| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165310 | A. Building<br>B. Wing | 03/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Heritage Specialty Care | 200 Clive Drive SW<br>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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, staff and resident interviews, the facility failed to provide baths for 3 of 9 residents sampled (Resident #2, Resident #3, and Resident #4). The facility reported a census of 123. Findings include: 1. Review of the Minimum Data Set (MDS) dated [DATE], revealed Resident #4 list of diagnoses included heart failure, chronic kidney disease, type 2 diabetes, chronic obstructive pulmonary disease and a left diabetic foot ulcer. The Brief Interview for Mental Status (BIMS) score of 15/15 indicated the resident had intact cognition. The MDS assessed the resident required moderate assistance of 1 staff for bathing. Resident #4's Care Plan dated 6/27/25, directed the moderate assistance of 1 staff for bathing. During an interview with the resident on 2/23/26 at 10:52 am, he stated he did not get a shower at all last week, he is to have his showers on Wednesday and Saturdays. The resident stated staff told him they did not have enough staff to give him his shower and we don't do baths on Sundays. Review of the bathing records revealed the following: a. In December 2025 the staff failed to provide a shower on December 3 and 31st.b. In January 2026, the staff failed to provide showers on 1/24, 1/28 and 1/31. c. In February 2026, the staff failed to provide showers on 2/4, 2/7, 2/11, 2/14, 2/18 and 2/21. 2. Review of the MDS for Resident #2, dated 1/9/26, revealed a list of diagnoses which included hemiplegia, right side affected. The BIMS score of score of 15/15 indicated intact cognition. The MDS assessed the resident required the assistance of 1 staff for bathing. Resident #2's Care Plan, dated 7/8/24, directed she required assistance of 1 staff for bathing. During an interview on 2/24/26 at 8:33 am, Resident #2 stated she did not receive twice weekly baths. Review of the bathing records revealed the following: a. In December 2025 the staff failed to provide a shower on December 9.b. In January 2026 the staff failed to provide a shower on January 13, 16 and 30th.c. In February 2026 the staff failed to provide a shower on February 10th. 2. Review of the MDS dated [DATE], revealed Resident #3 list of diagnoses included stroke with left side hemiplegia and epilepsy. The BIMS score of 15/15 indicated intact cognition. The MDS assessed the resident required the assistance of 1 staff for bathing. Resident #3's Care Plan, dated 11/21/23 directed he required assistance of 1 staff for bathing. During an interview on 2/24/26 at 11:45 am, Resident #3 stated he takes his bath/shower on Tuesday and Fridays.Review of the bathing records revealed the following: a. In January 2026 the staff failed to provide a shower on January 13.During an interview on 2/25/26 at 10:45 am, Staff B, Certified Nursing Assistant (CNA) stated the residents are not getting their baths as they should because staff are pulled to work other units when a staff member does not show up for work, which leaves units short. Review of a facility policy titled Activities of Daily Living (ADL's), Supporting, revised March 2028) revealed a Policy statement which declared Residents will be 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. |

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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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record reviews, facility policy review, provider interview, staff and resident interviews, the facility failed to complete wound care as ordered, and failed to assure a resident attended schedule appointments for 1 of 9 sampled residents (Resident #4). The facility reported a census of 123 residents.Findings include: Review of Resident #4's Minimum Data Set (MDS) dated [DATE], revealed a list of diagnoses which included heart failure, chronic kidney disease, type 2 diabetes, and a left diabetic foot ulcer. The Brief Interview for Mental Status (BIMS) score of 15/15 indicated intact cognition. The MDS assessed Resident #4 alert, oriented and could give accurate information. The MDS identified the resident required moderate assistance of 1 staff for dressing, toileting, bathing and walking. The resident utilized a walker in their room and a wheelchair outside of their room.Review of Care Plan, revised 11/12/25, revealed a Focus area to address I am at increased risk for skin impairments/pressure ulcers due to catheter use, diabetes and