STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057893	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALIYA OF OAK LAWN	**6300 WEST 95TH STREET , OAK LAWN, Illinois, 60453**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Complaint Investigations: 2598942/2619149 2598889/2618395	S0000		09/22/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) 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 300.1210 General Requirements for Nursing and Personal Care 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	S9999		09/22/2025

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

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S9999	Continued from page 1 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: 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations are not met as evidenced by: Two deficient practice statements used: Based on interview and record review, the facility neglected to follow established clinical protocols, manufacture's guidance, internal training guidelines, and to follow their policy and procedures outlined in the Subacute Rehabilitation (SAR) Long-Term Acute Care (LTAC) Ventricular Assist Device (VAD) Training Manual, Heart Failure (HF) Left Ventricular Assist Device (LVAD) HF-LVAD HeartMate-3 Patient Guide, VAD Emergency Guide, LVAD Pocket Reference Guide. This affected one of one resident (R1) reviewed for providing services for a resident utilizing a LVAD. This neglectful practice resulted in R1 LVAD batteries not being monitored or changed when reached 50% capacity, R1 batteries depleted the pump stopped, R1 sent to hospital for cardiac arrest, R1 expired.	S9999		

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S9999	Continued from page 2 Based on interview, record review, and policy review, the facility failed to provide appropriate, person-centered care and treatment to ensure the highest practicable physical, mental, and psychosocial well-being of 1 of 1 resident's (R1) reviewed with a Left Ventricular Assist Device (LVAD), who was found unresponsive. The facility failed to follow its own emergency response protocol, resulting in a failure to identify that R1's LVAD system had stopped functioning due to depleted batteries, contributing to cardiac arrest and subsequent death. Findings include: R1's face sheet diagnoses encounter for surgical aftercare following surgery on the Circulatory System, unsteadiness on feet, Cognitive Communication Deficit, Type 2 Diabetes Mellitus without complications, Chronic Obstructive Pulmonary Disease (COPD), Acute and Chronic Congestive Systolic Heart Failure, Ventricular Tachycardia, and presence of heart assist device. R1's Minimum Data Set (MDS) dated 07/13/2025 shows Brief Interview for Mental Status (BIMS) score of 11 (Cognitive Deficits). Physician order sheet shows orders for full code. R1's progress note dated 07/24/2025 denotes in-part, 71-year-old male admitted to facility Alert (A) x Orient (O) x3 sometimes forgetful, NKA (No Known Allergies), room air. PMHX: (past medical history) Coronary Artery Disease (CAD) status post (s/p) Coronary Artery Bypass Grafting (CABG) and stent with End Stage Heart Failure with ejection fraction (EF) 15% (heart failure s/p Implantable Cardioverter-Defibrillator (ICD) HeartMate 3 on 8/2021, COPD without oxygen, Type 2 Diabetes Mellitus (DM), End Stage Renal Failure (ESRF) stage 3. Head to toe assessment completed, Pupils' Equal Round Reactive Light Accommodation (PERRLA), lungs clear, active Range of Motion (ROM) for all extremities, left upper arm fracture (refusing to wear sling), active bowel sounds, last bowel movement (BM) 07/2024. Skin intact, drive line insertion site Left Lower Quadrant (LLQ) with anchor on (RLQ Right Lower Quadrant, scattered bruising, drive line dressing change Monday, Wednesday, Fridays (M, W, F). LVAD needs to be checked twice a day (BID). RN (Registered Nurse) spoke with LVAD nurse (name noted) giving numbers in case of needing to be contacted, (phone number listed) during office hours, after hours, or emergency number (phone number listed). Resident very pleasant and cooperative, cell phone, shoes, clothes, LVAD batteries (6), LVAD battery charger, LVAD wall power unit, battery holders (4) all at bedside within reach. Call light, bed controller,	S9999		

