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	03/05/2025

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 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** 44972 Based on observation, clinical record review, policy review, and resident and staff interviews, the facility failed to assess and document follow up skin assessments for 1 of 4 residents reviewed (Resident #1). The facility reported a census of 131 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had diagnoses that included anemia, congestive heart failure, chronic kidney disease (stage 5) requiring dialysis, right femur fracture, diabetes, and depression. The MDS indicated the resident required extensive assistance with toileting, positioning, and transfers, had skin tears and was at risk for pressure ulcers. Resident #1 received antidepressant, diuretic, and antiplatelet medications during the observation period. The Care Plan initiated 1/16/25 with a revision date of 2/3/25 revealed the resident had impairment to the right upper leg related to a surgical incision with a goal of no complications related to skin impairment. Interventions included monitoring for and documentation of location, size, and treatment of skin injuries and weekly treatment documentation to include measurement of each area of skin breakdown, type of tissue and exudate, and any other notable changes or observations to the skin. Review of the Skin and Wound Evaluations revealed no evaluation was completed on Resident #1's initial admission on 1/16/25 or his re-admission on 2/3/25. A Skin and Wound Evaluation form was completed on 2/13/25 at 8:14 AM that revealed a bruise was noted to Resident #1's spine that was present on admission on 2/3/25 but noted the exact date as 2/13/25. No measurements were documented. A Skin and Wound Evaluation form was completed on 2/20/25 at 7:17 AM that revealed a bruise was noted to Resident #1's spine that was present on admission on 2/3/25 but noted the exact date as 2/20/25. No measurements were documented and the bruise was noted to be resolved at that time. On 2/8/25 the facility Progress Notes stated Resident #1 declined admission skin assessment and pictures. Staff were to re-attempt in the morning. (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	A Wound Evaluation was completed on 2/9/25 for a bruise to Resident #1's spine. It documented the bruise was present on admitted d 2/3/25 and measured 20.86 cm in length and 14.16 cm in width with the area measuring 232.38 cm 2. The Progress Notes lacked documentation of the source of the bruise or notification of the emergency contact. A Wound Evaluation was completed on 2/13/25 for a bruise to Resident #1's spine. It documented the bruise was present on admission but the area was not assessed. There was a picture taken of a note that stated dialysis. This indicated it was not assessed because the resident was out of the facility at dialysis. In an observation on 2/19/25 at 7:54 AM, Resident #1 was lying in bed on his right side. He lifted his shirt to show the surveyor the bruise on his back. A faint bruise that was approximately baseball size remained on the center of his lower back over his spine. He denied any pain to the area and stated he was unaware he had a bruise until the hospital emergency department brought it to his attention during his visit on 2/13/25. In an interview on 2/20/25 at 12:08 PM, Staff A, Certified Nursing Assistant (CNA), reported she did not remember ever seeing a large bruise on Resident #1's back. She stated the resident never complained of the gait belt being painful or hurting his back. Staff A stated she had assisted him with his morning cares so she had seen his back and had assisted him to change his shirt while in his chair and did not remember seeing a bruise. She reported if she would have noted a bruise she would have reported it to the nurse. In an interview on 2/20/25 at 2:07 PM, the Director of Nursing (DON) and the Regional Director of Clinical Services reported they had talked with Staff B, Registered Nurse (RN) and she reported she had not seen Resident #1 on his re-admitted [DATE]. In a phone interview on 2/24/25 at 11:56 AM, Staff B, RN, reported it was the responsibility of any nurse finding a skin issue to assess, document, and photograph the area. She reported she was the nurse who assessed and photographed the bruise to Resident #1's back on 2/9/25. Staff B, noted the nurse who readmitted the resident had documented the resident had non-pressure wounds but had no description of what or where the wounds were. She decided to assess the resident's skin and document any skin issues even though they were found about 1 week prior. She stated that was why she put present on admission. Staff B stated she did not know of the bruise to Resident #1 lower back prior to 2/9/25 and found it when checking over his skin. She reported skin assessments were to be completed weekly and if a resident was out of the facility at an appointment or dialysis, it should be completed upon their return. In an interview on 2/24/25 at 1:23 PM Staff C, RN reported she was the one responsible for the Wound Evaluation on 2/13/25 and 2/20/25. She stated she did not assess the wound on 2/13/25 as the resident was at dialysis on that date. She stated she took the picture of dialysis so it didn't appear the assessment was not completed in a timely manner per their policy. Staff C stated there is no expectation of other nurses to complete the evaluation when the resident returned to the facility. She was unsure of where the bruise to Resident #1's spine came from but suspected it was from a fall he had here at the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/25/25 at 11:50 AM, the DON stated it was the expectation all non-pressure skin issues be assessed minimally on a weekly basis until healed and if the resident was not available for the assessment, a nurse follow-up and complete the assessment upon their return. In a facility provided policy titled Prevention of Pressure Injuries last revised 4/2020, it stated staff were to: 1. Conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident's risk factors, and prior to discharge. 2. Inspect the skin on a daily basis when performing or assisting with personal care or activities of daily living (ADLs) and weekly usually on the first scheduled bath day of the week, if any new issue noted complete the risk management and skin and wound evaluation.

