| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445526 | A. Building<br>B. Wing | 03/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Heartland | 3025 Fernbrook Lane<br>Nashville, TN 37214 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38439<br><br>Based on facility policy review, medical record review, and interview, the facility failed to ensure all alleged violations involving abuse are reported immediately, but not later than 2 hours after the allegation is made for 4 of 5 (Resident #1, #24, #47, and #209) sampled residents reviewed for abuse.<br><br>The findings include:<br><br>1. Review of the facility policy titled, Patient Protection and Response Policy for Allegations/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation, with revision date 2/1/2023 revealed, .Any partner having either direct or indirect knowledge of any event that might constitute abuse, neglect .must report the event immediately .it is the policy of this facility that abuse allegation .are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse .are reported immediately, but not later than 2 hours after the allegation is made .<br><br>2. Review of the medical record revealed Resident #1 admitted to the facility on [DATE], with diagnoses that included Epilepsy, Muscle Weakness, and Mild Cognitive impairment.<br><br>Review of the Quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #1 had a Brief Interview for Mental Status score of 7 which indicated severe cognitive impairment.<br><br>Review of Resident #1's Progress Notes dated 1/12/2025 revealed, .nurse alerted to resident's room by cnas (Certified Nursing Assistants) and weekend manager. Resident has laceration to rt [right] eye brow. Noted swelling around eye and bruising where the eye meets his nose. Noted blood in sclera. Resident states he has a mild headache. Denies hitting head on any objects. This nurse initiated neurochecks. Notified NP [Nurse Practitioner], POA [Power of Attorney] and DON [Director of Nursing]. Site was cleansed and covered with bandage. Ice applied to eye to attempt to reduce swelling and bruising. Resident given one time dose of Tylenol 325mg [milligram] 2 tabs .<br><br>Review of the medical record revealed Resident #209 was admitted to the facility on [DATE] with diagnoses which included Vascular Dementia, Unspecified mood disorder, Anxiety disorder, and Homelessness.<br><br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445526 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/13/2025 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Heartland | | STREET ADDRESS, CITY, STATE, ZIP CODE 3025 Fernbrook Lane Nashville, TN 37214 | |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Quarterly MDS dated [DATE], revealed Resident #209 had a BIMS score of 15, which indicated no cognitive impairment.<br><br>Review of Resident #209's Progress Notes dated 1/13/2025, revealed Resident oriented to new room, without complaint or issues reported. Resident has baseline confusion with words .Resident ate meals x 3 and ambulated unit without issues noted .<br><br>3. Review of the Quarterly MDS dated [DATE], revealed Resident #24 had a BIMS score of 8, which indicated moderate cognitive impairment.<br><br>Review of the medical record revealed Resident #47 admitted to the facility on [DATE] with diagnoses which included Unspecified Dementia with psychotic disturbance, Delusional Disorders, Anxiety disorder, and Restlessness and Agitation.<br><br>Review of the Quarterly MDS dated [DATE], revealed Resident #47 had poor short term and long-term memory.<br><br>Review of Resident #47's comprehensive care plan with edit date 3/6/2025 revealed, .I have hx [history] of yellout [yelling out] toward others and disrupting environment. I have a hx of throwing objects at others .I do talk to myself and imagine objects .<br><br>4. During an interview on 3/11/2025 at 10:32 AM, Certified Nursing Assistant (CNA) C was asked if she ever witnessed resident to resident abuse. CNA stated, .I know of some residents that hit each other, [Named Resident #209] hit [Named Resident #1], he got hit in the eye, [Named Resident #47] hit [Named Resident #24]. [Named Resident #24] got hit in the back of her head because she was trying to get [Named Resident #47]'s lunch tray .<br><br>During an interview on 3/11/2025 at 10:50 AM, the Administrator was notified staff reported to this surveyor Resident #209 hit Resident #1 and Resident #47 hit Resident #24. The Administrator stated, Who told you that, I think I may have a file on [Named Resident #209] and [Named Resident #1] but I don't know anything about [Named Resident #24] hitting [Named Resident #47] .<br><br>After the Administrator was informed of the allegation of abuse between Resident #1 and Resident #209, the Administrator provided the following investigation:<br><br>Review of a typed statement signed by Assisted Director of Nursing (ADON) E dated 1/12/2025 revealed, . Resident has laceration to rt eye brow. Noted swelling around eye and bruising where the eye meets his nose. Noted blood in sclera .Denies hitting head on any objects .Room was assessed for items that resident may have hit head on .Nightstand is on the left side of bed had some blood on corner of nightstand. Resident tends to roll over to grab stuff out of his night stand which would correlate where the cut would hit if he had rolled to grab something .<br><br>Review of a typed statement signed by DON dated 1/12/2025 revealed, On 1/12/2025 at approx. [approximately] 16:45 [4:45 PM] I was notified of a laceration to [Named Resident #1] .R [right] eyebrow. ADON was charge nurse on this day and she was instructed on steps for investigation. Investigation revealed that [Named Resident #1] was attempting to retrieve something from his table which caused the laceration to his R eye .<br><br>(continued on next page) |

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|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Heartland | | STREET ADDRESS, CITY, STATE, ZIP CODE 3025 Fernbrook Lane Nashville, TN 37214 | |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of an email provided by the Administrator revealed the Administrator had emailed himself a typed statement. The email was dated 1/13/2025 which revealed, .I [Administrator] spoke with both [Named Resident #209 and Resident #1] today. [Named Resident #1] said a tall, dark, [NAME] looking [AGE] year-old looking kid decided he needed a black eye on Friday 1/10/25 [2025]. He said he was doing good ever since the incident with his eye and that the staff and other residents are good to him .[Resident #209] said he knew about his roommate's eye but that he was in the common area when this all happened as staff rushed into the room to respond to [Resident #1]. He denies ever touching [Resident #1] and reassured he'd never do anything like that. There were no other witnesses .<br><br>Review of the email revealed the Administrator was aware of the allegation of abuse when Resident #1 told the Administrator someone blacked his eye.<br><br>During an interview on 3/11/2025 at 10:59 AM, the Administrator was asked if he reported Resident #1's allegation of abuse to the state agency. The Administrator stated, .