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S9999	Continued from page 3 and TV remote within reach next to resident. R1's emergency room records dated 09/16/2025 denotes in-part patient coming from the nursing home, report from Emergency Medical Service (EMS), noted an unwitnessed cardiac arrest. The patient has an LVAD (Left Ventricular assist device). According to EMS when they arrived Cardiopulmonary Resuscitation (CPR) was in progress. EMS continued CPR. Assessment of the patient HeartMate 3 shows that the patient is on battery backup, that there is no power to this his unit. CPR continued. The patient's HeartMate 3 was connected to power source and began operating. Of note the advance heath care team stated that the patient had been on battery backup for over 300 minutes prior to arrival. On 09/16/2025 at 1:10pm, V13 (Emergency Room Nurse) stated R1 arrived at the hospital for cardiac arrest, with EMS (Emergency Medical Service.) V13 stated that R1's Left Ventricular Assist Device's, batteries and the backup battery were dead upon arrival to the Emergency Room. V13 explained that the LVAD system is designed to pump blood to the heart because R1 has heart failure. V13 said the batteries should never be allowed to deplete. The event log file for R1's LVAD system denotes in part: "the event log captured low voltage advisory and few voltage hazard events on battery power 9/15 at 3:55am through 4:20am, then the patient changed to charged batteries. Also noted a lone low flow event 09/15 at 3:56am with flow noted at 2.0. looked to be patient related as this was associated with elevated Pulsatility Index (PI) values. Further low voltage advisory events on battery power noted 09/16 at 12:59 which progressed into low voltage hazard events 09/16 at 3:28am. Battery power depleted 09/16 at 4:51am which enabled the EBB (emergency backup battery) in the controller and ran the VAD at the low limit of 5200 RPM until the EBB depleted as well on 09/16 at 6:48am, resulting in the VAD turning off. Unable to determine the time the VAD was off due to the timestamp being reset to 1/1/2000 once the power was restored to the VAD. On 9/24/25 at 2:43pm, V19 Licensed Practical Nurse (LPN) said he was R1's nurse on the 3:00pm to 11:00pm pm shift on 09/15/2025, he was orientating a new nurse V18 (LPN). V19 said he checked R1's LVAD, he (V19) checked the connections, he (V19) checked the batteries, and the aide assessed the vital signs. V19	S9999		

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S9999	Continued from page 4 said this was completed prior to him (V19) discharging an unrelated resident, that resident was discharged around 8:00pm. V19 said both of R1's LVAD's external batteries had three green bars. V19 said he did not change R1's batteries at that time. V19 said he did not change R1's LVAD's batteries during his shift, V19 said he did not plug R1's LVAD to the wall outlet prior to him (V19) leaving his shift. V19 said he left at 11:30pm. V19 said he reported to V3 (RN) the oncoming nurse to monitor R1 because R1 had an LVAD and R1 was an elopement risk. V19 said R1 has cognitive deficits. V19 said V18 completed all of the documentation for R1 because V18 was in orientation. V19 said he did not get training at Aliya Oak Lawn for LVAD patients. V19 said V18 documented N/A -alarms and system check for LVAD, that was an error, the time is correct. V19 said N/A was for the dressing change, the facility did not have the correct dressing for R1's LVAD, and he (V19) did check the batteries and ensured the drive lines were connected. V19 said he did not complete a system check for R1's LVAD during his shift. V19 said he worked with LVAD patients in the past at another facility and he would complete a system check of the LVAD, V19 describes there's a button on the controller, and you press it, and it will take you through all the systems in the controller. V19 said he did not plug R1's LVAD into the wall outlet because R1 could let him know when he's going to bed, and could request to be plugged in. Facility presents timecard for V19 denoting V19 punched out at 12:45am on 9/16/25. This supports that V19 had the opportunity to change R1's LVAD external batteries during his shift, V19 remained on duty for 7 hours after he observed R1 LVAD batteries at three bars. On 09/24/2025 at 12:42pm, V18 (LPN) said he was on orientation and V19 was the preceptor, V18 said his shift was on 9/15/25 on the 3:00pm-11:00pm shift, V18 stated he did not get training at Aliya Oaklawn for LVAD patients. V18 said he observed V19 check R1's LVAD's batteries. V18 said he completed the documentation for R1's care, and he documented N/A for LVAD-alarms and system check, V18 said that was an error, and the N/A documentation was for the dressing change. V18 said the time does reflect when the batteries were checked. V18 said the LVAD is for heart failure. R1's progress notes denotes V18 documented at 5:01pm on 09/15/2025, for the LVAD alarms and system check. The Facility presents a timecard for V18 denoting V18	S9999		

