STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003339	A. BUILDING: _____ B. WING _____	C 11/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL PAVILION	900 SOUTH KIWANIS DRIVE FREEPORT, IL 61032

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S 000	Initial Comments Complaint #2319685/IL166916	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.690a) 300.1010i) 300.1030a)1)2)5) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3)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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. Section 300.1010 Medical Care Policies i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures. Section 300.1030 Medical Emergencies a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as: 1) Pulmonary emergencies (for example, airway obstruction, foreign body aspiration, and acute respiratory distress, failure, or arrest). 2) Cardiac emergencies (for example, ischemic pain, cardiac failure, or cardiac arrest). 5) Other medical emergencies (for example, convulsions and shock). Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which	S9999		

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S9999	Continued From page 2 allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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.	S9999		

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S9999	Continued From page 3 Findings include: Based on interview and record review, the facility failed to provide care need details to staff that R1 had a wound vacuum device, failed to timely respond to a report of an unresponsive resident, failed to ensure a resident was monitored and not left unattended once found unresponsive, failed to thoroughly assess a resident to identify the source of hemorrhagic blood loss and provide immediate treatment in attempt to control blood loss and failed to contact Emergency Medical Systems (EMS) in a timely manner. These failures resulted in R1 sustaining hemorrhagic blood loss leading to R1's cardiac arrest. R1 required initiation of cardiopulmonary resuscitation (CPR) initiated by EMS staff upon their arrival to the facility, intubation for mechanical/artificial breathing support and transport to the local hospital emergency department. R1 required multiple rounds of CPR while in the emergency room, expiring on 11/20/23 at the local hospital. These failures affect one of five residents (R1) reviewed for neglect on the sample list of five. Findings include: R1's electronic face sheet printed on 11/21/23 showed R1 has diagnoses including but not limited to aneurysm of artery of lower extremity, hypertensive heart disease, ischemic cardiomyopathy, acute post hemorrhagic anemia, and atherosclerotic heart disease. R1's nursing progress notes written by V3 (Assistant Director of Nursing) dated 11/20/23 showed, "Notified by nursing staff that resident was slumped over and unresponsive, blood noted	S9999		

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S9999	Continued From page 4 to be on bed and floor due to his wound vac being dropped and broken, sternal rub initiated. Respirations noted to be at 12. Oxygen applied. Unable to obtain blood pressure at this time...Resident left facility via ambulance..." The EMS (emergency medical services) report documents on 11/20/23 at 7:50am, EMS arrived at the facility in response to R1 was found unresponsive and not breathing. Upon arrival, EMS staff arrived to (R1) at 7:51am and noted R1 sitting upright in a wheelchair in R1's room, with multiple staff members present. Staff states (R1) was "fine" 5 minutes ago. EMT staff noted large amount of blood to R1's right side of his pelvic area and on the floor under the R1's wheelchair. (Facility) staff states R1 "pulled out" his wound vac (vacuum). No patient care provided by staff and no further information on R1 was passed on to EMS staff. EMS moved R1 in the wheelchair to the hall and placed R1 supine on the stretcher in the hall. Baseline vitals were assessed with agonal respirations noted and no pulses present. EMS initiated CPR via manual compressions. R1's shirt and pants were cut by EMS staff and a large wound with exsanguinating hemorrhage with a large blood clot noted to R1's right pelvic area. 4X4 gauze and direct pressure applied to wound area, AED (automated external defibrillator) pads placed on R1's chest and pulse check showed no palpable pulses and PEA (pulseless electrical activity) on the cardiac monitor. EMS applied 15 liters/minute via bag valve mask ventilation and CPR continued. R1 moved outside via stretcher and loaded into ambulance without incident. EMS staff attempted to place an intravenous line but was unsuccessful. EMS was able to obtain Intraosseous (IO) line successfully in left leg upon first attempt and EMS administered a normal	S9999		

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saline fluid bolus and 1 mg (milligram) of epinephrine via IO site. Pressure bag placed over fluid bag; EMS staff intubated R1. Reassessment of wound area showed continued bleeding. EMS staff continued direct pressure of wound area. EMS administered 1mg of Epinephrine and pulse check showed no palpable pulses present and PEA on the cardiac monitor- CPR continued and cardiac monitor continued to show PEA. This report documents EMS gave a total of three doses of Epinephrine with continued CPR while enroute to the emergency room, and that EMS notified the emergency room R1 was due for a 4th round of Epinephrine.

R1's local emergency room records dated 11/20/23 showed, "...Per EMS, the patient had a wound vac to his right groin area which was removed at some point and there was a significant amount of blood on the patient's clothes and he was actively bleeding from his right wound...There is an open wound in the right inguinal area with blood clots present not actively bleeding. EMS actively putting pressure on this wound ...Patient intubated upon arrival. We continued with CPR per ACLS (Advanced Cardiac Life Support) protocol with massive transfusion protocol. Patient had ROSC (Return of Spontaneous Circulation) at 8:29AM ...Patient lost pulse at 8:51AM and CPR was re-initiated ...patient expired at 9:11AM ...clinical impression: Cardiac arrest."

On 11/21/23 at 9:55AM, V5 (Certified Nursing Assistant-CNA) stated, "I found (R1) around 7:11AM when I was delivering his breakfast tray. He was in his wheelchair and when I set his tray down, I called his name and he didn't answer. Then I saw a big pool of blood on the bed & floor and ran and got the nurse. He wasn't responding

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at all. After I let her know, I just moved on with the rest of my day because she didn't tell me to do anything with (R1) and I assumed she was heading to his room."

