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	02/04/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19126 Based on clinical record review, staff and resident interviews, observations, and policy review, the facility failed to follow physician's orders for wound treatments for 1 of 4 residents reviewed (Resident #4). The facility reported a census of 134 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #4 had diagnoses which included non-pressure chronic lower leg ulcers, diabetes, renal insufficiency, stroke, and heart failure. According to the Brief Interview for Mental Status (MDS) score, the resident had a score of 15, which indicted the resident had intact cognitive ability. The MDS indicated the resident received daily dressing changes. Review of Resident #4's Care Plan dated 1/20/25, informed staff the resident had impaired skin to both lower extremities with open wounds. The Care Plan directed the staff to monitor and document location, size, and treatment of skin injury. Observation on 2/4/25 at 10:00 am revealed the resident sitting in a recliner as Staff A-LPN removed his soiled bilateral wound dressings. Also present in the room at this time was the resident's Wound Physician who makes weekly rounds to monitor the healing progress of the wounds. Staff A-LPN removed the bilateral lower leg wound dressings, she acknowledged both dressings have a date of 2/2/25 written on them which indicated the dressings were last changed on Sunday, February 2, 2025. Review of a Physician's order dated 1/28/25 included the following wound care orders: a. Wound Care to the left lower extremity, cleanse the area with normal saline, pat dry, apply Vaseline gauze to areas, cover with an absorbent pad, wrap with kerlix and secure with tape every day shift. a. Wound Care to the right lower extremity, cleanse the area with normal saline, pat dry, apply Vaseline gauze to areas, cover with an absorbent pad, wrap with kerlix and secure with tape every day shift. Review of Resident #4's Treatment Administration Records revealed the staff failed to complete the daily dressing change ordered on 1/29/25, 1/30/25, and 2/3/25. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Resident on 2/4/25 at 10:00 am., the resident stated the staff told him they did not do his wound treatments yesterday because they did not have enough staff to do the dressing change. During an interview with the resident's Wound Physician on 2/4/25 at 10:20 am, the physician stated it is very important the staff change his dressings daily as she has ordered to prevent infections. The Physician stated this is not the first time the staff has failed to complete the daily dressing change. During an interview with Staff B-RN on 2/4/25 at 11:00 am, Staff B stated she worked the day shift on 2/3/25 and was responsible for the dressing change for Resident #4. Staff B-RN stated she did not do the dressing change because she left her shift early and did not have time to do the dressing changed before she left. Staff B-RN stated she passed it on to the nurse who relieved her, stating it must not have been done. Review of a September 2017 policy for Ulcer/Skin Breakdown stated that during resident visits, the physician will evaluate and document the progress of wound. The physician will help guide the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions. The physician will order pertinent treatments for treating a wound; for example, pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19126 Based on record reviews, interviews, policy reviews, and observations the facility failed to maintain a clean, homelike, and safe environment. The facility reported a census of 134 residents. Observations on 2/3/25 at 9:05 am with Staff A-LPN revealed the following: a. Observation at 9:10 am revealed 15 4-person tables and 1-6 person table with black metal bases, each table base revealed dust accumulation and dried food particles splattered on the bases of each table. b. Observation at 9:20 am revealed at the entrance of the skilled unit across from the nurses station, the base of the North pillar had exposed insulation material with approximately 1/2 of the original wood covering noted to be missing. c. Observation at 9:30 am revealed the bottom of the wall directly next to the janitors closet on 3-B Hall revealed a hole in the wall behind and directly above the rubber baseboard. The hole measured approximately 12 inches long and 6 inches high. Staff B states this is probably the result of a resident driving an electric wheelchair, running into the wall. d. Observation at 9:35 am, the south dining room had 14-4 person tables with black metal bases, each table base revealed dust accumulation and dried food particles splattered on the base of each table. e. Observation at 9:45 am revealed the door to resident rooms 1-C-20, 1-C-24 and 1-C-28 had a piece of dark burgundy hard plastic sticking out from the bottom of the door. The hard plastic appeared jagged with rough edges exposed. f. Observation at 9:48 am, revealed the radiator cover had fallen off the radiator in room [ROOM NUMBER]-A-5. During an interview with Staff C-Maintenance Supervisor on 2/4/25 at 10:17 am, Staff C stated the radiator covers come off frequently on Station 2, he stated he does rounds and checks them daily Monday-Friday. He reports room [ROOM NUMBER]'s radiator cover comes off about every other day. He reports maintenance staff work Monday-Friday but not on the weekends, so the radiator covers do not get checked on the weekend. Staff C stated the resident room doors are checked about 1 time a month. Review of the logs failed to identify what the maintenance staff checked and only had a check mark which indicated they checked them. The last door check completed on January 6, 7, & 8 of 2025, he stated he cannot remember the condition of those doors during that check. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 2/3/25 at 1:30 pm of room [ROOM NUMBER] on Station 4. It was noted on the floor between the window and the bed, a large amount of brown crumbly food items, black pieces of a plastic fork, brown spot on the carpet, a used Foley catheter that remained connected to the urine drainage bag which contained approximately 400 cc of dark urine. There were several open food containers noted on the bed side stand and a full glass of milk. Staff D-Housekeeping Supervisor stated the resident transferred to the hospital on 1/31/25 and housekeeping staff failed to clean the room. During an interview with the Staff D-Housekeeping Supervisor on 2/3/25 at 1:54 pm, Staff D stated she had 3 staff assigned to housekeeping this past weekend. She indicated each housekeeper are to clean their usual wings and then work together on Station 4. She replied apparently they didn't work together as this room did not get cleaned. Review of a Homelike Environment Policy dated February 2021 stated the residents are to be provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongs to the extent possible.