

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146030	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2025
NAME OF PROVIDER OR SUPPLIER Heartland Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Trowbridge Road Neoga, IL 62447	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>35347</p> <p>Based on observation, interview, and record review, the facility failed to safely transfer R1 from the wheelchair to toilet resulting in R1 sustaining a broken arm requiring emergency evaluation and treatment at the hospital. This failure affects one resident (R1) of five reviewed for accidents in the sample of five. This past non-compliance occurred from 4/3/2025 to 4/4/2025.</p> <p>Findings include:</p> <p>R1's medical diagnosis list (4/16/2025) documents R1's diagnoses include: Unsteadiness on Feet, Muscle Weakness, Pain in Right Knee, Pain in Left Knee, Osteoarthritis, and Polyneuropathy.</p> <p>R1's quarterly assessment (2/25/2025) documents R1 does not reject care from staff, utilizes a wheelchair for mobility, and is dependent on staff or requires maximal staff assistance for mobility. The same record documents R1 requires staff assistance to transfer from the bed to wheelchair and onto the toilet.</p> <p>R1's Fall Notes (4/3/2025) document R1 requires maximum assistance of two staff for transfers.</p> <p>R1's Care Plan (printed 4/15/2025) in effect on 4/3/2025 documents R1 has a transfer deficit and requires the hands-on assistance of two staff members for transfers.</p> <p>The facility Serious Injury Incident and Communicable Disease Report (4/8/2025) documents R1 activated R1's call light on 4/3/2025 to get staff assistance to use the bathroom. The same report documents V3 (Certified Nurse Aide) responded to R1's call light, transferred R1 to R1's wheelchair, and then transferred R1 to the toilet when R1 became weak and complained of left arm pain after completing the transfer to the toilet.</p> <p>R1's nursing Progress Notes (4/3/2025) document when staff went to take R1 to the bathroom after supper on 4/3/2025, R1 started screaming out in pain and grabbing (R1's) left arm and stated I know it's broke! It hurts! It hurts! followed by staff obtaining a medical order to send R1 to the hospital emergency department for evaluation and treatment.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R1's hospital report (4/3/2025) documents Patient comes from the nursing home was falling when the nursing staff caught her. The same report documents R1's left upper arm had swelling, deformity, and tenderness present and R1 had an acute fracture of the left proximal humeral shaft (upper arm) with displacement. The same record documents R1 received an intravenous injection of fentanyl (narcotic medication used to treat severe pain) while in the emergency department and was prescribed hydrocodone (oral narcotic medication used to treat moderate to severe pain) upon discharge from the hospital.</p> <p>V3's handwritten incident statement (4/4/2025) documents I bear hugged (R1) to move (R1) from the wheelchair to the toilet. (R1) started to become weak. I got (R1) on the toilet and (R1) was c/o (complaining of) (R1's) arm hurting.</p> <p>On 4/16/2025 at 10:44AM, V3 (Certified Nurse Aide) reported when V3 transferred R1 to the toilet on 4/3/2025, V3 kinda bear hugged (R1) to put (R1) on the toilet and (R1) got weak (during the transfer) and R1 became heavier in V3's arms. V3 denied using a gait belt during the transfer. V3 denied R1 has any behaviors that interfere with care and denied R1 resists receiving care from staff. V3 reported after transferring R1 to the toilet, R1 then complained that R1's left arm hurt and was kinda whining that it really hurt. V3 reported (R1) is a two assist (requires the assistance of two staff for transfers) I guess. I thought (R1) was a one (requiring the assistance of only one staff member for transfers). (R1) used to be on a different hall and (R1) would be back and forth and sometimes independent.</p> <p>On 4/15/2025 at 1:07PM, V2 (Director of Nursing) reported the nursing department uses multiple ways to communicate a resident's transfer status to staff including green colored dots affixed near residents' name tags outside of their bedroom doors, written transfer status information located in binders for staff to reference, and therapy communication sheets to reference. V2 reported R1 was supposed to be assisted by two staff on 4/3/2025 but V3 (Certified Nurse Aide) was alone at the time of R1's transfer to the toilet. V2 denied the facility had any staffing issues at the time of R1's transfer and injury on 4/3/2025. V2 reported V3 should have also used a gait belt on R1 during the transfer.</p> <p>On 4/16/2025 at 1:11PM, V5 (R1's medical provider) reported R1's arm injury (fractured humerus) is consistent with V3's transfer of R1 on 4/3/2025. V5 stated proper transfer with two assist (two staff assisting R1 during transfers) and a gait belt (being used during R1's transfer) would have prevented the injury.</p> <p>The facility Gait Belt Policy and Procedure (undated) documents gait belts are to be utilized on all residents requiring physical assistance with transfer unless contraindicated and direct care staff will utilize a gait belt for all transfers requiring hands-on assistance with a pivot or manual transfer. The same policy documents all direct care staff will be provided with a gait belt for their own use.</p> <p>On 4/16/2025 at 11:11AM, R1 was seated in a reclining chair with R1's left arm in a sling. R1 reported being in a lot of pain since R1's arm injury occurred on 4/3/2025.</p> <p>On 4/16/2025 at 11:17AM, V4 (Certified Nurse Aide) reported R1 moans and groans a lot (with pain) since 4/3/2025 when R1's arm was injured.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R1's medical orders (printed 4/16/2025) document an order for staff to document R1's pain level every shift as part of R1's pain management plan.</p> <p>R1's pain assessments (1/1/2025-4/16/2025) document R1 experienced pain on five out of 92 days from 1/1/2025 to 4/3/2025 prior to the injury sustained on 4/3/2025 and then has experienced pain every day (14 out of 14 days) from 4/3/2025-4/16/2025.</p> <p>On 4/15/2025 at 1:07PM, V2 (Director of Nursing) reported R1 has a medical order to be non-weight bearing on R1's left arm for a period of 6-8 weeks.</p> <p>Prior to the survey date of 4/16/2025, the facility had taken the following actions to correct the non-compliance:</p> <ol style="list-style-type: none"> 1. On 4/3/2025, R1 was sent to the hospital for evaluation and treatment and then returned to the community. 2. On 4/3/2025, the Quality Assurance Committee developed a Plan of Correction for the 4/3/2025 incident. 3. On 4/3/2025, the Director of Nursing and therapy staff provided nursing staff with education and training on proper transfer techniques using a gait belt. 4. On 4/3/2025, the Director of Nursing provided in-service education to nursing staff on the gait belt policy and procedure. 5. Starting on 4/3/2025, the Director of Nursing will audit five resident transfers weekly for proper use of gait belts for four weeks. 6. The facility QAPI Committee will continue to monitor the facility's performance to ensure corrective actions to the 4/3/2025 incident are effective. 7. Completion date of systemic changes: 4/4/2025.