[Named Resident #1] had the dates mixed up .the day before I knew he had the injury. He has Dementia I was looking at the big picture, the fact he had an injury, we had an investigation about the injury .In this case looking at the facts related to the day prior. I used deductive reasoning. I felt I had the information I needed to have .<br><br>After the Administrator was informed of the allegation of abuse between Resident #24 and Resident #47, the Administrator provided the following investigation:<br><br>Review of a typed statement signed by the Administrator and DON dated 3/11/2025 revealed, .2:30pm Admin [Administrator] and DON spoke with [Named CNA C] in DON office. [Named CNA C] explained that she had witnessed [Named Resident #47] hit [Named Resident #24] on the head with her hand. She stated that the nurse witnessed the event as well and assumed that the nurse being her supervisor was aware .<br><br>Review of a typed statement signed by the Administrator dated 3/11/2025 revealed, 2:50 PM .Admin and DON called [Named Licensed Practical Nurse LPN Q] on the phone and was asked about the event between [Named Resident #47 and Named Resident #24]. [Named LPN Q] was asked if she had witnessed the event in question. She recalled that she saw [Named Resident #47] playing with [Named Resident #24]'s hair in a non-aggressive manner. [Named LPN Q] stated that she asked [Named Resident #24] if she wanted to have [Named Resident #47] moved away from her to which [Named Resident #24] said that she didn't mind [Named Resident #47] playing with her hair . The written statement was completed 4 hours after this Surveyor reported the allegation of resident-to-resident abuse and this was not reported to the state agency.<br><br>Review of a typed statement signed by the Administrator dated 3/11/2025 revealed, .Admin [Administrator] interviewed .[Named Resident #24] and she reported no concerns of care regarding other staff members nor issues with other resident in the facility. She stated that she feels safe here when asked .<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Heartland | | STREET ADDRESS, CITY, STATE, ZIP CODE 3025 Fernbrook Lane Nashville, TN 37214 | |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 3/13/2025 at 11:00 AM, CNA K stated, .we were passing out trays around January. I had just taken [Named Resident #1]'s tray and he asked me who is that man over there referring to his roommate [Named Resident #209]. I told him it was his roommate, and he is on his side of the bed. I went down the hall and when I came back [Named Resident #1] was in the bed and he was bleeding around his eye, and it immediately started swelling up and getting red. His roommate [Named Resident #209] was the only person in the room. [Named Resident #1] said he hit me with his fist. The ADON knew about it he told her the same thing. They moved [Named Resident #209] to another room.<br><br>During an interview on 3/13/2025 at 11:15 AM, CNA D stated, .the next morning [1/13/2025] [Named Resident #1] was saying some guy punched him in the face .<br><br>The facility failed to report the abuse incident between Resident #1 and Resident #209, and the abuse incident between Resident #24 and Resident #47 to the State Survey Agency.<br><br>44724 |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38439<br><br>Based on medical record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments Section GG (Functional Abilities) were incomplete for 2 of 16 (Resident #20 and #21) MDS assessments reviewed.<br><br>The findings include:<br><br>1. Review of the medical record revealed Resident #20 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Insomnia, Sleep Apnea, Cardiomyopathy, and Chronic Pain Syndrome.<br><br>Review of the annual Minimum Data Set (MDS) dated [DATE], revealed Resident #20 had a Brief Interview for Mental Status score (BIMS) of 15, which indicated the resident was cognitively intact and Section GG was dashed and not completed.<br><br>2. Review of the medical record revealed Resident #21 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Hypertension, Seizure Disorder, and Dysphagia, pharyngoesophageal phase.<br><br>Review of the quarterly MDS dated [DATE], revealed Resident #21 had a BIMS score of 9, which indicated the resident was moderately cognitively impaired and Section GG was dashed and not completed.<br><br>3. During a telephone interview on 3/12/2025 at 4:10 PM, the MDS Coordinator confirmed she was on vacation the week of 2/10/2025 to 2/18/2025, Resident #21's assessment date was due to be completed on 2/13/202. MDS Coordinator confirmed Resident #21's assessment was completed by the ADON on 2/18/2025 which was done outside of the assessment period. The MDS Coordinator confirmed section GG for Resident #21 should have been completed by the Assessment Reference Date (ARD) Date of 2/13/2025. MDS coordinator confirmed no assessment was done for Resident #21 during the ARD period of 2/11/2025 and 2/13/2025 and section GG was blank and incomplete.<br><br>During an interview on 3/12/25 at 4:43 PM, the MDS Coordinator confirmed she was on vacation the week of 2/10/2025 to 2/18/2025 and when she returned she realized the assessment for Resident #20 was incomplete. MDS Coordinator confirmed the assessment was due to be completed on 2/12/2025 and the facility had appointed someone to complete section GG in her absence. MDS Coordinator confirmed the Director of Nursing and herself had a video meeting and a list of assessments with due dates had been given to the DON with a list of completion dates. The MDS Coordinator confirmed that Section GG for Resident #20 was on the list and should have been completed between 2/10/2025 and 2/12/2025 and it was not completed until 2/18/2025. The MDS Coordinator confirmed that the annual MDS assessment dated [DATE] is incomplete and inaccurate if it was not completed at least 2 days prior to the Assessment Reference Date (ARD) of 2/2/2025. The MDS Coordinator confirmed if the section is dashed, it is incomplete.<br><br>46252 |

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| NAME OF PROVIDER OR SUPPLIER Heartland | | STREET ADDRESS, CITY, STATE, ZIP CODE 3025 Fernbrook Lane Nashville, TN 37214 | |

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|---|---|
| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724<br><br>Based on facility policy review, medical record review, observations, and interview, the facility failed to provide scheduled showers/baths for 1 of 28 (Resident #28) sampled residents reviewed for bathing.<br><br>The findings include:<br><br>1. Review of the undated policy titled, Bathing Policy, revealed .As a standard, residents are placed on a 3x [time]/week shower/full bed bath schedule. However, if a resident asks for a shower/full bed bath in addition to the schedule, every attempt is made to accommodate .Shower schedules are placed in the reference book at the nurse's stations. Documentation is by exception only, meaning that refusals of shower/full bed baths be documented .<br><br>2. Review of the shower schedule provided by the facility revealed Resident #28 was scheduled to receive a shower on night shift from 6:00 PM to 6:00 AM on Monday, Wednesday, and Friday.<br><br>3. Review of the medical record revealed Resident #28 was admitted to the facility on [DATE], with diagnoses which included Traumatic Subdural Hemorrhage, Diabetes Mellitus, Orthostatic Hypotension, and Chronic Pain.<br><br>Review of the Annual Minimum Data Set (MDS) dated [DATE], revealed Resident #28 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated moderately impaired cognition. Continued review revealed Resident #28 was dependent for shower/bath, substantial assistance with upper body dressing, and dependent for lower body dressing and toileting hygiene.<br><br>During an observation and interview on 3/10/2025 at 10:59 AM, Resident #28 was dressed in a blue shirt and red/black checked pajama pants. Family Member (FM) P stated, .we have had issues with him [Resident #28] getting a shower since he admitted . The facility has told us he is scheduled to get a shower on night shift 3 days a week. Since 2/15/2025 he has only had 4 showers, we ask about the showers when we come in because we are here every day from around 7 [7:00 AM] to around 7:30 [7:30 PM] .We mentioned it in his care meeting with the social worker and nurse management and nothing has improved .[Named Certified Nursing Assistant (CNA) N] has provided him 3 of his showers on day shift .<br><br>During an observation and interview on 3/11/2025 at 10:22 AM, Resident #28 continued to have on the same blue shirt and red/black checked pajama pants he had on 3/10/2025. FM P stated, .yes he still has on the same clothes this morning and his shower was scheduled last night .<br><br>During an observation and interview on 3/11/2025 at 3:00 PM, Resident #28 had on a blue short sleeve shirt and gray jogging pants. FM P stated, .still no shower, I helped him change his shirt and pants today .<br><br>During an observation and interview on 3/12/2025 at 9:00 AM, Resident #28 continued to have on the same blue shirt and gray jogging pants he had on 3/11/2025.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER: Heartland | | STREET ADDRESS, CITY, STATE, ZIP CODE: 3025 Fernbrook Lane Nashville, TN 37214 | |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation and interview on 3/13/2025 at 8:30 AM, Resident #28 continued to have on the same blue shirt and gray jogging pants he had on 3/11/2025. FM P confirmed Resident #28 continued to have on the same clothes. FM P stated, .I was here until 8:00 PM last night and he didn't get a bath .<br><br>During an observation and interview on 3/13/2025 at 10:00 AM, Resident #28 was up in his wheelchair dressed in different clothes. FM P stated, .[NAME] gave him a shower this morning .she is so good .<br><br>During an interview on 3/13/2025 at 10:15 AM, CNA P was asked why she gave resident #28 a shower. CNA P stated, .I gave him his bath. He asked me for it . The CNA was asked how she would chart his shower. CNA P stated, .we have no way to chart showers .if a resident refuses a shower, then we report it to the nurse and she would document the refusal . CNA P was asked if she routinely cares for Resident #28 and she stated, yes. CNA P was asked if it was common for Resident #28 to have on the same clothes with no evidence of shower being given on night shift and she stated, .all I can say is I try to do the best I can for him and the family .<br><br>During an interview on 3/13/2025 at 10:30 AM, License Practical Nurse (LPN) O stated, .the CNAs should fill out a shower sheet if a resident gets a shower and we keep it at the nurses desk .I have some shower sheets for February and March but I don't see any shower sheets for [Named Resident #28] .he is scheduled to receive a shower on night shift .I don't see any refusals charted for his shower .<br><br>During an interview on 3/13/2025 at 11:37 AM, the Director of Nursing (DON) was asked to review Point of Care History for Resident #28's bathing from 2/22/2025 to 3/12/2025. The DON was asked if a resident refused a bath or shower would it be charted on the Point of Care History and she stated, yes, it would be charted if he refused. The DON verified no refusals were charted. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38439<br><br>Based on facility policy review, medical record review, and interview, the facility failed to follow physician orders for 2 of 28 sampled residents (Resident #8 and Resident #207) reviewed.<br><br>The findings include:<br><br>1. Review of the undated facility policy titled, PHYSICIAN ORDER RECAP PROCESS [Named Electronic] SOFTWARE revealed When the nurse receives the order, she will review the physician orders for any changes and obtain any clarifications or additional orders necessary. The nurse confirmation of this order attests that she has completed this review process. When the physician makes the required visit, he will review .make any changes he/she deems necessary and sign this order. This will serve as documentation that he has reviewed and renewed the orders .<br><br>Review of the facility policy titled, LAB AND X-RAY SERVICES, dated 3/2024 revealed, The center maintains agreements/contracts for .laboratory .services. These studies will be obtained only upon the written order of the patient's physician .The center ensures that the patient's physician or physician extender is made aware of test results that fall outside the clinical reference ranges within a reasonable timeframe after receiving the results. If the study cannot be done in the center, administration shall assist in arranging adequate and safe transportation of the patient to the office or laboratory where the test will be performed .<br><br>2. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE], with diagnoses which included Chronic Obstructive Pulmonary Disease, Osteoarthritis, and Chronic Diastolic Heart Failure.<br><br>Review of the Annual Minimum Data Set (MDS) dated [DATE], revealed Resident #8 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated no cognitive impairment.<br><br>Review of Resident #8's Resident Orders dated 3/1/2025-3/12/2025 revealed a physician's order for Breo Ellipta (inhaler that treats asthma and Chronic Obstructive Pulmonary Disease) 100-25 mcg (microgram)/dose 1 inhalation once a day at 7:00 AM - 11:00 AM.<br><br>During a medication observation Licensed Practical Nurse (LPN) A prepared Resident #8's medication. During the preparation LPN A looked for Resident #8's Breo Ellipta and was unable to find the inhaler in the medication cart. LPN A stated, I will put in an order to the pharmacy.<br><br>During a telephone interview on 3/12/2025 at 11:37 AM, [Named Pharmacy #1]'s Certified Technician stated, the inhaler was delivered on 2/13/2025 it is a one-month supply so the facility should have the medication to give.<br><br>During an interview on 3/13/2025 at 12:00 PM, LPN A was asked if Resident #8 received her Breo Ellipta inhaler from the pharmacy. LPN A stated, .She still doesn't have any .<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3. Review of Hospital #1's History of Present Illness dated 2/25/2025 for Resident #207 revealed .History of present illness .presents complaint of knee pain. The patient had multiple previous surgeries on her right knee .she had a revision last on the right side in 2023. She tells me she has had drainage from the wound since about Christmas time. She also felt weak and feverish. This grew mixed organisms. Due to the patient's continue drainage she wants to proceed with resection surgery. She has history of coronary artery disease. She has undergone balloon angioplasty as well as stent placement-this is noted in previous record .