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S9999	Continued from page 5 punched out at 12:45am, on 09/16/2025. This supports that V18 had the opportunity to change R1's LVAD's batteries during his shift, V18 remained on duty for 7 hours after the LVAD batteries was observed at three bars. On 09/17/2025 at 11:13am, V3 (RN) said she was R1's nurse during the night shift (11pm-7:00am) on 9/15/25, V3 said she was familiar with R1, and she knew who R1 was. V3 said she was prompted to enter R1's room because the medication administration record showed orders to check R1's LVAD. V3 said she checked R1's blood pressure, it was low, but she wasn't concerned because R1's blood pressure usually runs low. V3 omitted checking R1's heart rate, respirations, and temperature. V3 stated that she documented the vital signs in the record. V3 said she hooked R1 up to the small charger (portable power unit/ wall outlet charger) at 3:30am and unhooked R1 at 6:00am. V3 stated that she spoke to R1, R1 even told her not to remove his batteries and to plug the pump into the portable charger. V3 said she knew the batteries were charged because the light was green. V3 described there's a button on the battery that you can be pressed, and it will illuminate. V3 said she has worked with LVAD systems in the past at another facility, but she did not receive training at the Aliya Oak Lawn nursing home for LVADs. At 3:43pm, during a follow up interview V3 stated she was confused, and she switched R1's batteries out and did not charge R1 batteries by connecting the LVAD to the portable power unit (wall out charger). V3 said she was confused during the first interview. V3 said she switched the batteries out at 3:30am. V3 omitted completing a system check for R1's LVAD, V3 said she did not connect R1's LVAD to the wall outlet to charge during the night. Review of R1's physician order sheet for R1 does not have any orders to check the LVAD at night, as V3 stated that is what prompted her to enter R1's room. V3 stated she completed R1's vital sign assessment, however V3's documentation on the asthma/ COPD record date and time of 9/16/25 at 6:10am, denotes V3 used vital signs results dated 9/15/25 at 7:22 am completed by V10 Certified Nursing Assistant (CNA). On 09/19/2025 at 12:12pm, V11 (CNA) said she was the aide for R1 on 09/15/2025 during the night shift, and saw R1 around 10:30pm or 11:00pm, R1 said he wanted a sandwich and R1 got a sandwich from the nurse station and went to his room. V11 said she rounded on R1 during the shift by walking pass his room. V11 said she did	S9999		

