an LVAD. R1's MDS (Minimum Data Set) dated November 9, 2024 shows R1 was cognitively intact, required setup assistance with eating, partial/moderate assistance with oral hygiene, personal hygiene, and bed mobility, substantial/maximal assistance with showering, and transfers between surfaces, and was dependent on facility staff with toilet hygiene, and lower body dressing. R1 had an indwelling urinary catheter and was always continent of stool. On December 16, 2024, V2 (DON-Director of Nursing) provided a copy of the local hospital's LVAD training packet for subacute rehab facilities. The undated LVAD training packet shows the following information regarding an LVAD: A Ventricular Assist Device (VAD) is a continuous flow pump implanted (into a patient's heart) to assist a failing native heart by taking blood from the left ventricle, flowing through the pump into the outflow graft to the ascending aorta. The training packet continues to show, Who receives a VAD? A patient who has advanced heart failure with symptoms at rest, a patient who cannot come off the heart lung machine after open heart surgery, and a patient in cardiogenic shock. The VAD pump is surgically implanted and has a driveline/electrical line that communicates between the pump inside the patient and the controller outside of the patient. The driveline must ALWAYS be covered with sterile occlusive dressing. The pump is powered by large batteries or wall power. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The EMR shows the following order for R1 dated November 7, 2024 through November 18, 2024: 7. Remove old dressing and take off gloves and discard in trash. 8. Wash hands or use antiseptic cleanser. 9. Apply second pair of gloves using sterile technique. 10. Activate one Chloroprep swab and scrub/cleanse in spiral direction beginning at the exit site continuing down and away from the exit with one side of the swab and the other side of driveline with other side of swab discard allow skin to dry for 3 minutes before Sorbaview (do not fan area). Every day shift every Monday, Thursday 2 of 3 . On December 18, 2024 at 1:00 PM, V2 (DON-Director of Nursing) said R1's LVAD dressing order was entered incorrectly by the nursing staff on November 18, 2024. V2 said the facility has an LVAD dressing order set that is supposed to be entered when the facility receives an LVAD resident. V2 continued to say the LVAD dressing orders have multiple steps to be followed, and R1's dressing order was missing steps 1 through 6 and steps 11 through 12. V2 continued to say R1 should have had the following orders in the EMR for the nursing staff to follow so they were aware of the site where the dressing change needed to be done and that the entire procedure was under sterile conditions: 1. LVAD drive line dressing wet kit instructions. Prepare room. 1. Close window/door and turn off all fans. 2. Wipe down the table with antimicrobial wipe, place mask on all the individuals in room. 3. Wash hands for 20-30 seconds. 4. Open kit using sterile technique. 5. Apply gloves using sterile technique. 6. Prepare kit to use (pen packages onto sterile field). 11. Apply Algidex patch (antimicrobial patch) yellow side up. 12. Apply Sorbaview dressing. Additional tips: extra gauze can be used to hold/secure the driveline during cleaning. If you do not use extra gauze to hold driveline, it may be used to blot skin that's very hairy to improve drying ability. If dressing and or patch is saturated with drainage call the VAD team for additional orders. V2 also continued to say all of the sterile dressing orders should be entered into the computer as scheduled treatments as well as prn (as needed treatments) in case the resident's LVAD dressing becomes dirty or dislodged and requires changing between scheduled dressing changes. The facility does not have documentation to show the sterile dressing orders were followed as ordered by the physician from November 7, 2024 to November 18, 2024 for R1. R1's hospital LVAD discharge orders dated December 4, 2024 show: Wound Care: 1. Type of sterile driveline dressing change: sterile dry kit. 2. Frequency of sterile driveline dressing change: Every Monday and Thursday. The EMR shows the following order for R1 dated December 11, 2024: L Vab (sp.) dressing change weekly every night shift every Tue. The order was entered by V15 (RN). The order was discontinued on December 12, 2024 at 6:55 PM by V16 (RN). The facility does not have documentation to show the sterile dressing change orders were ever entered for R1 upon his return to the facility on [DATE]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The local hospital LVAD care instructions provided to the facility on [DATE] when R1 was transferred to the facility from the hospital show: LVAD Driveline Dressing Dry Kit instructions for SAR (Subacute Rehab): Prepare Room: Close windows/door and turn off all fans. Wipe down table with antimicrobial wipe, place mask on