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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** 44972 Based on observation, clinical record review, staff, resident, and family interviews, and policy review, the facility failed to provide a safe transfer for 1 of 4 residents reviewed (Resident #10). The facility failed to utilize a gait belt during a 2 person transfer as directed by the Care Plan. The facility reported a census of 131 residents. Findings include: The admission Minimum Data Set (MDS) dated [DATE] documented Resident #10 had a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. The MDS indicated the resident carried diagnoses that included non-displaced bicondylar fracture of left tibia, dementia, and Alzheimer's disease. Resident #10 was wheelchair dependent and required moderate assistance for toileting, extensive assistance for bathing, dependent on staff for personal hygiene, and maximum assistance with transfers. The resident received antianxiety, Opioid, and antiplatelet medication. Review of Resident #10's Care Plan dated 1/22/25 revealed a focus area for Activities of Daily Living (ADL) with a goal the resident would participate during her ADLs as her condition allowed. Per the Care Plan resident was dependent on the assistance of 2 staff for a stand and pivot transfer and she was to be non weight bearing on the left lower extremity. Review of residents Progress Notes revealed: 1. 1/23/25 at 10:31 AM - Nursing/therapy communication - Resident to be transfer assist of 2 for stand pivot transfers. No ambulation. Non weight bearing to left lower extremity. 2. 2/5/25 at 7:33 PM - Skilled Evaluation - Resident transfers with assist of 1 staff and is non compliant with non weight bearing status to left lower extremity. 3. 2/10/25 at 11:26 PM - Focused Evaluation - Resident requires the assist of 1 for transfers. In an interview on 2/27/25 at 1:40 PM, Staff D, Certified Nursing Assistant (CNA) reported she assisted Resident #10 to the bathroom on 2/23/25 with the assistance of Staff E, Registered Nurse (RN). She stated the family had requested they get the resident up and take her to the bathroom. She reported they transferred her from her bed to the wheelchair, the wheelchair to the toilet, the toilet back to the wheelchair, and then the wheelchair back to her bed. Staff D, CNA stated she had to put her arms around her from the front (like a bear hug) and lifted her out of the chair and turned her towards the toilet due to her being combative. She reported she did the same thing when she took her off the toilet and when they transferred her back into bed. She acknowledged they did not use a gait belt for the transfers. She reported her normal transfer was to use a gait belt and a walker to transfer her. She stated the resident was fighting and so stiff and would not assist with the transfers at all. She stated they lifted her from under her arms to get her to stand up from the toilet and then she bear hugged her again to get her into the wheelchair and then again to transfer her from the wheelchair back into the bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/27/25 at 3:23 PM, Staff E, RN reported the family had come to her on 2/23/25 and asked her to take Resident #10 to the bathroom. She and Staff D, CNA went into the resident's room to assist her. When they approached the resident, she seemed to be in pain and was combative. She reported they used 2 staff to complete a pivot transfer from the bed to the wheelchair and wheelchair to toilet. Another CNA assisted Staff D, CNA to put Resident #10 back to bed. She stated the resident was combative the entire time and seemed to be in pain. In an interview on 3/3/25 at 9:37 AM with Staff F, RN with the hospice agency caring for the resident, she stated the family had voiced concerns with the transfer of the resident to the bathroom on 2/23/25. They reported they felt the staff was rough with the resident and did not use a gait belt for the transfer. In an interview on 3/3/35 at 11:58 AM with Resident #10's daughter, she stated she had requested staff assist the resident to the bathroom. She reported she could tell her Mom was in a lot of pain but she declined to use her brief for toileting. She reported 2 staff came in to assist the resident to the bathroom. Her