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S9999	Continued from page 6 not go into R1's room to check on R1, R1 was a resident that wandered, and if he's sleeping you don't wake him. V11 said she thought the nurse gave R1 some good medicine to sleep all night. V11 said she doesn't check the LVAD because she is not a Nurse. On 9/17/25 at 2:10pm, V4 (RN) said she was R1's nurse for the morning shift of 9/16/25, V4 said upon arrival to the unit she did rounds, she (V4) always checked on the residents that have intravenous medications, and she checked on R1. V4 said R1 was okay, she entered his room to check on him, she observed R1's chest rise and fall. V4 said she did not check R1's LVAD because V3 (RN) reported to her that R1 was okay, and that she (V3) charged R1 batteries, and it was full. V4 said she just took V3 (RN) words for fact. V4 said she has not received any training on LVAD system at the Aliya Oak Lawn. During this interview, V4 was asked to demonstrate how to check the LVAD batteries to determine the capacity, V4 picked up the gray battery, V4 could not identify where the button was located on the battery to determine if the battery was charged or not. V4 was observed to flip the battery over and over, V4 did not identify the button on the front of the battery to check the battery capacity. V4 stated she did not check R1's LVAD system or batteries when rounding on R1 upon the start of the shift on 9/16/25. V4 observed on video surveillance, V4 did not enter R1's room as stated during the interview to observe that R1 chest was rising and falling. On 09/17/2025 at 1:33pm, V9 (LPN) said she immediately called 911 when she heard code blue. V9 said she observed a nurse doing CPR, one nurse was writing, and one was doing vitals. V9 said she did not check R1's LVAD for functioning and she did not check the batteries. V9 said she went to print papers for R1's transfer to the hospital. V9 said she did not receive training on emergency response to a patient with an LVAD at the Aliya Oak Lawn. On 09/18/2025 at 10:01am, V2 (CNA) said she was going to assess R1's vitals and observed R1 with no pulse, V2 said she notified V1, and immediately returned to start CPR on R1.V2 said she remember getting tired when doing chest compressions and she switched out with V1. V2 said when they were in the room, she heard someone say that the LVAD was not plugged up and some said that's okay as long as the batteries are attached. V2 said she doesn't know the name of the person because she is fairly new to the facility. V2 said she did not check the LVAD, and she did not check the batteries. V2 said she has not had any training for emergency response to	S9999		

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S9999	Continued from page 7 a patient with an LVAD. On 09/18/2025 at 11:23am, V7 (RN) stated that she cared for R1 quite often when R1 was on the back wing, on the Med bridge unit. V7 said she worked 16 hours often (first and second shift), and she changed R1 batteries at the beginning of each shift. V7 said there was 5 bars on the battery and when she changed them, the batteries, there would be 2 bars remaining. V7 said R1 often would mess with his LVAD and remove the batteries. V7 said the stationary charger was at R1's bedside on the table within R1's reach. V7 said R1 was verbal, always stated he wanted to go and smoke, and R1 wandered, wanting to go home. V7 said R1 had cognitive deficits. V7 said all the nurses were aware that R1 would remove his batteries, and the unit manager was aware also. V7 said she checked R1 more frequent because of this behavior. V7 said more frequent was about every two hours. V7 described entering the room, checking the batteries capacity and LVAD connections. V7 said she was a cardiac nurse from (hospital name) and she was familiar with the LVAD. V7 said she was off duty when the facility offered the training in July 2025, and when she returned to duty, she received a packet, and someone went over the packet with her. V7 said she doesn't recall who the person was that went over the packet with her. The unit manager was not available for interview during this survey, per V5 (Administrator) she resigned effective immediately on 9/16/25. On 9/18/25 at 12:41pm, V6 (Director of Nursing) stated that her expectation is that the Nursing staff follow the facility policy when caring for a resident with LVAD systems. V6 said she expects her staff to complete rounds on the residents initially upon coming on for the shift, and then every few hours after that. V6 said initially she was under the impression that V3 did complete rounds on R1 but after reviewing the facility surveillance she learned that V3 did not enter R1's room from 1:00am to the time she left duty. V6 said her expectation is that staff complete vital assessments on the residents, check the LVAD system to ensure the system is functioning and the batteries are full, and to change the batteries. V6 said she does not have any documentation that the staff received LVAD training in July 2025. V6 said R1's family was upset by his death and had concerns about the LVAD system. V6 said she is learning during this survey that staff did not receive training for the LVAD/ LVAD emergency response. V6 said the LVAD should be checked for functioning during a code blue emergency situation.	S9999		

