STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185399	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartland Villa Nursing and Rehabilitation Center	8005 US Hwy 60 West Lewisport, KY 42351

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44370 Based on interview, record review and review of the facility's policy, the facility failed to ensure residents received prompt assessment and care for 1 of 3 sampled residents, Resident #2 (R2). On [DATE] at 8:30 PM, staff heard R2 yelling out and when Certified Nursing Assistant (CNA) 5 entered the resident's room she found R2 sitting on the floor near the foot of the bed. Staff lifted R2 from the floor and placed the resident on the bed. However, the facility failed to ensure nursing neurological (neuro) assessments and change in condition assessments (CIC) were completed for R2 after the unwitnessed fall. At approximately 12:00 AM (about 3.5 hours after the fall), R2 was screaming and yelling out with pain stating, call the ambulance, my legs are broke. R2 was sent to the emergency room (ER) for evaluation where it was determined she had a left impacted femur fracture, a thoracic compression fracture, and a traumatic subdural bleed with a midline shift. The hospital admitted R2 to its intensive care unit (ICU). On [DATE], R2 was admitted to hospice care and expired on [DATE]. The State Survey Agency (SSA) determined the deficient practice had been corrected on [DATE], prior to the initiation of the investigation. Deficient practice was determined to be Past Noncompliance. The findings include: Review of the facility's policy titled, Documentation and Charting Policy, dated [DATE], revealed services provided to a resident and/or any changes in the resident's medical or mental condition were to be documented in the resident's medical record as applicable. The documentation should include incidents, accidents, and changes in the resident's condition. Review of the facility's policy titled, Falls Policy, dated [DATE], revealed the intent of the policy was to ensure the facility provided an environment that was as free from accident hazards as possible, over which the facility had control to prevent avoidable falls/accidents. Continued policy review revealed all residents were to have a fall risk assessment upon admission, quarterly, annually, and with a significant change of condition to identify risk for falls. (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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's policy titled, Neuro-Check Policy, with a review date of [DATE] (reviewed after R2's fall with no changes made), revealed the policy was to provide timely and consistent neurological (neuro) assessments for residents who had experienced a head injury, fall or other neurological concern to ensure prompt detection and response to changes in the resident's condition. Continued review revealed a neuro-check must be conducted as soon as possible after an event such as an unwitnessed fall, a witnessed fall in which a head injury, or other incident necessitating neurological evaluation. Per policy review, the assessment was to include an evaluation of the resident's level of consciousness (LOC), pupillary response, limb movement, and overall orientation. Continued review of the facility's, Neuro-Check Policy, dated [DATE], revealed a licensed nurse was to perform neuro-checks, unless a physician ordered the neuro-checks to end sooner or be continued for longer. Per the policy, the following sequence of neuro-checks was to be performed: 1. Perform neuro-checks every 15 minutes times 4 (x 4) for one hour, 2. Then every 30 minutes x 2 for one hour, 3. Then every 1 hour x 4 for 4 hours, 4. Then every 4 hours x 4 for a total of 16 hours. Further review of the facility's, Neuro-Check Policy, revealed licensed staff were to document each neuro-check, noting the time, the findings, and any significant changes. Review further revealed any changes in a resident's condition must be reported to the physician for further direction. Review of the facility's Neuro-Check Guidelines with a review date of [DATE] (dated after R2's fall), revealed for the initial assessment, the facility was to conduct a full neuro assessment as soon as possible after an event or incident in which the resident had an unwitnessed fall or a witnessed fall with observation of the resident hitting their head or any head injury. Per the review, staff were to document all neuro-checks and record the time and results of each neuro-check including any changes in the resident's condition. Further review revealed staff were also to ensure any new symptoms were reported to the physician. Review of R2's closed record revealed an Admission Face Sheet found in the resident's electronic medical record (EMR). Review of the Admission Face Sheet revealed the facility admitted R2 on [DATE], with diagnoses that included Alzheimer's Disease with late-onset, pathological fracture pelvic and history of falls. Review of R2's Quarterly Minimum Data Set (MDS) Assessment, with an Assessment reference Date (ARD) of [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of five out of 15. This score indicated R2 was severely cognitively impaired. Continued MDS review revealed the facility also assessed R2 to be dependent on staff for bed mobility, transfers, and ambulation. Review of the MDS, revealed the facility assessed R2 as dependent on staff in walking 10 feet. The facility assessed R2 to use a wheelchair for mobility. Review of R2's Fall Risk Score, dated [DATE] revealed the facility assessed the resident to have a fall risk score of 16, which indicated she was considered a high risk for falls. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's, Fall Incident Report, dated [DATE] at 8:30 PM, documented by Registered Nurse (RN) 1, revealed R2 had sustained an unwitnessed fall on [DATE] at approximately 8:30 PM (indicating the RN immediately completed the Report). Per review, Resident sitting on buttock with legs under her, and had been wearing pajama pants with footwear in place. Continued review revealed R2 was alert and oriented times one; her wheelchair was at the foot of her bed; and the resident was attempting to scoot herself on the floor. Further review revealed the facility assessed R2 with no injuries noted, and no signs or symptoms or complaints of pain voiced. Additional review revealed R2 was assisted to stand and ambulate a few steps back to her bed by CNA 5 and RN 1. The review revealed R2 tolerated the transfer well. However, there was no documented evidence indicating RN 1 completed the CIC and initiated the neuro-checks, nor obtained R2's vital signs or assessed her range of motion (ROM). Review of the Progress Note for R2 dated [DATE] at 9:35 PM, documented by RN 1 revealed the resident had been found on the floor on her buttocks, with no injuries or complaints of (c/o) pain. Per review, R2 was stating, get me up. Continued review revealed the Note had been struck through on [DATE] and noted as a late entry. Further review revealed no documentation noting RN 1 completed a Change of Condition (CIC) note, that was to be completed with any medical change. In addition, the facility failed to initiate neuro-checks after the resident's unwitnessed fall. Review of R2's Progress Note, dated [DATE] at 2:10 PM, documented by RN 1 and entered as a late entry for [DATE], revealed the nurse had been called to R2's room by CNA 5 because the resident was on the floor. Continued review revealed R2 was agitated and yelling, put me to bed. Per review, RN 1 noted her assessment of R2 which revealed the resident was sitting on her legs scooting towards the bed, wearing pj (pajama) pants and socks. Further review revealed R2 was able to stand up to get back in bed with the assist of two staff members. Additional review revealed RN 1 assessed R2 to have no abnormalities, and no pain voiced. CNA 5 and the RN assisted R2 to lie on her bed and made her comfortable, with her call light in reach, bed alarm on, and low bed in place. Review of the facility's, Acute Change in Condition (CIC) note dated [DATE] at 2:21 AM, revealed Resident is exhibiting an acute change in condition and was yelling out and complaining of severe pain to her left hip/leg and Tylenol was not effective. Per review, R2 had a fall on [DATE] at approximately 8:00 PM. Continued review revealed Date first observed: [DATE]. Things that make condition worse: touching. Record review revealed R2's vital signs dated [DATE] at 2:25 AM, revealed a blood pressure (B/P) reading of ,d+[DATE]; temperature 97.3; pulse 75 and respirations 20. NEED MEASURE, AND MAYBE NORMS FOR HER Further review of the CIC note revealed R2's pain was new and the description of her pain was left hip/leg pain. Per review of the Neuro evaluation of the CIC note revealed no changes observed with the Summary of Observation/Evaluation documented as R2 had a fall on [DATE] evening at approximately 8:00 PM, but showed no signs of pain at that time. Review further revealed at approximately 1:00 AM, R2 had been lying on her bed and began yelling out in pain to her left hip/leg, and was yelling call the ambulance. Additional review revealed the physician was notified and a new order was received to sent R2 to the ER for evaluation and treatment. Review of the Hospital History and Physical Note, dated [DATE] revealed admitting diagnoses included; a traumatic right side cerebral hemorrhage with unknown loss of consciousness, compression fracture of T1 vertebrae, and a closed non-displaced impacted fracture of the left femur initial encounter. The resident was admitted to the intensive care unit with a diagnosis of intracranial hemorrhage. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the Physician's Note dated [DATE], revealed, meeting on [DATE] with patient's son and daughter at bedside. Patient's prognoses remains very guarded, patient remains in significant discomfort on physical restraints, nasogastric (NG) tube in place. She has severe dementia and cannot communicate her needs. Family wants to transition her care to comfort only. We will discontinue tube feeds and physical restraints and will continue end-of-life care. Hospice was consulted. In interview on [DATE] at 10:46 AM, Licensed Practical Nurse (LPN) 1 stated on [DATE], in the report she received from LPN 2, R2 had fallen the night before and had been sent to the ER. She stated RN 1 had not completed a CIC note, nor initiated neuro-checks for R2 after the resident's fall. LPN 1 explained that the facility completed neuro-checks on a paper form, which were never started for R2. However, they should have been. She stated she informed the Director of Nursing (DON) of that information. The LPN stated there was a falls binder at the desk that instructed staff on how to handle residents' falls. In interview on [DATE] at 4:18 PM, CNA 5 stated she had been charting at the nurse's station on [DATE], when she heard R2 yelling out. She stated she went to R2's room and found the resident sitting on the floor and she immediately informed RN 1. The CNA stated RN1 made sure R2 had no injuries while the resident was still lying on the floor. CNA5 stated she and RN 1 lifted R2 from up off the floor, by getting the resident up under the arms and lifted her up and put her in the bed. Per the CNA, R2 had not complained of pain. She stated R2's feet were not touching the floor enough for her to