STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0046169	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD NRSG & REHAB CENTER	**14716 S EASTERN AVENUE , PLAINFIELD, Illinois, 60544**

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S0000	Initial Comments Complaint Investigations 2579999/IL2641893 25710082/IL2644458 25710072/IL2644511 25710084/IL2644609 2579979/IL2643456 25710080/IL2644095 2579963/IL2642006 2579984/IL2642632 2579977/IL2643361 2579978/IL2643407 25710209/IL2647133	S0000		10/21/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1030c) 300.1210b) 300.1210c) 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	S9999		10/21/2025

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

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S9999	Continued from page 1 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 300.1030 Medical Emergencies c) At least one staff person shall be on duty at all times who has been properly trained to handle the medical emergencies in subsection (a). This staff person may also be counted in fulfilling the requirement of subsection (d) if the staff person meets the specified certification requirements. 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 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. These Requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents with LVADs (Left Ventricular Assist Devices) received care and services to ensure their LVADs were functioning. This failure resulted when R1 experienced a change in condition and staff did not know to assess the function of his LVAD. R1 experienced cardiac arrest, was emergently transferred to the hospital, and later expired. This applies to 1 resident (R1) reviewed for LVADs and has the potential to affect 1 other resident (R4) in the facility that uses an LVAD. The findings include: 1.On 10/14/2025 at 2:09 PM, R2 (R1's roommate) stated that on 10/12/2025 around 4:00 AM, he heard R1	S9999		

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S9999	Continued from page 2 "coughing and hacking like I do to clear my throat" and he asked R1 if he needed the nurse. R2 stated he could not understand what R1's answer was, so R2 put on the call light. On 10/15/25 at 1:29 PM, V16 (Agency CNA/Certified Nurse Assistant) said she was the assigned CNA providing care for R1 on 10/12/25 and responded to R2's call light. V16 stated she works for a staffing agency and has worked at the facility less than 10 times. V16 stated R2 said R1 was in distress and was having difficulty breathing and she immediately notified V12 (Agency LPN/Licensed Practical Nurse). R1's 10/12/2025 ambulance Patient Care Report showed paramedics were dispatched at 4:11 AM and arrived at R1 at 4:18 AM, and that CPR (cardio-pulmonary resuscitation) was initiated at 4:20 AM. The Report narrative showed "…Upon arrival crew found two staff members standing next to the patient stating that he had stopped breathing. Staff stated prior to our arrival that the patient was not waking up, but still breathing. Crew immediately started assessing the patient and checking vitals. Patient was in cardiac arrest…. Patient had a black satchel next to his side crew asked the staff what the satchel was, but staff stated that she was unsure and did not know his medical history…One of the crew members was assessing the black satchel next to the patient- device was an LVAD that did not appear working. Crew removed both batteries and replaced them with two that were on the charger next to the patient's bed. LVAD device appeared to turn green and the screen turned on and appeared to be working. Crew did a quick rhythm check and the patient had a rhythm, but did not have a carotid pulse…" On 10/15/2025 at 10:59 AM, V7 (Hospital Outpatient Nurse Practitioner with VAD Team) described an LVAD device in very basic terms as a piece of metal that is surgically implanted to the heart that provides assistance for the heart to pump. V7 stated a "driveline" comes out of the patient's body, and the line is connected to a "controller." V7 stated the "controller" is powered by two rechargeable batteries, or it can be plugged into a wall outlet. V7 stated the data collected from R1's LVAD device on 10/12/2025 showed "low battery" at 1:39 AM and "no external power" at 2:22 AM. V7 stated the data showed the device as "off" at 4:21 AM. On 10/15/2025 at 11:33 AM, V12 (Agency LPN) stated she was assigned to R1 on 10/12/2025. V12 stated she enlisted the help of V17 (Registered Nurse/RN) and she called 911 when R1 became verbally unresponsive.	S9999		

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S9999	Continued from page 3 On 10/15/25 at 3:52 PM, V17 (RN) said he has never received any LVAD training and has been assigned as R1's nurse once previously. V17 said he had never changed the batteries in an LVAD before, but if he had to, he would "call google and find out." V17 said on 10/12/25, V12 (Agency LPN) told him R1 was not looking good so he went with her to check R1, he noticed labored breathing and went to get oxygen. On 10/17/25 at 10:33 AM, V12 said the only nurse working on the same side of the building with her on 10/12/25 was V17 (RN). V12 stated this is her first skilled facility and she usually works in Assisted Living or Memory Care. V12 said she had not had any LVAD training. V12 said the nurse she received report from told her that R1 had a "heart monitor" but did not call it an LVAD or mention any LVAD assessments that V12 that needed to do. V12 stated that on 10/12/2025, she did not assess R1's LVAD and she was just looking at R1's breathing and took his vital signs. V12 stated when V16 (CNA) told her R1 stopped breathing, V17 went to get the backboard, and then the paramedics showed. On 10/15/25 at 2:39 PM, V11 (Paramedic) said on 10/12/25 during R1's CPR, he noticed the "satchel" next to R1 with a line going into his abdomen. V11 stated he asked V12 (Agency LPN) what the satchel was and V12 told him she did not know. V11 said he continued ALS (Advanced Life Support) for R1. On 10/16/25 at 2:09 PM, V23 (Firefighter/Paramedic) said R1 was already in cardiac arrest when he arrived at the bedside. V23 stated he asked about the satchel and the guys on the ambulance said the staff told them they didn't know what it was. V23 said he then opened it and saw the two batteries. V23 said he removed the batteries one by one, checked their power/charge level, saw that each battery was dead/black. V23 stated he replaced them both with two batteries from R1's battery charging station and a green light immediately came on. V23 said the LVAD was not plugged in to any other power source besides the two dead batteries. V23 said after he replaced R1's LVAD batteries, he pressed a button on the LVAD main screen, the screen illuminated for the first time and showed some numbers, and he heard the paramedics say R1 had a cardiac rhythm on their monitor. V23 said R1 was then transferred to the hospital. On 10/14/25 at 4:09 PM, V6 (R1's Son-In-Law/Emergency Contact) said R1 was in the facility because he could not be left by himself since having a stroke. V6 said he thought the facility staff were monitoring R1's LVAD	S9999		