On 11/21/23 at 9:59AM, V6 (LPN) stated, "(V5-CNA) came and told me that there was blood on (R1's) floor a little after 7. I went down to his room and he was in his wheelchair. I asked him where the blood came from and he didn't respond verbally but just looked at me. I was trying to figure out if he had a wound vac or dialysis or what was going on. I asked (V3-Assistant Director of Nursing) to come down and she came down and had (V8-CNA) call 911 after she saw all of the blood. I don't work there that often so I don't know him that well. I didn't get information in nursing report from (V3) that he had a wound vac. I saw blood on the floor and I think there was some on his bed. His clothes were saturated with blood and I was trying to feel through his clothes where the blood was coming from. I didn't see his wound vac anywhere near him at the time but I wasn't really paying attention to that. I would have had to cut his clothes off to see where the blood was coming from. I told the paramedics to be careful when they moved him because we were unsure of where the blood was coming from. Looking back, I wouldn't have handled this situation any differently. (V3) told me she would document everything we did and not to document anything in (R1's) chart so I didn't. (Facility) is very particular in these situations how they want things documented and I'm not getting in trouble for anything so I did what (V3) told me to do." (R1's electronic medical record showed 1 nursing progress note regarding R1's change in condition on 11/20/23 that was documented by V3-ADON. No records were present in R1's medical record that were documented by V6).

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S9999	Continued From page 7 On 11/21/23 at 9:46AM, V3 (Assistant Director of Nursing) stated, "I worked from 6am-7am on 11/20/23. (V6-Licensed Practical Nurse-LPN) arrived at 7am and I gave her report and went to my office. (V6) sent me a text message at 7:38am and said something was wrong with (R1's) wound vac. I went into his room, said hi to him and the wound vac was on the floor with blood spilling out of it. I asked (R1) what happened and he said "UGH" and slumped over. I went to the doorway to get (V6) to help me and she came in and got a pulse and said he was breathing. I told her to stay with (R1) and not to leave him so I could go get the paperwork ready ...I saw a little bit of blood on the edge of the bed but I was more concerned about (R1). I just assumed since the wound vac had fallen on the floor that was where the blood was coming from. Neither I nor (V6) checked to see if there was any other source of the blood. It all happened pretty fast and we didn't really have time to do much." On 11/21/23 at 12:45PM, V2 (Director of Nursing) stated, "I was not in the facility when (R1's) change in condition occurred. All I really know is that I was told they had to call 911, paramedics got here and ended up coding him and doing CPR. I would assume that the nurse's would know to identify where the bleeding is coming from and apply pressure to a site that is actively bleeding. That is common sense but I guess they were worried about his vitals too because they had a hard time with them." On 11/21/23 at 2:31PM, V3 stated, "I saw a little bit of blood on the bed and there was blood on the floor in (R1's) room in front of his wheelchair next to the wound vac. I can't remember if I saw the actual machine or not or just the canister for	S9999		

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the wound vac. I told (V6) to document everything she did so I don't know why she didn't document anything."

On 11/22/23 at 9:19AM, V10 (R1's physician) stated, "(R1) was up in a wheelchair and was fine and sought me out and introduced himself when I saw him for the first time. He had the wound vac for a wound in his groin area from a surgery. If staff found him in the condition he was in, I would expect them to see where the bleeding is coming from and control the bleeding. Yes, overall blood loss is probably related to his death and can definitely contribute to cardiac arrest. What I have kind of read of the reports here at the hospital is the large amount of blood loss occurred at some point but we can't be sure when all of the blood loss occurred. When a resident is experiencing a rapid decline in condition I would expect the staff to respond immediately and assess the resident's vital signs, lung sounds, and any other emergency management they feel is reasonable at the time."

The facility's policy titled, "Abuse Prevention Program Facility Policy and Procedure" dated January 2019 showed, "...Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being....This facility desires to prevent abuse, neglect, exploitation, mistreatment and misappropriation of resident property by establishing a resident secure environment."

The facility's policy titled, "Cardio-Pulmonary Resuscitation" dated 2023 showed, "Upon discovery of an unresponsive resident that is a Full Code status: 1. Determine unresponsiveness by shouting "Are you okay" and gently shake or

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S9999	Continued From page 9 tap on the resident. 2. If no response, call for help of other staff members. 3. Instruct other staff responding to the scene to obtain emergency supplies and notify 911 or emergency personnel. DO NOT leave the resident...5. determine if resident is breathing by opening airway with the head tilt chin lift method and check for breathing using your ear and face next to the residents' nose and mouth for no more than 10 seconds. 6. If resident is not breathing, give 2 rescue breaths using a mouth shield/barrier; preferably ambu-bag...8. Determine if unresponsive resident has a pulse or heart beat by checking carotid artery pulse or use a stethoscope to listen to heart tones. If none, then begin chest compressions...9. Continue the cycle of 30 chest compressions followed by 2 breaths until resident shows signs of life, or help arrives and takes over or physician gives order to cease. 10. Document events in medical record." The facility's policy titled, "Emergency Care" dated 02/2023 showed, "Emergency medical care refers to the care given to residents with urgent and critical needs. The circumstances under which the care given may or not be optimal; whatever facilities are at hand are used in the most effective manner...Principles of Emergency Management: To preserve life, to restore the resident to useful living, and to prevent deterioration before a more definite treatment can be given. 1. Maintain a patent airway, employing resuscitation measures, if necessary. 2. Stop bleeding...5. Protect wounds with sterile dressings or with dressings that are as clean as possible..." (AA)	S9999		