STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145370	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sullivan Healthcare & Senior Living	11 Hawthorne Lane Sullivan, IL 61951

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, interview and record review the facility failed to provide lifesaving equipment for emergency airway management, for a resident in cardiac and respiratory arrest. This failure affected one of 18 residents (R1) reviewed for advanced directives and has the potential to affect all 72 residents residing in the facility. R1 subsequently expired. The Immediate Jeopardy began on [DATE] when R1 was found to have no pulse or respirations and Cardiopulmonary Resuscitation (CPR) was initiated. Staff could not locate a functional bag valve mask (BVM) mask to provide a full seal over R1's nose and mouth, in order to provide effective ventilation during the medical emergency. V1, Administrator was notified of the Immediate Jeopardy on [DATE] at 1:58 pm. The surveyor confirmed by interview and record review that the Immediate Jeopardy was removed on [DATE], but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings include: R1's Physician Order for Life Sustaining Treatment (POLST) form dated [DATE] documents R1 wished to have Cardiopulmonary Resuscitation (CPR), full treatment with the primary goal of sustaining life. R1's Diagnoses Sheet updated [DATE] documents the following: Unspecified Asthma, Uncomplicated, Hypertensive Heart Disease Without Heart Failure and Age-Related Osteoporosis with Current Pathological Fracture, Unspecified Site, Initial Encounter for Fracture ([DATE]). R1's Re-Admission Summary note dated [DATE] documents R1 returned from the hospital after right hip surgical repair. R1's Health Status Note [DATE] at 4:19 pm documents: R1 was found to have no pulse or respirations, CPR was initiated by facility staff, and 911, Emergency Medical Service (EMS) was called. R1's Death Certificate dated [DATE] document R1's cause of death included: Asthma, Dementia and Schizophrenia. (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility handwritten CPR time line notes, documents R1 was lowered to the floor (from bed) at 3:33 pm. At 3:34 pm alternating facility staff V11, Licensed Practical Nurse (LPN),V2, Director of Nursing, V18, Resident Care Coordinator preformed eight cycles of chest compressions. The same time line documents V12, Licensed Practical Nurse provided manual ventilation (with no BVM mask as documented below) for the duration of the facility staff provision of CPR. According to the same time line, EMS arrived at 3:41 pm and took over R1's CPR. EMT's (V15 and V16) and provided R1 with three cycles of CPR and completed a three lead ECG. R1's Emergency Medical Service (EMS) Report, written by V14, Lead Paramedic, dated [DATE] documents EMS was notified at 3:37 pm and arrived at the patient at 3:39 pm, and departed the facility at 3:58 pm. The report further documents: Upon Emergency Medical Technician (EMT) arrival, R1 was laying on the ground unresponsive, pulseless, and apneic (not breathing) with facility staff providing CPR (by facility timeline above, seven minute duration). The EMT's report also documents R1 was cyanotic (blueish - purple discoloration of the skin caused by low levels of oxygen in the blood). EMT's applied a cardiac monitor (ECG) electrocardiogram leads, to measure the electrical activity of R1's heart. R1's ECG reading displayed R1's heart entirely stopped beating (Asystole). V14, Lead Paramedic called the local hospital, and gave report of R1's assessment as documented. V17, Physician confirmed R1's ECG monitor reading of Asystole, indicated R1's had already deceased . V17 gave the order to cease CPR. On [DATE] at 10:37 am V14, Lead Paramedic on the scene, stated V12, Licensed Practical Nurse (LPN) was providing ventilation using a handheld manual Ambu-bag for resuscitation without a required BVM mask, which did not provide an adequate seal over R1's mouth and nose. V14 said V12, LPN was holding the oxygen tube in R1's mouth without the benefit of a BVM mask complete seal. V14 said R1's manual ventilation with an Ambu bag and no BVM mask during CPR, was inadequate for resuscitation. V14 stated a BVM mask is required for life- sustaining ventilation during CPR therefore, R1 did not have adequate life sustaining ventilation during CPR, which lead to R1's death. On [DATE] at 11:05 am V12, LPN confirmed he did not have any kind of a mask on R1 to provide R1's ventilation with the manual Ambu bag. V12, LPN said he used one hand to hold the oxygen tube in R1's mouth and tried to cover R1's nose with the same hand, while he squeezed the Ambu bag with his other hand. V12, LPN said V12, LPN was not able to find a mask on the emergency