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	11/06/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, staff and resident interview and facility policy review the facility failed to provide safe transfers for 3 of 4 residents reviewed (Residents #1, #6, #7). The facility reported a census of 115 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident#1 dated 8/1/25, listed diagnoses of stroke, high blood pressure (HTN), heart failure, non-Alzheimer's Dementia, Bipolar disorder, seizure disorder. The MDS reflected the Brief Interview for Mental Status (BIMS) score of 15 out of 15 intact cognition. The MDS identified Resident #1 dependent on staff for transfers, dressing, toileting, and hygiene. The Care Plan for Resident#1 reflected a revision date of 5/8/25, directed she needed the assistance of two staff and the stand lift to transfer. The Nurse Progress Note dated 8/19/2025 at 3:30 PM revealed an Incident, Accident, Unusual Occurrence Note Provider notified on call aware situation and laceration to left side head. New order to send to Emergency Department (ED) for further eval. The Progress Note dated 8/19/2025 at 3:41 PM, identified a Communication from Nursing to Therapy a change in condition or an area with a deficit that may warrant therapy: A fall from full body lift, sustained laceration to back of head. Assist of two staff with stand lift. The Encounter Note dated 8/21/25, revealed nursing reported on 8/19/25 Resident#1 was mid transfer with full body lift when she slipped out of the sling and fell to the ground from approximately sitting height. She struck her head and sustained a laceration. As she is anticoagulated due to medication, Resident#1 sent to the emergency room (ER) for immediate evaluation. Head Cat scan unremarkable, she received five staples to the laceration on her left side of her scalp and discharged back to the facility in stable condition. The Disciplinary Action Form dated 8/29/25, revealed on 8/19/25 the facility terminated the employment of Staff D, Certified Nurse Aid (CNA) because he failed to adhere to safety protocols and the Individualized Care Plan. The resident's Care Plan directed two-person transfer utilizing the stand lift, the employee attempted the transfer independently, selected the incorrect (full body) lift. The resident fell from the lift, sustained a laceration that required staples in the ER. The Encounter Note dated 10/24/25 at 7:23 AM reflected Resident#1 developed new or worsening pain. The note reported skin discoloration, the Provider ordered her to the hospital for ultrasound of the breast. The Nurse Progress Note dated 10/24/2025 at 8:29 described Resident#1 with abnormal bruising on right breast and right upper arm, she denied any recent injury or fall. No other areas of bruising or open skin noted. The Nurse Progress Note dated 10/24/2025 at 9:28 AM reflected a new order from the Provider to hold the blood thinning medication for 72 hours and ultrasound right breast for unexplained mass/bleeding internal. The Nurse Progress Note dated 10/24/2025 at 1:28 PM Resident assessed immediately, pain assessment 8 out of 10. Alert and oriented, unable to describe what happened. No open area, bleeding, signs or symptoms (s/s) of infection noted. Her skin warm to touch. No visible other injuries noted. Sent the resident to hospital for further evaluation, related to mass, internal bleeding. The Ultra Sound (US) of Right Breast dated 10/24/25, revealed diffuse (spread) edema within the breast with no drainable fluid collection. This may represent mastitis (inflammation of the breast tissue) or hematoma (is a collection of blood outside of blood vessels, likely resulting from trauma or potentially an underlying condition). Clinical follow -up is recommended to ensure resolution and no underlying pathology. The History and Physical dated 10/28/25, showed Resident#1's extensive ecchymosis (a discoloration of the skin resulting from bleeding underneath, typically caused by bruising) over body. The note identified Resident #1 stated this is not a new lift at facility, she felt they are not properly placing her and lift before they moved her which is caused bruising. The Physical Exam described the breasts: Extensive dark red/purple/black ecchymosis over bilateral breasts. Some areas of ecchymosis with mild yellowing indicating age. Tender to touch. A photograph included in the document showed dark purple and yellow edges to both breasts, the top of her abdomen and three quarters of her right arm. The Physician's Progress Note last updated 11/2/25, identified multiple bruises mostly on right arm, left side of abdomen, lateral side of legs, both exposed breast area not extending to skin covered under the breast. The Cat scan of the chest showed hyperdensity and asymmetric enlargement of the right pectoralis major and minor musculature with adjacent edema and stranding extending into the right breast. This is concerning for a hematoma. On 11/3/25 at 3:05 PM a transport driver wheeled Resident#1 back inside the facility and Staff C, CNA pushed her to her room. Staff B, CNA and Staff C transferred Resident #1 to her wheelchair (w/c) with the full body lift. Resident #1 leaned to the left significantly during the transfer from the transport wheelchair to her personal w/c, the lift sling failed to hold her right buttock and leg. After staff sat