all individuals in room. Wash hands for 20-30 seconds. Open kit using sterile technique. Apply gloves using sterile technique. Prepare kit to use (open packages onto sterile field). Remove old dressing and take off gloves, discard in trash. Wash hands or use antiseptic cleanser. Apply second pair of gloves using sterile technique. Activate one Chloroprep swab and scrub/cleanse in spiral direction beginning at the exit site working outward up to 4 inches never return to the exit site with dirty swab then discard. Activate second Chloroprep swab and clean along driveline. Clean one side of driveline beginning at the exit site continuing down and away from the exit site with one side of swab and the other side of driveline with other side of swab. Discard. Allow skin to dry for 3 minutes before applying Sorbaview (do not fan area). Apply Algidex patch yellow side up. Apply Sorbaview dressing. Apply [name of indwelling catheter] anchor distal to the Sorbaview dressing). 2. The EMR (Electronic Medical Record) shows R2 was admitted to the facility on [DATE]. R2 has multiple diagnoses including, acute on chronic combined systolic and diastolic congestive heart failure, lack of coordination, diabetes, chronic kidney disease, fluid overload, presence of heart assist device, encounter for adjustment and management of other part of cardiac pacemaker, epilepsy, long-term use of anticoagulants, presence of an LVAD, and depression. R2's MDS (Minimum Data Set) was not completed at the time of this investigation. The EMR shows an order dated December 9, 2024 to Apply Algidex patch during the LVAD dressing changes on Mondays and Thursdays. On December 16, 2024 at 10:23 AM, V2 (DON) and V8 (ADON-Assistant Director of Nursing) showed the dressing kits used for LVAD dressing changes. V8 said only one resident has orders for the antimicrobial patch. V8 was unaware the facility's standing LVAD dressing change orders show an antimicrobial patch as part of the order. V8 continued to show the antimicrobial patches are not kept in the dressing kits and she has the patches in her office. V8 said she places the patches in the medication room for the staff on dressing change days. At 10:50 AM, V8 walked to R2's room and showed R2's LVAD dressing site. V8 confirmed the LVAD dressing, and securement device were not dated. V8 palpated the gauze covering R2's LVAD driveline dressing site and said she did not feel an antimicrobial patch under the gauze dressing, as ordered. On December 16, 2024 at 2:00 PM, V7 (RN) was in R2's room. V7 said she was told to change R2's LVAD dressing. V7 said when she removed the dressing, there was no antimicrobial patch around R2's drive line as ordered. 3. The EMR shows R3 was admitted to the facility on [DATE]. R3 has multiple diagnoses including, metabolic encephalopathy, parainfluenza pneumonia, acute respiratory failure, COPD (Chronic Obstructive Pulmonary Disease), emphysema, acute on chronic combined systolic and diastolic heart failure, atrial fibrillation, acute kidney failure, chronic kidney disease, history of falling, presence of heart assist device (LVAD), and long-term use of anticoagulants. R3's MDS was not completed at the time of this investigation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On December 16, 2024 at 9:45 AM, R3 was sitting up in his bed. R3 said he has had his LVAD for almost six years. R3 was visibly upset and said the facility staff does not know how to do a proper sterile dressing change. R3 said, They don't clean the wound correctly. The dressing was supposed to be changed the day I got here, which was Tuesday and didn't get changed until Thursday or Friday. They don't even give me a mask to wear. They leave my door wide open, and people walk in and out without masks. R3's hospital discharge orders, printed December 10, 2024 show the following order: Type of sterile driveline dressing change: Sterile wet kit. Frequency of sterile driveline dressing change: Daily. The EMR shows the following order for R3 dated December 12, 2024: L Vab (sp.) dressing change daily wet kit, every night shift. The facility does not have documentation to show the multi-step LVAD dressing change orders were entered by the nursing staff. On December 17, 2024 at 3:34 PM, R3's nursing orders and documentation were reviewed regarding R3's LVAD dressing with V2 (DON). V2 said the nursing staff failed to enter the correct LVAD dressing orders when R3 was admitted to the facility and based on the orders entered, would have no idea if the dressing was a sterile dressing based on what the EMR shows. On December 17, 2024 at 9:10 AM, V4 (Hospital LVAD Educator) said the SAR sterile dressing change orders, with the multiple steps should be followed for every LVAD patient, which is taught in the LVAD training classes.