crash cart. On [DATE] at 11:18 pm V10, Physician/Medical Director (MD) confirmed he spoke to V1, Administrator on [DATE] and told V1 to continue to CPR on (R1) until the paramedics arrived and ran a strip (ECG). V10 confirmed V14, Lead Paramedic had given this surveyor accurate information regarding the necessity to use a BVM, in order to maintain a complete seal when ventilating a patient in cardiac arrest. V10 MD stated, R1's ventilation would not be adequate life-sustaining ventilation during CPR if the staff did not use a BVM with the Ambu bag during resuscitation. On [DATE] at 12:10 pm V12, LPN and this surveyor reviewed the contents of the crash cart. There was a new Ambu bag still in a plastic bag. There was one mask to attached to the Ambu-bag for resuscitation, also in the manufacturer plastic bag. V12, LPN stated, Those are brand new. There were not mask in here (emergency crash cart), I swear. I did the best I could (providing R1 ventilation during CPR, [DATE]) without the mask. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] 12:15 pm at V11, Licensed Practical Nurse (LPN) confirmed she was R1's nurse that initiated R1's CPR. V11, LPN stated V11 provided chest compression on R1 during CPR and V12, Licensed Practical Nurse provided ventilation. V11, LPN stated, I remember distinctly (V12, LPN) holding the oxygen tube in (R1's) mouth, while using his other hand to manage the Ambu bag. (V12, LPN) did not have a mask on (R1) during resuscitation and did not have his hand over (R1's) nose, at all. On [DATE] at 2:15 pm V2, Director of Nursing (DON) stated, I am the one who told (V13 LPN) to go get a new mask. The mask she gave me was broken. I was standing by to relieve (V11, LPN), who was giving chest compressions. (V12, LPN) continued to hold the oxygen in (R1's) mouth with one hand, and the Ambu bag with the other. I was not watching for (R1's) chest to rise and fall. I was more concerned with switching places with (V11, LPN) on compressions (chest). On [DATE] at 2:10 pm V13, LPN stated, I got the Ambu bag out of the storage bag. (facility started of CPR at 3:34 pm, per the facility timeline above). I was separating the Ambu bag so we could fill it up with oxygen. The mask (BVM) was in the storage bag and was broke. (V2, DON) sent me to get a new one (BVM), while (V12, LPN) started giving (R1) oxygen during CPR. When I came back down, EMT's (EMT's arrived at 3:41 pm per the facility timeline above) were here. We didn't need the mask I found. (seven minutes after CPR was started). He (R1) was already dead. The Facility Assessment last updated [DATE] documents the facility will ensure staff are educated and have competencies in the areas necessary to provide the level and type of support and care needed for their resident population. The facility Matrix documents currently 72 residents reside in the facility. The undated and untitled facility policy documents the following: Policy: The facility will strive to provide emergency care to the residents as required. Emergency care shall be provided in a calm and confident manner in an effort to preserve life, prevent worsening of the situation and promote recovery. The same policy documents: In addition to the above procedures the facility shall maintain the following controls to facilitate quality emergency care: 1. Emergency equipment shall be portable and readily available at all times. 2. An emergency cart shall he maintained containing at the minimum the following equipment: Portable oxygenation unit (including necessary oxygen tank, tubing, face mask and cannula): airway; bag-valve mask; manual ventilation device/ Ambu bag; suction machine: tubing and catheter; gloves; stethoscope; and B/P cuff. The facility presented an abatement plan to remove the immediacy on [DATE]. The survey team reviewed the abatement plan and was unable to accept the plan to remove the immediacy. The abatement plan was returned to the facility for revisions. The facility presented a revised abatement plan on [DATE] and the survey team accepted the abatement plan on [DATE]. The Immediate Jeopardy that began on [DATE] was removed on [DATE] when the facility took the following actions to remove the immediacy: Surveyor was able to determine onsite, the facility took the following measures to remove the immediacy: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1. Provided in-service training and video for Cardio Pulmonary Resuscitation and Basic Life Support on [DATE]. V2, Director of Nursing (DON) was in-person and V27, Registered Nurse (RN), BLS Certified, [NAME] Health Care was present via tele-monitor. 2. Inspected all onsite Ambu bags on [DATE]. V1, Administrator/RN and V2, DON. 3. Facility will maintain 2 Ambu bags on the crash cart implemented [DATE]. Confirmed with V1, Administrator/RN. 4. Began a crash cart audit checklist to be completed nightly [DATE]. 