STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525521	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartland Country Village	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434 Based on interview and record review, the facility failed to protect 1 of 10 residents (R1's) right to be free from neglect by a nurse. R1 states that NU Q (Nurse), along with two other facility CNAs (Certified Nursing Assistants), refused to transfer R1 from her wheelchair to her bed, causing R1 to fear for her safety and call emergency services for assistance. R1 states she feels totally lost and cries every other day due to the treatment she receives at this facility. Evidenced by: The facility policy titled, Abuse Prevention/Reporting Policy and Procedure, last revised on 4/28/2021, states in part: Policy: Every resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's symptoms. Residents must not be subjected to abuse by anyone, including but not limited to employees, other residents, physicians, consultants, volunteers, family members, legal guardians, friends, or other individuals. Every resident has the right to be free from mistreatment, neglect, and misappropriation of property . Abuse also includes deprivation by an individual, including a caretaker of goods or services necessary to attain or maintain physical, mental, and psychosocial well-being . Definitions . Neglect: the willful failure of the facility, its employees or service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress . Prevention . 7. Staff will be instructed to report any signs of stress from family and other individuals involved with the resident that may lead to abuse, neglect, or misappropriation of resident property, and intervene as appropriate . 9. Facility management is required to accept all allegations of abuse and conduct a complete and thorough investigation including reporting to the proper authorities. 10. Facility staff/supervisors will immediately intervene, identify, and correct reported or identified situations in which abuse, neglect or misappropriation of resident property is a risk for occurring. 11. All reports whether from family, residents or staff will be reported immediately to the Administrator and Abuse Coordinator and/or D.O.N (Director of Nursing) and the resident's Primary Health Care Provider . 13. An analysis of the allegation/incident is conducted to immediately determine resident's immediate needs, training level of staff, environmental safety, appropriate behavior of staff, resident, family, care plan, monitoring for resident's well-being, safety of resident, any injuries sustained by the resident, trends, or re-occurrences . (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the State Operations Manual (SOM), neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Willful, as defined at S483.5 in the definition of abuse, and means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. R1 was admitted to the facility on [DATE], with admitting diagnoses that include in part: congestive heart failure (the heart can't pump enough blood to meet the body's needs), generalized anxiety disorder, obstructive sleep apnea (a sleep disorder that occurs when the throat muscles relax and narrow or close during sleep), peripheral vascular disease (reduced blood flow and tissue damage, especially in the legs and feet), polyosteoarthritis (arthritis in 5 or more joints), adjustment disorder with mixed anxiety and depressed mood, atrial fibrillation (irregular heart beat), mild intermittent asthma (restriction in airways causing breathing difficulties), cognitive communication deficit, nontraumatic intracerebral hemorrhage (Non-traumatic brain bleed), and chronic kidney disease, stage 4 (severe). R1's most recent Quarterly Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 10/30/24, indicates R1 has a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating that she is cognitively intact. E0100 Psychosis indicates R1 did not demonstrate hallucinations or delusions during the assessment period. E0200 Behavioral Symptoms indicates R1 did not demonstrate physical behavioral symptoms such as hitting, verbal behavioral symptoms such as threatening others, or other behavioral symptoms such as screaming or throwing objects during the assessment period. E0800 Rejection of Care indicates that the patient did not reject cares during the assessment period. E1100 Change in behavior or other symptoms indicates R1's MDS behavioral assessment was the same as the prior assessment. GG0115 Functional limitation in range of motion indicates R1 has impairment on both sides in her upper extremities. GG0120 Mobility devices indicates R1 utilizes a walker and wheelchair for mobility. GG0130 Self-care indicates R1 is dependent on staff for toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, and putting on or taking off footwear. GG0170 Mobility indicates R1 requires substantial/maximal assistance to roll left and right. Additionally, it indicates R1 is dependent on staff for chair/bed-to-chair transfers and tub/shower transfers, and it also indicates the resident did not attempt to move from sitting to standing, transfer on or off a toilet, or walk 10 feet during the assessment period. Section GG indicates R1 is dependent on staff for all mobility with her manual wheelchair. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/16/24 at 10:10 AM, Surveyor interviewed R1 regarding the incident that occurred on 10/31/24. R1 appeared visibly upset and told Surveyor that she wanted to go to bed that night and that staff would not help transfer her from her wheelchair to her bed. R1 indicated that she had a verbal disagreement with the staff, which turned into the staff refusing to help her. Surveyor asked R1 how she felt while this was happening. R1 stated, I feel like I'm totally lost, and nobody is going to help me. R1 paused for a moment and looked away before continuing, Like . what the hell am I going to do? R1 raised both arms and shrugged, still teary-eyed and visibly upset, I cry every other day being here . Surveyor asked R1 if she could recall names of the staff members involved in this incident. R1 said she could not, but that EMS (Emergency Medical Services) and the Sheriff responded to her 911 call. R1 also indicates that EMS had to force the nurses to help her. Surveyor asked if R1 was willing to show Surveyor the report that EMS provided her. Surveyor reviewed the document in R1's presence. The document appears to be a carbon copy from the local EMS provider. There is a section titled situation, and is labeled Possible elder abuse. This document is dated 10/31/24. EMT R (Emergency Medical Technician) signed this document. On 11/1/24 at 12:06 AM, an administration note was written by NU Q. This note contains the text: Note Text: Was a behavior observed? YES. (Of note: Surveyor was unable to find any other documentation related to this incident. Additionally, this incident was not included on the grievance log provided by the facility.) (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/24 at 10:00 AM, Surveyor interviewed EMT R. EMT R is licensed as an EMT-Basic in the State of Wisconsin and was working as the on-call supervisor on 10/31/24. EMT R confirms he was working on 10/31/24 and responded to R1's 911 call. Surveyor asked EMT R what he found once he arrived on scene. EMT R indicated he does not respond to all calls when he is the on-call supervisor; however, he decided to respond with the two EMT-Basics and volunteer driver on shift for this call due to the nature of the dispatch notes. Surveyor asked EMT R about the dispatch notes and when the call was paged out. EMT R stated the call was paged out at 10:51 PM and EMT R added himself to the call at 10:59 PM, as the dispatch notes he had received indicated that an [AGE] year-old female needed assistance getting in to bed, staff was refusing to help, and she felt like she was being neglected. EMT R stated he arrived on scene after the ambulance and walked through the unlocked front door. EMT R stated he approached the nurses' station, as he did not initially know which room to go to, and noticed facility staff sitting at the desk were on their phones with earbuds in their ears. EMT R stated he asked where the patient was and one of the staff members pointed down the hallway without saying anything. Surveyor asked EMT R if he received any kind of report or information from the nurse. EMT R stated he did not. Surveyor asked EMT R if him or his crew were ever denied access to the patient. EMT R stated no. EMT R stated he then arrived to R1's room and was briefed by the EMT who responded with the ambulance. EMT R then spoke with R1 directly regarding her concerns. EMT R stated, while referring to his patient care report, that R1 told him she had woke up at 9:00 AM, got her morning medications, and was transferred to her wheelchair about 10:00 AM. R1 told EMT R that she had been in her wheelchair since 10:00 AM, and staff are refusing to move her from her wheelchair to her bed. R1 also told EMT R that she wears depends and had urinated and defecated multiple times in her depends, told staff multiple times, and staff refused to change her depends. EMT R states NU Q told him that R1 got into an argument with her, and R1 told NU Q, I hope she gets into a car accident on the way home and dies. NU Q then advised R1 that she no longer felt safe for her life or nursing license going into R1's room. EMT R stated he offered to have him and his crew remain in the room during the transfer if that would make her feel safe to perform the transfer. EMT R stated that NU Q still refused to transfer the resident and told EMT R that she talked to the DON, and the DON told her R1 can sleep in the wheelchair until 6:00 AM, when day shift shows up and then it's up to them if they want to transfer R1 or not. Surveyor asked EMT R what happened after she refused to transfer the patient with EMS in the room. EMT R stated he said, I want to make sure I have this correct; you are refusing to care for this patient by changing her depends and transferring her to bed? EMT R stated NU Q's response was that she did not feel safe moving the patient even with the EMTs there. EMT R then stated, You are neglecting this patient as of now. EMT R stated NU Q responded with, I don't care, I'm in fear for my life and walked out of the resident's room. A Sheriff's Deputy then arrived on scene and was advised by NU Q that EMS was refusing to let them transfer R1, which EMT R corrected that the facility staff were refusing to transfer R1. EMT R stated NU Q finally agreed to transfer the resident after speaking with the Sheriff's Deputy again. Surveyor asked EMT R what happened after R1 was finally transferred into bed. EMT R indicated he provided the resident with the county complaint phone number and R1 stated to him that she was concerned nursing staff would find it and throw it away. EMT R indicated he then assisted the resident with charging her phone because R1 reported nursing staff had unplugged her call light on her in the past. Surveyor asked EMT R to describe the patient's demeanor during the call. EMT R stated R1 was upset and angry when staff was in the room, EMT R believes this is due to staff's refusal to help R1. EMT R also stated there was no harsh words or disagreement noted during the transfer interaction when it finally happened. EMT R noted they were not able to clear from this call until 11:59 PM due to staff refusal to assist R1. Surveyor asked EMT R if in his professional opinion, he would consider this incident to be neglect or abuse. EMT R stated, Yes, completely. Surveyor asked EMT R if he was able to obtain any staff names during the call. EMT R referenced his patient care report again and gave the first name of NU Q. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/16/24 at 3:25 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked NHA A what she knew about this situation. NHA A stated she did not start employment with this facility until 11/15/24 and had only heard about this incident from the CEO (Chief Executive Officer). Surveyor asked if this incident was reported as required to Police and the State Agency. NHA A indicated she was told by the CEO that this incident was already reported. Surveyor advised NHA A that this incident was not reported to the State Agency, and asked NHA A if it should have been. NHA A stated, yes, because it is an allegation of abuse. Surveyor asked NHA A what was done following the incident to prevent reoccurrence. NHA A stated they got into contact with the agency that the CNAs were employed by and replaced them. Surveyor asked if there was any education or audits she was aware of pertaining to this situation. NHA A stated no. Surveyor asked if there was a file or investigation that for this incident. NHA stated no.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434 Based on interview and record review the facility did not ensure resident was free from misappropriation of property for 2 (R1 and R10) of 2 residents reviewed for misappropriation. R1 had three and R10 had two hydrocodone-acetaminophen (Norco) tablets go missing between 11/26/24 and 11/28/24. The facility did not recognize medications were missing until the narcotic count was conducted and incorrect on 11/28/24. The facility investigated this incident and concluded that the three missing Norco tablets were misappropriated by RN S. RN S was terminated from the facility. This incident was not reported to the State Survey Agency. This is evidenced by: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled, Abuse Prevention/Reporting Policy and Procedure, last revised on 4/28/2021, that states, in part: Policy: Every resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's symptoms. Residents must not be subjected to abuse by anyone, including but not limited to employees, other residents, physicians, consultants, volunteers, family members, legal guardians, friends, or other individuals. Every resident has the right to be free from mistreatment, neglect, and misappropriation of property . Abuse also includes deprivation by an individual, including a caretaker of goods or services necessary to attain or maintain physical, mental, and psychosocial well-being . Definitions . Misappropriation of resident property: The deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings, phone, money, food, clothing, personal hygiene products, jewelry, magazines, mail, money, or any item or service designated for exclusive use by the resident .Prevention . 7. Staff will be instructed to report any signs of stress from family and other individuals involved with the resident that may lead to abuse, neglect, or misappropriation of resident property, and intervene as appropriate . 9. Facility management is required to accept all allegations of abuse and conduct a complete and thorough investigation including reporting to the proper authorities. 10. Facility staff/supervisors will immediately intervene, identify, and correct reported or identified situations in which abuse, neglect or misappropriation of resident property is a risk for occurring. 11. All reports whether from family, residents or staff will be reported immediately to the Administrator and Abuse Coordinator and/or D.O.N (Director of Nursing) and the resident's Primary Health Care Provider. 12. Corporate RN and/or designated corporate staff will be informed within 2 hours of all allegations of abuse and/or reportable events.13. An analysis of the allegation/incident is conducted to immediately determine resident's immediate needs, training level of staff, environmental safety, appropriate behavior of staff, resident, family, care plan, monitoring for resident's well-being, safety of resident, any injuries sustained by the resident, trends, or re-occurrences . Investigation . 5. An Event Report will be initiated by the Charge Nurse upon discovery/allegation and the Administration (NHA and DON) will be notified immediately regardless of the time of discovery or allegation of Abuse. 6. Resident's family and the attending physician should be notified of the situation after the call to administration and order for treatment is obtained if indicated .8. If the crime does not appear to cause serious bodily injury to the resident, it will be reported per state regulations after forming the suspicion to the local authorities and State Department of Health . Reporting and Response . If the events that cause the allegation involve abuse and/or result in serious bodily injury, reporting must be within 2 hours of the allegation being made or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency . According to the State Operations Manual (SOM), misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. Willful, as defined at S483.5 in the definition of abuse, and means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Example 1 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1 was admitted to the facility on [DATE], with admitting diagnoses that include, in part: congestive heart failure, generalized anxiety disorder, obstructive sleep apnea, peripheral vascular disease, polyosteoarthritis (arthritis in 5 or more joints), adjustment disorder with mixed anxiety and depressed mood, atrial fibrillation (irregular heart beat), mild intermittent asthma, other lack of coordination, rotator cuff tear or rupture, other chronic pain, generalized muscle weakness, dysphagia, cognitive communication deficit, nontraumatic intracerebral hemorrhage (Non-traumatic brain bleed), unsteadiness on feet, chronic kidney disease, stage 4 (severe), history of falling, and hypertension. R1's most recent Quarterly Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 10/30/24, indicates R1 has a Brief Interview of Mental Status (BIMS) of 15 out of 15, indicating that she is cognitively intact. E0100. Psychosis indicates R1 did not demonstrate hallucinations or delusions during the assessment period. E0200. Behavioral Symptoms indicates R1 did not demonstrate physical behavioral symptoms such as hitting, verbal behavioral symptoms such as threatening others, or other behavioral symptoms such as screaming or throwing objects during the assessment period. E0800. Rejection of Care indicates that the patient did no reject cares during the assessment period. E1100. Change in behavior or other symptoms indicates R1's MDS behavioral assessment was the same as the prior assessment. The facility provided self-report documents that indicate on 11/28/24 at 6:30 PM, RN S, RN T, and NU Q were conducting the narcotic count and found 3 hydrocodone tablets were unaccounted for from the day shift reconciliation of the control log and the medication administration record (MAR). Pending investigation, the facility suspended RN S and RN T, who were on the off-going shift when the count was conducted. The [County Sherriff's Department] was notified, and the open case number was listed in the file. Surveyor unable to obtain a report at the time of survey as this continues to be an open investigation with the department. Facility self-report documents indicate an audit was completed of narcotic control logs and provided staff education. An interview of R1 was conducted on 12/2/24 by NHA A (Nursing Home Administrator), states, in part: .She states she knows she has Norco Rx (prescription) PRN (as needed). She further states she has never asked for her PRN Norco in the last 30 days. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The self-report documents included a document titled, Narcotic Count Discrepancy - November 28, 2024. was typed by IDON U. This document states, in part: I, [Name], Interim DON, was telephoned by the night nurse NU Q at 6:20 PM that the narcotic count was incorrect from the day shift (0600-1830) (6:00 AM-6:00 PM) staff by RN T (trainer) and RN S (trainee). The count was incorrect with 3 hydrocodone tabs unaccounted for in the Narcotic Documentation Register book . I simultaneously called both the facility Administrator [Initials] (NHA A) & the DON of Record [Initials] to inform them of the discrepancy and to provide guidance as to the process to undertake in the initial stage of this warranted investigation . RN S said, she was searching the trash bins, the bottom of the narcotic containment box & the medication cart for pills that may have slipped out. RN S was very troubled/rattled on the telephone call and in rapid succession was seeking plausible & varied rationales for the discrepancy referring to having shared the cart with RN T& had previously worked jointly with another day nurse, despite, that day's narcotic counts were correct. It was difficult at times to differentiate the upset of the situation from the seemingly frantic searches. The training nurse, RN T sounded calm, yet very concerned and sought guidance to assist in the clarification and offered his apology. Both day nurses acknowledged they shared the medication cart & both had administered medication to the residents . Both day nurses were sent home having been informed of their work suspension pending an internal investigation and its final determination . Another document titled, Witness Statement was also provided by the facility with R1 and R10's names on top. This document is dated 11/28/24 and indicates that R1 stated she had not requested her PRN dose of hydrocodone. Writer of the witness statement also notes, R1 has not requested her hydrocodone since 10/22/24. R1's Medication Administration Record indicates she was administered one hydrocodone-acetaminophen tablet 5-325 MG on 11/26/24 at 3:00 PM, 11/28/24 at 10:00 AM, and 11/28/24 at 5:20 PM, all by RN S. (Of note: R1 did not request her Norco tab at all prior to this in November 2024, or at all from December 1st through December 12th, 2024.) On 11/27/24 at 7:38 PM, an Orders - Administration note is written that states: Note Text: C/O (Complaint) 4/10 pain to neck. Declines narcotic r/t (related to) side effect of nausea. Declines Zofran (antiemetic) to help if nausea occurred. Example 2 R10 was admitted to the facility on [DATE] with diagnoses that include chronic kidney disease stage 3A, dependance on supplemental oxygen, benign prostatic hyperplasia, chronic respiratory failure with hypoxemia, hypertension, type 2 diabetes, congestive heart failure, malignant neoplasm of posterior wall of bladder, and ischemic cardiomyopathy. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's most recent Quarterly Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 9/17/24, indicates R10 has a Brief Interview of Mental Status (BIMS) of 15 out of 15, indicating that he is cognitively intact. E0100. Psychosis indicates R1 did not demonstrate hallucinations or delusions during the assessment period. E0200. Behavioral Symptoms indicates R1 did not demonstrate physical behavioral symptoms such as hitting, verbal behavioral symptoms such as threatening others, or other behavioral symptoms such as screaming or throwing objects during the assessment period. E0800. Rejection of Care indicates that the patient did no reject cares during the assessment period. E1100. Change in behavior or other symptoms indicates R1's MDS behavioral assessment was the same as the prior assessment. A document titled, Witness Statement was also provided by the facility with R1 and R10's names on top. This document is dated 11/28/24 and indicates that R10 stated that he did not request his PRN hydrocodone on 11/28/24. R10's Medication Administration Record indicates he was administered one hydrocodone-acetaminophen tablet 5-325 MG on 11/26/24 at 4:35 PM and 11/28/24 at 4:42 PM, both by RN S. (Of note: R10 did not request his PRN Norco at all prior to these two dates in November 2024, additionally R10 receives scheduled Norco tabs twice a day that have documented pain scores that indicate R10's pain is well controlled). A termination form was included in the self-report documents provided by the facility. This form indicates RN S was terminated by the facility for violation of the controlled substance policy along with potential narcotic diversion. A section titled performance event states: Nurse asked to take the cart on her own w/o (without) supervision from her orienting RN. Surveyor reviewed the state's license database and reviewed RN S's license. RN S is licensed as a Registered Nurse in this State, with two orders on her license. The first order is for findings from the state Board of Nursing and contains findings of fact that RN S had multiple pain documentation compliance issues associated with narcotic administration. The State Board of Nursing limited RN S's license on 8/10/23 under the condition that she undergo an AODA (Alcohol and Other Drug Abuse) assessment and complete additional education regarding administration of medication and medical record documentation. The second order states RN S completed these tasks, and her license was reinstated without restriction on 12/6/23. On 12/16/24 at 2:00 PM, Surveyor interviewed ADON C (Assistant Director of Nursing). Surveyor asked ADON C who is responsible for making self-reports at the facility. ADON C indicates NHA A (Nursing Home Administrator) is responsible. Surveyor asked ADON C what she would do if neglect or abuse was reported to her. ADON C indicates she would remove the resident from the harmful situation, investigate, provide staff education, and tell NHA that a self-report needs to be made. Surveyor asked ADON C if medication diversion is abuse. ADON C indicates yes, it's misappropriation since you're taking medications from a resident. Surveyor asked ADON C if the facility performed an audit following this incident to determine if any residents had negative outcomes. ADON C indicates the previous DON (Director of Nursing) performed the house audit. Surveyor asked ADON C if she had reviewed RN S's license prior to her employment. ADON C indicates she did not. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartland Country Village	634 Center St Black Earth, WI 53515