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 33330 Based on interview and record review, the facility failed to ensure nursing staff was trained and was able to demonstrate competency to care for residents with implanted cardiac LVADs (Left Ventricular Assist Devices). This applies to 4 of 4 residents (R1, R2, R3, and R4) reviewed for improper nursing care in the sample of 4. The findings include: Facility documentation shows R1, R2, R3, and R4 were admitted to the facility between November 5, 2024 and December 11, 2024. Facility documentation continues to show R1, R2, R3, and R4 had LVADs due to multiple cardiac diagnoses. On December 16, 2024, V2 (DON-Director of Nursing) provided a copy of the local hospital's LVAD training packet for subacute rehab facilities. The undated LVAD training packet shows the following information regarding an LVAD: A Ventricular Assist Device (VAD) is a continuous flow pump implanted (into a patient's heart) to assist a failing native heart by taking blood from the left ventricle, flowing through the pump into the outflow graft to the ascending aorta. The training packet continues to show, Who receives a VAD? A patient who has advanced heart failure with symptoms at rest, a patient who cannot come off the heart lung machine after open heart surgery, and a patient in cardiogenic shock. The VAD pump is surgically implanted and has a driveline/electrical line that communicates between the pump inside the patient and the controller outside of the patient. The driveline must ALWAYS be covered with sterile occlusive dressing. The pump is powered by large batteries or wall power. The facility's signed agreement between the facility and the LVAD hospital, signed by V2 (DON-Director of Nursing) on June 11, 2024 shows: Facility accepting patient will be responsible for the following: Superusers (Charge RN-Registered Nurse/Educators/DON/ADON-Assistant Director of Nursing) will come for initial and annual competency training by the referring implanting center. The training course will be offered monthly through [LVAD hospital]. All staff caring for VAD patient to have had initial competency completed and direct training from the implanting center staff. Training from industry personnel and/or online module training will be supplementary training, and not considered core competency. All staff must have annual competency by their designated Superuser, who must attend yearly training from implanting center. Facility responsible for keeping records of training and use of VAD trained RNs when making daily assignments. For all turn over or new staff hires it is the responsibility of the facility leadership to register staff for initial training and provide annual competencies On December 16, 2024 at 9:33 AM, V1 (Administrator) identified V2 (DON), V8 (ADON/LPN-Licensed Practical Nurse), and V11 (ADON) as LVAD superusers. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On December 17, 2024 at 9:10 AM, V4 (LVAD Hospital Educator) said the LVAD contract shows in person training classes for the LVAD. V4 said since the onset of COVID, those classes have been held virtually, but are still required as the contract shows. V4 continued to say V2, V8 and V11 have not attended a training since March of 2023. V4 said, We require the superusers to attend training annually. Due to updates in medicine, things can change with LVADs, and we want the superusers to be up to date on those changes. We also want to know they are proficient in caring for the LVAD patients. We also allow the superusers, if proficient, to train the staff in their building. We would prefer the staff attend the online training, which is about four hours. We expect the nurses to know how to do troubleshooting of the LVAD, how to do the dressing changes, how to understand the readings and alarms on the LVAD machine, and how and when to notify the LVAD team. The facility did not have any LVAD residents until August when they got one patient. We recently sent three or four more. There have been some issues with those residents, and what you are seeing is the unacceptable side of the staff members not being competent. The facility needs to keep records of who has been trained and when. There is no way to do this training in under an hour. At the shortest, it takes three hours. There are concerns that the facility does not know what they are doing based on how we received [R1]. We were unaware (of the lack of training) when [R1] was over there. We will not send other patients to that facility unless they receive training. On December 17, 2024 at 11:17 AM, V2 (DON) said no superusers have attended LVAD training since March of 2023. V2 continued to say LVADs were covered at the annual skills fair at the facility but it was a basic 10-minute training. V2 said, We do not have anything to show the staff caring for the LVAD residents are competent to take care of them. On December 17, 2024 at 2:24 PM, V16 (RN) was assigned to care for R2, R3, and R4. V16 said he has not had training regarding LVAD patients for over two years. All I know is what I learned two years ago. There