STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146030	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartland Senior Living	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to promptly respond to a call light for a newly admitted resident who was identified as being at high risk for falls. This failure affects one (R1) of three residents reviewed for accidents. This failure resulted in R1 sustaining a fall resulting in R1 being transferred to the hospital where R1 was found to have acute swelling and bleeding on both sides of the brain. Findings include:The facility's policy titled Policy and Procedure: Call Light System, which is undated, documents that it is the policy of the facility to provide a means of communication to meet the needs of each resident. Staff are required to follow established procedures to respond to residents' requests and needs.The policy documents that the callˆlight procedure requires staff to: respond promptly when a call light is activated. respond to the resident's need or request. if the staff member responding is unable to meet the need, they must locate the staff member who can meet the need.R1's Electronic Health Record (EHR), documents that R1 was admitted to the facility on [DATE], and was transferred to the local hospital within approximately five hours of admission due to an unwitnessed fall.R1's Baseline Care Plan, signed by V3, Licensed Practical Nurse (LPN) on January 18, 2026, showed R1 was identified as a fall risk and required staff supervision due to unsteady gait and safety concerns with transfers and ambulation.R1's nursing notes dated January 17, 2026, documented that R1 sustained an unwitnessed fall with suspected injury and loss of consciousness. This note also documented that R1 had bleeding to the left arm due to a skin tear. Emergency Medical Services (EMS) were contacted for an emergency transfer to the local hospital.R1's Incident Report dated 1/17/26 documents that at approximately 4:25 p.m., a Certified Nurse Assistant (CNA) was going to respond to R1's bathroom call light and found R1 on the floor. The CNA alerted another CNA, who then notified the nurse. The report documents that when the nurse arrived in R1's room, R1 was found unresponsive and lying prone on the bathroom floor. The report also documents that after review, it was determined R1 had taken herself to the bathroom without assistance and R1 had attempted to stand from the toilet, lost her balance, and fell. R1 was transported to the local Emergency Room, where a head scan showed R1 sustained edema and bleeding on both sides of the brain.On 3/6/26 at 10:27 a.m., V5, CNA stated she was at the nurses' station when R1 fell and was not paying attention to the callˆlight panel because she knew that most of the residents were in the dining room eating dinner.On 3/6/26 at 12: 09 p.m., V7, CNA stated she was passing hall trays and noticed R1's call light was blinking and sounding. V7 stated she assumed V5 was going to answer R1's call light because V5 was just standing at the nurses' station. V7 stated she continued to pass out meal trays on the 300 hall and when she returned to the 200 hall where R1 resided V7 noticed the call light outside of R1's room was still flashing and sounding. V7 stated it was at that point that she went into R1's room and found R1 lying flat on her face on the floor, and unresponsive. V7 stated approximately seven minutes had passed from the time she initially saw R1's call light going off until the time she answered it. On 3/6/26 at 10:11 a.m., V3, Licensed Practical Nurse (LPN) stated she was in the dining room passing medications when a CNA notified her that R1 had fallen. V3 stated that when she reached R1, R1 was unresponsive and had a skin tear that was (continued on next page)

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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F 0689 Level of Harm - Actual harm Residents Affected - Few	bleeding on one arm. V3 stated she contacted EMS, and when EMS arrived and attempted to move R1, R1 complained of pain in her right shoulder.On 3/6/26 at 2:30 p.m., V1, Director of Nursing (DON) stated he was aware that R1 was a fall risk and that staff would also have been aware because all newly admitted residents are treated as being at risk for falls. V1 stated his expectation is that any staff member who is aware of a call light should respond immediately unless actively assisting another resident, in which case the call light should be answered within five to eight minutes. V1 stated he would have expected V7 to communicate with V5 to ensure R1's call light was answered, stating that V7 should have sought assistance before finishing passing trays or answered the call light herself.R1's brain scan dated 1/17/26 documents that R1 sustained acute swelling and bleeding on both sides of the brain as a result of the fall.