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/24 at 8:17 AM, Surveyor interviewed IDON B (Interim Director of Nursing) and HR F (Human Resources). Surveyor asked HR F if a background check was conducted on RN S and if her license was reviewed. HR F indicates that they were. Surveyor informed HR F and IDON B of the Board of Nursing findings listed above and asked if they were aware of these findings prior to hiring RN S. HR F and IDON B both indicated they were not aware. IDON B indicates that they were told she had an issue with her license in the past but that she only had to take a few classes and was reinstated. IDON B also states he was not the DON when RN S was hired. Surveyor asked IDON B and HR F if they would have hired RN S if they were aware of the orders on her licenses. IDON B and HR F both indicate they would not have hired RN S had they known. (Of note: When Surveyor requested a copy of RN S's license, the two orders from the Board of Nursing were in the screenshot provided by the facility.) On 12/12/24 at 4:31 PM, Surveyor interviewed NHA A. Surveyor asked NHA A who is responsible for submitting self-reports. NHA A indicates that she is responsible. Surveyor asked NHA if medication diversion is a form of misappropriation. NHA indicates that it is a form of abuse. Surveyor asked NHA A if medication diversion requires a self-report. NHA indicates that it does. Surveyor asked NHA A how soon a self-report needs to be made. NHA A was unsure but indicated that it should be submitted as soon as possible. Surveyor asked NHA A if this incident was reported to the State Agency. NHA A states, she knows it was late, and that it was just submitted yesterday (12/11/24). Surveyor asked NHA A if this self-report should have been made within 2 hours since this is considered abuse. NHA A states, yes.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434 Based on interview and record review, the facility did not ensure that all alleged violations are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials in accordance with State law through established procedures for 2 of 2 allegations involving (R1 and R10) and did not implement their policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for 1 of 2 allegations investigations (R1) reviewed. Facility became aware of a neglect allegation on 10/31/24 at around 10:00 PM and this allegation was not investigated or reported to the State Survey Agency or law enforcement for R1. Facility became aware of a misappropriation allegation on 11/28/24 at 6:30 PM and did not report this allegation until 12/11/24 this allegation involved R1 and R10. This is evidenced by: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled, Abuse Prevention/Reporting Policy and Procedure, last revised on 4/28/2021, that states, in part: Policy: Every resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's symptoms. Residents must not be subjected to abuse by anyone, including but not limited to employees, other residents, physicians, consultants, volunteers, family members, legal guardians, friends or other individuals. Every resident has the right to be free from mistreatment, neglect, and misappropriation of property . Abuse also includes deprivation by an individual, including a caretaker of goods or services necessary to attain or maintain physical, mental, and psychosocial well-being . Definitions . Neglect: the willful failure of the facility, its employees or service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress . Misappropriation of resident property: The deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings, phone, money, food, clothing, personal hygiene products, jewelry, magazines, mail, money, or any item or service designated for exclusive use by the resident .Prevention . 7. Staff will be instructed to report any signs of stress from family and other individuals involved with the resident that may lead to abuse, neglect, or misappropriation of resident property, and intervene as appropriate . 9. Facility management is required to accept all allegations of abuse and conduct a complete and thorough investigation including reporting to the proper authorities. 10. Facility staff/supervisors will immediately intervene, identify and correct reported or identified situations in which abuse, neglect or misappropriation of resident property is a risk for occurring. 11. All reports whether from family, residents or staff will be reported immediately to the Administrator and Abuse Coordinator and/or D.O.N (Director of Nursing) and the resident's Primary Health Care Provider. 12. Corporate RN and/or designated corporate staff will be informed within 2 hours of all allegations of abuse and/or reportable events.13. An analysis of the allegation/incident is conducted to immediately determine: resident's immediate needs, training level of staff, environmental safety, appropriate behavior of staff, resident, family, care plan, monitoring for resident's well-being, safety of resident, any injuries sustained by the resident, trends or re-occurrences . Investigation . 5. An Event Report will be initiated by the Charge Nurse upon discovery/allegation and the Administration (NHA and DON) will be notified immediately regardless of the time of discovery or allegation of Abuse. 6. Resident's family and the attending physician should be notified of the situation after the call to administration and order for treatment is obtained if indicated .8. If the crime does not appear to cause serious bodily injury to the resident, it will be reported per state regulations after forming the suspicion to the local authorities and State Department of Health . Reporting and Response . If the events that cause the allegation involve abuse and/or result in serious bodily injury, reporting must be within 2 hours of the allegation being made or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and ot other officials (including to the State Survey Agency . Example 1 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1 was admitted to the facility on [DATE], with admitting diagnoses that include, in part: congestive heart failure, generalized anxiety disorder, obstructive sleep apnea, peripheral vascular disease, polyosteoarthritis (arthritis in 5 or more joints), adjustment disorder with mixed anxiety and depressed mood, atrial fibrillation (irregular heart beat), mild intermittent asthma, other lack of coordination, rotator cuff tear or rupture, other chronic pain, generalized muscle weakness, dysphagia, cognitive communication deficit, nontraumatic intracerebral hemorrhage (Non-traumatic brain bleed), unsteadiness on feet, chronic kidney disease, stage 4 (severe), history of falling, and hypertension. R1's most recent Quarterly Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 10/30/24, indicates R1 has a Brief Interview of Mental Status (BIMS) of 15 out of 15, indicating that she is cognitively intact. E0100. Psychosis indicates R1 did not demonstrate hallucinations or delusions during the assessment period. E0200. Behavioral Symptoms indicates R1 did not demonstrate physical behavioral symptoms such as hitting, verbal behavioral symptoms such as threatening others, or other behavioral symptoms such as screaming or throwing objects during the assessment period. E0800. Rejection of Care indicates that the patient did no reject cares during the assessment period. E1100. Change in behavior or other symptoms indicates R1's MDS behavioral assessment was the same as the prior assessment. GG0115. Functional limitation in range of motion indicates R1 has impairment on both sides in her upper extremities. GG0120. Mobility devices indicates R1 utilizes a walker and wheelchair for mobility. GG0130. Self-care indicates R1 is dependent on staff for toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, and putting on or taking off footwear. GG0170. Mobility indicates R1 requires substantial/maximal assistance to roll left and right. Additionally, it indicates R1 is dependent on staff for chair/bed-to-chair transfers and tub/shower transfers, and it also indicates the resident did not attempt to move from sitting to standing, transfer on or off a toilet, or walk 10 feet during the assessment period. Section GG indicates R1 is dependent on staff for all mobility with her manual wheelchair. On 12/16/24 at 10:10 AM, Surveyor interviewed R1. R1 stated there was an incident that occurred on 10/31/24. R1 appeared visibly upset and told Surveyor that she wanted to go to bed that night and that staff would not help transfer her from her wheelchair to her bed. R1 indicated that she had a verbal disagreement with the staff, which turned into the staff refusing to help her. Surveyor asked R1 how she felt while this was happening. R1 states, I feel like I'm totally lost and nobody is going to help me. R1 pauses for a moment and looks away before continuing, Like . what the hell am I going to do?. R1 raises both arms and shrugs, still teary-eyed and visibly upset, I cry every other day being here . Of note the facility did not report this allegation to the State Agency or to Law Enforcement. It should be noted Law Enforcement was aware of the incident as Law Enforcement responded to a 911 call from R1 regarding the neglect allegation. Of note: Surveyor unable to find any other documentation related to this incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/16/24 at 3:25 PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A what she knew about this situation. NHA A states she did not start employment with this facility until 11/15/24 and had only heard about this incident from the Chief Executive Officer (CEO). Surveyor asked if this incident was reported as required to the police and the State Agency. NHA A indicates she was told by the CEO that this incident was already reported. Surveyor advised NHA A that this incident was not reported to the State Agency, and asked NHA A if it should have been. NHA A, states, yes because it is an allegation of neglect. Cross Reference: F600 Example 2 The facility provided self-report documents that indicate on 11/28/24 at 6:30 PM, RN S (Registered Nurse), RN T, and NU Q were conducting the narcotic count and found 3 hydrocodone tablets were unaccounted for from the day shift reconciliation of the control log and the medication administration record (MAR). Pending investigation, the facility suspended RN S and RN T, who were on the off-going shift when the count was conducted. The [County Sherriff's Department] was notified, and the open case number was listed in the file. Surveyor unable to obtain a report at the time of survey as this continues to be an open investigation with the department. Facility self-report documents indicate an audit was completed of narcotic control logs and provided staff education. The self-report documents included a document titled, Narcotic Count Discrepancy - November 28, 2024. was typed by IDON U (Interim Director of Nursing). This document states, in part: I, [Name], Interim DON, was telephoned by the night nurse NU Q at 6:20 PM that the narcotic count was incorrect from the day shift (0600-1830) (6:00 AM-6:00 PM) staff by RN T (trainer) and RN S (trainee). The count was incorrect with 3 hydrocodone tabs unaccounted for in the Narcotic Documentation Register book . I simultaneously called both the facility Administrator [Initials] (NHA A) & the DON of Record [Initials] to inform them of the discrepancy and to provide guidance as to the process to undertake in the initial stage of this warranted investigation . RN S said, she was searching the trash bins, the bottom of the narcotic containment box & the medication cart for pills that may have slipped out. RN S was very troubled/rattled on the telephone call and in rapid succession was seeking plausible & varied rationales for the discrepancy referring to having shared the cart with RN T& had previously worked jointly with another day nurse, despite, that day's narcotic counts were correct. It was difficult at times to differentiate the upset of the situation from the seemingly frantic searches. The training nurse, RN T sounded calm, yet very concerned and sought guidance to assist in the clarification and offered his apology. Both day nurses acknowledged they shared the medication cart & both had administered medication to the residents . Both day nurses were sent home having been informed of their work suspension pending an internal investigation and its final determination . The self-report documents included the State Survey Agency Misconduct Incident Report form, that was written by hand and signed on 12/6/24. (Of note: Surveyor checked the reporting incidents and this incident was not reported to the State Survey Agency). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/24 at 4:31 PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A who is responsible for submitting self-reports. NHA A indicates that she is responsible. Surveyor asked NHA if medication diversion is a form of misappropriation. NHA indicates that it is a form of misappropriation. Surveyor asked NHA A if medication diversion requires a self-report. NHA indicates that it does. Surveyor asked NHA A how soon a self-report needs to be made. NHA A was unsure but indicated that it should be submitted as soon as possible. Surveyor asked NHA A if this incident was reported to the State Agency. NHA A states, she knows it was late, and that it was just submitted yesterday (12/11/24). Surveyor asked NHA A if this self-report should have been made completed within 24 hours. NHA A states, yes. Cross Reference; F602

