STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445526	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartland	3025 Fernbrook Lane 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policyˆreview, medialˆrecord review,ˆobservation, and interview, the facilityˆfailedˆto follow physicians orders forˆa percutaneous enteral gastrostomy (PEG) tube (a tube inserted through the skin and into the stomach to administer medications andˆ supplements)ˆwhen staff failed toˆadminister the ordered enteral feeding at the correct rate ˆfor 1 of 2 residents (Residentˆ#7)ˆreviewed forˆtube feedings.ˆ The findings include:ˆ 1. Review of the facility policy titled, Preparation and General Guideline, datedˆ1/1/2019, revealed .Medications are administered as prescribed in accordance with good nursing principles and practice.administered in accordance with written orders of the prescriber.ˆˆ ˆ 2. Review of the medical record revealed Resident #7ˆwasˆreadmitted ˆto the facilityˆon 7/8/2019, with diagnoses includingˆDysphagia (difficulty swallowing,) Dementia, and Ileus (functional obstruction of the intestines caused by paralyzed muscles). Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #7 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment, which indicated Resident #7 was cognitively intact. Review of the Physician's Order dated 4/10/2026, revealed .OSOMOLITE 1.5 [enteral nutrition formula designed for tube feeding] @ [at] 50 ml [milliliters] / [per] hr [hour].ˆˆ During an observation in Resident #7's room on 4/13/2026 at 10:04 AM, 11:41 AM, 11:43 AM, 2:20 PM, and 3:30 PM tubing feeding rate was running at the incorrect rate of 55 ml/hr. During an observation and interview in Resident #7's room on 4/13/2026 at 3:52 PM, the Assistant Director of Nursing (ADON) was asked what the orders for Resident #7's tube feeding rate is. The ADON stated, I will have to check.it is supposed to be running at 50 ml. Review of Nurse's Notes dated 4/13/2026, revealed .Resident continuous feed of Osmolite noted to be running at incorrect rate of 55 ml [per hour]. Pump was corrected to the correct rate of 50 ml. During an interview on 4/14/2026 at 4:02 PM, the Director of Nursing (DON) was asked if she expected her staff to follow MD (Medical Director) orders. The DON stated Absolutely. The DON was asked if a resident has an order for the tube feeding to be running at 50 ml/hr should it be running at 55 ml/hr. The DON stated, no it should not.

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