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S9999	Continued from page 8 On 9/24/25 at 11:44am, V17 (ADON-Assistant Director of Nursing) said she was the preceptor for LVAD training. V17 said she received her training in February or March of 2025, she was not sure. V17 said the staff received LVAD training hosted by the (hospital name LVAD contact person). V17 said the webinar was held in the conference room, and other nursing staff was responsible to review the webinar while at the Nurse's station on the Med bridge unit. V17 said all the LVAD patients are assigned to the Med-bridge unit. V17 said the staff had the LVAD binder during the webinar. V17 said the policy/protocol/practice is for staff to use the binder located at the nurse's station for reference. V17 said staff should familiarize themselves with the patient that has the LVAD and familiarize themselves with the machine. V17 said staff is made aware of the patient with an LVAD during nurse-to-nurse report at the start of the shift. V17 said the staff should ensure that the batteries are charged by using the buttons and using the controller. V17 said if the light is green, it is ok, and staff should proceed with routine care. Staff should monitor the blood pressure, ensure orders are in place, complete daily weights, be attentive by being alert to alarms from the monitor. V17 said if the alarm sounds staff should go to the patient, look at the monitor, check what alarms has triggered, the lights would appear, silence the alarm by clicking the blinking light, this allows the nurse to check the connections from patient to the monitor, once connections are checked the nurse should push the button again. If the alarm remains off the nurse can proceed with routine care. If the alarm continues contact the Tech from the LVAD company to receive further instructions. V17 said at night the resident's LVAD should be plugged into the wall outlet. V17 said during an emergency, if a resident is found unresponsive the nurse should check the LVAD connections, batteries and check if the LVAD is running, V17 said the nurse should replace the batteries if the batteries are not charged. V17 said she does not know how to run a system check on the LVAD, V17 said she has never seen R1's LVAD system, she has never entered R1's room to observe R1's LVAD system. V17 said she is not competent in LVAD training, policy/procedures. V17 said she recommends that herself and the nursing staff have hands on training with the LVAD system. V17 said there is not a stop order in place for admitting LVAD patients. V17 said she did not inform the Nursing staff that she was the LVAD preceptor because she did not feel competent in her role as the preceptor. V17 said she informed the Director of Nursing of this today. V17 said resident rounds should be conducted every two hours, staff should go inside the room, assess the patient, check	S9999		

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S9999	Continued from page 9 for breathing, look for rise and fall in chest, observe for changes in condition, changes in breathing, check if resident is perspiring excessively, these signs could indicate a change in condition. V17 said she was aware that R1 was admitted with and LVAD in July 2025. On 09/18/2025 at 12:57pm, V15 (Medical Doctor/ Medical Director) said R1 was planning to discharge home, R1 had heart failure with some functioning capacity, V15 stated that if the batteries to R1's LVAD was depleted it would exacerbate R1's death. V15 stated that there should be at least one nurse on duty that is trained on the LVAD. V15 said the facility did not inform him of the occurrence. On 09/17/2025 around the start of 5:25-5:30pm review of facility video surveillance with assist from V5 (Administrator), V5 made the surveyor aware that the time stamp was incorrect, and that the video was one hour behind. Video surveillance for the Med bridge unit was reviewed from 1:00am until 7:02am (V3 was observed to leave the unit with her bag). V3 did not enter R1's room between the hours of 1:00am to 7:02am. V3 was observed on the video sitting at the nurse's station, using V3's personal phone, blowing kisses while on the phone, laughing, observed rocking back and forth in a chair at the nurse station, walking down the hall waving her hands in the air, V3 was observed walking down the hall with her phone in her hand. V3 was also observed at the medication cart while on her phone. V3 observed to adjust the phone ensuring to prop the phone up while she was at the medication cart. Video shows V3 entering a room on the right-hand side of the hall (front facing the bistro). V5 zoomed into the video, there was three black hand sanitizer pumps on the wall, V3 entered the room between the second and third hand sanitizer pump. Immediately after video observation, during a tour with V5 to identify what room V3 entered, the room was identified as room number seven. That was not R1's room that V3 entered. V3 was observed to enter a room on the left-hand side of the hall, and rooms on the back unit. V3 observed to handle medications that was dropped off by pharmacy. V3 observed talking to V9 (LPN) at the nurse station several times. V3 observed to remove her white jacket and leave the unit and return. Video surveillance shows V4 (RN) entering the unit, V4 was observed to fully enter multiple rooms on the left-hand side and when V4 got to R1's room, V4 poked her head in the door frame briefly. V4 did not enter R1's room (this was identified by the placement of the black hand sanitizer pumps on the wall). Review of R1's asthma/ COPD assessment completed by V3 (RN) with effective date of 09/16/2025 at 6:10am, it is	S9999		