5. In serviced licensed nurses on restocking crash cart after use [DATE]. 6. In serviced licensed nurses on the crash cart checklist, replacement of faulty supplies, and notification to nursing management [DATE]. V2, DON. 7. CPR certifications training for licensed nurses on [DATE]. Confirmed. 8. Began daily audits to ensure the crash cart checklist is conducted nightly [DATE]. 9. Began random audits of the crash cart inventory supplies [DATE]. 10. The Quality Assurance Quality Improvement Team meeting is scheduled for the third Wednesday in [DATE] to further address the event. V1, Administrator confirmed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 31642 Based on observation, interview and record review the facility failed to implement post fall interventions for (R2 and R3), and failed repeatedly to recognize, document and investigation falls from bed (R3). These failures affected two of four residents (R2, R3) reviewed for falls on the same list of 25. Findings include: 1. R2's Diagnoses Sheet dated 8/22/23 documents the following: Dementia in Other Disease Classified Elsewhere, Unspecified, Other Seizures, Weakness and Other Osteoporosis Without Current Pathological Fracture. R2's Minimum Data Set, dated dated dated [DATE] documents R2's Brief Interview of Mental Status score of seven out of a possible 15, indicating R2 has severe cognitive impairment. R2's Medication Administration Record dated December 2024, document the following: Monitor all bruising to upper extremities. Notify the Physician if any worsening or changes in condition. On 12/12/24 at 10:50 am R2 was lying in bed. R2's bed was elevated approximately 42 inches (included the mattress) off the floor. R2's call light was within reach. R2's bed control was not within reach and hung over the headboard of her bed. R2's bilateral arms and hands, were covered in bruises there were varying in size, color and there were too many to count. Some of the bruises were fading and had yellow halo-like edges, others were dominant purple without evidence of fading. R2 stated she fell a couple of times since being in the facility but can't remember when the falls occurred. R2 stated the nurses keep her bed high, so they can change her incontinence brief. R2 stated she doesn't remember falling out of bed, but she may have. Two unidentified CNA's came into R2's room to assist R2 and R2's's roommate R5. On 12/12/24 at 11:05 am V1, Administrator entered R2's room. V1, Administrator /Registered Nurse confirmed R2's bed remained elevated approximately 42 inches off the floor. V1 confirmed R2's bed was not safe and should not be elevated. V1 stated the R2's bruises were from a fall in November from R2's wheelchair, and a fall 12/04/24 from R2's bed. V1 stated R2 has low bed as the intervention for the 12/04/24 fall (not documented on R2's Care Plan). R2's A.I.M. For Wellness- Event Record documents the following: Note Text: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Event Details: (R2) appears to have experienced an alleged Intentional (sic) Change in Plane; Unwitnessed. Event was first noted on 12/04/2024 (at) 12:30 AM. Evaluation of the resident and event occurred on or about 12/04/2024 1:00 AM (sic). Just prior to/at the time of the event (R2) appears to have been resting in bed. (R2's) account of the event is Unable to relate event details d/t (due to) cognitive impairment. Witness to the event includes: N/A. Location of the event is: (R2's room. Description of the environmental the time of the event includes: 1/2 rails up x2, floor dry, clean, et (and) uncluttered. Staff's immediate response is noted as Assessed for injury. The same A.I.M. For Wellness- Event Record documents: Facility staff actions/interventions and response at time of the event includes Assisted to bed et bed lowered to lowest position. Frequent visual checks d/t agitation. Additional event details and/or follow up recommendations to manage (R2's) condition and/or needs: Hospice review meds for alternative form. Low bed. R2's Skin Evaluation dated 12/6/2024 at 5:08 pm documents: Note / Notification / Education: Skin note: Laceration to left eye brow has resolved. All bruising previously noted has faded. Some bruising remains but healing well. On 12/12/24 at 11:35 am V2, Director of Nursing stated R2 fell [DATE] and that is what her arm bruises are from. R2 had a facial bruise, she was sent to the hospital, and returned to the facility the same day after an 11/19/24 fall. 2. R3's Diagnoses Sheet dated 7/10/24 documents the following: Quadriplegia Unspecified, and Unspecified Dementia, Unspecified Severity, With Other Behavioral Disturbance. R3's Minimum Data Set, dated dated