impaired mobility. Interventions included, in part:a. Monitor and document location, size and treatments of skin injury and to report abnormalities, failure to heal, signs and symptoms of infection to the physician. Initiated: 6/25/25.b. Weekly treatment documentation to include, measurement of each area of skin breakdown, type of tissue and exudate (drainage), and any other notable changes or observations. Initiated: 6/25/25c. Wound Vac (a device used to promote healing) on at all times to left heel. Initiated: 6/25/25.Review of the Order Summary Report (the summary includes the resident's current orders), revealed the following orders: a. Apply Iodoflex iodine pad to left lateral heel ulcer and cover with dry gauze. Secure the gauze wrap and change every other day, to follow up in 1 week or sooner if need. Start Date: 1/10/26.b. Iodoflex External Pad (Cadexomer iodine) apply to left lateral heel topically in the morning every 2 days for diabetic ulcer. Once out of Iodoflex may use betadine gauze. Start Date: 1/23/26. Review of the January and February 2026 Treatment Administration Records (TAR) revealed:a. Apply Iodoflex iodine pad to left lateral heel ulcer and cover with dry gauze. Secure the gauze wrap and change every other day, to follow up in 1 week or sooner if need. Start Date: 1/10/26. Review of the TARS revealed the treatment not completed as scheduled on 1/26/26, 2/3/26, and 2/9/26. b. Iodoflex External Pad (Cadexomer iodine) apply to left lateral heel topically in the morning every 2 days for diabetic ulcer. Once out of Iodoflex may use betadine gauze. Start Date: 1/23/26. Review of the TARS revealed the treatment not completed as scheduled on 1/23/26, 1/27/26, and 2/8/26. During an interview on 2/24/26 at 7:45 am, the Podiatry wound clinic provider stated Resident #4 received services for wound follow up. The provider stated Resident #4 confides in her and she is concerned with his wound care needs not being met. The provider explained her concerns are with missed appointments at the wound clinic and the infectious disease provider. She stated wanted to see the resident every week. She stated Resident #4 had his first appointment 9/19/25, and then she did not see him again until 10/21/25. She stated the resident did have hospitalizations during this time. She added the resident was a no show for the following wound care appointments: 10/28/25, 10/31/25, 11/4/25; and a no show for the following infectious disease appointments: 10/30/25, 11/24/25. The provider added Resident #4 missed appointments on 12/9/25 and 1/14/26 due to a lack of transportation. The provider stated there has also been concerns with the facility being able to get the supplies for wound care treatments She stated she gives supplies if able, and makes changes to the orders as needed. The provider stated the resident has also reported the facility has not completed wound care treatments every other day, instead they do them every 2 to 4 days. Review of the electronic health record (EHR) revealed a provider note dated 1/9/26 with an order for the resident to return in one week (1/16/26). The EHR review revealed Resident #4 did not attend a wound clinic appointment on 1/16/26. The resident returned to the clinic on 1/21/26. During an observation and interview on 2/23/26 at 10:45 am, Resident #4 sat in his recliner with his feet down. Resident #4 reported he has appointments at the wound clinic every other week. Resident #4 (continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | stated he has missed appointments as the facility forgot to set up a ride for him or they do not have a staff to drive the van. Resident #4 observed to have a white gauze bandage with light blue tape applied to anchor the dressing in place. The dressing lacked a date. At 11:25 am Staff A, Licensed Practical Nurse entered the resident's room. Resident #4 asked Staff A if she was going to change the dressing on his foot. Staff A informed the resident the dressing change had already been done for the day. Review of the February 2026 Treatment Record indicated the morning left lateral heel wound treatment on 2/23/26 was signed off by a Staff B, Certified Medication Aide (CMA). During an interview on 2/24/26 at 12:15 pm, Staff B-CMA stated she accidently signed off all treatments for Resident #4 by mistake the morning of 2/23/26. During an observation on 2/24/26 at 9:10 am, Resident #4 sitting in his recliner. The residents rested on the floor, with a white Kerlix wrap on his left foot anchored by light blue tape. The resident stated it is the same dressing that he had on yesterday. Staff C, LPN and Assistant