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ALIYA OF OAK LAWN	6300 WEST 95TH STREET , OAK LAWN, Illinois, 60453

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S9999	Continued from page 10 denoted that R1 was alert, required head of bed to be elevated, shortness of breath or trouble breath when lying down, most recent pulse, 63- regular, dated 09/15/2025 at 7:02am. Respiration 15, dated 09/15/2025 at 7:22am. Blood pressure 88/64 dated 09/15/2025 at 7:22am. Auscultation clear bilaterally. Review of R1's vital sign assessment log, the above vital signs was completed by V10 (CNA) on 09/15/2025 at 7:22am and not V3. Review of R1's baseline care plan with V6, R1 did not have any goals and interventions listed for the LVAD. Review of R1's comprehensive care plan with V6, R1 did not have a comprehensive plan of care developed with goals and interventions for the LVAD. Review of R1's physician order sheet, order dated 7/25/25; check LVAD two times a day for LVAD alarms and system checks. Review of R1's Medication Administration Record for the LVAD order, it is denoted that R1's LVAD was being checked at 9:00am and 5:00pm. There are no orders, for checking the alarms and system during the night shift. There is no plan of care for monitoring, assessing, and managing R1's LVAD at night. On 09/26/2025 at 1:48pm, V20 (LPN) said she heard the code blue announcement, she responded. V20 said she did compressions. V20 said she did not check R1's LVAD for functioning, she did not check the batteries. V20 said she worked with R1 in the past, she was aware that R1 had an LVAD. V20 said she has not received any training/ in-service for LVAD patients at the Aliya Oak Lawn. V20 said a nurse showed her what to do for R1 when she worked with R1. V20 said she doesn't recall the name of that nurse. V20 said V21 (LPN) did respond to the code blue for R1. V20 said she did not receive training on emergency response to a patient with an LVAD at Aliya Oak Lawn. On 09/25/2025 V21 (LPN) said she can't remember if she responded to the code blue for R1. R1's physician order sheet, order date 07/24/2025 shows orders for full code. R1 does not have an individualized plan of care for the full code status, there is not an individualized plan of care with goals and interventions to implement when and if R1 is found/observed to be unresponsive, there	S9999		

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S9999	Continued from page 11 are no plan of care with goals and interventions to implement for the LVAD when and if R1 is found/observed unresponsive. R1's plan of care for R1 what's admitted to the facility for a skilled stay requiring physician ordered medically necessary services, including direct therapy services, skilled nursing care management, and evaluation of the patient care plan observation and assessment of the patient's condition and or teaching and training activities related to the reason for stay or in preparation for transition to a lesser care environment. R1 requires skill services related to primary diagnosis aftercare s/p (status post) LVAD. Facility policy/protocol/ procedures for LVAD Patient Emergency Assessment denotes in-part: call rapid response team or 911. LVAD functioning? Auscultate left lower chest, continuous humming sound equals pump is working. No initiate: ACLS (advance cardiac life support) protocol, controller will probably be alarming: device check: check VAD parameters, controller alarm lights/sounds, continuous tone: urgent. Check power source. Check all cables connections. Change controller if instructed by VAD team. Transport urgently to ER (emergency room). Facility Emergency Response, denotes in-part VAD hazard alarm, call VAD team immediately (number listed) If patient is unresponsive: is VAD running? (listen for hum and check VAD numbers) YES: Treat underlying cause (patient could be unresponsive for other reasons; respiratory, stroke, blood sugar) NO: 1st attempt to get pump running quickly if unable to quickly okay to administer CPR and/or defibrillate. DO NOT disconnect VAD. If patient is responsive: Step 1-Check the connection between the system controller and the LVAD, (driveline), Step 2-Check the connection between the system controller and the batteries or between the system controller and power-based unit. Step 3-If the device still fails to operate and patient is stable, call VAD coordinator: (phone number listed). Facility policy/ procedures/ protocol for Ventricular Assist Device SAR/LTAC Training, denotes in-part, how to contact VAD team, heart failure, a ventricular assist device (VAD) is a continuous flow pump implanted 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. VAD reduce the need of the native heart to pump vigorously to eject blood via the aortic valve, thereby reducing workload and oxygen demands of the native heart. General component; pump, driveline, controller and power x2.	S9999		