has been no training at the facility. I do not know who our superusers are. On December 17, 2024 at 3:59 PM, V7 (RN) said she is frequently assigned to care for LVAD residents. V7 said, I have not had LVAD training for at least 1.5 years. Two weeks ago, I had an agency nurse working with the LVAD residents and she asked me what the LVAD numbers meant and how to document them. I showed her after she asked me, but I had not provided her training before she cared for them. I do not know who our super users are. On December 17, 2024 at 4:02 PM, V17 (Physician/Medical Director) said, I was not aware the staff were not up to date on their LVAD education. They should have been compliant with that before they accepted LVAD residents. They have to dedicate staff to care for those residents. We need to find out where this fell through the cracks, including the DON not scheduling the training. On December 17, 2024 at 4:27 PM, V8 (ADON) went through all binders and materials at the nurse's station on the unit where R1, R2, R3, and R4 resided. V8 was unable to find an LVAD binder with education materials, or a binder with education materials for agency staff. Later V8 returned and said she was able to find the LVAD binder on another floor of the facility because the facility had previously had a resident on that floor, but as of December 17, 2024 the binder had not been available to the staff working on the unit with R1, R2, R3, and R4. The facility identified the following staff as staff who cared for R1, R2, R3, and R4 since December 1, 2024: (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V6 (LPN-Licensed Practical Nurse), V7 (RN), V10 (RN), V15 (RN), V16 (RN), V18 (Agency Nurse), V19 (Nurse), V20 (Nurse), V21 (Nurse), V22 (Nurse), V23 (Agency Nurse), V24 (Agency Nurse), V25 Nurse, V26 (Agency Nurse), V27 (Nurse), V28 (Agency Nurse), V29 (Nurse), V30 (Agency Nurse), and V31 (Agency Nurse). On December 17, 2024 at approximately 4:40 PM, V2 (DON) said, she was unable to provide documentation to show nursing staff were trained to care for LVAD residents or that they were competent to care for them. On December 18, 2024 at 9:50 AM, V4 (RN-LVAD Educator) said he works closely with the LVAD team at the local hospital. V4 said, We pulled [R2] out of the facility last night and had him return to our hospital because we were concerned about his care and the facility's lack of education regarding caring for LVAD residents.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 Based on interview and record review, the facility failed to administer medications as ordered by the physician to residents with diagnoses of heart failure requiring the use of implanted LVADs (Left Ventricular Assist Devices). This applies to 2 of 4 residents (R2 and R4) reviewed for improper nursing care in the sample of 4. The findings include: 1. The EMR (Electronic Medical Record) shows R2 was admitted to the facility on [DATE]. R2 has multiple diagnoses including, acute on chronic combined systolic and diastolic congestive heart failure, lack of coordination, diabetes, chronic kidney disease, fluid overload, presence of heart assist device (LVAD), encounter for adjustment and management of other part of cardiac pacemaker, epilepsy, long-term use of anticoagulants, and depression. R2's MDS (Minimum Data Set) was not completed at the time of this investigation. The EMR shows the following order for R2 dated December 7, 2024: Milrinone Lactate (heart failure medication) Intravenous Solution. Use 20 mg. (Milligrams) intravenously every shift for heart failure 20 mg/100 ml (Milliliters), inject 34.725 mcg/minute. On December 10, 2024 at 9:46 PM, V9 (NP-Nurse Practitioner) documented, Primary Chief Complaint: Medication Given in Error. Nurse called to report that [R2] had been receiving another patient's bag of Milrinone. Nurse went to change the bag of Milrinone and noted that most of the bag had not infused the full volume as it should have. Nurse looked carefully at the bag she took down and noted that it had another patient's name on the bag. The concentration of the other patient's bag is (90 mg/112 ml x 24 hours) than [R2's] prescription (53 mg/66 ml x 24 hours) for Milrinone. [R2] is currently stable and has not had any change in condition. His vital signs are stable and consistent with his baseline. Of note, the other patient's Milrinone was to run at a higher rate of infusion than [R2's]. So, [R2] received a stronger concentration of Milrinone but at a lower rate of infusion. Nurse hung the correct bag at 7:20 PM. Diagnosis, Assessment/Plan: CHF (Congestive Heart Failure) acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure (Primary). Condition is guarded. Vital signs every 1-hour x 4 times. If stable revert to vital signs every shift. Obtain a STAT EKG (Electrocardiogram). On December 10, 2024 at 11:33 PM, V10 (RN-Registered Nurse) documented, This writer observed a medication incident on this shift. The incident has been reported to management and [on call physician group]. This writer received orders to monitor vital signs every hour x 4 times and STAT EKG to be performed. The patient remains in a stable condition. No signs of irregular heartbeat, dizziness or chest pain observed. Nursing staff informed to monitor the patient and notified MD of any changes with his current health status. