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	08/26/2025

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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff and resident interviews, and facility policy, the facility failed to ensure each resident had the call light accessible for Resident #3, Resident #6, and for multiple residents observed in resident rooms. The facility reported a census of 118 residents. Findings include: 1.The MDS (Minimum Data Set) dated 7/24/2025 revealed Resident #6 had no cognitive impairment, required moderate assistance of staff to transfer from bed to chair and had a history of falls. The resident had diagnoses including heart failure and neoplasm of the pelvis. The resident's care plan reported the resident had a history of falls. It directed staff to encourage the resident to use the call light. Observation on 8/18/2025 at 8:25 am revealed the resident sat up in bed eating breakfast. The resident's soft touch call light sat on the bedside stand out of reach, and the bed control sat on the floor. The resident indicated she could not reach the call light and stated she would yell for help if needed. 2.The MDS dated [DATE] revealed Resident #3 had no memory impairment, required partial assistance for transfers from one surface to another and had diagnoses including stroke and hemiplegia. The Care Plan revealed the resident had a fall risk dated 10/12/2024, and it directed staff to encourage the use of a call light and ensure it is within reach. On 7/30/2025, Staff B, CNA (Certified Nursing Assistant) reported when she arrived to work, she heard the resident calling out for assistance and rattling the bed rail. Staff B observed the resident's call light on the wall and out of reach. The resident had been incontinent of bowel and bladder. The Facility Incident Report dated 7/30/2025 included the resident reported the third shift aide failed to check and change him and he could not call for help since the call light was out of reach. Staff assessed the resident and failed to identify a skin issue. The facility educated staff and disciplined the night shift aide assigned to the resident. On 8/18/2025 at 10:00 a.m. the resident verified the incident occurred one time.The facility policy titled Answering the Call Light revised March 2021 included: .5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.3. Observations on 8/18/25 during a facility wide call light audit at 8:35 am-8:54 am revealed the following: a. At 8:35 am, the call light in room [ROOM NUMBER] C 27 noted to be hanging on the wall, the resident in bed without access to her call light. b. At 8:37 am, the call light in room [ROOM NUMBER] C 26 not assessable to the resident, the resident in bed, the call light on the floor next to the resident's bed.c. At 8:43 am, the call light in room [ROOM NUMBER] B 43 the call light in the top drawer not accessible to the resident as the resident rested in bed.d. At 8:45 am, the call light in room [ROOM NUMBER] B 16 noted on the floor. The resident in bed eating breakfast, the resident asked where the call light was, she stated she had no idea.e. At 8:47 am, the call light is noted to be hanging on the wall, the resident in his wheelchair. The call light not assessable to the resident. f. At 8:47 am, the call light noted to be hanging on the wall. The resident is sitting in his wheelchair watching TV. The call light was not assessable to the resident.

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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, maintenance record review, staff interviews, and facility policy review, the facility failed to provide a clean and homelike environment. The facility reported a census of 118 residents. Findings include: Observation on 8/18/25 at 8:00 am revealed a large, blackened area on the carpet in the main lobby area, located between the conference room and Administrator's office. The blackened area measured approximately 15 feet long by 6 feet wide. Observation on 8/19/25 at 8:46 am revealed the carpet at the entrance of the skilled unit coming from Station 3 had a darkened area which measured approximately 13 feet long by 3 feet in width. On 8/20/2025 at 10:25 a.m., Staff C, DON (Director of Nursing) reported when she first started in June, the facility had a resident who had a visitor who brought some things in from home, and they discovered bed bugs. They isolated the belongings, bagged them up, and treated the room. On 8/20/2025 at 11:25 am, Staff D, the Corporate Director of Facilities manager, revealed the facility had the carpet cleaned two times in the last six months, two months ago and then within the last six weeks. When they found bed bugs in a room, they followed facility policy and procedure. The facility notified him, and staff removed the resident from his room and provided a shower. They bagged and laundered his clothing and relocated the resident to another room for that night. They bagged everything in the room, and laundered and dried it at 160 degrees. The facility had a contract to pests. They pulled light and plug covers, and removed furniture from the room. If the facility owned the chair in the room, it was put in the dumpster. If the family owned the chair they worked with the family and treated the chair. Room was left empty for 24 hours and rechecked by the contracted company. On 8/20/2025 at 11:41 am, Staff E, Maintenance reported station 4 had bed bugs in a room. Staff took the resident to the shower room, bagged the clothing, moved him to another room, and the contracted company came. They had not had further issues. The resident had bed bugs at home and family came into the building and brought clothing from home. They asked family to refrain from bringing in clothing and they took care of the issue at home. [Contracted company name redacted] came quarterly and as needed. Housekeeping has control of the carpet cleaning. On 8/20/2025 at 12:05 pm, Staff F, Housekeeping Supervisor reported the facility had a commercial company clean the facility carpet. At this point, the carpet was worn down and cleaning was not very effective. They were working on replacing the carpet, but they had not identified when it would get completed. The most recently provided service on August 7. They planned to remove the carpet and install laminate flooring. The facility had four housekeepers during the day and two on the evening shift. Daily housekeeping tasks included the cleaning of each bathroom, wiping down handrails, toilets, and everything a resident touched. Housekeeping staff deep cleaned one room every day, stripped and wax floors in the fall, and buffed floors every Tuesday. During an interview with Staff A, Maintenance Supervisor at 8:10 am, Staff A stated the corporation had a plan to replace the dirty carpet but it won't probably happen until next year.