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S9999	Continued from page 4 because the facility had to be LVAD certified to take care of R1. On 10/17/25 at 9:41 AM, V7 (LVAD Nurse Practitioner/NP) said the facility should be assessing and monitoring their LVAD patients according to the facility's policy and procedures. On 10/15/25 at 4:14 PM, V2 (Director of Nursing-DON) said the facility does not have a policy on LVADs, they follow the LVAD manufacturer "Clinical Theory and Operation" and "System Controller: Alarms & Troubleshooting" handout. On 10/17/25 at 4:05 PM, V2 said V12 (Agency LPN) should have followed the LVAD Emergency Protocol from the LVAD binder kept at the nurse's station. V2 said even if an LVAD resident is managing their own LVAD, if the resident becomes incapacitated, the staff should know how to troubleshoot and manage the LVAD. After "Contact the Patient's LVAD Team Immediately," the first intervention showed "ASSESS IF PUMP IS RUNNING: Auscultate the left chest over the apex of the heart. A continuous mechanical revving sound indicates the pump is running. Assess the System Controller. If the green pump running symbol [drawn symbol] is illuminated, the pump is running." On 10/17/25 at 12:03 PM, V21 (R1 and R4's Physician) stated a nurse providing care for an LVAD resident should be trained in LVADs. V21 said the bedside nurse should know basic things about their patients, including what devices/machines their patients have and why they have them. V21 said it is a standard expectation that the bedside nurse should be checking the battery of the LVAD at a minimum every shift during their nursing assessment. R1's Face sheet shows he was first admitted to the facility on 5/18/25 with diagnoses of chronic combined systolic and diastolic congestive heart failure, atrial fibrillation, presence of heart assist device, ischemic cardiomyopathy, cerebral infarction due to embolism of bilateral carotid arteries, and need for assistance with personal care. R1's Care Plan (initiated 9/12/25) showed R1 is at potential risk for cardiac complications related to diagnosis including hypertension, atrial fibrillation, stroke, congestive heart failure, cardiomyopathy, peripheral vascular disease, heart assist device and sedentary lifestyle causing deconditioning. R1's POS (Physician Order Sheet) as of his discharge to hospital on 10/12/25 does not show any orders for LVAD assessment, such as auscultating heart sounds or checking LVAD battery function/charge status.	S9999		

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S9999	Continued from page 5 On 10/23/2025 at 1:11 PM, V7 (VAD Team NP) stated R1 expired on 10/19/2025. 2. R4's Face sheet shows an initial admission date of 7/17/25 with diagnoses unstable angina, chronic systolic and diastolic congestive heart failure, ventricular tachycardia, end stage heart failure, atrial fibrillation, hypertension, and presence of heart assist device. On 10/15/25 at 12:05 PM, R4 said he has been missing the power cord for his mobile power unit to connect his LVAD to wall electricity while he sleeps at night. R4 said he is afraid his batteries will die while he is asleep because they only last seven hours. R4 said he has been missing the cord since he was admitted and the staff are aware, and he asked them to contact the LVAD team to send his missing cord. On 10/21/25 at 2:05 PM, R4 said the staff have come to him and he has taught them about his LVAD, and he "ain't getting paid for this sh*t!" R4 then demonstrated how to check the battery charge level and noticed that one of his two batteries was low. He then removed that battery and the LVAD started beeping continuously until he replaced it with a charged battery. R4 then said, "See? It's not that hard!" On 10/17/25 at 4:05 PM, V2 (DON) said she was not aware that R4 did not have the necessary LVAD cord to connect to wall electricity at night. On 10/17/25 at 12:03 PM, V21 (R4's Physician) said it is concerning that R4 does not have the required cord for his LVAD to connect to wall electricity while he sleeps. V21 said he thinks the facility staff should be reaching out to the LVAD team to obtain the missing equipment so R4 does not have to rely on batteries. The facility provided an undated handout from LVAD manufacturer entitled "Clinical Theory and Operation." On page 31 of the handout, it showed "Equipment Required for Discharge: …One mobile power unit with power cord…" (AA)	S9999		