Director of Nursing donned a gown and completed a wound dressing change to Resident #4 left lateral foot wound. Staff C stated the dressings she removed was not dated to indicate when it was last completed. During an interview on 3/2/26 at 11:00 am, Staff C, LPN, stated when a resident goes out to a wound clinic appointment the staff are to receive the paperwork from the resident upon return, review for new orders and schedule the next appointment if appropriate. Staff C indicated Resident #4 usually goes to the wound clinic on Wednesday and that he does not refuse these appointments. She stated he is able to voice his ideas and knows the wound treatments that are ordered. Review of an undated Wound Care procedure. The procedure states the purpose of wound care is to promote healing. When a staff member does the treatment, they are to prepare items needed to complete the wound treatment, the staff should verify there is a physicians' order. They are to review the resident's care plan to assess for any special needs the resident may have and then assemble the equipment. The procedure directs the staff if the resident refuses the treatment, they are to document the reason why and notify the resident's physician. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, review of food temperature logs, resident and staff interviews, the facility failed to provide food that is palatable for 1 of 9 sampled residents (Resident #4). The facility reported a census of 123 residents. Findings include: Review of Resident #4's Minimum Data Set (MDS) dated [DATE], revealed a list of diagnoses which included heart failure, chronic kidney disease, type 2 diabetes, and a left diabetic foot ulcer. The Brief Interview for Mental Status (BIMS) score of 15/15 indicated the resident's cognition intact. The MDS assessed Resident #4 alert, oriented and could give accurate information. Review of Resident #4's care plan initiated on 6/25/25, the care plan directed staff to provide a diet low in sodium, regular texture and thin liquids as the resident is at a risk due to his chronic obstructive pulmonary disease, heart failure and kidney disease and to monitor his tolerance of the diet that is ordered. During an interview with Resident #4 on 2/23/26 at 10:52 am, he stated he eats all of his meals in his room and reports the food is cold almost every meal. Resident #4 stated the staff frequently serve the food later than scheduled and it doesn't feel it taste very good. An observation on 2/23/26 started at 12:45 pm of the meal service provided at Station 3 revealed: a. At 12:45 pm there are 12 residents seated in Station 3 dining room waiting for lunch. b. At 12:46 pm the dietary aide wheeled out the beverages and started to pass beverages.c. At 12:58 pm the dietary staff wheeled the hot food cart out to the dining room and begin to serve the residents. At this time the residents are asking for forks. Staff D-Food Service Supervisors present and attempted to find a plug in for the hot cart. The hot cart had to be moved close to the dietary door as the food cart plug in cord was too short to reach. Residents asked for forks to eat their meal but were told they did not have any forks for them to use. d. At 1:08 pm the dietary staff prepared Resident #4's tray of food directly from the food cart and Staff D-Food Service Supervisor took it directly to the resident. e. At 1:09 pm Staff D, Food Service Supervisor set the food tray on the residents over the bed table, and took the temperature of the food items. Temperature (in Fahrenheit) Results included: Pork chop - 101.8 F degrees, potatoes - 121.8 F degrees and the white milk - 45.4 F degrees. Staff D left the resident's room, went to the kitchen and prepared a fresh tray of food for the resident. f. The dietary staff served the last tray of food to Station 3 residents at 1:27 pm.Review of the temperature logs for the noon meal on 2/23/26 revealed prior to serving the meat the temperature was 189 degrees and after serving the meal was 171 degrees, the potatoes/starch was not temped before or after the meal and the milk temperature before serving was 34 and after serving the milk was 39 degrees. During an interview on 3/2/26 at 10:20 am, Staff-D Food Service Supervisor stated they are working on ways to keep the food hotter and the beverages colder when they are served. Review of the facility policy titled Food Preparation and Service, revised April 2019 directed, in part Food Service/Distribution #1. Proper hot and cold temperatures are maintained during food service. Foods that are held in the temperature danger zone are discarded after 4 hours. |