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 49434 Based on interview and record review, the facility did not ensure a thorough investigation was completed for 1 of 2 Residents (R1) reviewed for neglect. On 10/31/24, the facility became aware of an allegation of neglect by NU Q. The facility did not assess residents, interview residents, take statements, conduct a facility audit, or report this incident to law enforcement. This is evidenced by: The facility policy titled, Abuse Prevention/Reporting Policy and Procedure, last revised on 4/28/2021, that states, in part: Policy: Every resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's symptoms. Residents must not be subjected to abuse by anyone, including but not limited to employees, other residents, physicians, consultants, volunteers, family members, legal guardians, friends, or other individuals. Every resident has the right to be free from mistreatment, neglect, and misappropriation of property . Abuse also includes deprivation by an individual, including a caretaker of goods or services necessary to attain or maintain physical, mental, and psychosocial well-being . Definitions . Neglect: the willful failure of the facility, its employees or service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress . Prevention . 7. Staff will be instructed to report any signs of stress from family and other individuals involved with the resident that may lead to abuse, neglect, or misappropriation of resident property, and intervene as appropriate . 9. Facility management is required to accept all allegations of abuse and conduct a complete and thorough investigation including reporting to the proper authorities. 10. Facility staff/supervisors will immediately intervene, identify, and correct reported or identified situations in which abuse, neglect or misappropriation of resident property is a risk for occurring. 11. All reports whether from family, residents or staff will be reported immediately to the Administrator and Abuse Coordinator and/or D.O.N (Director of Nursing) and the resident's Primary Health Care Provider . 13. An analysis of the allegation/incident is conducted to immediately determine resident's immediate needs, training level of staff, environmental safety, appropriate behavior of staff, resident, family, care plan, monitoring for resident's well-being, safety of resident, any injuries sustained by the resident, trends, or re-occurrences . Reporting and Response . If the events that cause the allegation involve abuse and/or result in serious bodily injury, reporting must be within 2 hours of the allegation being made or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/16/24 at 10:10 AM, Surveyor interviewed R1 regarding the incident that occurred on 10/31/24. R1 appeared visibly upset and told Surveyor that she wanted to go to bed that night and that staff would not help transfer her from her wheelchair to her bed. R1 indicated that she had a verbal disagreement with the staff, which turned into the staff refusing to help her. Surveyor asked R1 how she felt while this was happening. R1 states, I feel like I'm totally lost, and nobody is going to help me. R1 pauses for a moment and looks away before continuing, Like . what the hell am I going to do?. R1 raises both arms and shrugs, still teary-eyed and visibly upset, I cry every other day being here . Surveyor asked R1 if she could recall names of the staff members involved in this incident. R1 said she could not, but that EMS (Emergency Medical Services) and the sheriff responded to her 911 call. R1 also indicates that EMS had to force the nurses to help her. Surveyor asked if R1 was willing to show Surveyor the report that EMS provided her. Surveyor reviewed the document in R1's presence. The document appears to be a carbon copy from the local EMS provider. There is a section titled, situation, and is labeled Possible elder abuse. This document is dated 10/31/24. EMT R signed this document. (Of note: Surveyor unable to find any other documentation related to this incident. Additionally, this incident was not included on the grievance log provided by the facility. On 12/16/24 at 3:25 PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A what she knew about this situation. NHA A states she did not start employment with this facility until 11/15/24 and had only heard about this incident from the Chief Executive Officer (CEO). Surveyor asked if this incident was reported as required to the police and the State Agency. NHA A indicates she was told by the CEO that this incident was already reported. Surveyor advised NHA A that this incident was not reported to the State Agency, and asked NHA A if it should have been. NHA A, states, yes because it is an allegation of abuse. Surveyor asked NHA A what was done following the incident to prevent reoccurrence. NHA A states they got into contact with the agency that the CNA's were employed by and replaced them. Surveyor asked if there was any education or audits, she was aware of pertaining to this situation. NHA A states, no. Surveyor asked if there was a file or investigation that for this incident. NHA states, no. (Of note: Facility unable to produce any documentation related to this incident upon Surveyor request.)

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(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 - Minimal harm or potential for 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** 49434 Based on interview and medical record review, facility staff did not provide care and treatment in accordance with professional standards of practice for 1 of 22 sampled residents (R1). R1 is not weighed according to physician order, and she is not assessed following complaints of chest pain. This is evidenced by: Example 1 R1 was admitted to the facility on [DATE], with admitting diagnoses that include, in part: congestive heart failure, generalized anxiety disorder, obstructive sleep apnea, peripheral vascular disease, adjustment disorder with mixed anxiety and depressed mood, atrial fibrillation (irregular heart beat), mild intermittent asthma, generalized muscle weakness, nontraumatic intracerebral hemorrhage (non-traumatic brain bleed), chronic kidney disease, stage 4 (severe), and hypertension. R1's most recent Quarterly Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 10/30/24, indicates R1 has a Brief Interview of Mental Status (BIMS) of 15 out of 15, indicating that she is cognitively intact. E0100. Psychosis indicates R1 did not demonstrate hallucinations or delusions during the assessment period. E0200. Behavioral Symptoms indicates R1 did not demonstrate physical behavioral symptoms such as hitting, verbal behavioral symptoms such as threatening others, or other behavioral symptoms such as screaming or throwing objects during the assessment period. E0800. Rejection of Care indicates that the patient did no reject cares during the assessment period. E1100. Change in behavior or other symptoms indicates R1's MDS behavioral assessment was the same as the prior assessment. R1's Physician Orders state, in part: Daily weight, update MD if change of 3lbs/day or 5lbs/week one time a day related to chronic kidney disease, stage 4 (Severe). R1's Comprehensive Care Plan states, in part: Focus: Cardiac Risk; CHF (Congestive Heart Failure), PVD (Peripheral Vascular Disease), Angina (Chest Pain), Polyneuropathy (Nerve damage in multiple sources), and Atherosclerosis heart disease of native coronary artery disease Date Initiated: 9/9/24. Goal: The resident will be free of peripheral edema through the review date. The residents Body weight will remain within normal limits through the review date. Date initiated: 9/9/24. Target date: 11/19/24. Interventions: Encourage adequate nutrition. Offer small frequent feedings. Give cardiac medications as ordered. Date initiated: 9/9/24. Focus: The resident has fluid overload or potential fluid volume overload r/t Kidney failure, CHF. Date initiated: 11/7/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Goal: The resident will comply with diet and/or fluid restrictions daily through the review date. Date initiated: 11/7/24. Target date: 11/19/24. Interventions. Administer medications as ordered. Monitor/document for side effects and effectiveness. Diet as ordered. Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Monitor and document intake and output as per facility policy. Monitor vital signs as ordered and record. Notify MD (Medical Doctor) of significant abnormalities. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Provide pillows; raise HOB (Head of Bed) as needed to facilitate breathing, increase comfort. Weigh at same time of day and record: Daily. Notify provider if weight gain of 3 lbs. in one day or 5 lbs. in one week. Date initiated: 11/7/24 for all interventions. R1's Weight documentation indicates that since the initiation of the intervention for daily weights listed previously and physician order, R1 was not weighed on the following dates: 11/15/24, 11/23/24, and 11/24/24. Example 2 According to R1's progress notes, she reported chest pain at the following 11/1/24: 11/10/24 at 11:26 PM, 11/11/24 at 4:03 PM, 11/19/24 at 10:01, 11/21/24 at 10:33 PM, 11/22/24 at 12:00 PM, 12/8/23 at 1:58 PM, and 11/24/24 at 10:48 AM. No patient assessment is documented for R1 at these times.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38725 Based on interview and record review, the facility did not ensure a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates they were unavoidable for 1 of 3 residents (R2) reviewed. R2 admitted to the facility with intact skin and developed a stage 3 pressure injury to her coccyx. This is evidenced by: The Facility's Policy and Procedure entitled Pressure Ulcers/Skin Breakdown-Clinical Protocol dated October 2010 documents the following in part: Assessment and Recognition 1. The nursing staff and Attending Physician will assess and document an individual's significant risk factors for developing pressure sores; for example, immobility, recent weight loss, and a history of pressure ulcer(s). 2. In addition, the nurse shall assess and document/report the following .f. Current treatments, including support surfaces . Treatment/Management 1. The physician will authorize pertinent orders related to wound treatments, including pressure reduction surfaces . R2 admitted to this facility for a short-term rehab stay. R2 had the following diagnoses: chronic obstructive pulmonary disease (COPD/a blockage of airways), type 2 diabetes mellitus with hyperglycemia (elevated blood sugar), atherosclerosis of native arteries of extremities with rest pain (thickening of arteries that carry blood away from heart) of bilateral legs, nicotine dependence, and chronic pain syndrome. R2's Nurses Note from admission documents the following: 11/11/2024 14:24 (2:24 PM) Admission Summary Late Entry: Note Text: Resident admitted to the facility 11/11/24 via family transport, Daughter, and Husband present during admission. Resident A/Ox 3 (alert and oriented- person, place, time) able to make needs known. Resident received print out of med (medication) list and meds list sent to pharmacy and reviewed with physician. Resident assessed by staff. Resident admitted with issues with skin integrity. Resident admitted with 3 surgical incisions Right groin 8.9x 0.1 x 0 Left Groin 7.4cm (centimeters) x 0.2 x 0, Right Upper Chest 8cm x 0.1cm, Resident has reddened area on the buttocks skin intact. Resident has LAL (low air loss) Mattress, and wheelchair. R2's Skin and Wound- Total Body Skin assessment dated [DATE] documents Enter the # of New Wounds New Wounds 4. Documentation from Facility's Wound Care Consultation Company: The following, is documented in part on 11/15/24: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartland Country Village	634 Center St Black Earth, WI 53515

