STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009211	A. BUILDING: _____ B. WING _____	C 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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S 000	Initial Comments Complaint Investigation 2469729/IL181689	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1030b) 300.1210b) 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. Section 300.1030 Medical Emergencies b) The facility shall maintain in a suitable location the equipment to be used during these emergencies. This equipment shall include at a minimum the following: a portable oxygen kit, including a face mask and/or cannula; an airway; and bag-valve mask manual ventilating device. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary	S9999		

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S9999	Continued From page 1	S9999		

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.

These requirements were not met as evidenced by:

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.

Findings include:

R1's Physician Order for Life Sustaining Treatment (POLST) form dated 02/24/20 documents R1 wished to have Cardiopulmonary Resuscitation (CPR), full treatment with the primary goal of sustaining life.

R1's Diagnoses Sheet updated 11/27/24 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 (11/27/2024).

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R1's Re-Admission Summary note dated 11/26/2024 documents R1 returned from the hospital after right hip surgical repair.

R1's Health Status Note 12/3/2024 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 12/03/24 document R1's cause of death included: Asthma, Dementia and Schizophrenia.

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 12/3/24 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).

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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 12/13/24 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 12/13/24 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.

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On 12/13/24 at 11:18 pm V10, Physician/Medical Director (MD) confirmed he spoke to V1, Administrator on 12/03/24 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 12/13/24 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, 12/3/24) without the mask."

On 12/13/24 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 12/13/24 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

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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 12/13/24 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 08/10/24 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

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S9999	Continued From page 6 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." (A)	S9999		