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On December 18, 2024 at 9:56 AM, V1 (Administrator) and V2 (DON-Director of Nursing) said there was a medication error and R2 received a medication labeled with another resident's name. The medication was Milrinone. V2 said R2's new Milrinone bag was started on December 9, 2024 between 2:00 and 3:00 PM by V11 (RN). V10 (RN) found the wrong medication bag infusing into R2 on December 10, 2024 at 7:00 PM. V2 said, [R2] received the incorrect dosage of the Milrinone medication continuously for 27 hours. On December 18, 2024 at 9:11 AM, V12 (Pharmacist) said, This is the only facility that I currently oversee using Milrinone. The cardiologists want this intravenous drug for short-term use. It is a very risky drug. Especially if the resident gets an increased dose. The reason [R2] got a higher dose than ordered is because they gave the medication intended for another resident. This was a huge medication error with the potential for substantial consequences including cardiac consequences. 2. The EMR shows R4 was admitted to the facility on [DATE] with multiple diagnoses including wedge compression fracture of first lumbar vertebra, difficulty walking, fracture of the superior rim of the right pubis, diabetes, chronic systolic heart failure, chronic pain syndrome, spinal stenosis, prostate cancer, colon cancer, bladder cancer, and presence of heart assist device (LVAD). R4's MDS dated [DATE] shows R4 is cognitively intact, is independent with eating, requires setup assistance with oral hygiene, partial/moderate assistance with toilet hygiene, showering, and lower body dressing, substantial/maximal assistance with transfers between surfaces, and is dependent on facility staff for bed mobility. R4 is occasionally incontinent of bowel and bladder. The EMR shows the following order for R4 dated December 3, 2024: Torsemide (diuretic) 10 mg. orally, daily. R4's December 2024 MAR (Medication Administration Record) shows R4 received Torsemide 10 mg. every day at 9:00 AM from December 3, 2024 through December 15, 2024. R4's hospital Summary of Discharge Medications dated December 2, 2024 at 2:24 PM shows the following order for R4: Torsemide 20 mg. by mouth daily. On December 17, 2024 at 3:34 PM, V2 (DON) said R4's Torsemide order was entered incorrectly when his orders were entered by the nurse at the facility. V2 also said she was unaware R4 was receiving the incorrect dosage of Torsemide since his admission to the facility 15 days earlier. On December 18, 2024 at 9:11 AM, V12 (Pharmacist) said, Torsemide is used as a diuretic, not urinary retention. [R4] has significant cardiac issues, and fluid overload, and shortness of breath are concerns for residents with LVADs and heart failure when they receive too low of a dose of Torsemide. LVAD residents can get fluid overloaded very easily and require hospitalization because of it. The incorrect dose of Torsemide can lead to significant consequences for LVAD residents. I do the medication review and compare the hospital records to the orders entered by the facility and look for discrepancies. I identified the medication error of the Torsemide being incorrectly ordered as 10 mg. when it should have been 20 mg. I sent an email to [V2] (DON), and also included [V11] (ADON-Assistant Director of Nursing), [V14] (Vice President of Clinical Services), and [V13] (Regional Consultant) on the email. The email was sent the day after [R4] was admitted to the facility, on December 3, 2024. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On December 18, 2024 at 9:50 AM, V4 (RN-LVAD Educator) said he works closely with the LVAD team at the local hospital. V4 said all significant medication errors should be reported to the LVAD team. V4 continued to say, We pulled [R2] out of the facility last night and had him return to our hospital because we were concerned about his care and the facility's lack of education regarding caring for LVAD residents. The facility's policy entitled Medication Administration, reviewed on 8/01/24 shows: All medication are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. Guideline: .5. Check medication administration record prior to administering medication for the right medication, dose, route, patient and time. 6. Read each order entirely. 7. Remove medication from drawer and read label three times; when removing from drawer, before pouring, and after pouring.21. If medication error/s identified, notify MD/NP (physician/nurse practitioner). Monitor resident's condition as ordered by the physician/NP .