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F 0686 Level of Harm - Actual harm Residents Affected - Few	.Support Surface: Bed- group 1, refuses air mattress. Chair- pressure reduction cushion .Focused Wound Exam: Stage 3 pressure wound coccyx full thickness. Etiology pressure .Duration >7 days Noted to be present on admission per staff .Wound size (L (length) x (by) W (width) x D (depth)): 0.8 x 0.3 x 0.2 cm . Granulation tissue 100% .Plan of Care reviewed and addressed: Recommendations off-load wound; reposition per facility protocol . Of note, there is no evidence on the admission skin evaluation that R2 had a pressure injury on admission. The following, is documented in part on 11/22/24: .Support Surface: Bed- group 1, refuses air mattress. Chair- pressure reduction cushion .Focused Wound Exam: Stage 3 pressure wound coccyx full thickness. Etiology pressure .Duration >14 days Noted to be present on admission per staff .Wound size L x W x D: 2.73 x 0.38 x 0.2 cm .Slough 20%, Granulation tissue 20% Skin intact normal color 60% .Plan of Care reviewed and addressed: Recommendations off-load wound; reposition per facility protocol . R2's Braden Scales (Predicting Pressure Sore Risk) document: 11/11/24 R2 scored 16, which indicates At Risk 15-18. 11/18/24 R2 scored 17, which indicates At Risk 15-18. Of note, this tool does not take into consideration a resident's history of wounds, diagnoses, etc. It is a tool to assist the assessor in looking at all the aspects of the residents' health regarding pressure injury development. R2's Discharge Orders document the following, in part: .Turn Q2h (every 2 hours) in bed and reposition Q1h (every 1 hour) in chair . It is important to note that R2 did not have any turning and repositioning orders placed during her stay at the facility. R2's Wound Care Orders begin 11/15/24, not on day of admission 11/11/24. R2's Care Plan documents the following: 11/15/24 Focus: The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) Activity Intolerance, Limited Mobility, Chronic Pain d/t (due to) arthritis. Interventions: 11/15/24 Bed Mobility: The resident is independent for repositioning and turning in bed as necessary. 11/15/24 Bed Mobility: The resident requires assistance by 1 staff to turn and reposition in bed as necessary. 11/15/24 Focus: The resident has actual impairment to skin integrity of the right and left groin and right chest r/t (related to) surgical wound. Resident has stage 3 pressure ulcer to coccyx. Interventions: 11/15/24 The resident needs pressure relieving/reducing cushion to protect the skin while up in chair. Resident has refused pressure reducing mattress for her bed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	It is important to note there was no intervention of turning and repositioning R2, despite this being in her discharge orders. On 12/11/24 at 11:42 AM, Surveyor interviewed RN K (Registered Nurse). Surveyor asked RN K if R2 had any other wounds besides the incisions she admitted with, RN K said he thought there was another one, on her back side, small. Surveyor asked RN K if this wound was present on admission or developed later, RN K replied there was not a treatment upon admission we did receive orders later to treat the wound. On 12/12/24 at 2:35 PM, Surveyor interviewed CNA J (Certified Nursing Assistant). Surveyor asked CNA J if R2 had any other wounds besides the incisions she admitted with, CNA J stated she had a sore to her bottom mid-way through her stay. Surveyor asked CNA J if R2 had a cushion in her wheelchair, CNA J said no, she mainly sat in a recliner. Surveyor asked CNA J if R2 had a cushion in her recliner, CNA J said no. Surveyor asked CNA J if R2 had an air mattress on her bed, CNA J replied that she couldn't recall as R2 was always already up in the recliner when she got there in AM and didn't go to bed or lie down until after her shift was over. Surveyor asked CNA J if R2 had any type of turning and repositioning schedule, CNA J stated not that she recalled. On 12/16/24 at 1:43 PM, Surveyor interviewed ADON/WN C (Assistant Director of Nursing/Wound Nurse). Surveyor asked ADON/WN C if R2 had any other wounds besides the incisions she admitted with, ADON/WN C said 2 slits to her coccyx. Surveyor told ADON/WN C that per her admission note, her skin to her coccyx was intact on admission. Surveyor asked ADON/WN C when did R2 develop the stage 3 wound to her coccyx, ADON/WN C replied I thought it was there on admit. Surveyor asked ADON/WN C if discharge orders included turning and repositioning for R2, is that included as an order here, ADON/WN C stated yes that would be an order. On 12/16/24 at 3:03 PM, Surveyor interviewed RN P. Surveyor asked if RN 2 had discharge orders including turning and repositioning is that included as an order at the facility? RN P stated if that is part of the signed orders yes, if it is only part of the summary, it's possible that it should be an order but would need to be clarified. On 12/16/24 at 4:06 PM, Surveyor interviewed ADON/WN C. Surveyor asked ADON/WN C if she would expect a wound to be found before it is a stage 3, ADON/WN C stated yes. R2 was admitted to the facility there was no evidence R2 had an open area to the coccyx upon admission. R2 developed a facility acquired stage 3 pressure injury. The facility did not find the pressure injury until it was noted to be a stage 3. The facility failed to implement interventions to prevent pressure injury development.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30992 Based on interview and record review, the facility did not ensure residents have an environment free of hazards and did not provide adequate supervision and assistive devices for 1 of 3 sampled residents (R6). R6 sustained a fall on 12/6/24 with no injuries. The facility did not thoroughly investigate this fall or attempt to determine a root cause analysis until three (3) days after the fall occurred. Evidenced by: The facility's policy, Fall Prevention and Risk Assessment, dated 12/16/24, states, in part, as follows: Purpose: To provide an environment that is safe and that minimizes the potential for resident injury due to falls. To identify fall risk factors particular to the individual resident that may be reduced through care planning and implementation of individualized interventions. General Information: Falls are a common source of injury and death among the elderly. Early identification of risk factors and staff intervention can reduce the risk of falls; Investigation and analysis post fall can identify other risk factors and provide information that may serve in planning interventions to prevent recurrence. Internal Factors: characteristics of the resident that places them at risk for falling, including the resident's physical and cognitive health, as well as their functional status. External Risk Factors: characteristics of the environment and other forces that act upon the resident, including medication side effects, the use of assistive devices or appliances and restraints. Fall: any event in which the resident comes to rest unintentionally upon the ground, floor or other lower level or plane, but not as a result of an overwhelming external force (for example, a push from another resident) The resident is considered to have fallen even if the event is not witnessed. The fall will be investigated to identify the internal and external factors contributing to the fall, circumstances within or beyond the facility's control in preventing the fall, and measures that the facility will take to minimize recurrence. The results of the investigation will be used by the facility's Fall Prevention Team in identifying and care planning additional interventions as may be required to ensure the resident's safety. Investigation results are also provided to the Quality Assurance Coordinator for review and analysis. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R6 was admitted to the facility 8/26/2013 with diagnoses including, but not limited to: Dementia with behavioral disturbance (a collection of behavioral and psychological changes that can occur in people with dementia), Alzheimer's disease (a brain disorder that gradually destroys memory and thinking skills, and eventually the ability to carry out daily tasks), acute cerebrovascular insufficiency a rare condition that occurs when one or more arteries that supply blood to the brain become obstructed), restlessness and agitation. Later in R6's stay diagnoses were added of unsteadiness on feet, restlessness and agitation and muscle weakness. R6's Annual Minimum Data Set (MDS), dated [DATE], indicates the following: R6 is severely cognitively impaired. R6 requires assistance with all cares. For chair/bed-to-chair transfers R6 requires partial/moderate assistance - Helper does less than all of the effort. R6's Care Area Assessment (CAA) for Falls with an Assessment Date of 10/16/24 indicates the folloiwng: History of Falls: R6 does have a history of falling but has not fallen for a few months. R6 would typically fall during the night. R6 was put on a toileting program and was put on the [NAME] morning get up list. This has minimized R6's falls. Physical performance limitations: R6 receives help while transferring but stays in her wheelchair while moving throughout the facility. Care Plan Considerations: R6 has had a decrease in falls since toileting plan and early get up list have been in place. Resident will continue to have no falls. R6's comprehensive care plan, dated 11/27/24, states, in part, as follows: Focus: I am vulnerable r/t (related to) cognitive deficit/Alzheimer's disease. Resident requires total dependence for ADL's (Activities of Daily Living) and mobility. Resident is rarely/never understood or understands. Goal: I will be safe in the facility, will received the assistance needed. Interventions: Monitor for incidents of potential injury to me and intervene as needed. Behavior Committee to review for effectiveness of approaches. Monitor for my safety, sign and symptoms of abuse an neglect, follow facility policy and procedures . R6's comprehensive care plan, dated 10/29/24, indicates, in part, the following: Focus: The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t Alzheimer's, Dementia, Limited Mobility. Goal: The resident will demonstrate the appropriate use of wheelchair to increase ability in locomotion through the review date.Transfer: The resident is able to pivot transfer with substantial assist of one. R6's comprehensive care plan, dated 8/7/24, indicates, in part, the following: The resident has had an actual fall with no injury, r/t (related to) poor balance, unsteady gait. Resident is at risk for further falls r/t cognitive impairment, unable to make needs know, incontinent or bowel and bladder, and immobility. Goal: The resident will resume usual activities without further incident through the review date. Interventions: Anti roll back bars installed on wheelchair, bed kept in low position, Prefers to wear tennis shoes, Resident prefers to scoot/self (e.g. propel) around the facility in her wheelchair. On 12/6/24 at 5:00 AM, IDON B (Interim Director of Nursing) documented that R6 sustained an unwitnessed fall in her room. Predisposing Physiological Factors: No records found Predisposing Situation Factors: No records found (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Statements: No statements found On 12/9/24 at 10:07 AM, R6's Progress Notes indicates the following: Fall Details: Date/Time of Fall: 12/6/24 at 5:00 AM. Fall was not witnessed. Fall occurred in the resident's room. Activity at the time of fall: unknown. The reason for the fall was not evident. Did an injury occur as a result of the fall: No Was fluid spilled on the floor: No Clutter present on the floor: No Floor mat that was on the floor: No Poor lighting in the area: No Bed was at an improper height: No Other furniture involved: No It is unknown whether the wheelchair was involved in fall. Wearing glasses at the time of fall: No Footwear at the time of fall: Shoes Resident was not using cane/walker as instructed. (Note, R6 uses a wheelchair.) Resident was not wearing oxygen. Resident was using incontinence supplies at the time of the fall. Incontinent at time of fall: No Bedside call light on when resident was found: No Bathroom call light on when resident was found: No Other residents were not involved in the fall. Medication Changes: Recent change to resident's medication: No The facility did not investigate this fall or attempt to determine a root cause analysis until three (3) days after the fall occurred. On 12/16/24 at 5:35 PM, Surveyor spoke with ADON C (Assistant Director of Nursing). ADON C stated falls should be investigated timely to determine a root cause analysis.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30992 Based on observations, record review, and interviews, the facility did not provide adequate colostomy supplies in order to meet the needs of 1 (R3) of 2 sampled residents. The facility was completing ostomy appliance changes multiple times every shift due to leaking of R3's ostomy appliance. The facility did not demonstrate the ability to maintain an adequate supply of ostomy appliances to meet R3's needs. Findings include: The facility policy, Supply Ordering Policy, and Procedure, undated, indicates, in part, as follows: The facility's designated person to order food is the dietary manager and the person ordering medical supplies is the Director of Nursing. The Nursing Home Administrator shall serve as back-up person for both departments. Take inventory from supply closets, par levels, and staff recommendations; Electronic orders for Medical Supplies are due Monday by Noon to (company name). The facility does not have a policy and procedure for colostomy/ileostomy care. R3 was admitted to the facility on [DATE] with diagnoses including, but not limited to, ileostomy status, muscle weakness, chronic kidney disease stage 4, and chronic diastolic heart failure. R3's Physician Orders, dated 11/25/24, document the following order: Change ileostomy bag every 3 days or PRN (as needed) one time a day every 3-day(s) date and initial bag. On 12/7/24 R3's family member, FM E (Family Member), voiced a concern to NHA A (Nursing Home Administrator) that is documented on the Grievance/Complaint Log. Supplies for specialized colostomy (ileostomy) needs to be ordered. On 12/12/24 at 11:00 AM, Surveyor spoke with RN D (Registered Nurse). Surveyor asked RN D to show Surveyor R3's ostomy appliances and supplies. RN D showed Surveyor an adequate supply of bags, however, there was only 1 ring left in stock and no paste. Surveyor asked RN D, how often is R3's ostomy bag/appliance changed. RN D stated, a minimum of two (2) times per shift including the bag and ring. RN D stated, R3 has high output. RN D stated, the ostomy leaks all the time. Surveyor asked RN D, do you have concerns that the facility has only 1 ring in stock. RN D stated, yes. RN D stated, FM E expressed concerns to the previous DON (Director of Nursing). Surveyor asked RN D, what day did FM E express concern. RN D checked her calendar and stated, 12/2/24. RN D stated, she is going to notify NHA A, that there is one (1) ring left. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/24 at 3:40 PM, Surveyor spoke R3 and FM E (Family Member). FM E stated, due to R3's colostomy frequently leaking, there are often times where the facility is running low or completely out of ostomy supplies. FM E stated, R3 has had ongoing issues with the ileostomy bag breaking and leaking due to the facility not using the correct supplies, specifically the paste (topical adhesive). FM E stated, this has been an ongoing issue for R3 during multiple hospital stays and it was home health that taught FM E the solution to this issue. FM E stated, the facility does not have the paste that is needed. FM E stated, if any one of the supplies is missing it's an issue. FM E stated, after he was using this solution from home health while R3 was at home, R3's ostomy supplies started to last from 4-5 days Vs 4-5 hours. FM E stated, he has shared this information with the previous DON (Director of Nursing) and NHA A (Nursing Home Administrator). FM E stated that they have had to provide their own ostomy supplies at times, including topical adhesives (paste) for the ostomy, when facility staff did not maintain an adequate supply. FM E stated the morning of 12/12/24 he ordered the paste off Amazon due to the facility not providing it. FM E was visibility upset the facility does not have adequate supplies after he has had multiple conversations with NHA A (Nursing Home Administrator) and given her the item numbers for supplies needed to ensure R3's ostomy care is done correctly. FM E and R3 both agreed they do not wish to file a formal grievance; however, this situation needs to be rectified immediately. On 12/12/24 at 4:15 PM, NHA A (Nursing Home Administrator) ordered R3's ostomy supplies with the exception of the paste, that is necessary to secure the ostomy bag and extend the wear time of the ostomy supplies. Of note, the prior order was placed by the facility on 12/4/24; this order also does not include the paste. Also of note, the paste was not ordered or supplied from any other source. On 12/12/24 at 4:35 PM, Surveyor spoke with NHA A (Nursing Home Administrator). Surveyor asked NHA A if there are questions related to R3's ostomy supplies. NHA A stated, she does not have any knowledge regarding ostomy supplies, however, she is doing the ordering since the previous DON (Director of Nursing) left abruptly. NHA A stated, the previous DON was responsible to locate ostomy supplies locally. NHA A stated, FM E spoke with her today and he was angry regarding the ongoing lack of R3's ostomy supplies. NHA A stated, she ordered the supplies FM E requested today with the exception of the paste that the supplier does not carry. Surveyor asked NHA A, did FM E speak with you regarding the rings and paste. NHA A stated, yes, FM E mentioned that today. Surveyor asked NHA A, did FM E speak with you regarding concerns with the paste and rings previously. NHA A stated, maybe there was something she missed. NHA A stated, the situation with ostomy supplies is not to R3 and FM E's satisfaction. Surveyor asked NHA A, do you expect staff to have the ostomy supplies needed to care for R3. NHA A stated, yes. NHA A stated, there is an issue so we're going to order something different.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434 Based on observation, interview, and record review, the facility did not provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident (R) for 2 of 14 residents (R1 and R2). R1 did not receive her ordered Benazepril (Lowers blood pressure) on 11/24/24 and 11/26/24. R1's Nitroglycerin (Lowers blood pressure) patch was administered late on 11/24/24, 12/2/24, 12/4/24, and 12/8/24. R1 did not receive her furosemide (diuretic) on 11/27/24. R2 did not receive an inhaler on 11/12/24 and a weekly injection on 11/18/24. This is evidenced by: The facility policy titled, Administering Medications, dated12/2012, states, in part: Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation . 4. Medications must be administered in accordance with the orders, including any required time frame. 5. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) .17. During administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by . 19. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR (Medication Administration Record) space provided for that drug and dose . 23. Staff shall follow established facility infection control procedures (e.g. Handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable . Example 1 R1 was admitted to the facility on [DATE], with admitting diagnoses that include, in part: congestive heart failure, generalized anxiety disorder, obstructive sleep apnea, peripheral vascular disease, atrial fibrillation (irregular heartbeat), mild intermittent asthma, nontraumatic intracerebral hemorrhage (non-traumatic brain bleed), chronic kidney disease, stage 4 (severe), and hypertension. R1's most recent Quarterly Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 10/30/24, indicates R1 has a Brief Interview of Mental Status (BIMS) of 15 out of 15, indicating that she is cognitively intact. E0800. Rejection of Care indicates that the patient did no reject cares during the assessment period. E1100. Change in behavior or other symptoms indicates R1's MDS behavioral assessment was the same as the prior assessment. R1's November and December 2024 MAR (Medication Administration Record) includes the following: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Benazepril HCl Oral Tablet 5 MG (Benazepril HCl) Give 1 tablet by mouth one time a day every other day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) The MAR has a 9 recorded for 11/24/24 and 11/26/24.The section titled Chart Codes indicates a 9 means Other/See Progress Notes. On 11/24/24 at 8:12 AM, an Orders - Administration Note was written that states, in part: .med not available. On 11/26/24 at 9:18 AM, an Orders - Administration Note was written that states, in part: .medication not available. Nitroglycerin Transdermal Patch 24 Hour 0.4 MG/HR (Nitroglycerin) Apply 1 patch transdermally every 24 hours related to OTHER FORMS OF ANGINA PECTORIS (I20.8) and remove per schedule. Remove patch: 8:00 AM. Apply patch: 8:00 PM. Start Date: 7/15/24. Nitroglycerin patch was applied over one hour late on the following dates: 11/24/24 at 9:57 PM 12/2/24 at 10:27 PM 12/4/24 at 9:37 PM 12/8/24 at 10:19 PM Nitroglycerin patch was removed over one hour late on the following dates: 11/4/24 at 9:05 AM 11/12/24 at 9:47 AM 11/14/24 at 9:47 AM 11/21/24 at 9:01 AM 11/22/24 at 6:54 PM 11/23/24 at 9:35 AM 11/26/24 at 9:20 AM 11/28/24 at 10:14 AM 11/30/24 at 9:39 AM 12/2/24 at 9:11 AM (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/6/24 at 9:07 AM 12/10/24 at 10:28 AM Furosemide Oral Tablet 20 MG (Furosemide) Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) Start date: 7/16/24. The MAR has a 9 recorded for 11/27/24. The section titled Chart Codes indicates a 9 means Other/See Progress Notes. On 11/26/24 at 9:18 AM, an Orders - Administration Note was written that states, in part: . not due today. No other documentation found regarding why this medication was not administered according to physician order. On 12/16/24 at 2:00 PM, Surveyor interviewed ADON C (Assistant Director of Nursing). Surveyor asked ADON C if the facility has a medication list for medications kept in a contingency stock. ADON C indicates that the facility does and provided Surveyor with a copy. Surveyor asked ADON C who is responsible for ordering medications. ADON C indicates some medications will automatically order through the electronic medical record system, and nurses can also order medication through the electronic medical record or there is paperwork that can be faxed to the pharmacy if needed. Surveyor asked ADON C if there is a reason R1's benazepril was not given on 11/24/24 and 11/26/24. ADON C reviewed the MAR, and progress notes, but found no indication of why this medication was not given. Surveyor asked ADON C if medications should be administered as ordered. ADON C states, absolutely, the medications also need to be put on hold and a provider contacted regarding the missed dose. 38725 Example 2 R2 admitted to this facility for a short-term rehab stay. R2 had the following diagnoses: chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus with hyperglycemia, atherosclerosis of native arteries of extremities with rest pain, bilateral legs nicotine dependence, and chronic pain syndrome. R2's Physician Orders include the following, in part: - Semaglutide (0.25 or 0.5 MG (milligrams)/DOS (dose)) subcutaneous Solution Pen-injector 2 MG/3 ML (milliliters) (Semaglutide) Inject 0.5 mg subcutaneously one time a day every Mon related to type 2 diabetes mellitus with hyperglycemia - Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 100-62.5-25 MCG (microgram)/ACT (asthma control test) (Fluticasone-Umeclidinium-Vilanterol) 1 puff inhale orally one time a day related to COPD R2's MAR (Medication Administration Record) documents the following, in part: Trelegy on 11/12/24 has 9 documented. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Semaglutide on 11/18/24 has 9 documented. Per key on MAR, 9 means other/see progress note. R2's Nurses Notes document the following for those dates above: 11/12/24 medication not available. 11/18/24 medication not available. It is important to note that there are not follow up notes regarding either of these medications. On 12/16/24 at 1:43 PM, Surveyor interviewed ADON/WN C (Assistant Director of Nursing/Wound Nurse). Surveyor asked ADON/WN C what it means if it says 9 on the MAR, ADON/WN C stated let me look and read from computer program other/ see progress note. Surveyor asked ADON/WN C who enters orders for new admissions, ADON/WN C either me, DON (Director of Nursing), or a floor nurse. Surveyor asked ADON/WN C how new admission orders get to the pharmacy to be filled, ADON/WN C said they are faxed to pharmacy. Surveyor asked ADON/WN C should R2's medications have been delivered before AM dose of Trelegy on 11/12/24, ADON/WN C replied yes it should've been. Surveyor asked ADON/WN C should R2's Semaglutide have been delivered by 11/18/24 to administer, ADON/WN C said Oh gosh, I don't know. On 12/16/24 at 3:03 PM, Surveyor interviewed RN P (Registered Nurse). Surveyor asked RN P what it means if it says 9 in the MAR, RN P said she would need to check the key in computer, then said other see progress notes. Surveyor asked RN P who enters orders for new admissions, RN P replied I would need to find out, we have not had any recently. Surveyor asked RN P should R2's medications have been delivered before AM dose of Trelegy on 11/12/24, RN P said if they were into the pharmacy by the cut off time, yes. Surveyor asked RN P should R2's Semaglutide have been delivered by 11/18/24 to administer, RN P stated yes. Surveyor asked RN P what the process is when a medication isn't available, RN P said to call the pharmacy, first check if it is in contingency, then call Provider to get hold order or new order. On 12/16/24 at 4:06 PM, Surveyor interviewed ADON/WN C. Surveyor asked ADON/WN C what the process is when medications aren't available, ADON/WN C stated first look in contingency, place medication on hold, and notify the Provider and proceed from there. On 12/16/24 at 3:56 PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A if she would expect the Nurse to call the pharmacy and the Provider if a medication isn't available, NHA A said yes.