<br><br>Review of the medical record revealed Resident #207 admitted to the facility on [DATE], with diagnoses which included Infection and Inflammatory reaction due to internal Right Knee Prostheses, Type 2 Diabetes Mellitus without complications, and Atherosclerotic Heart Disease.<br><br>Review of Resident #207's Resident Orders dated 3/9/2025-3/11/2025 revealed a physician's order to administer Vancomycin 1000mg intravenous every 12 hours at 8:00 AM and 8:00 PM which started on 3/7/2025. Continued review revealed a physician's order to draw Vancomycin Trough on 3/11/2025.<br><br>Review of the Medication Administration History (MAH) dated 3/1/2025-3/12/2025 revealed an order for Vancomycin 1,000 mg every 12 hours through 3/25/2025 at 8:00 AM and 8:00 PM. Further review of the MAH dated 3/11/2025 revealed the 8:00 AM dosage of Vancomycin 1000 mg was .Not administered: On Hold . Further review revealed the Vancomycin was charted as given on 3/11/2025 at 1:59 PM, 5 hours and 59 minutes past the scheduled administration time.<br><br>Review of Resident #207's Progress Notes dated on 3/11/2025 at 1:26 PM revealed, .MD [Medical Doctor] contacted regarding vanc [Vancomycin] being held due to waiting on trough draw for morning dose. Orders to hold morning dose and resume PM dose after trough results . The Progress Notes revealed the MD was not contacted until<br><br>5 hours 36 minutes pass the time of the Vancomycin to be administered. Review of the Progress Notes revealed no nurse tried to obtain the lab work for the trough and did not notify the MD until 5 hours and 36 minutes past the time for the medication administration.<br><br>During a medication observation on 3/12/2025 at 9:05 AM, Assistive Director of Nursing (ADON) B was observed administering Vancomycin 1,000 mg per Resident #207's PICC (Peripherally Inserted Central Catheter) line.<br><br>During an observation and interview on 3/10/2025 at 11:22 AM, Resident #207 stated, .I got here yesterday evening around 5:00 PM .I had to have surgery on my leg .I am supposed to get some IV [intravenous] medication . Resident #207 was noted to have a single lumen IV site to her left arm.<br><br>Observation on 3/11/2025 at 8:00 AM, 9:00 AM, and 10:00 AM in Resident #207's room revealed no Vancomycin was being administered for her AM dose of IV therapy.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Heartland | | STREET ADDRESS, CITY, STATE, ZIP CODE 3025 Fernbrook Lane Nashville, TN 37214 | |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 3/11/2025 at 4:30 PM, the Assistant Director of Nursing (ADON) was asked about Resident #207's AM dose of Vancomycin. The ADON stated, .the nurse notified the lab of the trough to be drawn when she admitted on [DATE] they usually come out at 3:00 AM .the nurse called at 3:00 AM this morning but the lab never came out . The ADON was asked if a Registered Nurse (RN) could have drawn the lab. The ADON stated, .I don't think you can draw from the midline .I guess we could have got a peripheral stick for the trough, but the lab would still need to pick the lab work up .she didn't get a dose this morning but the lab is still supposed to come out and get the trough so she can get the evening dose .<br><br>During a medication observation and interview on 3/12/2025 at 9:05 AM, ADON was observed starting the infusion of Vancomycin 1000 mg for Resident #207 through her PICC (peripherally inserted central catheter) line. The ADON was asked about Resident #207's lab for her trough level. The ADON stated, .the trough was obtained around 7:30 PM last night. She got her dose last night .<br><br>During a telephone interview on 3/12/2025 at 11:54 AM, the Pharmacist was asked at what time a trough should be performed for a resident receiving Vancomycin Intravenously. The Pharmacist stated, it should be drawn 30 minutes before the Vancomycin is due to be given. The Pharmacist was asked why Resident #207's trough was ordered to be completed at 3:00 AM and she stated, I don't know why the trough would be scheduled at 3:00 AM. The lab does normally draw the lab work. The trough would be more accurate if done 30 minutes before the next dose. I know they did obtain the trough, and the Vancomycin dosage was increased for the evening dose today. I do not do the dosing it is done by the IV consultant. The trough must have been low .<br><br>During a telephone interview on 3/12/2025 at 2:05 PM, the Pharmacist Consultant stated, .I wasn't surprised her trough was low with her weight and the dosage she was on I recommended Vancomycin 1500 mg every 12 hours .I was not aware the lab was drawing troughs at 3:00 AM .It is not really a trough, needs to be closer to the time it is due to be done .I assumed the level was drawn at a normal time. I wasn't aware that it was not being done at an appropriate time .I would expect a nurse to draw the lab at the appropriate time and wait on the lab to pick it up .<br><br>During an interview on 3/12/2025 at 4:15 PM, Licensed Practical Nurse (LPN) O stated, .the lab comes and obtains our lab . LPN O was asked how the facility notifies lab work needs to be completed. LPN O stated, . we put it in the computer hit stat and it goes straight to the lab .<br><br>During an interview on 3/13/2025 at 4:20 PM, the MD was asked about Resident #207's trough not being completed until after she missed her morning IV Vancomycin. The MD stated, .I was notified about it not being done, labs are a problem in all these facilities .If you can find a lab that will work with us that would be good .<br><br>During an interview on 3/13/2025 at 6:30 PM, the DON was asked if she would expect her nursing staff to follow Physician orders. The DON stated, .yes, I would expect the nurses to follow the orders . |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46252<br><br>Based on facility policy review, medical record review, observation, and interview, the facility failed to provide care and services for a resident with a percutaneous endoscopic gastrostomy (PEG) tube (tube inserted into the stomach to administer medications, supplements and liquid food) when staff failed to notify physician and resident representative of a change in status resident weight loss, and refusal of peg tube feedings for 1 of 3 (Resident #6) sampled residents reviewed for enteral feedings.<br><br>The findings include:<br><br>1. Review of the facility policy titled, Patient Care Policies -Policies and Procedure Regarding Change in Patient Status, revised on 3/2024, revealed .The patient or patient representative is encouraged to be involved in all decision-making regarding changes in the plan of care .Notification of Patient Representative . The charge nurse on duty is notified immediately of any change in a patient's condition. The charge nurse will then assess the patient's condition and notify the physician or physician extender and the patient's representative .