

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525521	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2024
NAME OF PROVIDER OR SUPPLIER Heartland Country Village		STREET ADDRESS, CITY, STATE, ZIP CODE 634 Center St Black Earth, WI 53515	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552</p> <p>Based on interview and record review, the facility did not ensure residents received treatment and care in accordance with professional standards of practice for assessing and monitoring when a resident experiences a change in condition for 1 (R1) of 3 residents reviewed.</p> <p>R1 expressed increase leg and hip pain on 4/16/24. The facility failed to monitor and assess the change in condition. On 4/23/24, it was discovered R1 had a fracture in the left hip area.</p> <p>Evidenced by:</p> <p>The facility policy, Change in a Resident's Condition or Status, dated 2/21, states, in part; .8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status .</p> <p>R1 was admitted to the facility on [DATE] with a diagnoses of auditory hallucinations, anxiety disorder, major depressive disorder, unspecified macular degeneration, age related osteoporosis, abnormal posture, brief psychotic disorder, abnormal weight loss, and vascular dementia.</p> <p>R1's most recent Minimum Data Set (MDS) dated [DATE], states that R1 has a Brief Interview of Mental Status (BIMS) of 1 out of 15 indicating R1 is severely cognitively impaired. R1 has an activated power of attorney.</p> <p>R1's Progress Notes state, in part; .4/16/24 10:44 AM Resident has been yelling out this morning, at first, she was complaining of pain, morphine and lorazepam given. Then she kept yelling [NAME]. I spoke to the Hospice nurse and had her look at left hip which seems larger than normal. We discussed getting an x-ray, hospice reached out to doctor office and got an order for an x-ray, I have placed the order with (mobile x-ray company name) for them to come in and do the x-ray at the facility 4/17/24 4:30 AM Late Entry 4/16/24. Resident more verbal complaining of pain. Left hip appears protruding from right hip. Xray obtained. Awaiting results. PRN (as needed) lorazepam, morphine, and Tylenol given with minimal effect .</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's Hospice notes from 4/16/24 states, in part; .R1 was heard in the hallway calling out which is not her baseline. Per DON (Director of Nursing), she is having pain. She was given scheduled morphine and RN (Registered Nurse) was going in to give her a prn as well. Discussed using the prns and we can get an increase if needed. Writer obtained order for x-ray from primary and DON will reach out to have mobile x-ray completed. Call placed to POA (Power of Attorney) to update her. The phone rings and then sounds as though it is answered, and no one is there. Writer called 3 times in a row with the same result. A message was left on her cell to call writer .Reassessment plan: will check tomorrow on her pain .follow up needed: will f/u (Follow-Up) on x-ray results and pain control .Concern/reason for communication: change in patient condition .Changes reported from prior assessment: Pt is having left hip pain. Upon inspection, area is not red, warm, or swollen. It is internally rotated.</p> <p>It is important to note there is no other documented monitoring or assessment from 4/16/24-4/23/24 in R1's Nursing Progress Notes.</p> <p>Surveyor reviewed R1's 24-hour nursing notes from 4/16/24-4/23/24. No additional monitoring or assessment completed for R1 during this time frame.</p> <p>R1's x-ray report, states, in part; .Date of service 4/19/24 Radiology Report Results there is a left intertrochanteric fracture with modest callus formation bridged by an ORIF (open reduction and internal fixation) with components in satisfactory position. The femoral head is in alignment within acetabular fossa. The pubic rami are unremarkable. Conclusion: Old left intertrochanteric fracture with modest healing. Recent subtrochanteric angulated fracture noted .</p> <p>Of note, despite R1's fracture the physician did not elect any changes to R1's current regime. R1 was treated conservatively with continued pain management.