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S9999	Continued from page 12 Driveline-Electrical line that communicates between the pump and the controller, “LIFELINE”- DO NOT CUT, DO NOT DISCONNECT FROM SYSTEM CONTROLLER OR THE PUMP WILL STOP!!!! Must ALWAYS be covered with sterile occlusive dressing. Battery power- Batteries can last from 8-17 hours depending on type of VAD, press button on battery to tell how much charge is left, change batteries if down to two lights (50%), always bring all batteries/wall power with patient if being transported/transferred. Every VAD patient must have back-up equipment due to the possibility of malfunction/equipment damage!! Back-up equipment includes extra system controller, extra Batteries clips (HM 2/3), Cell Phone to call hospital contact. Heart Ware Power Sources- one battery is expected to last 7-8 hours, Each, battery drains individually, once one battery drains to less than 25% it automatically switches to the other battery, Batteries are intended for daytime use, the AC adapter will always be the primary source of power if connected, Patients are to always sleep connected to AC adapter and one fully charged battery. While in the hospital the AC adapter should always be plugged into the red outlets. Power module/ mobile power unit aka wall power, patient always sleep on the wall power, assures continuous power, must be plugged into 2-prong grounded outlet (use red outlets if available) amplifies alarms of systems controller with heartmate 2 or 3. Patient will have either mobile power unit (small box only for home use) or power module (big box). In case of a power outage switch to batteries immediately. Keep power modules plugged in at all times to keep the internal battery charged. Batteries HeartMate 3 last 10-17 hours (batteries drain simultaneously). Monitoring battery power- change to fully charged batteries or plug into wall power if power gets to 2 green bars! Switch Power Sources one at a time never double disconnect power sources. Nursing care of VAD patient- patient assessment check vital signs and VAD parameters every shift, controller and power module self-test to be performed every morning, daily weights in the morning. Weights should be consistently with clothing/equipment, contact VAD team of weigh increase greater than 5 pounds in one week. Strict intake and output. Assess driveline site every shift- make sure anchor devices is in place, perform sterile dressing changes as ordered (call VAD team with any abnormalities). Blood pressures (BP)- an automatic blood pressure cuff may not work and the preferred way to check a BP is using the doppler method. Viewing pump and systems perimeters-press display button – pump speed, press display button twice- pump flow in liters per minute, press display button three times- Pulsatility index, press display button four	S9999		