<br><br>Review of the facility policy titled, Patient Care Policies Nutrition Support - Enteral/Total Parenteral Nutrition (TPN), revised 3/2024, revealed .Nutrition support will be provided according to physician orders and assessed nutritional needs. Patients who receive tube feeding or TPN will be routinely assessed and recommendations made when appropriate .<br><br>Review of the facility policy titled, Medication Administration - General Guidelines, revised on 2/25/2025, revealed .Consistent medication refusal must be reported to the prescriber and there must be documentation of prescriber notification of such. Refusal of anticoagulants .and any narrow therapeutic index medication should be closely monitored and reported to the physician as needed .<br><br>Review of the facility policy titled, Weight Monitoring, revised 3/2021, revealed .Patients weights will be monitored to maintain acceptable nutritional parameters .Weights will be monitored and evaluated for significant changes, 5% in 30 days and 10% in 180 days .<br><br>2. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE], with diagnoses which included Encounter for surgical after care following surgery on digestive system, unspecified Dementia, unspecified severity, without behavioral disturbance, psychotropic disturbance, mood disturbance, and anxiety, other Specified Eating Disorder, Chronic embolism (an obstruction or blockage in a blood vessel) and thrombosis (a blood clot within blood vessels that limits the flow of blood) of right popliteal (back of the knee) vein, Dysphagia Oropharyngeal phase (swallowing problems occurring in the mouth and/or the throat), and Gastrostomy (a surgical opening (gastrostomy) into the stomach) status.<br><br>Review of the Vitals Report for Resident #6 revealed the following weights:<br><br>On 10/03/2024 at 2:55 PM Weight: 151.8 pounds (lbs) and Routine BMI (Body Mass Index) (a calculated measure of body weight relative to height): 27.76.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 10/08/2024 at 4:17 PM - Weight: 148.7 lbs and BMI: 27.19.<br><br>On 11/07/2024 at 3:41 PM - Weight: 145.1 lbs and BMI: 26.54.<br><br>On 12/02/2024 at 2:32 PM - Weight: 144.2 lbs and BMI: 26.37.<br><br>On 01/07/2025 at 12:02 PM - Weight: 150.4 lbs and BMI: 27.51.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. Further review revealed Resident #6 was dependent on staff for all Activities of Daily Living (ADL) care, always incontinent of bowel and bladder, Non-Alzheimer's Dementia, Dysphagia, oropharyngeal phase, had a recent surgery involving the gastrointestinal tract (The organs that food and liquids travel through when they are swallowed, digested, absorbed, and leave the body as feces), had weight loss of 5% or more in the last month or loss of 10% or more in last 6 months not on physician-prescribed weight-loss regimen, had a feeding tube while a resident, 51% or more of total calories the resident received through parenteral or tube feeding, 501 CC/day or more average fluid intake per day by tube feeding, and received anticoagulant medication, and diuretic medication.<br><br>Review of the Comprehensive Care Plan dated 1/17/2025, for Resident #6 revealed a plan of care with problems and interventions to include Enhanced Barrier Precautions, Tube Feeding with interventions to include assess for complications, NPO Status, provide frequent oral care, Lubricate lips, Dysphagia, cognitive deficits related to Dementia with interventions to include involve my representative in medical and financial matters as needed/requested, at risk for complications, Nutrition/Hydration with interventions to include medication as ordered, observe for signs and symptoms of dehydration and notify medical doctor, Provide tube feeding as ordered, weigh monthly if stable and monitor for significant changes, with no problems or interventions for refusal of medications or refusal of tube feedings.<br><br>Review of the Vitals Report for Resident #6 dated 1/23/2025 at 5:32 PM revealed a weight of 149.8 lbs.<br><br>Review of the progress notes for Resident #6 dated 1/26/2025 revealed, .Resident refused 3rd bolus for today .<br><br>Review of the progress notes for Resident #6 dated 1/31/2025 at 6:00 PM, revealed Resident refused total of 3 bolus feed this shift. She did let this nurse flush her tube with H20 total 600 mL H20 for this shift ADON [Assistant Director of Nursing] aware .<br><br>Review of the Vitals Report for Resident #6 dated 2/10/2025 at 1:29 PM revealed a weight of 146.8 lbs.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Medication Administration Record (MAR) dated 2/1/2025 to 2/28/2025, for Resident #6 included furosemide 80 mg tablet 1 tablet one a day with 2 scheduled doses documented as not administered refused, Tube feeding formula Jevity 1.5 240 ml bolus with 120 ml flush before and after at 5 AM, 9 AM, 1 PM, and 9 PM with 36 scheduled bolus tube feedings documented not administered refused, Tube feeding medication flush every shift flush with 30 ml of water before and after meds. Flush with 15 ml of water between meds with 4 medication flushes documented not administered refused, Tube feeding shift total every shift with 13 shift totals documented as not administered refused, Tube flush shift total every shift flush total with 7 shift totals documented as not administered refused, tube residual check every shift. Check residuals. If greater than 100 mL, hold feeding until physician is notified. Record amount of residual in vitals with 9 shift residuals documented as not administered refused.<br><br>On 2/1/2025 through 2/28/2025 it was documented on the MAR that Resident #6 refused 3 consecutive bolus tube feedings on 2/17/202, 2/18/2025. 2/23/2025, 2/26/2025 and 2/27/2025. On 2/28/2025 Resident #6 refused 4 consecutive bolus tube feedings. There was no documentation in the medical record of notification of physician and/or responsible party.<br><br>Review of the Food & Nutrition Service progress note dated 2/28/2025 revealed, Nutrition Monthly enteral review - Resident continues on tube feedings of Jevity 1.5 240 ml bolus 5 x per day at 5 A, 9 A, 1 P, 6 P, and 9 P .she is NPO, but could not eat, but has refused ever since she had a tooth problem and refused to eat after that and has refused all offers of being seen by SLP. She seems very content with present feeding. She has lost quite a bit of weight which was therapeutic for her as she had gained up to 204 # [pounds] in April 2023 with BMI of 37.3 which is close to being morbidly obese. WEIGHTS: HT: 62 CBW:146.8# BMI: 26.85 in optimal range IWR:99-121# Weight up 2.6# 1.8% X 30 days. P: continue with current POC. RD [Registered Dietitian] to follow .<br><br>Review of the Vitals Report for Resident #6 dated 3/04/2025 at 5:10 PM revealed a weight: 146.0 lbs.<br><br>Review of the Vitals Report for Resident #6 dated 3/10/2025 at 8:35 AM revealed a weight: 130 lbs.<br><br>Review of the physician orders for Resident #6 dated 2/12/2025 through 3/11/2025, revealed .NPO [nothing by mouth] .Tube feeding formula Jevity 1.5, 240 ml [milliliter] bolus [a single large dose] with 120 ml flush before and after at 5 AM, 9 AM, 1 PM, 5 PM, and 9 PM .furosemide [given to treat fluid retention] tablet 20 mg [milligram] 1 tab [tablet] .Twice A Day .furosemide tablet .80 mg 1 tab .Once A Day .Enhanced Barrier Precautions [using gown and gloves during specific high-contact resident care activities] r/t [related to] tube feeding q [every] shift .