dated [DATE] documents R3's Brief Interview of Mental Status score of three out of a possible 15, indicating R3 has severe cognitive impairment. R3's Fall Risk assessment dated [DATE] documents R3 has had three or more falls in the past three months. R3's A.I.M. For Wellness- Event Record dated 12/9/2024 documents the following: Note Text: Event Details: (R3) appears to have experienced an alleged Intentional Change in Plane; R3 was being assisted away from exit door in his wheelchair. R3 continued down the hall, propelling R3's wheelchair, then leaned forward and tumbled out of chair on to floor hitting head. R3's Care Plan updated 12/09/24 documents R1 has had falls on 12/9/24 with an interventions follows: 12/09/24-IDT (Interdisciplinary Team) note; Resident agitated, fidgeting in wheelchair and slid out of wheelchair. I (intervention) Pressure alarm placed in wheelchair until self-releasing seatbelt arrives (ordered). On 12/12/24 at 12:35 pm V8, R3's Family Member stated R3 has had about nine falls since his April 2024 admission. R3 has had to go out to the hospital twice. Fortunately, R3 has not fractured anything. On 12/12/24 at 2:30 pm V11, Licensed Practical Nurse (LPN) stated, He (R3) has had a mattress on his floor next to his bed for as long as I remember. Almost every morning I come in; he is on the mattress at the side of his bed. We do not document it as a fall when he rolls out of bed. We don't do a fall report at all when he does that. Yes, it is a change in plan. We were told it is care planned for him to be on the mattress. He gets fidgety and ends up there. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/12/24 at 3:15 pm R3 was lying in bed with his bed alarm pad under him and the volume box attached to quarter side rail. A full size twin mattress was on the floor. V25, Certified Nursing Assistant (CNA) removed the mattress from the floor and placed at the foot of R3's bed in preparation to transfer R3 to R3's wheelchair. On 12/12/24 at 3:18 pm V8, R3's Family Member stated V8 is in the facility every day. V8 said she had never been told in care plan meetings, or otherwise, that R3 had rolled out of bed. On 12/12/24 at 3:25 pm V25, Certified Nursing Assistant (CNA) stated, About every other night (R3) rolls off the bed onto the mattress on the floor. We have been told we don't need to do vitals because it is not a fall and (R3) is care planned to do that. V25 said, It made more sense to transfer (R3's) alarm from his bed to the chair. That is where he likes to be. He propels his wheelchair himself and that alarm alerts us if he tries to get up. I figured (V24, PTA) knew more about the alarm then I did. On 12/12/24 at 4:40 pm V26, Registered Nurse (RN) stated Almost every morning I work, (R3) ends up being on that mattress at the side of his bed. I come in at 6:00 am. Sometimes, he is in bed, but by the time I pass meds he is on the mattress on the floor. I have been told though he has a change in elevation when he rolls out of bed. The mattress prevents him from getting hurt. We have been told, it is not considered a fall, so we don't have to do a fall note, neuro (neurological assessment) or vitals. (V2, Director of Nursing) distinctly said he (R3) is care planned for rolling onto the floor mattress, so it does not warrant a report. On 12/12/24 at 4:50 pm V2, Director of Nursing (DON) acknowledged R3 rolling out of bed onto the mattress bed side, is a change in plane. V2, DON stated, (R3) consistently does that. We would be doing fall investigations every day on him (R3). We do not consider R3 rolling out of his bed a fall, so I have no fall investigations in Risk (electronic medical records). Since we don't consider those falls, we have not reported them to the doctor or (V8, R3's Family Member). The facility policy Fall Preventions dated 11/10/2018 documents the following: Policy: To provide for resident safety and to minimize injuries related to falls; decrease falls and still honor each resident's wishes/desires for maximum independence and mobility. Responsibility: All staff Procedure: 5. Immediately after any resident fall the unit nurse will assess the resident and provide any care or treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. 6. The unit nurse will place documentation of the circumstances of a fall in the nurses notes or on an AIM for Wellness form along with any new intervention deemed to be appropriate at the time. The unit nurse will also place any new intervention on the CNA assignment worksheet. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Report all falls during the morning Quality Assurance meetings Monday through Friday. All falls will be discussed in the Morning Quality Assurance meeting and any new interventions will be written on the care plan.