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S9999	Continued from page 13 times-power in watts , press display button five times-charge status of the backup battery in the system controller-1.charged-2.charging-3.fault, press display button six times, blank screen indicates the screen is off, which is normal. Driveline dressing. Facility Abuse policy and prevention program dated 10/22 denotes in-part this facility affirms the right of all residents to be free from abuse neglect exploitation misappropriation of property deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse neglect exploitation and misappropriation of property and mistreatment of residents. In order to do so the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that it has within its control to prevent occurrence of abuse neglect exploitation misappropriation of property deprivation of goods and services by staff and mistreatment of residents. This facility is committed to protecting our residents from abuse neglect exploitation misappropriation of property and mistreatment by anyone including but not limited to facilities app or the residents' consultants' volunteers' staff from other agencies providing services to the individual family members or legal guardians friends or any other individuals. Neglect means the failure to provide goods and services to a resident that are necessary to avoid physical harm pain or mental anguish neglect means a facility's failure to provide or willful withholding of adequate medical care mental health treatment psychiatric rehabilitation personal care or assistance with activities of daily living that is necessary to avoid physical harm mental anguish or mental illness of a resident including deprivation of goods and services by staff. 3.Orientation and training of employees; during orientation of new employees, the facility will cover at least the following topics, sensitivity to the residents and resident's needs, what constitute abuse, neglect, exploitation, and misappropriation of resident's property. 4.Establishing a resident sensitive environment the facility desires to prevent abuse neglect exploitation mistreatment deprivation of goods and services by staff and mistreatment of residents' property by establishing a resident sensitive and resident secure environment. This will be accomplished by a comprehensive quality management approach involving the following resident assessment as part of the resident's life history on the admission assessment comprehensive care plan and NMDS assessments staff will identify residents with increased vulnerability for abuse neglect exploitation his	S9999		

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S9999	Continued from page 14 treatment history of trauma or misappropriation of residence property who have needs triggers and behaviors that may lead to conflict. Through the care plan processing staff will identify any problems goals and approaches which will reduce the chance of abuse neglect exploitation mistreatment or misappropriation of resident property for these residents. Staff will continue to monitor the goals and approaches on a regular basis and update as necessary. Staff supervision supervisors will monitor the ability of the staff to meet the needs of residents including that assigned staff have knowledge of individual residents' care needs. Situations such as inappropriate language and sensitive handling or impersonal care will be corrected as they occur incidents that do not meet the definition of abuse neglect exploitation misappropriation of property or mistreatment will be handled through counseling training and if necessary or repeated the facility progressive disciplinary action. In summary there were multiple staff on duty on 09/15/2025 and 09/16/2025 (night shift) that could have checked, changed and ensured that R1's LVAD batteries had adequate voltage to run the pump thereby circulating blood to R1's heart. The facility policy/procedures/protocol reflects to change the batteries at 50% capacity, the policy does not mention to wait for an alarm to sound before addressing, checking and changing the batteries. The Facility Assessment Tool dated 08/29/2025 denotes in-part our resident profile, diseases/conditions, physical and cognitive disabilities-categories-heart/circulatory system, congestive heart failure. Decisions regarding caring for residents with conditions not listed above, facility resources including but not limited to staff skill sets and material resources. Mandatory in-services related to specific diagnoses or equipment, involvement of Medical Director, corporate resources. Services and care the facility offers based on our residents' needs, resident support needs, other special needs, dialysis, hospice, ostomy care, tracheostomy care, bariatric care, palliative care, end of life care, LVAD. Provide person-centered/directed care: Psycho/social/spiritual support: Identify hazards and risks for residents. Training topics, competencies: general staff-Abuse, Neglect and Exploitation. Nurses- Left Ventricular Assist Device. On 10/3/25 at 2:40pm, facility presented policy titled 'Left Ventricular Assist Device' dated 01/2025, review date 09/2025 denoting general: to provide guidance on	S9999		

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S9999	Continued from page 15 the care of resident with LVAD. Responsible party Nursing staff, when a resident is admitted with in LVAD it will be noted in the medical record. Nurse will enter orders for LVAD care and monitoring based on discharge instructions from hospital or from LVAD clinical directly. All prothrombin time/international normalized ratio PT/ INR results, changes in resident condition, and equipment concerns will be directed to the LVAD clinic to which the resident is assigned. Nursing staff will check to ensure that the battery backup is charged. Facility LVAD training for nurses will be completed through LVAD clinic. This policy was not present when request was made to review the LVAD policy, procedures, and or protocol on 9/17/25, 9/19/25 and 9/23/2025. (AA)	S9999		