<br><br>Resident #6's daily source of nutritional intake per physician's orders via peg tube was Jevity 1.5 calorie and 240 ml given 5 times a day with a total of 1200 ml/day or 1800 calories, with a Water flush intake total of 1200 ml per day.<br><br>A Weight Calculation revealed on 2/10/2025 a weight of 146.8 and 3/12/2025 a weight of 135.4 for Resident #6 which resulted in a significant and severe weight loss of 7.77% (11.4 lbs) in 30 days. A 5% body weight loss in 30 days is considered a significant weight loss. A greater than 5% body weight loss in 30 days is considered severe weight loss.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the MAR dated 3/1/2025 to 3/12/2025 for Resident #6 revealed tube feeding formula Jevity 1.5 240 ml bolus with 120 ml flush before and after at 5 AM, 9 AM, 1 PM, 5 PM, 9 PM, with 17 scheduled bolus tube feedings documented not administered refused, Tube feeding medication flush every shift flush with 30 ml of water before and after meds. Flush with 15 mL of water between meds with 4 medication flushes documented as not administered refused, Tube feeding shift totals every shift with 9 shift totals documented as refused, Tube flush shift totals with 4 shift totals documented as refused, Tube residual check every shift with 5 residual checks documented as refused.<br><br>On 3/1/2025 through 3/12/2025 it was documented on the MAR that Resident #6 refused 3 consecutive bolus feedings on 3/9/2025 and refused 4 consecutive bolus feedings on 3/8/2025 with no documentation in the medical record of notification of physician and/or responsible party.<br><br>Review of the progress notes for Resident #6 dated 12/31/2024 to 3/12/2025 revealed there was no documentation the physician, practitioner, or POA was notified of the resident's refusal of tube feedings and weight loss.<br><br>During observation on 3/10/2025 at 12:05 PM, 3/11/2025 at 8:14 AM, and 3/12/2025 at 8:30 AM, Resident #6 was lying in bed with dry chapped lips.<br><br>During a telephone interview on 3/12/2025 at 11:39 AM, the POA T was asked if the facility had notified her of Resident #6's weight loss. POA T stated, .No, they haven't called me . The POA T was asked if she had been notified that Resident #6 had 28 refusals in the last 30 days of her bolus tube feedings. POA stated, . No, but I will be calling them .<br><br>During an interview on 3/12/2025, at 2:09 PM the RD was asked about Resident #6. RD confirmed she was not notified of Resident #6's consistent refusals of bolus tube feedings and that Resident #6 had a body weight loss of 7.77% in 30 days.<br><br>During an interview on 3/12/2025 at 5:05 PM, LPN O was asked about Resident #6's bolus tube feeding and medication refusals. LPN O stated Resident #6 had refused her 1:00 PM and 5:00 PM bolus tube feeding today. LPN was asked if the provider was notified. LPN O stated, No, the NP is aware [named Resident #6] has been refusing feedings.<br><br>During a telephone interview on 3/12/2025 at 6:30 PM, the Nurse Practitioner (NP) was asked about Resident #6. The NP stated she was familiar with Resident #6, did not have access to her computer. To the best of her knowledge Resident #6 was a long-term care resident with a peg tube receiving Jevity 1.5 calorie bolus tube feedings with H20 flushes. The NP was asked if she had been notified by the nursing staff that Resident #6 had refused bolus tube feedings. The NP stated, Not to my knowledge. The NP was asked what the expectation of nursing staff is when a resident refuses bolus tube feedings and/or medication. The NP stated the expectation is for the staff to notify the provider if a resident refuses 3 bolus tube feedings in a shift, if a resident refuses medications, and if medication is not given especially critical medications.<br><br>Review of the Vitals Report for Resident #6 dated 3/12/2025 at 6:34 PM revealed a weight: 135.4 lbs.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of physician orders for Resident #6 dated 3/13/2025, revealed orders for CBC (complete blood count) w/differential (the number of different types of white blood cells) one time, CMP (Comprehensive Metabolic Panel a routine blood test measuring 14 different substances in the blood sample)-Comp Metabolic Panel one time, Tube feeding formula - Jevity 1.5 @ (at) 55 ml continuous 22 hours per day 4PM to 2AM and flush with 55ml H2O (water) 22 hours per day from 4 AM to 2 AM and Flush with 55ml H2O time 22 hours 4 AM to 2 AM. Everyday. Can hold for ADL Care. The physician's order revealed Resident #6 had 1815 calories via peg tube per day and 1210 ml of water.<br><br>During an observation and interview on 3/13/2025 at 8:29 AM, revealed Resident #6 was lying in bed, lips dry chapped, head of bed elevated, kangaroo feeding pump at bedside with Jevity 1.5 formula infusing at 55 mL/hour. Resident #6 was asked when the tube feeding pump was started. Resident #6 stated this morning a nurse brought it in. Resident #6 was asked if she remembered refusing bolus tube feedings and or medications. Resident #6 stated Yes. Can you tell me a reason you would refuse tube feedings and /or medications. Resident #6 stated not time yet. Resident #6 was asked how you know it is not time yet. Resident #6 stated, I don't know.<br><br>During an interview on 3/13/2025 at 11:45 AM, ADON E was asked about the initiation of Resident #6's continuous tube feeding per pump. ADON E stated she initiated the order for Resident #6 to be placed on continuous tube feeding with H20 flush per pump this morning around 7:30 AM. ADON E stated the orders were initiated through the RD that wanted the tube feedings adjusted due to Resident #6's weight loss. ADON E was asked about Resident #6's refusal of tube feedings and how she knew Resident #6 did not refuse the continuous tube feeding. ADON E stated Resident #6 had a BIMS score of 11 or 12 and usually understands what is said to her. ADON E stated Resident #6 was told the continuous tube feeding was ordered due to Resident #6 was refusing the bolus tube feedings and losing weight. ADON E stated Resident #6 when asked about starting the continuous feeding said 'OK'. ADON E was asked if a change in the diet order of a resident receiving tube feedings would be considered a change in condition. ADON E stated I think it would be. ADON E was asked what the facility policy is when a resident has a change in condition. ADON E stated the responsible party or POA should be notified. ADON E was asked when should staff notify the provider if a resident receiving tube feedings is refusing the feedings. ADON E stated if the resident refuses feedings 2 to 3 times in a shift the nurse should notify the provider, and the responsible party should be notified. ADON E was asked if she notified Resident #6's POA about the tube feeding order change. ADON E stated No, the RD put in the new order and usually notifies the responsible party or POA.<br><br>During an interview on 3/13/2025 at 3:45 PM The ADON B was asked when should staff report bolus tube feeding refusals. ADON B stated that more than one tube feeding refusal in a shift should be reported to the supervisor. ADON B confirmed that staff was not communicating Resident #6's refusals of bolus tube feedings and medications to him. ADON B was asked if notified of a resident's refusal of tube feedings and/or medication what would he do? ADON B stated he would speak to the resident to investigate the refusals, call the Nurse Practitioner (NP), and notify the family or responsible party. ADON B was asked what can happen if a resident consistently refuses tube feedings? ADON B stated if refusals are consistent, it can cause dehydration, malnutrition, and weight loss. ADON B stated that Resident #6's refusals definitely should have been caught sooner.<br><br>(continued on next page) |