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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. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and resident interviews, observations and policy review the facility failed to administer medications as ordered for one of three residents reviewed (Resident #8). The facility reported a census of 118 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] revealed Resident #8 had an admission date of 8/12/25. The resident had a Brief Interview for Mental Status score of 9 out of 15, which revealed moderate cognitive impairment. The resident had diagnoses which included Non-Alzheimer's Dementia, Traumatic Brain Injury and anxiety. The resident required partial/moderate assistance with activities of daily living. Review of the Facility Incident Report dated 8/12/25 at 11:53 am revealed the following: Resident #8 received another's medication in error on 8/13/25 during morning medication pass. The Incident Report revealed the facility received a phone call from the pharmacy provider reporting they sent the wrong medications for Resident #8. The pharmacy placed another resident's medications (a resident not at the facility) into the medication bubble pack with Resident #8's name on the bubble pack. The pharmacy sent 4 medication bubble packs for Resident #8 which included: Diltiazem ER (extended release) 360 milligrams (anti-hypertensive), Furosemide 20 milligrams (diuretic), Lisinopril 10 milligrams (anti-hypertensive) and Potassium ER 20 milligrams (supplement to treat low potassium). Review of the resident's physician orders dated 8/12/25 revealed the resident had the following medication orders: Amlodipine 10 milligrams one time daily (anti-hypertensive)Aspirin EC (enteric coated) 81 milligrams daily (blood thinner)Fluoxetine HCL 10 milligrams daily (anti anxiety) Lisinopril 20 milligrams 2 tablets daily (anti-hypertensive)Pravastatin Sodium 40 milligrams daily (high cholesterol)A review of the Facility's Progress Notes revealed the following notation regarding the medication error dated 8/13/25 at 12:00am: The Medical Provider notified of the medications. Hourly vitals initiated from the time the medication was given per medical provider. The daughter became aware. During an interview with Staff G-LPN (Licensed Practical Nurse) on 8/20/25 at 12:45 pm, the staff stated he worked on the day shift of 8/13/25 on Resident #8's unit. He went into her room and offered her the morning medications. He reported she took the medications whole with water. The process he did to pass her medications; he checked each medication he gave against the medication administration record for the resident, compared them to make sure he gave the correct medications. He said the medications in the card matched the [Electronic Health Record] medication administration record. He stated at about 10:00 am Staff H-LPN/Assistant Director of Nurses (ADON) approached him and asked if he gave Resident #8 her medications earlier, he said he had. Staff G stated Staff H told him he gave the resident the wrong medications. Staff G pulled up the resident's medication administration record at that time, Staff G stated it was a different one from the one he saw earlier. Staff G stated he knew that [Electronic administration record] had made some errors recently. He stated he gave Resident #8 her medications between 7:30-8:00 am that morning. He stated he had no idea how the electronic medication record got changed. During an interview with Staff H at 8/19/25 at 2:30 pm., Staff H stated she got a call from their pharmacy provider pharmacist, and they reported they sent the resident the wrong medications to the facility which was discovered at the pharmacy level. Staff G gave the incorrect medications to the resident on 8/13/25 at 8:13 am. When Staff H asked the nurse about the medications, he had already given the medications. He said he looked at the meds and claimed the medications in the card with Resident #8's on them matched the medication administration record. The resident was given Lasix, diltiazem, lisinopril and potassium in error. Staff H stated she examined the medication cards for Resident #8 prior to sending them back to the pharmacy and stated each card was missing 1 pill. She stated the medication cards had Resident #8's name on them but they were not the resident's medications. If Staff G would have compared the medication cards to the electronic medication administration record he would have recognized the error prior to giving the resident the wrong medications. During an interview with a Pharmacy Representative on August 25, 2025 at 8:40 regarding Resident #8's medication error. The Pharmacist stated they sent the wrong medication to the facility on 8/12/25. They discovered the error the following morning at about 10:00 am and alerted the facility. The Pharmacist spoke to Staff H and reported the error. Staff H removed 4 medication bubble packs to return to the pharmacy. The 4 bubble packs were each missing 1 pill which he indicated were given to Resident #8 that morning. A review of the Facility Policy titled Administering Medications dated as last revised April 2019 had documentation of the following: a. As required or indicated for a medication, the individual administering the medication records in the resident's medical record. aa. The

