STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165310	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Specialty Care	200 Clive Drive SW Cedar Rapids, IA 52404

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 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** 19126 Based on clinical record review, staff and resident interviews, and observations the facility failed to follow a physician's order for wound treatment for 1 of 3 residents reviewed (Resident #4). The facility reported a census of 143 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #4 had diagnoses which included Non-traumatic brain dysfunction, Parkinson's, dementia, chronic pain, and a history of falls. The resident could ambulate independently in her room with the aide of a wheeled walker. The resident had a Brief Interview for Mental Status score of 11 which indicated moderate cognitive impairment. The MDS indicated the resident had 1 fall since the prior assessment completed on 7/5/24 which resulted in skin tears. Review of the Care Plan dated 8/19/24, the family reported the resident had a fall in her room but had the ability at that time to get herself up from the floor. The Care Plan directed the staff to remind the resident to use the call light to ask for assistance and identified the resident as a fall risk. The Care Plan informed staff the resident ambulated with the assist of 1 staff. Observation on 10/14/24 at 10:45 am, Resident #4 was sitting on the bed in her room. Observations of the resident's right forearm revealed a white circle bandage dated 10/12/24 with initials of Staff D, LPN, observations of the resident's left forearm revealed a white circle bandage dated 10/12/24 with initials of Staff D written in black pen. Observation on 10/15/24 at 2:55 pm with Staff A, Director of Nurses (DON) observed the resident's right and left forearm bandages, both white circle bandages were dated 10/12/24 with initials of Staff D written on the bandages in black pen. Review of the October Treatment Administration Record revealed Resident #4 had 2 wound orders: a. Wound care to skin tear on the left forearm once daily. To cleanse the wound with normal saline, pat dry, paint with skin prep around the wound and cover with Tegaderm Foam Adhesive every day shift until healed. Ordered on 10/2/24. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Wound care to skin tear on right upper extremity, cleanse wound with normal saline, pat dry, paint with skin prep around the wound and apply Tegaderm Foam Adhesive every other day until healed. Ordered on 10/2/24. Review of the October Treatment Administration Record revealed the following: a. The staff failed to complete the wound care to the resident's left forearm and right upper extremity on 10/4/24. b. Staff D signed off she completed the wound care to the resident's left forearm and the right upper extremity on 10/12/24. c. Staff E, CMA signed off on the treatment sheet they completed the left forearm dressing change for the resident on 10/13/24 day-shift. d. Staff B signed off on the treatment sheet she completed the left forearm and right upper extremity dressing on 10/14 and 10/15/24. During an interview with Staff B, Licensed Practical Nurse (LPN), on 10/15/24 at 2:45 pm, Staff B was questioned about the date on Resident #4's bilateral arm dressings which had a date of 10/12/24. Staff B quickly responded she hadn't gotten around to doing the dressing change yet and then stated, oh is it due today? Review of a Corrective Action Form dated 10/15/24, Staff B, LPN, received disciple on that date for documenting on 10/14 and 10/15 that daily skin treatments were completed but the bandages noted on the resident's arm on 10/15/24 revealed a date of 10/12/24. The form stated the staff not only failed to complete the treatments as ordered but falsified the documents to show they were completed. During an interview with Staff A, DON, on 10/16/24 at 2:10 pm, Staff A acknowledged the dressing observed on 10/15 in fact had a date on them of 10/12/24. Staff A stated she would expect the staff to complete physician's orders as prescribed. Review of a Administration Medications policy dated April 2019 directs the staff to administer medications in accordance with prescribers orders, including any required time frames.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19126 Based on clinical record review, staff and resident interviews, and observations the facility failed to answer resident call lights within 15 minutes of activation for 2 of 6 residents reviewed (Residents #4 and #10). The facility reported a census of 143 residents. Findings include: 1. According to the Minimum Data Set (MDS) dated [DATE], Resident #4 had diagnoses which included Non-traumatic brain dysfunction, Parkinson's, dementia, chronic pain, and a history of falls. The resident could ambulate independently in her room with the aide of a wheeled walker. The resident had a Brief Interview for Mental Status score of 11 which indicated moderate cognitive impairment. Review of the Care Plan dated 8/19/24 the family reported the resident had a fall in her room and had the ability at that time to get herself up from the floor. The Care Plan directed the staff to remind the resident to use the call light to ask for assistance. Observation on 10/14/24 at 10:45 am revealed Resident #4 sitting on her bed, the room was dark, the curtains were pulled. At the foot of the bed was a wheeled walker. An interview with the resident at this time revealed she was frustrated because the staff fail to answer her call light timely, she stated due to her disease she sometimes needs assistance going to the bathroom and the staff just do not answer her call light so she has to go to the bathroom by herself. She reported she has had several falls in her room going to the bathroom. The resident activated her call light with the Surveyor present at 10:55 am. Staff C, Certified Nurses Aide (CNA), answered the resident's call light at 11:18 am - 23 minutes after the call light was activated. During an interview with Staff C, Certified Nurses Aide to inquire why the staff took 23 minutes to answer the resident's call light, the staff stated she was walking back from her lunch when she noted Resident #4's call light on. She stopped to inquire what she needed. The aide stated they have 4 staff on this hall but 2 were at lunch, 1 aide was doing a 1:1 with a resident so that left only 1 staff to answer the call lights at that time. 2. According to the MDS dated [DATE], Resident #10 had a BIMS score of 15 which indicated she was alert and oriented and able to give accurate information. The resident had diagnoses which include paraplegia and neuromuscular dysfunction. The resident required total assistance to transfer, toilet, and for personal hygiene needs. During an interview on 10/14/24 at 11:06 am, Resident #10 revealed last weekend she had to wait for 1 hour for the staff to answer her call light, she was wanting to get out of bed for a meal. She stated it is a constant problem in the facility, the staff do not answer the resident call lights for a long time. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the resident's room revealed a white wall clock hanging directly over her bed, visible to her while in bed. During an interview with Staff A, Director of Nurses on 10/16/24 at 4:00 pm, the DON stated the floor nurses audit the resident call lights to assure the staff answer their call lights timely. Staff A stated she expects the staff to answer the resident's call lights within 15 minutes of activation.