mom did not have the immobilizer on her left lower extremity at the time of the transfer as she frequently declined to wear it. She reported the 2 staff members transferred her to the wheelchair without using a gait belt and it did not go well. She stated her Mom was yelling out in pain with the transfer and while in the wheelchair. In an interview on 3/5/25 at 1:43 PM, the Director of Nursing (DON) stated it was the expectation the staff use a gait belt for all 2 person transfers if the resident allowed. Review of facility provided policy titled Safe Lifting and Movement of Residents stated staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44972 Based on observation, record review, staff and family interviews, and policy review the facility failed to complete pain assessments as directed, update Narcotic Records with changes in medication prescriptions, and complete follow up assessments when pain interventions were ineffective for 1 of 3 residents reviewed (Resident #10). The facility reported a census of 131 residents. Findings include: Resident #10 was admitted to Heritage Specialty Care on 1/22/25 for aftercare following a left tibial plateau fracture sustained sometime in the 3 weeks prior to her hospitalization from multiple falls at home. The resident was moved from the Rehab Unit to the Chronic Confusion or Dementing Illness (CCDI) Unit on 2/13/25 due to exit seeking and wandering behaviors. The resident was admitted to hospice care on 2/21/25 for vascular dementia. The admission Minimum Data Set (MDS) dated [DATE] documented Resident #10 had a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. The MDS indicated the resident carried diagnoses that included non-displaced bicondylar fracture of left tibia, dementia, and Alzheimer's disease. Resident #10 was wheelchair dependent and required moderate assistance for toileting, extensive assistance for bathing, dependent on staff for personal hygiene, and maximum assistance with transfers. The resident indicated pain 3-4 days in the previous 5 days The resident received antianxiety, Opioid, and antiplatelet medication. The Care Plan dated 1/22/25 indicated a focus area for Activities of Daily Living (ADL). Interventions included Resident #10 was dependent on a wheelchair for mobility and was to be non ambulatory due to being non weight bearing to the left lower extremity per physician order (resident was noted to be noncompliant with this). The resident was dependent with the assistance of 2 staff for toileting, and was dependent with the assistance of 2 and a stand pivot non weight bearing to left lower extremity for transfers. The resident had a focus area related to the use of opioid medications due to pain. Interventions included administering opioid medication as prescribed by the physician and to monitor for side effects such as sedation, dizziness, nausea, vomiting, constipation, and respiratory distress. A focus area related to pain from fractures of the left knee, multiple lumbar compression fractures with some being newer and some chronic in nature was also present. Interventions included to evaluate the effectiveness of pain interventions routinely. Monitor, document, and report to the nurse as needed any signs or symptoms of nonverbal pain and to notify the physician if interventions were unsuccessful or if the resident's complaint was a significant change from their past experience of pain. The Medication Administration Record/Treatment Administration Record (MAR/TAR) for February 2025 revealed the following pain/anxiety/agitation related orders for Resident #10: 1. Lorazepam Concentrate 2 milligrams/milliliter (MG/ML) Give 0.25 ml by mouth at bedtime for anxiety and sleep -Start Date 02/21/2025 at 8:00 PM - Discontinue (D/C) 2/24/25 at 3:42 PM 2. Lorazepam Oral Tablet 0.5 MG Give 1 tablet by mouth two times a day related to dementia -Start Date 01/22/2025 at 4:00 PM - D/C 2/24/25 at 3:42 PM (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Morphine Sulfate (Concentrate) Oral Solution 100 MG/5 ML Give 0.5 ml by mouth four times a day for pain -Start Date 02/24/2025 at 7:00 AM - D/C Date 02/24/2025 at 2:52 PM 4. Acetaminophen Tablet 325 MG Give 2 tablets by mouth every 6 hours as needed for elevated temperature or pain DO NOT EXCEED MAX DOSE OF 3000 MG DAILY. -Start