bear weight. She stated she had not seen RN 1 further assess R2 after that, nor obtain the resident's vital signs or perform ROM (range of motion). In interview on [DATE] at 7:17 AM, LPN 2 stated she arrived to work on [DATE] at 10:00 PM, and R2 had been at the nurse's station sitting in her wheelchair and had been calm and in no distress. She stated she received in report from RN 1 that R2 had experienced a fall. LPN 2 stated she was not aware that a CIC had not been completed until she started charting and realized there was not an assessment for her to follow up on. The LPN stated she checked on R2 several times and completed neuro-checks of the resident; however, she had not documented the neuro-checks on the facility's form, nor in the resident's medical record. She stated the form for R2's neuro-checks had not been started and she had not started one either. The LPN stated she had completed a CIC when R2 started yelling out and complaining of pain. Per LPN 2, she administered Tylenol which had not been effective, so she notified the Medical Director who ordered an in-house x-ray. She stated she notified R2's daughter who did not want to wait on the in-house x-ray, so she called the Medical Director back and received an order to send R2 out (to the ER). LPN 2 explained when a resident sustained a fall, an incident report was to be completed, which triggered a Change in condition assessment to be completed and documentation the medical record. She further stated unwitnessed falls should have neuro-checks initiated. In interview on [DATE] at 3:07 PM, RN 1 stated she had worked at the facility for about a year and had been a nurse for almost [AGE] years. She stated she had been working on [DATE], when CNA 5 made her aware R2 had been found on the floor. RN 1 stated she went to R2's room and assessed the resident for injuries. She stated R2 had no complaints and she and CNA 5 picked the resident up and sat her in her chair. RN 1 stated R2 stood on her legs without pain and slept the rest of her shift. In continued interview RN 1 stated the CIC documentation had been completed by LPN 2 and the LPN should have started the neuro-checks when she saw they had not been completed. She stated she had not completed a CIC which had been an oversight on her part. The RN stated that night ([DATE]) had been a busy night; however, she should have completed a CIC assessment and initiated neuro-checks following R2's unwitnessed fall. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In interview on [DATE] at 3:07 PM, RN 1 stated the next day on [DATE], she received a call from the Assistant Director of Nursing (ADON) to come to the facility and complete documentation as her initial note lacked documentation. RN 1 stated she wrote a progress note and included more information in her late entry note. She stated she received disciplinary action and education related to the facility's falls process and documentation. In interview on [DATE] at 12:13 PM, the former Assistant Director of Nursing (ADON) stated in the early morning hours of [DATE], (she could not recall the specific time) LPN 2 notified her of R2's fall and that the resident was being sent to the ER. The ADON stated she was also told that RN 1 failed to complete a CIC assessment for R2 and failed to initiate neuro-checks for the resident after the unwitnessed fall. She stated she called RN 1 and requested the nurse come to the facility to complete her documentation as it had been lacking. The ADON further reported RN 1 should have completed the CIC assessment and initiated neuro-checks of R2 as per the facility's policy. In an interview with the Medical Director on [DATE] at 5:17 PM, he stated that he was made aware of R2s fall but could not recall the time or which nurse made him aware. He stated he expected the facility to follow policies and document when a resident has a fall or a change in condition and to initiate neuro assessment,s if applicable. In interview on [DATE] at 2:08 PM, the Director of Nursing (DON) stated she had been the DON since [DATE] and was still learning her role. She stated the nurses called her when a resident had a fall. She explained she had a missed call from RN 1 on [DATE] around 10:00 PM. The DON stated she was made aware of R2's fall when she arrived to work on [DATE]. She stated she had been told by the ADON that RN 1 failed to initiate neuro-checks or complete a CIC assessment when R2 experienced the unwitnessed fall. Per the DON, the ADON called RN 1 and had her come to the facility and complete her documentation, to change her note and add information regarding the fall. She stated when a resident sustained a fall, she expected the nurse to perform a head-to-toe assessment to check for injuries. The DON stated the head-to-toe assessment was to include obtaining the resident's vital signs, checking their ROM (range of motion), and initiating neuro-checks as per the facility's policy. She stated an incident report and Change in Condition assessment(s) should also be completed, and the resident's family and physician notified. The DON further stated the Neuro-Check Policy had only been reviewed and no changes had been made to the policy. In interview on [DATE] at 2:19 PM, the Administrator stated he had been the Administrator since [DATE], and he was still learning his role. The Administrator stated the DON and ADON made him aware of R2's fall and told him the Change in Condition assessment was incomplete. He stated he was not clinical but expected staff to follow the facility's policy and protocols related to care provided to residents. The Administrator further stated the Neuro-Check Policy had only been reviewed and no changes had been made to the policy.