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F 0761 Level of Harm - Minimal harm or potential for actual harm 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. 49434 Based on observation, interview, and record review, the facility did not ensure that all drugs and biologicals used in the facility were labeled and stored in accordance with currently accepted professional principles, including the appropriate storage of medications in secure containers, for 1 of 1 medication carts. Surveyor observed RN K (Registered Nurse) dispense several medications into a medication cup, including a controlled substance, and left the medication cup unattended on the medication cart for several minutes. Surveyor observed R6, who is cognitively impaired, self-propelling in her wheelchair and using the medication cart to self-propel herself down the hallway. The medications on top of the cart were accessible to R6. This is evidenced by: The facility policy titled, Administering Medications, dated12/2012, states, in part: Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation . 17. During administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by . On 12/11/24, at 4:20 PM, Surveyor observed RN K prepare 5 medications for R11. The medications prepared included acetaminophen, Eliquis, famotidine, metoprolol, Omega 3 fatty acid, and tramadol. All medications were dispensed according to physician order. When RN K entered R11's room, R11 stated he did not want his medications, and RN K returned to his cart and placed the unsecured cup of pills on top of the medication cart. (Of note: Tramadol is an opioid used to treat moderate to severe pain and is a schedule IV medication. This means that according to the U.S. Drug Enforcement Administration, this medication must be always stored behind at least two differently keyed locks and the keys cannot be stored with or near the locks.) On 12/11/24 at 4:22 PM, Surveyor observed RN K prepare and administer one medication to R12. The pill cup remained accessible to anyone in the hallway and out of RN K's sight and reach while he is in R12's room. On 12/11/24 at 4:25 PM, Surveyor observed RN K prepare and administer one medication to R13.The pill cup remained accessible to anyone in the hallway and out of RN K's sight and reach while he is in R13's room. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/24 at 4:28 PM, Surveyor observed RN K prepare and administer one medication to R14. The pill cup remained accessible to anyone in the hallway and out of RN K's sight and reach while he is in R14's room. Surveyor also observed R6 sitting in her wheelchair in the hallway and self-propelling near the medication cart. On 12/11/24 at 4:30 PM, Surveyor observed RN K return to R12's room and administer the medications from the medication cup. While RN K was administering the medication, Surveyor observed R6, utilizing the medication cart to self-propel. R6 reached to the top of the medication cart and pushed herself past the medication cart. On 12/11/24 at 4:32 PM, Surveyor interviewed RN K. Surveyor asked RN K if medications should be locked up if they are out of his sight or control. RN K states yes. Surveyor asked RN K if medications should ever be left unattended. RN K states, no.