Date 01/22/2025 at 3:43 PM - D/C Date 02/18/2025 11:14 AM - Used 5 times (effective x 4 and unknown x 1) 5. Acetaminophen Tablet 325 MG Give 2 tablets by mouth every 6 hours as needed for elevated temperature or pain DO NOT EXCEED MAX DOSE OF 3000 MG DAILY. - Start Date 02/18/2025 11:15 AM - D/C Date 02/24/2025 at 3:42 PM (Not used) 6. Ativan Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth one time only for increased agitation until 02/20/2025 11:59 PM -Start Date 02/20/2025 11:15 PM (Given at 12:12 AM on 2/21/25) 7. Lorazepam Concentrate 2 MG/ML Give 0.25 ml by mouth every 2 hours as needed for anxiety Behavior Codes: 1= (specify), 2=(specify), 3=(specify), 4=See Progress Notes (PN) Intervention Codes: 1=(specify), 2= (specify), 3=(specify), 4=See PN -Start Date 02/21/2025 7:02 PM -D/C Date 02/24/2025 at 7:56 AM (Used x 1 and was ineffective) 8. Lorazepam Concentrate 2 MG/ML Give 0.25 ml by mouth every 2 hours as needed for anxiety for 14 Days Behavior Codes: 1= Restless, 2= Anxious , 3= Agitated, 4=See PN Intervention Codes: 1= offer snack , 2= offer fluids, 3= Reposition, 4=See PN -Start Date 02/24/2025 8:00 AM -D/C Date 02/24/2025 at 3:42 PM (used x 1) 9. Lorazepam Oral Concentrate 1 MG/0. 5 ML Give 1 ml by mouth one time only for severe pain - Start Date 02/24/2025 1:00 PM -D/C Date 02/24/2025 at 3:42 PM (Given at 1330) 10. Morphine Sulfate (Concentrate) Oral Solution 100 MG/5 ML Give 0.25 ml by mouth every 2 hours as needed for pain/dyspnea (shortness of breath) -Start Date 02/21/2025 7:00 PM -D/C Date 02/23/2025 at 10:29 PM (Used 3 times - Ineffective x 2 and Unknown x 1) 11. Morphine Sulfate (Concentrate) Oral Solution 100 MG/5 ML Give 0.5 ml by mouth every 2 hours as needed for pain or dyspnea (shortness of breath) -Start Date 02/24/2025 10:30 PM -D/C Date 02/24/2025 2:52 PM (Not used) 12. Morphine Sulfate Oral Solution 20 MG/5 ML Give 1 ml by mouth every 1 hour as needed for severe pain -Start Date 02/24/2025 3:45 PM -D/C Date 02/24/2025 at 3:43 PM (Not used) 13. Morphine Sulfate Oral Solution 20 MG/5 ML Give 1 ml orally one time only for severe pain - Start Date 02/24/2025 1:00 PM -D/C Date 02/24/2025 at 3:42 PM - (Given at 1329) 14. Oxycodone HCl Capsule 5 MG Give 1 capsule by mouth every 6 hours as needed for moderate to severe pain -Start Date 01/22/2025 4:31 PM -D/C Date 02/24/2025 at 3:42 PM (Given 14 times in February. All were effective except 3 which were unknown) 15. Check pain level every shift for Pain -D/C Date 02/24/2025 1542 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MAR/TAR for Resident #10 for February 2025 revealed the following medications were given and found to be ineffective with no further interventions documented: Lorazepam Concentrate 2 MG/ML Give 0.25 ml by mouth every 2 hours as needed for anxiety - Medication was given on 2/23/25 at 3:55 AM and found to be ineffective Morphine Sulfate (Concentrate) Oral Solution 100 MG/5 ML Give 0.25 ml by mouth every 2 hours as needed for pain/dyspnea - Medication was given on 2/21/25 at 8:31 PM and documented as unknown if effective, given on 2/23/25 at 3:24 AM and documented as ineffective and given on 2/23/25 at 5:15 PM and documented as ineffective. Review of the MAR/TAR for Resident #10 for February 2025 revealed an order to check the resident's pain level every shift. The MAR/TAR lacked documentation of a pain assessment being completed on the following dates and shift: 1. 2/1/25 on the day shift 2. 2/5/25 on the evening shift 3. 2/8/25 on the evening and night shifts 4. 2/12/25 on the day and night shifts 5. 2/13/25 on the evening shift 6. 2/15/25 on the night shift 7. 2/21/25 on the evening and night shift 8. 2/22/25 on the evening shift 9. 2/23/25 on the day shift Review of the facility's Individual Narcotic Record for Resident #10 revealed one sheet for the resident's Lorazepam order and one sheet for the resident's Morphine order. 1. The Lorazepam sheet was dated 2/21/25 and had the order written as Lorazepam 2 mg/ml Give 0.25 ml by mouth at bedtime. The facility did not start a new Individual Narcotic Record for the changes in the Lorazepam orders. 2. The Morphine sheet was dated 2/21/25 and had the order written as Morphine sulfate 100 mg/5 ml Give 0. 