Printed: 05/28/2025
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| | 445526 | A. Building<br>B. Wing | 03/13/2025 |

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| Heartland | 3025 Fernbrook Lane<br>Nashville, TN 37214 |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 3/13/2025 at 4:30 PM, the Director of Social Services was asked if she was aware of Resident #6 refusing tube feedings and medications. Social Services Director stated I heard in the last two days she was refusing her tube feeding. That was new to me I would try my best to follow up. The Social Services Director was asked who notifies families and/or RP of resident change in condition. Social Services Director stated nursing should notify family and/or RP of resident changes in condition.<br><br>During an interview on 03/13/2025 at 6:30 PM, The Director of Nursing (DON) stated Resident #6 was re-weighed DON on 3/12/2025 due to the weight was wonky The scales were calibrated by Medical Equipment Services on 3/6/2025. DON was asked when staff should notify the provider of tube feeding refusals and medication refusals. DON stated staff should notify the provider if a resident refuses medications and if a resident is consistently refusing tube feedings. DON was asked if the resident's representative should be notified of refusals of tube feedings and medications. DON stated resident representatives should be notified of resident changes in condition. |

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observe each nurse aide's job performance and give regular training.<br><br>30974<br><br>Based on policy review, Certified Nursing Assistant (CNA) training record review, and interview, the facility failed to ensure 8 of 13 CNAs (CNA F, G, H, I, J, K, L, and M) employed for a full year received at least 12 hours of in-service training.<br><br>The findings include:<br><br>1. Review of the facility's policy titled Patient Care Policies, dated 2024, revealed .The center's in-service training program will provide additional partner training based on individual partner's assessed needs and in compliance with NHC, State and federal regulations .<br><br>2. Review of the Inservice Training Hours revealed:<br><br>a. CNA F had a hire date of 10/17/2023, and had only competed 5.76 in-service hours from 1/2/2024 -present.<br><br>b. CNA G had a hire date of 6/6/2023, and had only completed 10.26 in-service hours from 1/2/2024 -present.<br><br>c. CNA H had a hire date of 12/5/2023, and had only completed 3.50 in-service hours from 1/2/2024 -present.<br><br>d. CNA I had a hire date of 6/20/2023, and had only completed 3.25 in-service hours from 1/2/2024 -present.<br><br>e. CNA J had a hire date of 7/10/2024, and had only completed 11.60 in-service hours from 1/2/2024 -present.<br><br>f. CNA K had a hire date of 9/12/2023, and had only completed 9.26 in-service hours from 1/2/2024 -present.<br><br>g. CNA L had a hire date of 9/12/2023, and had only completed 10.46 in-service hours from 1/2/2024 -present.<br><br>h. CNA M had a hire date of 1/2/2024, and had only completed 11.96 in-service hours from 1/2/2024 -present.<br><br>(continued on next page) |

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|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Heartland | | STREET ADDRESS, CITY, STATE, ZIP CODE 3025 Fernbrook Lane Nashville, TN 37214 | |

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3. During an interview on 3/13/2025 at 3:31 PM, the Facility Educator was asked how many CNA in-service hours are required for a year. The Facility Educator confirmed 12 hours yearly. The Facility Educator was asked who is responsible to ensure they are completed as required. The Facility Educator stated, Mine and theirs because they know to complete those .every month from the time they are hired there is a report of who has not completed them .I have given verbal warnings and I have written them up and some don't even care and the 2 that are highlighted are habitual for not doing what they are supposed to get done .has been reported to the Director of Nursing (DON) and the Administrator .the DON has taken them off the schedule and has suspended them for noncompliance and they still don't get it done . |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38439<br><br>Based on policy review, medication review, observation, and interview, revealed the facility failed to ensure medications were properly stored and secured for 2 of 16 (Resident #20 and #36) residents when medications were found unattended and unsecured in resident rooms.<br><br>The findings include:<br><br>1. Review of the facility's policy titled, STORAGE OF MEDICATION, with a revision date of 2/25/2025, revealed .Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of supplier. The medication is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorize to administer medications .<br><br>Review of the facility's policy titled, SELF-ADMINISTRATION OF MEDICATIONS, with a revision date of 2/25/2025, revealed .residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer .a physician order should be obtained then an assessment is conducted by a member of the interdisciplinary team of the resident's cognitive .physical, and visual ability to carry out this responsibility .<br><br>2. Review of the medical record revealed Resident #20 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Insomnia, Sleep Apnea, Cardiomyopathy, and Chronic Pain Syndrome.<br><br>Review of the annual Minimum Data Set (MDS) dated [DATE], revealed Resident #20 had a Brief Interview for Mental Status score (BIMS) of 15, which indicated the resident was cognitively intact.<br><br>Review of the Care Plan reviewed on 2/12/2025, revealed .Cognitive Deficit not related to Dementia .I have forgetfulness at times and am at risk for poor decision making and poor safety awareness . and no care plan for self-administration of medications.<br><br>Observations in Resident #20's room on 3/10/25 at 11:32 AM and at 4:02 PM, revealed 1 bottle Tums Antacid on the Resident's bedside stand, unsecured and unattended. The resident did not have a physician's order for the use of the Antacid.<br><br>Review of the medical record revealed Resident #20 had no Self-Administration of Medication assessment completed until 3/11/2025.<br><br>Review of the Physician's Orders dated 3/12/2025, revealed .Tums (medication used for heart burn) (antacid) .chewable .200 mg [milligram] .2 tabs [tablets] .Three times a day .<br><br>Review of the medical record revealed Resident #20 had no order for the use of the antacid until 3/12/2025.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview in Resident #20's room on 3/10/2025 at 4:02 PM, Licensed Practical Nurse (LPN) R was asked are residents supposed to keep medications at their bedside. LPN R confirmed all medication should be securely locked on the medication cart. LPN R confirmed she was unaware if Resident #20 had been assessed for self-administration of medications and was unsure if the resident had an order for the use of the medication.<br><br>During an interview on 3/13/25 at 6:27 PM, the Director of Nursing (DON) confirmed that Resident #20 was not assessed for self-administration of medications until 3/12/2025 and the medications should not have been at bedside but should have been stored in the locked and secured medication cart.<br><br>3. Review of the medical record revealed Resident #36 admitted to the facility on [DATE], with diagnoses which included Chronic Pain, Generalized Osteoarthritis, Anxiety disorder, and History of falling.<br><br>Review of the Admission Minimum Data Set (MDS) dated [DATE], revealed Resident #36 had Brief Interview for Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. Continued review revealed Resident #36 required substantial assistance to maximal assistance with ADL (Activities of Daily Living) care.<br><br>Review of the Medication Administration History dated 3/1/2025-3/12/2025 revealed Resident #36 had an order for Asper Creme (Lidocaine Hydrochloride) liquid roll-on, 4% as needed for pain.<br><br>During a medication observation on 3/12/2025 8:25 AM, Licensed Practical Nurse (LPN) A prepared Resident #36's medications and goes into the resident's room. We arrived in the room and Resident #36 stated, .will you put my Asper Creme [topical pain relief product] on . and opened a roll-on applicator of Asper Creme that was sitting on her overbed table. The nurse left the room and told Resident #36 let me look and make sure you have an order for it. At 8:34 AM, Resident #36 took the lid off the Asper Creme and self-applied it to her left side above her waistline and stated, .silly they can't rub this on me . LPN A stated, . she has never done that, it is normal for her to have it in her room. I don't see where she can self-administer the medication, but she does have an order for it .<br><br>During an interview on 3/12/2025 at 9:00 AM, the Director of Nursing (DON) was asked if Resident #36 should have Asper Creme in her room and self-administer the medication. The DON stated, No, the Asper Creme should not be in her room, and she should not be self-administering the medication.<br><br>44724 |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>38439<br><br>Based on observation and interview, the facility failed to ensure a safe, sanitary, and comfortable environment for 6 of 22 (Residents #23 and #26's room, Residents #9 and #20's room, Resident #13 and #37's room, Residents #1 and #41's room, Residents #7 and #24's room, and Resident #53's room) resident occupied rooms and bathrooms observed.<br><br>The findings include:<br><br>1. Observations in the shared bathroom for Resident #23 and #26 on 3/10/2025 at 12:06 PM, and 4:09 PM, and on 3/11/2025 at 10:00 AM, revealed 2 teal wash basins stacked inside of each other in the bathroom floor, unlabeled and uncontained.<br><br>2. Observations in the shared room for Resident #9 and Resident #20 on 3/10/2025 at 11:32 AM, revealed 1 bottle of Sea Breeze facial astringent (facial cleanser) on top of the dresser uncontained, and unsecured.<br><br>3. Observations in the shared room for Resident #13 and #37 on 3/10/25 at 11:55 AM, revealed the following:<br><br>a. a bottle of sterile water opened and uncontained sitting on the bedside stand next to the refrigerator.<br><br>b. a 16.9 oz (ounce) bottle of California Mango shampoo on top of the refrigerator<br><br>c. a 12 oz bottle of California Cleansing gel on top of the refrigerator<br><br>d. 2 graduate dispensers on back of the toilet, unlabeled and uncontained<br><br>e. a teal wash basin in the bathtub, unlabeled and uncontained<br><br>f. a 7.5 oz bottle of Dial hand soap on the dresser near the window<br><br>g. 3 aerosol bottles of Febreze air freshener on the dresser near the window<br><br>Observations in the shared bathroom for Resident #13 and #37 on 3/10/25 at 12:01 PM, revealed the following:<br><br>a. a teal wash basin on the toilet seat, unlabeled and uncontained<br><br>b. a blue denture cup on back of the toilet, unlabeled and uncontained<br><br>c. a teal wash basin in the bathtub, unlabeled and uncontained<br><br>d. a 7.5 oz bottle of Dial hand soap on the sink, unsecured<br><br>(continued on next page) |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | e. a 28 oz bottle of Suave shampoo and conditioner on the sink, unsecured.<br><br>4. Observations in the shared Room and bathroom for Resident #1 and #41 on 3/10/25 at 11:50 AM, revealed the following:<br><br>a. a 7.5 oz bottle of foaming bodywash on the nightstand near the television.<br><br>b. a teal bath basin on floor in bathroom, a graduate dispenser on back of toilet in the bathroom, a denture cup with a silver toothbrush and white toothbrush resting on the inside, and 2 teal wash basins in the bathtub, all unlabeled and uncontained.<br><br>5. Observations in the shared room and bathroom for Resident #7 and #24 on 3/10/25 at 11:45 AM, revealed the following:<br><br>a. a bottle of Glade Air Freshener sitting on the window seal.<br><br>b. a teal bed pain on the grab bar next to the toilet, unlabeled and uncontained.<br><br>c. a 7.5 oz bottle of skin cleanser.<br><br>d. a 7.5 oz bottle of foaming body wash.<br><br>e. a white and a blue toothbrush inside of a clear plastic cup on top of the sink.<br><br>6. Observation in Resident #53's room on 3/10/25 at 4:13 PM, revealed a clear plastic spray bottle sitting in the window seal of the room labeled [NAME] Powder<br><br>7. During an interview on 3/10/2025 at 4:09 PM, Licensed Practical Nurse (LPN) R confirmed that no chemicals such as air fresheners should be left out in resident rooms, they should be secured in the nurses' medication cart or the medication room. LPN R confirmed that all personal items such as denture cups, bed pans, urinals, graduate dispensers, wash basins should be cleaned, labeled with their name and then stored in a plastic bag and put in the resident's drawer until they are needed.<br><br>During an interview on 3/10/2025 at 3/12/25 at 5:24 PM, the Director of Nursing (DON) confirmed that all medical personal items such as bed pans, wash basins, urinals, graduate dispensers, denture cups, should be labeled, covered, and stored in the bottom drawer of the residents bedside night stand or left in the bathroom but they must be labeled and contained, and items such as air fresheners, facial cleansers, should not be left in resident's room unsecured but should be locked on the medication cart or in the medication room until they are needed. The DON confirmed the facility does have residents who wander into other resident's room and that some residents have a STOP sign across their doorway to deter wandering residents from entering their rooms. |