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F 0801 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 44552 Based on observation, interview, and record review, the facility does not have a full-time qualified dietician or director of food and nutrition services. This has the potential to affect all 22 residents. The facility's failure to have a full-time registered dietician (RD) or a certified dietary manager to ensure effective nutritional and dietary services are provided to residents created a finding of immediate jeopardy that began on 10/30/24. NHA A (Nursing Home Administrator) was notified of the immediate jeopardy on 12/16/24 at 3:30 PM. The immediacy was removed on 12/22/24 and continues at a severity/scope level of F (potential for more than minimal harm/widespread) as the facility continues to implement its removal plan. This is evidenced by: Per the State Operations Manual, .If a qualified dietician or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; . Surveyor requested dietary policies on 12/11/24 3:20 PM, 12/12/24 9:30 AM, 12/12/24 11:31 AM, 12/12/24 4:45 PM, 12/16/24 12:13 PM, and 12/16/24 3:30 PM. NHA A indicated NHA A looked in the kitchen for any dietary policies and was unable to locate any dietary policies. Surveyor asked [NAME] G regarding dietary policies and [NAME] G indicated there are not any dietary policies in the kitchen. The facility was able to provide Surveyor with a few dietary policies 12/16/24 at 6:00 PM, but they were not the dietary policies requested. On 12/11/24 at 9:15 AM, DA H (Dietary Aide) indicated she is the only dietary aide at the facility. DA H indicated the kitchen is short staffed and currently without a dietary manager and there is not a full-time registered dietitian (RD). On 12/11/24 at 9:30 AM, [NAME] G indicated she has been at the facility for almost two weeks. [NAME] G indicated there is no dietary manager (DM) and there is not a full-time RD. [NAME] G stated there was not a DM or Full-time RD when she started two weeks ago. [NAME] G indicated the NHA A (Nursing Home Administrator) cooks and prints off the meal tickets. (continued on next page)

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F 0801 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 12/11/24 at 5:00 PM, Surveyor observed NHA A cooking supper on 12/11/24. There was no cook or dietary aide in the kitchen for supper on 12/11/24. On 12/16/24 at 8:00 AM, 11:30 AM and 5;15 PM Surveyor observed NHA A cooking breakfast, lunch, and supper. There was not a dietary aide working on 12/16/24. On 12/11/24 at 3:20 PM, NHA A (Nursing Home Administrator) indicated there has not been a dietary manager since October 30th. NHA A indicated there is an on-call manager rotation and if there is no cook staff will step in and cook. On 12/12/24 at 8:30 AM, NHA A indicated her first day at facility was November 15th. NHA A indicated the dietary manager is responsible for the meal tickets and ensuring they are out for the cook to follow. NHA A indicated they have hired a new dietary manager and dietary manager will be starting next Monday, 12/16/24. NHA A stated there were issues with the meal tickets not being printed, but NHA A is now responsible for them until the dietary manager completes orientation. The facility has a Registered Dietician, and she is at the facility once a week. NHA A indicated she has been working on ordering supplies and food. NHA A indicated there was a delay in ordering because she needed money put on the facility credit card and was purchasing items with her own money. NHA A indicated there was a time where there was no one responsible for ordering supplies and food. NHA A indicated she now is ordering supplies and food, and facility is getting caught up on needed items. In addition to problems with ordering, the failure to have a person responsible for the day-to-day operations of food and dietary services led to the following problems: 1. There was not sufficient dietary support staff to provide meals to residents of the facility. There were no qualified dietary staff to prepare and serve meals to residents for multiple meals. Nursing staff and management cook meals. (Refer to F802 for issues related to lack of sufficient dietary support staff.) 2. Staff were not following accepted standards of practice including documenting food temperatures, documenting temperatures for refrigerators/freezers, storing food items near chemicals, and unkept cooking area. (Refer to F812 related to failure to store, prepare, and serve foods in a sanitary manner.) 3. The facility failed to ensure all residents receive proper diets per order. The facility did not have a system to ensure meal tickets were always available to staff. The facility failed to have Thick-It (a product that thickens liquids/food for consumption for those with swallowing issues) in house for residents who have an order for nectar consistency liquids. (Refer to F805 for food prepared in a form designed to meet individual needs.) The facility's failure to have a full-time registered dietician (RD) or a certified dietary manager to ensure effective nutritional and dietary services are provided to residents created a reasonable likelihood for serious harm, thus leading to an immediate jeopardy situation which began 10/30/24. The facility removed the immediate jeopardy on 12/22/24 by taking the following actions: (continued on next page)

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F 0801 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	All staff will be educated prior to their next working shift 1. CDM (Certified Dietary Manager) started working on 12/16/24. 2. We currently employ a registered dietician (RD) who works 2 days a week. The RD will review and sign off on all competencies intiated by the CDM prior to QAPI (Quality Assurance Process Improvement) Meeting. 3. Prior to food and nutritional service staff working a competency to be completed by the CDM, with sign off by the RD. 4. Competency checks for all food and nutritional services employees will be completed on 12/19/24 and 12/20/24, until all dietary staff are checked off. No dietary staff will work after 12/20/24 until competency checked. 5. All staff were trained on Serve Safe food handling and sanitation of kitchen and dishroom. All new staff will be required to complete training and competency checkoff by the CDM with susbsequent sign off by the RD. 6. In the event of a staff call off, the staff shall first contact the CDM. If the CDM cannot be reached, all staff will contact the NHA (Nursing Home Administer) for staffing assistance. 7. In the event of a call in, only qualified staff will work in the kitchen (Serve Safe certified and competencies checked off.). 8. The schedule will be developed by the certified dietary managerand provided in advance for the food and nutritional services employees. 9. The dietary schedule will remain posted and updated by the CDM as needed in a visible area of the kitchen. 10. The CDM will provide education to all dietary staff on the following: emergency prepardness plan, scheduling, competencies and audits. 11. The CDM/Administrator/Designee will conduct audits 5 days a week for 4 weeks, then weekly, followed by monthly thereafter. - Interviews confirm knowledge of qualified dietary staff - Interviews confirm knowledge of emergency food supply and following diets as ordered - All staff working in the dietary department will have the competency checks completed - Schedule completed for dietary staffing. 12. QAPI (continued on next page)

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F 0801 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The results of these audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee for patterns, trends, and continued recommendations for process monitoring and improvement.

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F 0802 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on observation, interview, and record review, the facility did not ensure there were sufficient dietary support staff to carry out the functions of the food service department. This has the potential to affect all 22 residents at the facility. The facility had nursing and management preparing and serving meals without proper training or competencies. The facility's failure to ensure there was sufficient and competent dietary support staff created a finding of immediate jeopardy that began on 12/2/24. The NHA (Nursing Home Administrator) was notified of the immediate jeopardy on 12/16/24 at 3:30 PM. The immediacy was removed on 12/25/24 and continues at a severity/scope level of F (potential for more than minimal harm/widespread) as the facility continues to implement its removal plan. This is evidenced by: Per State Operations Manual, .483.60(a) Staffing .The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population . On 12/11/24 at 5:00 PM, Surveyor observed NHA A cooking supper. There was no cook or dietary aide in the kitchen for supper on 12/11/24. On 12/16/24 at 7:30 AM, 11:30 AM, and 5:15 PM Surveyor observed NHA A cooking breakfast, lunch, and supper respectively. There was not a dietary aide working on 12/16/24. On 12/16/24 at 7:30 AM, NHA A (Nursing Home Administrator) indicated she was cooking today. NHA A indicated the agency staff cook told her she would not be picking up any more shifts. NHA A indicated the evening cook is out now due to an injury and the part time cook is off for the next couple of weeks due to surgery. NHA A indicated the new dietary manager should be starting today. On 12/11/24 at 9:15 AM, DA H (Dietary Aide) indicated she is the only dietary aide at the facility. DA H indicated the kitchen is short staffed and currently without a full-time registered dietician (RD) or certified dietary manager (CDM). On 12/11/24 at 9:45 AM, RN K (Registered Nurse) indicated there has been staffing issues with the kitchen and not having a cook. RN K indicated there is not a full-time RD or CDM. RN K indicated he has seen previous social worker cooking. RN K indicated he knows of at least four times that there wasn't a cook working. RN K indicated the administrator cooks meals as well. RN K indicated meals are often served late. On 12/11/24 at 9:45 AM, CNA I (Certified Nursing Assistant) indicated she has observed resident diets not being followed by kitchen staff. CNA I indicated she has observed diets not being followed since she started working at facility in October. (continued on next page)

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F 0802 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 12/11/24 at 10:00 AM, CNA J (Certified Nursing Assistant) indicated there has been quite a few times where there was no cook or kitchen staff. CNA J indicated CNA J has cooked meals while at the facility. CNA J indicated she has not received any education or competency check while at the facility, but previously she was a cook. CNA J indicated she just knows resident diets at the facility, but others who have jumped in to help with cooking do not know and meal tickets are not always available or accurate. CNA J indicated there have been issues with residents receiving the incorrect diet. On 12/11/24 at 2:40 PM, HR F (Human Resources) indicated she has worked at the facility for around a month. HR F indicated there is an on-call schedule for managers and the on-call manager is expected to cook if the cook doesn't show up or the shift is open. HR F indicated she is on the on-call rotation. HR F indicated she has not received any education or competency checks to be able to work in kitchen. HR F indicated she is unsure who is responsible for training or completing the competency checks for staff to be able to work in kitchen. Surveyor asked HR F to provide any documentation in staff files regarding education for kitchen. At the time of exit, Surveyor had not received any staff education or competencies for working in the kitchen. On 12/11/24 at 3:00 PM, TM L (Therapy Manager) indicated she has worked at the facility for around a month. TM L indicated she is on the on-call manager rotation list. TM L indicated she heard the expectation is the on-call manager is expected to cook if there isn't a cook on the schedule or one doesn't show up. TM L indicated she has not had any training to be able to work in the kitchen. TM L indicated the previous Therapy Manager had to cook in the kitchen because there wasn't a cook. On 12/11/24 at 3:59 PM, MM M (previous Marketing Manager), indicated she served in multiple positions while at the facility. MM M indicated she was responsible for scheduling/transportation/marketing director when she worked at facility. MM M indicated there are staffing concerns in the kitchen. MM M indicated she worked in the kitchen at least twice a week while at the facility. MM M indicated she did not receive any training or competency checks to be able to work in the kitchen. R1 was admitted to the facility on [DATE] with diagnoses including heart disease, hypertension, vascular disease, renal disease, and hyperlipidemia. R1's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/30/24 indicates R1 has a Brief Interview Mental Status (BIMS) score of 15, indicating R1 is cognitively intact. On 12/16/24 at 10:10 AM, Surveyor interviewed R1. Surveyor asked R1 about her concerns at the facility. R1 stated, she is concerned about her health because she is not getting proper nutrition. R1 also stated, I usually can't eat lunch or dinner because of my diet. R1 indicated lunch and dinner usually contains deli meat or cheese and she is on a no added salt diet related to her heart disease and cannot have nitrates due to her stage 4 kidney disease. R1 also stated, If I eat nitrates, my kidneys will get worse, and I will have to go on dialysis so I'm avoiding that at all costs. After discussing additional concerns, resident states, I just cry every other day being here. I'm just lost. R7 was admitted to the facility on [DATE] with diagnoses including pneumonia, hypertension, heart failure, and anxiety disorder. R7's most recent MDS with ARD of 9/30/24 indicates R7 has a BIMS score of 13 indicating R7 is cognitively intact. (continued on next page)