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interviews, and clinical record review the facility failed to offer toileting assistance for one of three residents reviewed. (Resident #3). The facility reported a census of 118 residents. Findings include:The Minimum Data Set (MDS) dated [DATE] revealed Resident #3 had no memory impairment, required partial assistance for transfers from one surface to another and had diagnoses including stroke and hemiplegia. The Care Plan revealed the resident had a fall risk dated 10/12/2024, and it directed staff to encourage the use of a call light and ensure it is within reach.On 7/30/2025, Staff B, CNA (Certified Nursing Assistant) reported when she arrived to work, she heard the resident calling out for assistance and rattling the bed rail. Staff B observed the resident's call light on the wall and out of reach. The resident had been incontinent of bowel and bladder. The Facility Incident Report dated 7/30/2025 included the resident reported the third shift aide failed to provide assistance when he had incontinent bowel and bladder. He could not call for help since the call light was out of reach. Staff assessed the resident and failed to identify a skin issue.On 8/18/2025 at 10:00 am the resident reported the incident occurred one time. He had no recall of the staff involved and no further concerns.On 8/20/2025 at 10:28 am, Staff C, DON (Director of Nursing) reported the morning Resident #3 did not have his call light within reach and called out for help, he had incontinent bowel. He reported to staff the night shift aide failed to place his call light within reach after she had been in there previously. She placed the call light on the box, on the wall. The resident was independent in his room and at times staff put it out of his way so he didn't roll over it. They re-educated staff and focused on what defines abuse and customer service.On 8/20/2025 at approximately 11 am, Staff B, CNA reported working at the facility since February, 2025, full time on the day shift from 6 am - 2 pm. Normally, staff did a room to room report with the night shift, however on July 30th, they did not do a room to room report. She entered the front door and walked down the hall to the nurse's station when she heard Resident #3 shaking his bed rail, and calling hey. That was what he did if he dropped his call light or cannot get to it. Staff B observed the resident with incontinent bowel and bladder. She asked him what was going on since he was normally continent. He reported someone put him into bed and took his call light. Staff B observed the call light on the wall, on top of the call light box. Staff B provided cares, transferred him to his chair and asked Staff G, ADON (Assistant Director of Nursing) to speak to him. The facility Activities of Daily Living (ADLs), Supporting, revised March 2018 included: Residents will provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene .1. Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable .2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: . c. Elimination (toileting).

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on the Centers for Medicare and Medicaid Services (CMS) Statement of Deficiencies form, the facility Quality Assurance and Performance Improvement (QAPI) Plan, and staff interview the facility failed to carry out Quality Assurance activities to ensure effective measures had been taken to correct deficiencies and prevent their ongoing prevalence. The facility reported a census of 118 residents. Findings include:The CMS 2567, dated June 12, 2025 reflected deficiencies identified for medication administration. The current complaint survey, conducted 8/18/2025 - 8/26/2025 also identified the above concern. In an interview on 8/20/2025 at 2:00 pm, the Administrator explained the QAPI team met monthly to discuss the Performance Improvement Projects (PIP) and quarterly with the full team. Data was collected via an online program, suggestion boxes, grievance forms, and when the [State Agency] found a deficiency. The facility prioritized the issues that impinged on residents' quality of life or rights. She explained there was a PIP in place for the previous survey deficiency but they were still struggling.On 8/20/2025 at 10:30 a.m., the DON (Director of Nursing) reported the QAPI team reviewed medication administration rights, reports of refusals and missed medications, and continue to do audits for the last survey ending in June. The facility QAPI Plan received from the administrator on 8/25/2025 included: Our companies written QAPI Plan provides guidance for our overall quality improvement program. QAPI activities and outcomes will be on the agenda of every staff meeting. The QAA (Quality Assessment and Assurance) committee will report all activities to the governing body during their regularly scheduled meetings. The QAA committee will have responsibility for reviewing data, suggestions, and input from residents, staff, family members and other stakeholders. The QAA committee will prioritize opportunities for improvement and determine which performance improvement projects will be initiated. When an issue or problem is identified that is not systemic and does not require a performance improvement project, the QAA committee will decide how to correct the issue or problem. These corrections may include an easy decision, corrective action plan, or rapid improvement cycle.