STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013437	A. BUILDING: _____ B. WING _____	C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND SENIOR LIVING	101 TROWBRIDGE ROAD NEOGA, IL 62447

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S 000	Initial Comments Investigation of Facility Reported Incident of April 3, 2025/IL190063	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999		

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S9999	Continued From page 1	S9999		

resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These requirements were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to safely transfer R1 from the wheelchair to toilet resulting in R1 sustaining a broken arm requiring emergency evaluation and treatment at the hospital. This failure affects one resident (R1) of five reviewed for accidents in the sample of five. This past non-compliance occurred from 4/3/2025 to 4/4/2025.

Findings include:

R1's medical diagnosis list (4/16/2025) documents R1's diagnoses include: Unsteadiness on Feet, Muscle Weakness, Pain in Right Knee, Pain in Left Knee, Osteoarthritis, and Polyneuropathy.

R1's quarterly assessment (2/25/2025)

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S9999	Continued From page 2	S9999		

documents R1 does not reject care from staff, utilizes a wheelchair for mobility, and is dependent on staff or requires maximal staff assistance for mobility. The same record documents R1 requires staff assistance to transfer from the bed to wheelchair and onto the toilet.

R1's Fall Notes (4/3/2025) document R1 requires maximum assistance of two staff for transfers.

R1's Care Plan (printed 4/15/2025) in effect on 4/3/2025 documents R1 has a transfer deficit and requires the hands-on assistance of two staff members for transfers.

The facility Serious Injury Incident and Communicable Disease Report (4/8/2025) documents R1 activated R1's call light on 4/3/2025 to get staff assistance to use the bathroom. The same report documents V3 (Certified Nurse Aide) responded to R1's call light, transferred R1 to R1's wheelchair, and then transferred R1 to the toilet when R1 became weak and complained of left arm pain after completing the transfer to the toilet.

R1's nursing Progress Notes (4/3/2025) document when staff went to take R1 to the bathroom after supper on 4/3/2025, R1 started screaming out in pain and grabbing (R1's) left arm and stated "I know it's broke! It hurts! It hurts!" followed by staff obtaining a medical order to send R1 to the hospital emergency department for evaluation and treatment.

R1's hospital report (4/3/2025) documents "Patient comes from the nursing home was falling when the nursing staff caught her." The same report documents R1's left upper arm had

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S9999	Continued From page 3	S9999		

swelling, deformity, and tenderness present and R1 had an acute fracture of the left proximal humeral shaft (upper arm) with displacement. The same record documents R1 received an intravenous injection of fentanyl (narcotic medication used to treat severe pain) while in the emergency department and was prescribed hydrocodone (oral narcotic medication used to treat moderate to severe pain) upon discharge from the hospital.

V3's handwritten incident statement (4/4/2025) documents "I bear hugged (R1) to move (R1) from the wheelchair to the toilet. (R1) started to become weak. I got (R1) on the toilet and (R1) was c/o (complaining of) (R1's) arm hurting."

On 4/16/2025 at 10:44AM, V3 (Certified Nurse Aide) reported when V3 transferred R1 to the toilet on 4/3/2025, V3 "kinda bear hugged (R1) to put (R1) on the toilet" and "(R1) got weak (during the transfer)" and R1 became heavier in V3's arms. V3 denied using a gait belt during the transfer. V3 denied R1 has any behaviors that interfere with care and denied R1 resists receiving care from staff. V3 reported after transferring R1 to the toilet, R1 then complained that R1's left arm hurt and was "kinda whining that it really hurt." V3 reported (R1) is a "two assist (requires the assistance of two staff for transfers) I guess. I thought (R1) was a one (requiring the assistance of only one staff member for transfers). (R1) used to be on a different hall and (R1) would be back and forth and sometimes independent."

On 4/15/2025 at 1:07PM, V2 (Director of Nursing) reported the nursing department uses multiple ways to communicate a resident's transfer status to staff including green colored dots affixed near

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S9999	Continued From page 4	S9999		

residents' name tags outside of their bedroom doors, written transfer status information located in binders for staff to reference, and therapy communication sheets to reference. V2 reported R1 was supposed to be assisted by two staff on 4/3/2025 but V3 (Certified Nurse Aide) was alone at the time of R1's transfer to the toilet. V2 denied the facility had any staffing issues at the time of R1's transfer and injury on 4/3/2025. V2 reported V3 should have also used a gait belt on R1 during the transfer.

On 4/16/2025 at 1:11PM, V5 (R1's medical provider) reported R1's arm injury (fractured humerus) is consistent with V3's transfer of R1 on 4/3/2025. V5 stated "proper transfer with two assist (two staff assisting R1 during transfers) and a gait belt (being used during R1's transfer) would have prevented the injury."

The facility Gait Belt Policy and Procedure (undated) documents gait belts are to be utilized on all residents requiring physical assistance with transfer unless contraindicated and direct care staff will utilize a gait belt for all transfers requiring hands-on assistance with a pivot or manual transfer. The same policy documents all direct care staff will be provided with a gait belt for their own use.

On 4/16/2025 at 11:11AM, R1 was seated in a reclining chair with R1's left arm in a sling. R1 reported being "in a lot of pain" since R1's arm injury occurred on 4/3/2025.

On 4/16/2025 at 11:17AM, V4 (Certified Nurse Aide) reported R1 "moans and groans a lot (with pain)" since 4/3/2025 when R1's arm was injured.

R1's medical orders (printed 4/16/2025)

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S9999	Continued From page 5	S9999		

document an order for staff to document R1's pain level every shift as part of R1's pain management plan.

R1's pain assessments (1/1/2025-4/16/2025) document R1 experienced pain on five out of 92 days from 1/1/2025 to 4/3/2025 prior to the injury sustained on 4/3/2025 and then has experienced pain every day (14 out of 14 days) from 4/3/2025-4/16/2025.

On 4/15/2025 at 1:07PM, V2 (Director of Nursing) reported R1 has a medical order to be non-weight bearing on R1's left arm for a period of 6-8 weeks.

Prior to the survey date of 4/16/2025, the facility had taken the following actions to correct the non-compliance:

1. On 4/3/2025, R1 was sent to the hospital for evaluation and treatment and then returned to the community.

2. On 4/3/2025, the Quality Assurance Committee developed a Plan of Correction for the 4/3/2025 incident.

3. On 4/3/2025, the Director of Nursing and therapy staff provided nursing staff with education and training on proper transfer techniques using a gait belt.

4. On 4/3/2025, the Director of Nursing provided in-service education to nursing staff on the gait belt policy and procedure.

5. Starting on 4/3/2025, the Director of Nursing will audit five resident transfers weekly for proper use of gait belts for four weeks.

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S9999	Continued From page 6 6. The facility QAPI Committee will continue to monitor the facility's performance to ensure corrective actions to the 4/3/2025 incident are effective. 7. Completion date of systemic changes: 4/4/2025. "B"	S9999		