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F 0802 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 12/11/24 at 12:10 PM, R7 indicated there was an issue recently with supper. R7 indicated there was no kitchen staff, supper was not served, and it was dark outside. R7 indicated she and some of her tablemates pooled together some food. R7 indicated one of the ladies had some crackers and another one had an apple. R7 indicated it was scary we were not sure if we were going to have food. It is important to note, R7 is referencing an incident from 12/2/24. Surveyor reviewed time stamp for the facility cook. The facility cook arrived at the facility late on 12/2/24 and clocked in at 7:30 PM. Through interview it was determined that facility nursing staff assisted in making meals for residents that evening as there was not a cook in the building. Subsequently, residents received their meal late. On 12/11/24 at 4:16 PM, LPN N (Licensed Practical Nurse), who is an agency staff, indicated she worked at the facility on 12/2/24 and had arrived a little late around 6:17 PM. LPN N indicated as soon as she arrived staff informed her there was no kitchen staff. LPN N indicated there were residents coming out of their rooms saying they were hungry and asking for supper. LPN N indicated she couldn't possibly pass medications and make supper. LPN N indicated the CNAs made soup and sandwiches. LPN N indicated there was not a lot of food in the kitchen and staff found cottage cheese and served that as well. LPN N indicated a cook showed up at 7:30 PM, but by that time supper was already served. LPN N indicated she was very thankful for the CNAs working that night. LPN N indicated there wasn't any Thick-It (a product that thickens liquids/food for consumption for those with swallowing issues) in house. LPN N indicated she was told that it had been out for a while. LPN N indicated she didn't know what to do and just gave the residents who had orders for thickened drinks thin liquid because they had to have something to drink. LPN N indicated she worked the 6:00 PM - 6:00 AM shift and reported all of this to the nurse that relieved her in the morning. LPN N indicated that nurse told her supplies such as the Thick-It was an issue and they have been without. LPN N indicated that nurse also reported meals are often served late. LPN N indicated she has never worked at a facility where there was absolutely no kitchen staff. LPN N indicated orders and specific diets were not followed that night, staff were just trying to get people fed. LPN N indicated she was so nervous and scared. LPN N indicated it was a horrible night and she will not be picking up any more shifts at the facility. On 12/12/24 at 3:00 PM, RN D (Registered Nurse) indicated there are issues with not having kitchen staff. RN D indicated one evening there wasn't a cook, so RN D and a CNA made the meal. RN D indicated the residents were very anxious over not having the meal served on time. RN D indicated there weren't meal tickets available that meal, but the CNA that was also cooking was familiar with residents. On 12/12/24 at 3:20 PM, FM O (Family Member) indicated she is activated power of attorney for her dad, and he recently moved to a different facility. FM O indicated the quality of care was poor at the facility. FM O indicated recently there was issues with not having Thick-It available. FM O indicated there were concerns with kitchen staff and meals. FM O indicated her father would voice concerns that there were not staff in the kitchen and that meals were served late. FM O indicated her dad told her that recently there were no staff during supper time and that CNAs had to quickly throw together a meal. FM O indicated she is an advocate for her dad, but her heart breaks for the residents at the facility. (continued on next page)

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	525521	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartland Country Village	634 Center St Black Earth, WI 53515

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0802 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 12/11/24 at 3:20 PM, NHA A (Nursing Home Administrator) indicated there has not been a dietary manager for the last couple of months. NHA A indicated there is an on-call manager rotation and if there is no cook staff will step in and cook. NHA A indicated she utilizes the staffing agency for nursing as well as cooks. NHA A indicated the facility has one cook from the staffing agency. The cook from agency has arrived late for the cook's scheduled shift several times. One of the other facility cooks has been calling in quite often. NHA A indicated she does not know of any education or competency checks for management and nursing staff that are helping in the kitchen. NHA A indicated she has not received any education or competency checks since being at the facility. NHA A indicated understanding staff competency requirements for working in the kitchen. NHA A indicated the kitchen has struggled with staffing and they just got approval for a higher rate of pay and she has reached out to the staffing agency. Surveyor asked NHA A to provide any education or competency checks that the facility may have on file for staff who work in the kitchen. At time of exit, Surveyor had not received education or competency checks for the nursing and management staff that are cooking and working in the kitchen. Of note, the facility was previously cited for F801, F805, and F812 on annual survey in September 2024. On 12/12/24 at 8:30 AM, NHA (Nursing Home Administrator) indicated her first day at facility was November 15th. NHA A indicated the dietary manager is responsible for the meal tickets and ensuring they are out for the cook to follow. NHA A indicated they have hired a new dietary manager and the dietary manager will be starting next Monday, 12/16/24. NHA A stated there were issues with the meal tickets not being printed, but NHA A is now responsible for them until the dietary manager completes orientation. Surveyor asked NHA A if the facility has a registered dietician. NHA A stated the facility has a Registered Dietician, and she is at the facility once a week. NHA A indicated NHA A has been working on ordering supplies and food. NHA A indicated there was a delay in ordering, but now they are getting caught up. The facility's failure to ensure there were sufficient dietary support staff to carry out the functions of the food service department created a reasonable likelihood for serious harm, thus leading to an immediate jeopardy situation that began 12/2/24. The facility removed the immediate jeopardy on 12/25/24 by taking the following actions: All staff will be educated prior to their next working shift beginning on 12/16/24 and completed on 12/22/24. The CDM and Administrator will ensure the following: The CDM and Administrator will ensure dietary staff are competent and sufficient to meet resident needs to include: - Resident needs and preferences are met, food supply is available to meet resident needs. - There are sufficient staff to prepare and serve meals in a timely manner and to maintain food safety. - Dietary staff received education on preparing altered diets per physician orders by the Certified Dietary Manager (CDM) on 12/20/24. (continued on next page)

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F 0802 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Emergency preparedness - In the event of a staffing concern, staff are to contact the CDM. - Back-up staffing will include dietary staff and departnment head staff that have completed dietary department competencies. - Back up emergency food supply put together with location and menu items to meet nutritional servings and portions. (All staff educated prior to working any shift after 12/21/24). Audits The administrator/designee will conduct audits 5 days per week for 1 week, weekly for 1 month and monthly for 3 months to include the following: - Observed and interview residents to determine if dietary needs are being met and dietary orders are followed. _ Complete observations and/or interviews indicate there are sufficient staff to prepare and serve meals in a timely manner and to maintain food safety. - QAPI The results of these audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee for patterns, trends, and continued recommendations for process monitoring and improvement.

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on interview, observation, and record review, the facility did not ensure food was prepared in a form designed to meet individual needs for 2 of 2 (R5 and R6) residents on altered diets. The facility failed to ensure residents who have specialized diets received their food in a consistency based on their assessed needs and physician orders. The facility did not have Thick-It (a product that thickens liquids/food for consumption for those with swallowing issues) in the building to thicken liquids. Staff were not trained and competent to prepare altered diets. Failure to ensure foods were served to residents in the appropriate texture created a finding of Immediate Jeopardy (IJ), that began on 11/30/24. NHA A (Nursing Home Administrator) was notified of the immediate jeopardy on 12/16/24 at 3:30 PM. The immediate jeopardy was removed on 12/25/24; however, the deficient practice continues at a severity/scope level of D (potential for more than minimal harm/isolated) as the facility continues to implement its removal plan. Evidenced by: The facility policy, titled, Therapeutic Diets, revision date 12/08, states, in part; .Therapeutic diets shall be prescribed by the attending physician .5. The Food Services Manager will establish and use a tray identification system to ensure that each resident receives his or her diet as ordered . On 12/11/24 at 5:00 PM, Surveyor observed NHA A cooking supper. There was no cook or dietary aide in the kitchen for supper on 12/11/24. On 12/16/24 at 7:30 AM, 11:30 AM and 5:15 PM Surveyor observed NHA A cooking breakfast, lunch, and supper respectively. There was not a dietary aide working on 12/16/24. On 12/16/24 at 7:30 AM, NHA A (Nursing Home Administrator) indicated she was cooking today. NHA A indicated the agency staff cook told her she would not be picking up any more shifts. NHA A indicated the evening cook is out now due to an injury and the part time cook is off for the next couple of weeks due to surgery. NHA A indicated the new dietary manager should be starting today. Of note, NHA A has not received education to cook therapeutic diets and has not completed competency checks to prepare altered diets. R5 was admitted to the facility on [DATE] with diagnoses including Alzheimer's, diabetes, pneumonitis due to inhalation of food and vomit, depression, kidney disease, and dysphagia (difficulty swallowing). R5's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 9/24/24 indicates R5 has a Brief Interview Mental Status (BIMS) score of 00, indicating R5 is severely cognitively impaired. R5 has an activated power of attorney. R5's meal ticket states, in part; .Texture: IDDSI (International Dysphagia Diet Standardisation Initiative) Level 5: Minced and Moist and Fluid: IDDSI Level 2: Mildly Thick . (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R5's most recent physician orders, states, in part; .Minced and Moist texture, Nectar/Mildly Thick consistency .order status Active .Order date 10/11/24 .start date 10/11/24. R6 was admitted to the facility on [DATE] with diagnoses including mood disturbance and anxiety, dementia, weakness, hypertension, mild protein-calorie malnutrition, restlessness and agitation. R6's most recent MDS with ARD of 10/16/24 indicates R6 has a BIMS score of 00, indicating R6 is severely cognitively impaired. R6 has an activated power of attorney. R6's meal ticket states, in part; .Texture: IDDSI Level 5: Minced and Moist and Fluid: IDDSI Level 2: Mildly Thick . R6's most recent physician orders, states, in part; .Mechanical Soft texture, Nectar/Mildly Thick consistency . order status Active .Order date 6/28/24 .start date 7/1/24. On 12/11/24 at 9:15 AM, DA H (Dietary Aide) indicated there have been times where there is no cook or dietary staff are running late. DA H indicated there was one time recently that breakfast wasn't served and there was no cook. DA H indicated she just served everyone cereal that day. Surveyor asked DA H if she knew what residents have a specialized diet specifically residents on minced and moist diets, and if she followed diets on that specific morning. DA H indicated, I don't know, I gave them toast. Surveyor asked DA H if she knew of any time where the facility did not have Thick-It for liquids. DA H indicated, Yes, we ran out the Saturday after Thanksgiving (11/30/24) and DA H indicated she just gave residents what they wanted to drink, when the facility was without Thick-It. On 12/11/24 at 9:30 AM, [NAME] G indicated there has been times where there wasn't Thick-It in house. [NAME] G indicated when she realized there wasn't Thick-It she reported it to the nurse because she didn't know who else to report it to. [NAME] G indicated there are two residents who require Thick-It in their liquids, R5 and R6. On 12/11/24 at 9:45 AM, CNA I (Certified Nursing Assistant) indicated she has observed resident diets not being followed by kitchen staff. CNA I indicated she has observed diets not being followed since she started working at facility in October. On 12/11/24 at 10:00 AM, CNA J (Certified Nursing Assistant) indicated she was aware of the facility being without Thick-It and she was working during this time. CNA J indicated it was reported to nursing. CNA J indicated there are two residents who have orders for nectar consistency for all liquids. CNA J indicated there was a staff sitting next to the two residents while they drank thin liquids. CNA J indicated the staff then watched if either resident started coughing. CNA J indicated meal tickets have been an issue and not always available for meals. CNA J indicated CNA J has cooked meals while at the facility. CNA J indicated she has not received any education or competency check while at the facility, but previously she was a cook. CNA J indicated she just knows resident diets at the facility, but others who have jumped in to help with cooking do not know and meal tickets are not always available or accurate. CNA J indicated it has been an issue with residents receiving the correct diets. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/11/24 at 3:59 PM, MM M (previous Marketing Manager), indicated she served in multiple positions while at the facility. MM M indicated she was responsible for scheduling/transportation/marketing director when she worked at facility. MM M indicated there was staffing concerns in the kitchen. MM M indicated she worked in the kitchen at least twice a week while at the facility. MM M indicated she did not receive any training or competency checks to work in the kitchen. MM M indicated there were issues with meal tickets and not having them available since there wasn't a dietary manager. MM M indicated there was no Thick-It in the facility starting over the Thanksgiving weekend and that it was reported to the NHA A (Nursing Home Administrator). MM M indicated the two residents who were supposed to have thickened liquids had a staff watch them while they were drinking thin liquids. MM M indicated she was not sure if their physician was notified, or any follow up was completed due to staff providing thin liquids. On 12/11/24 at 4:16 PM, surveyor interviewed LPN N (Licensed Practical Nurse), who is an agency staff. LPN N indicated she worked at the facility on 12/2/24 and had arrived a little late around 6:17 PM. LPN N indicated as soon as she arrived staff informed her there was no kitchen staff. LPN N indicated there were residents coming out of their rooms saying they were hungry and asking for supper. LPN N indicated she couldn't possibly pass medications and make supper. LPN N indicated the CNAs made soup and sandwiches. LPN N indicated there was not a lot of food in the kitchen and staff found cottage cheese and served that as well. LPN N indicated a cook showed up at 7:30 PM, but by that time supper was already served. LPN N indicated she was very thankful for the CNAs working that night. LPN N indicated there wasn't any Thick-It (a product that thickens liquids/food for consumption for those with swallowing issues) in house. LPN N indicated she was told that it had been out for a while. LPN N indicated she didn't know what to do and just gave the residents who had orders for thickened drinks thin liquid because they had to have something to drink. LPN N indicated she worked the 6:00 PM to 6:00 AM shift and reported all of this to the nurse that relieved her in the morning. LPN N indicated that nurse told her supplies such as the Thick-It was an issue and they have been without. LPN N indicated that nurse also reported meals are often served late. LPN N indicated she has never worked at a facility where there was absolutely no kitchen staff. LPN N indicated orders and specific diets were not followed that night, staff were just trying to get people fed. LPN N indicated she was so nervous and scared. LPN N indicated it was a horrible night and she will not be picking up any more shifts at the facility. On 12/12/24 at 3:00 PM, RN D (Registered Nurse) indicated there are issues with not having kitchen staff. RN D indicated one evening there wasn't a cook, so RN D and a CNA made the meal. RN D indicated the residents were very anxious over not having the meal served on time. RN D indicated there weren't meal tickets available that meal, but the CNA that was also cooking was familiar with residents. RN D stated RN D has not received training to prepare altered diets. On 12/16/24 at approximately 8:30 AM, Surveyor observed R5 and R6's meal tray. R5 and R6 received nectar thick liquids and the meal tray appeared to have food cut in small/minced pieces and appeared moist. It should be noted NHA A prepared the morning meal and has verbalized that she has not received any education to prepare altered diets. Additionally, numerous staff have stated they have not been trained or did not follow resident diets while working in the kitchen and preparing resident meals. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/11/24 at 3:20 PM, NHA A (Nursing Home Administrator) indicated there has not been a dietary manager for the last couple of months. NHA A indicated there is an on-call manager rotation and if there is no cook staff will step in and cook. NHA A indicated she utilizes the staffing agency for nursing as well as cooks. NHA A indicated the facility has one cook from the staffing agency. The cook from agency has arrived late for the cooks scheduled shift several times. One of the other facility cooks has been calling in quite often. NHA A indicated she does not know of any education or competency checks for management and nursing staff that are helping in the kitchen. NHA A indicated she has not received any education or competency checks since being at the facility. NHA A indicated understanding staff competency requirements for working in the kitchen. NHA A indicated the kitchen has struggled with staffing and they just got approval for a higher rate of pay and she has reached out to the staffing agency. Surveyor asked NHA A to provide any education or competency checks that the facility may have on file for staff who work in the kitchen. At time of exit, Surveyor had not received education or competency checks for the nursing and management staff that are cooking and working in the kitchen. Of note, the facility was previously cited for F801, F805, and F812 on annual survey in September 2024. According to SwallowStudy.com: Thin liquids move fast and can spill out of the mouth and into the throat and airway before you are ready to swallow. Thickening a liquid can slow down the flow of the liquid, especially if you have a delayed swallow. Thin liquids are unpredictable and difficult to control in the mouth and throat. Thickening a liquid can keep the sip of liquid together in one ball (also known as a bolus). This is especially helpful if you have decreased airway closure and thin liquid splashes or falls into your airway and to the lungs before, during or after the swallow. https://swallowstudy.com/thickened-liquids/ 8 Signs of Dying from Aspiration Pneumonia notes that Mortality estimates for aspiration pneumonia vary. At least 5 percent of people who are hospitalized for aspiration will die .Among geriatric populations, mortality skyrockets. A 2013 study of elderly patients put 30-day mortality at 21 percent. First responders, doctors, nurses, and other healthcare providers must always treat aspiration pneumonia as a medical emergency with a high mortality risk .In the immediate aftermath of aspiration, a patient may be unable to breathe or swallow, presenting a medical emergency. After the risk of hypoxia has passed, the dangers of aspiration pneumonia have not. Aspiration pneumonia can cause numerous complications, including: Sepsis Respiratory failure Acute respiratory distress syndrome (ARDS) Bacterial pneumonia (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	https://blog.sscor.com/8-signs-of-dying-from-aspiration-pneumonia The facility's failure to ensure foods and fluids were served to residents in the appropriate texture/form created a reasonable likelihood for serious harm, thus leading to an immediate jeopardy situation thqt began 11/30/24. The facility removed the immediate jeopardy on 12/25/24 by taking the following actions: - The NHA/Director of Nursing (DON)/ Certified Dietary Manager9CDM) or designee immediately checked to ensure that the identified residents (R5 and R6) received the correct altered diet. - The NHA/DON/CDM or designee completed an audit of all tray tickets to ensure that all diet orders match the tray tickets for all facility residetns and reviewed all resident diets to ensure residents received the correct [NAME] as ordered by the physician. - The NHA/DON/CDM or designee reviewed all residents who receive altered texture diets. Orders were verified and updated as deemed appropriate on 12/20/24. - Dietary care plans were reviewed for accuracy and updated to reflect any new orders and recommendations for all residents by the DON/CDM/NHA or designee on 12/20/24. All staff education initiated on 12/19/24 to ensure that physician order, including appropriate dietary recommendations are in place for all residents. Staff will receive education prior to starting their next working shift by DON/Administrator. - All staff educated initiated on the procedure on tray ticket system for resident meal delivery and appropriate diet 12/19/24. Competency and validation will be completed on staff to ensure that tray ticket is present on meal tray, that the meal validates what the tray ticket indicates is the appropriate diet for the resident. Staff will receive education prior to starting their next working shift by CDM/DON/ or Administrator. Education will also include what to do if there is no ticket or if the tray ticket does not match what is on the actual resident plate or tray. - All staff education initiated on the procedure on tray ticket system for resident meal delivery and appropriate diet 12/19/24. Competency and validation will be completed on staff to ensure that tray ticket is present on meal tray, that the meal validates what the tray ticket indicates is the the approriate diet for the resident. Staff will receive education prior to starting their next working shift by CDM/DON/NHA. Education will also include what to do if there is no ticket or if the tray ticket does not match what is on the actual resident plate/tray. - All staff education initiated regarding immediate steps to take if the tray ticket does not match the meal on the tray and what imnmediate steps to take to ensure that resident receives appropriate therapeutic [NAME] on 12/20/24. Staff will receive education prior to starting their next working shift NHA/DON. - Dietary staff educated on menus and receipes to properly make any altered textureed diets per the physician orders by the CDM on 12/20/24. - Staff will be able to verbalize where the menus are located and where they can obtain the recipe for making therapeutic altered diets. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Tray ticket system has been created to reflect current diet orders for all residents by facility CDM. - Facility policies and procedures including: (Acceptance of Therapeutic Diet) reviewed by CDM on 12/20/24 and remain up-to-date. - QAPI (Quality Assurance and Performance Improvement) for cooks to understand how to follow the recipes specific to altered textured diets and where they would obtain those recipes. Audit 2 times per week, and monthly times 6 months to ensure correct consistency for altered diets. All results will be reviewed by the QAPI Committeefor trends and ongoing process improvement.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44552 Based on observation, interview, and record review, the facility did not maintain a safe and sanitary environment in which food is prepared, stored, and distributed. This has the potential to affect all 22 residents who reside in the facility. Staff were not following accepted standards of practice including: Taking food temperatures and documenting Monitoring and documenting temperatures for refrigerators and freezers Unkept cooking area. Storing food items near chemicals Evidenced by: The facility policy, Preventing Foodborne Illness- Food Handling, states, in part; .Food will be stored prepared, handled, and served so that the risk of foodborne illness is minimized .3. All employees who handle, prepare, or serve food will be trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents. 5. Functioning of the refrigeration and food temperatures will be monitored at designated intervals throughout the day and documented according to state-specific requirements . On 12/16/24 at 7:30AM, Surveyor observed NHA A (Nursing Home Administrator) preparing scrambled eggs. NHA A attempted to take the temperature of the eggs and the thermometer was not working. NHA A indicated, There is nothing I can do, I will get batteries. Surveyor observed NHA A plate the scrambled eggs and serve the eggs without taking the food temperature. At 9:22AM, dietary staff showed Surveyor the working thermometer and indicated it had needed new batteries. On 12/16/24 at 9:00AM, NHA A (Nursing Home Administrator) gave Surveyor a tour of kitchen area. NHA A indicated the oven stove top will not to be used until the area was clean. Surveyor observed the stove top with burnt food stuck on it and crumbs on top of the stove top. Surveyor observed the freezers and refrigerator temperature logs to have multiple open spots indicating temperatures were not recorded. NHA A indicated she would be completing the temperature logs for today since she was the acting cook. Surveyor observed a container of sugar below the sink next to chemicals. NHA A indicated the sugar should not be stored in this area. The facility did not maintain a safe and sanitary environment in which food is prepared, stored, and distributed.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 44552 Based on interview and record review, the facility did not ensure the facility wide assessment developed by the facility included all relevant details to ensure the facility provided care and services to residents to meet their individual needs within the facility's identified resources. This has the potential to affect all 22 residents residing in the facility. The facility assessment must reflect the resident population and the resources needed to care for this population. Facility Assessment, updated 11/3/24, states in part; .2. Services Provided based on resident need .Nutrition: The facility practices include individualized dietary requirements, liberal diets, specialized diets, IV (Intravenous through the vein) nutrition, tube feeding (feeding through a tube that enters the abdominal wall and into the stomach), cultural or ethnic dietary needs, assistive devices, fluid monitoring or restrictions . It is important to note, under Staff training/education and competencies the facility does not have outlined the specific training needed for staff to work in the kitchen to ensure competency. The facility assessment does not include education and competency checks for dietary manager. On 12/16/24 at 6:04 PM, NHA A (Nursing Home Administrator) indicated understanding regarding the need for the facility assessment to include all staff training and competency including the kitchen staff. The facility assessment must reflect the resident population and the resources needed to care for this population.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525521	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartland Country Village	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)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 44552 Based on interview and record review, the facility did not identify issues to which quality assessment and assurance activities are necessary or develop and implement appropriate plans of action to correct identified quality deficiencies. This has the potential to affect all 22 residents. The facility has failed to identify key areas of deficient practice and implement action plans to correct these deficient practices or identify areas needing improvement to develop, implement, monitor, and evaluate action plans to achieve specific goals to improve quality in kitchen and meal service. Evidenced by: The facility procedure states in part; .Meeting & Policy/Procedure Date: 12/16/24 .QAPI Purpose .Monitor and sustain facility operational performance of clinical and non-clinical systems through self-identification and improvement of opportunities for improvement . On 12/16/24 at 12:13 PM, Surveyor asked NHA A (Nursing Home Administrator) for any kitchen/meal areas that they may be working on in QAPI (Quality Assurance Performance Improvement) and to provide the action plan. NHA A provided Surveyor with document that states in part; QAPI Plan 12/16/24 .the document outlines steps facility will take to work towards getting kitchen/meals in compliance. Surveyor asked NHA A when this document was started, NHA A indicated it was started today, 12/16/24. On 12/16/24 at 6:04 PM, NHA A indicated understanding that a QAPI plan for the kitchen should have been started prior to Surveyors entering the building. The facility failed to identify key areas of deficient practice and implement action plans to correct these deficient practices.