</p> <p>R1's Hospice notes from 4/23/24: RN performed comprehensive assessment, medication reconciliation, and plan of care review. Symptoms addressed and recommendations: Pt in her Broda chair with her eyes open. Writer heard her saying, Am I going to get in tonight? She appears comfortable, no facial grimacing, legs are relaxed and not tight to body, Requested RN to give her prn morphine, this was administered. Per DON her x-ray came back with a recent subtrochanteric angulated fracture of left hip. DON has called primary physician and plan is to continue with pain management. DON also just called POA without a return call back .Primary caregiver perception of symptom management: They feel that her pain is managed well, and no changes are needed currently in per pain regimen .</p> <p>Surveyor requested additional Hospice documentation from 4/17/24-4/22/24. No additional documentation was received.</p> <p>On 5/7/24 at 2:10 PM, DON B (Director of Nursing) indicated R1 expressed an increase in pain on 4/16/24, all notifications were made, and an x-ray was ordered. DON B indicated R1 has scheduled morphine, lorazepam, and PRN's. DON B indicated R1 was given scheduled pain medications as well as PRN's. DON B indicated Hospice is at the facility daily and observed and worked with R1 as well. DON B indicated if any assessments or on-going monitoring were completed regarding R1 it would be documented in R1's progress notes. Surveyor asked DON B if DON B would expect on-going monitoring and assessment to be done when a change in condition is discovered. DON B indicated, Yes. DON B indicated on 4/23/24, DON B discovered by going on the (x-ray company) portal that R1 had a left hip fracture. DON B indicated an investigation was started and notifications were made.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1 expressed increase leg and hip pain on 4/16/24. The facility and Hospice recognized the change in condition. However, the facility failed to provide on-going monitoring and assessment to ensure R1's condition did not worsen while awaiting the x-ray results.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552</p> <p>Based on interview and record review, the facility failed to adequately assess and provide necessary care and services to attain or maintain the highest practicable physical wellbeing for 1 (R1) of 3 residents reviewed.</p> <p>R1 expressed increase pain in left leg and hip on 4/16/24. The facility did not document and re-assess R1's pain levels while R1 was experiencing an increase in pain. The facility failed to care plan R1's goals regarding an acceptable level of pain for R1. The facility failed to care plan what non-verbal indicators R1 demonstrates when R1 is experiencing pain.</p> <p>Evidenced by:</p> <p>The facility policy, Administering Pain Medications, dated 10/22, states, in part; .Purpose The purpose of this procedure is to provide guidelines for assessing the resident's level of pain prior to administering analgesic pain medication . 1. The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. 2. Pain management is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals . 5. Acute pain (or significant worsening of chronic pain) should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained. 6. For stable chronic pain the resident's pain and consequences of pain are assessed at least weekly .</p> <p>R1 was admitted to the facility on [DATE] with diagnoses of auditory hallucinations, anxiety disorder, major depressive disorder, unspecified macular degeneration, age related osteoporosis, abnormal posture, brief psychotic disorder, abnormal weight loss, and vascular dementia.</p> <p>R1's most recent Minimum Data Set (MDS) dated [DATE], states that R1 has a Brief Interview of Mental Status (BIMS) of 1 out of 15 indicating R1 is severely cognitively impaired. R1 has an activated power of attorney.</p> <p>R1's care plan, states, in part; .At risk for alteration in comfort secondary to chronic pain and arthritis, Gerd, constipation, dry eyes, RLS rhinitis .pain med/tx (medication/treatment) will be effective in maintaining adequate comfort level this review period 6/1/24 .Offer soothing massage, relaxing music and dim lighting prn (as needed). Observe need for routinely scheduled pain meds. Administer medications as ordered. Observe pain prn. Observe for any adverse reactions to medications and document. Assist with repositioning q (every) 2-3 hours when in bed for comfort and prn .</p> <p>It is important to note R1's care plan does not indicate R1's acceptable level of pain. R1's care plan does not indicate how R1 expresses she is in pain and what non-verbal indicators R1 demonstrates when in pain.</p> <p>(continued on next page)</p>		

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