25 mg by mouth every 2 hours as needed. The facility did not start a new Individual Narcotic Record for the changes in the Morphine orders. Review of the Progress Notes for Resident #10 revealed falls on the following dates: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. 2/9/25 at 1:35 PM - Fall in the bathroom - Left eyebrow bleeding, hematoma left forehead, skin tear to left upper extremity forearm. The family declined transfer to the emergency department. Advanced Registered Nurse Practitioner (ARNP) notified. 2. 2/18/25 at 7:00 PM - Witnessed fall by Certified Nursing Assistant (CNA). The resident was walking and lowered self to the floor. No injuries. No pain or discomfort. 3. 2/20/25 at 8:55 PM - Found lying on her right side next to the bed, her walker next to her. No new injuries noted. 4. 2/20/25 at 10:21 PM - Attempted to self transfer, missed the wheelchair and landed on the floor on her buttocks. No injuries noted. 5. Fall 2/21/25 at 9:45 AM - Found lying on floor with head on a pillow by CNA next to roommates bed by the door. No pain reported. No injuries. Range of motion (ROM) to extremities with limitation on left lower extremity related to previous fracture and immobilizer in place. Review of x-ray results dated 2/24/25 of the left femur related to uncontrolled pain revealed an acute commuted left intertrochanteric fracture with foreshortening and varus evaluation. In a phone interview on 2/27/25 at 11:23 AM, a family member of Resident #10 stated she did not feel the resident ever got good pain relief while at the facility. The pain got progressively worse from 2/21/25 to 2/23/25 and felt the facility did not do anything about it. In a phone interview on 3/3/25 at 9:37 AM, Staff F, Registered Nurse (RN) reported the family's biggest concern was that her pain was very unmanaged. It was felt the facility was not giving the resident pain medication as ordered and was not keeping up on her pain control. The resident began having increased pain on Sunday morning 2/23/25 and that later in the day, it didn't look like pain medication was being given as ordered. Morphine was increased at that time. In a phone interview on 3/3/25 at 11:58 AM, another family member of Resident #10 reported she did not feel the facility was giving the resident pain medication that was scheduled for her. She felt the family should not have to advocate for the resident to get the pain medication and that the facility should have been assessing and giving the medications as ordered and in a timely fashion. She felt the resident was in terrible pain on Monday 2/24/25 when they got to the facility. In a phone interview on 3/3/25 at 12:48 PM, a friend of the resident reported they had asked the staff on Sunday 2/23/25 to give the resident some pain medication related to her increased pain but were denied by staff stating the resident was unable to have any more pain medication for another 1 to 2 hours. She stated it was disturbing to see how little the staff cared that the resident was in such pain. In an interview on 3/5/25 at 12:55 PM, the Director of Nursing (DON) stated it was the expectation that staff start a new Individual Narcotic Record each time a narcotic prescription was changed. The Individual Narcotic Record for each medication would include scheduled and as needed medication if necessary . He further stated it was the expectation that if an as needed medication was given for pain and was assessed to be ineffective, the staff were to follow up with further pain medication if applicable, try other interventions, and/or notify the provider for further direction. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a facility provided policy titled Pain Assessment and Management with a revision dated of 3/2020, stated pain management was a multidisciplinary care process that included the following: 1. Assessing the potential for pain; 2. Recognizing the presence of pain; 3. Identifying the characteristics of pain; 4. Addressing the underlying causes of the pain; 5. Developing and implementing approaches to pain management; 6. Identifying and using specific strategies for different levels and sources of pain; 7. Monitoring for the effectiveness of interventions; and 8. Modifying approaches as necessary. It further stated acute pain (or significant worsening of chronic pain) should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained.