STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165310	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024

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 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 44972 Based on facility document review, staff interview, and policy review, the facility failed to comply with all applicable Federal Regulations regarding Medicare requirements governing billing practices by failing to serve Skilled Nursing Facility (SNF) Advanced Beneficiary Notice (ABN) forms 48 hours before the resident ended skilled services for 2 of 3 residents reviewed for liability and appeal notices (Residents #112 and #122). The facility identified a census of 140 residents. Findings include: Review of facility documentation for Resident #112 revealed the resident received Medicare benefits for skilled services 6/10/24 through 6/21/24. The facility failed to provide the required SNF ABN (CMS form 10055), to inform the resident of the potential liability if skilled serves continued, 48 hours prior to skilled services ending. Review of facility documentation for Resident #122 revealed the resident received Medicare benefits for skilled services 4/3/24 through 4/23/24. The facility failed to provide the required SNF ABN (CMS form 10055), to inform the resident of the potential liability if skilled serves continued, 48 hours prior to skilled services ending. In an interview on 8/22/24 at 10:56 AM, the Administrator stated the facility identified during a mock survey in July, the ABN's were not being completed correctly since their long-term social worker retired. It was his expectation the Notice of Medicare Non-Coverage (NOMNC) and ABN be given at the same time. Now that the issue had been identified they planned to initiate audits and talk about them in their morning meetings and he would also be adding it to Quality Assurance to monitor for compliance. In a facility provided policy titled Medicare Advanced Beneficiary Notice dated 4/21, it stated the following: If the admissions coordinator or business office manager believes (upon admission or during the resident's stay) that Medicare (Part A of the Fee-for-Service Medicare Program) will not pay for an otherwise covered skilled service(s), the resident (or representative) is notified in writing why the service(s) may not be covered and of the resident's potential liability for payment of the non-covered service(s). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165310	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER: Heritage Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE: 200 Clive Drive SW, Cedar Rapids, IA 52404	

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	a. The facility issues the Skilled Nursing Facility Advanced Beneficiary Notice (CMS form 10055) to the resident prior to providing care that Medicare usually covers, but may not pay for because the care is considered not medically reasonable and necessary, or custodial. b. The resident (or representative) may choose to continue receiving the skilled services that may not be covered, and assume financial responsibility.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on observation, clinical record review, document review, and staff interview, the facility failed to maintain a clean, homelike environment. The facility reported a census of 140 residents. Findings include: 1. A Brief Interview for Mental Status (BIMS) score Evaluation Scoring Report provided by the facility on 8/19/24 detailed Resident #61 and Resident #71 with BIMS scores of 15 out of 15 indicating intact cognition. On 8/19/24 at 2:15 PM Resident #61 reported his room just got cleaned today because the State was here. He reported it had been approximately three weeks since his floors has been cleaned in the room. The rooms are just plain dirty. Resident #61's roommate also chimed in and said, everything he is saying is true. Observation at this time reveal a black built up substance splattered across the floor in front of the bedside stand and the bed. The black substance could be scraped up off the floor but did not come up easily. The Surveyor noted a housekeeper had her cart parked in front of Resident #61 room mid-morning cleaning the room. Staff J housekeeper at that time reported the resident rooms were cleaned daily. Further observation of the room revealed the left window screen popped out of the frame approximately two inches at the bottom. A cobweb stretched approximately 8 inches in length by 4 inches wide along the bottom of the window between the screen and the outside window. The Surveyor ran a finger down the window frame and a layer of thick gray dust came up. Resident #61 responded, I told you. A heavy dust layer noted on the room window blinds. Multiple cobwebs ran from the right window to the blinds and cobwebs ran from the bottom of the right window frame all the way up the entire window greater than 24 inches. Inspection of the bathroom revealed two approximate 12 inch hairs hanging off the front right side of the toilet seat with a 3 centimeters (CM) x 3 CM yellow substance dried on the backside of the toilet seat. On 8/20/24 at 7:40 AM Resident #71 reported they do clean his room, usually once a day. They sweep, mop and take out the trash. Despite that, he voiced his room is just not clean. He is being treated for an eye infection and he feels that it is all the dust in the room. He reported the blinds have a heavy layer of dust and there are cobwebs in the windows. They don't clean the windows. He reported the floors aren't always cleaned. Observation at this time revealed a heavy layer of dust on the window blinds. The surveyor ran a finger along the blinds which revealed a large gray built up of dust. The right window had a cobweb approximately 3 inches by 5 inches running in the lower corner of the window and a cobweb 2 inches by 4 inches in the middle window at the right lower corner. The floor had a plastic cup, Kleenex, straw wrapper on the floor with dust along the floorboards. Observation on 8/21/24 at 7:30 AM revealed Resident #71 room unchanged with heavy dust on the blinds, cobwebs in the windows, and dust along the floorboards. On 8/21/24 at 9:22 AM observation of Resident #61 room remained unchanged with cobwebs in the windows and heavy dust remain in the resident's room. The black substance remained stuck down to the floor in front of Resident #61 bedside table. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the August 2024 Deep Clean Schedule showed Resident #61 room scheduled for deep clean on 8/14/24. A review of the Quality Control Form Housekeeping Department Deep Clean Check List signed off by Staff J on 8/09/13 from 9:10 AM to 10:05 AM documented she deep cleaned the following areas: shower, toilet, shelf, light fixtures, toilet handle bars and wall bars, sink faucet and sink counter, sink counter and drawers, soap dispenser, paper towel dispenser, mirror, washcloth/towel bar holders, dresser/drawers, bed head and foot board/frame/mattress, bed control cord and call light cords, pictures/white board/bulletin boards, window and frame, window curtains/window blinds, chairs, wheelchair and walker, television (TV) and TV mount, bed table, telephone, trash containers, privacy curtains and tracks, plumbing, wall and wall vents, ceiling and ceiling vents, closet and closet doors, and floors. The entry door, bathroom door, heating vents, baseboards and sprinklers were not signed off. A 8/21/24 11:37 AM review of the August 2024 Deep Clean List showed Resident #61 room scheduled for deep clean on 8/07/24. A review of the Quality Control Form Housekeeping Department Deep Clean Check Lists submitted by the Housekeeping Manager lacked any documentation Resident #71 room had the deep clean performed as scheduled. On 08/21/24 at 9:26 AM no housekeeping carts noted on the station 3 hallways cleaning at this time. On 8/21/24 at 9:43 AM the housekeeping cart noted parked in front of room [ROOM NUMBER]A11 in Station 3. Observation 8/21/24 at 10:03 PM showed the housekeeper cleaning room [ROOM NUMBER]A8 and a caution wet floor sign in 3A11 room doorway. room [ROOM NUMBER]A10 did not have a wet floor sign indicating the floor had not been mopped. At 10:04 AM Staff J pushed her housekeeping cart up the hallway to room [ROOM NUMBER]A6 after cleaning room [ROOM NUMBER]A8. Staff J did not place a wet floor sign in room [ROOM NUMBER]A doorway to indicate the floor was wet from being mopped. Staff J observed cleaning high touch areas in room [ROOM NUMBER]A6 by the sink. At 10:11 AM observed housekeeper sweeping the floor of room [ROOM NUMBER]A. Staff J moved her housekeeping cart down to the Station 3 dining room. Staff J did not mop room [ROOM NUMBER]A6. During an interview on 8/21/24 at 10:20 AM the Housekeeping/Laundry Supervisor reported the housekeepers do deep cleaning every month. She makes out a deep clean schedule for them to follow and they have a cleaning list they have to sign off. Deep cleaning consists of dusting the lights, above the curtains, ceiling vents/ light fixtures, bars of the bed, cleaning under the bed and dressers. She verbalized the floors are stripped and waxed in September. 08/21/24 10:23 AM Staff J reported they clean all the resident rooms daily. She stated they clean the bathroom toilets, high touch areas in the bathroom, sweep and mop the floor, empty trash and clean anything else that looks like it needs cleaning. On 8/21/24 11:56 AM Staff A, Licensed Practical Nurse (LPN) reported residents have complained to her that their floors are not being mopped. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/21/24 at 1:06 AM the Housekeeping/Laundry Supervisor reported she expects the deep cleaning schedule to be followed and completed. She explained the window cleaning would consist of taking the window curtains down cleaning and dusting the blinds if the window has blinds. The staff are to remove the window screen and clean the windows. She stated if there were cobwebs between the screen and window, the staff should clean as part of the deep cleaning. She reported she did not have signed off records for some of the station 3 rooms as not all the staff had submitted their records. She did not have deep clean records for June or July 2024, but she knew that the rooms had been cleaned as she would go back and inspect the rooms. She further reported they do not have a daily cleaning sign off list, but the expectation is all resident rooms are sweep and mopped. During an interview on 8/22/24 at 9:30 AM the Housekeeping/Laundry Supervisor reported she had not found any documentation to show the staff signed Resident #71 room had been deep cleaned for August 2024. She also had not found any documentation to support the deep cleaning had been completed for any of the station 3 resident rooms for June or July 2024. The Cleaning and Disinfecting Resident Rooms Policy revised August 2013 directed the housekeeping staff in the following: a. Walls, blinds and window curtains in resident areas would be cleaned when the surfaces are visibly contaminated or soiled. b. Floor mopping solution will be replaced every three resident rooms, or changed no less often than at 60 minute intervals. The Resident Room Cleaning Procedure lacked direction on frequency of mopping resident room floors and lacked direction on cleaning the windows. 2. Upon initial walk through of Station 3 on 8/19/24 from 11:00 AM to 1:00 PM noted many unmade resident beds throughout the station. On 8/19/24 at 3:38 PM room [ROOM NUMBER]B17 Resident #38 unmade bed visible from the hallway. The bed had a fitted sheet over the mattress with a turning sheet and two paper chux (disposable absorbent pads) visible at the center of the bed. The room had a strong urine odor. The two paper chux noted to have saturated urine visible. Both paper chux had approximate 8 inches by 4 inches of circular tan-brown drainage within the saturation of the paper chux. The bottom fitted sheet observed with dried yellow/tan drainage approximately 4 inches by 12 inches running across the bed. Fitted bottom sheet with 6 inch by 16 inch area of urine soaked through the bottom sheet into the mattress. Resident #38 observed dressed, sitting up in the wheelchair eating snacks in the dining room. During an observation on 8/20/24 at 4:20 PM room [ROOM NUMBER]B17 room door wide open. Resident #38 bed observed with a large amount of tan drainage, approximately 8 inches by 7 inches across a lift sheet on the bed and two paper chux laying on the bed both with large amount of tan drainage approximately 6 inches by 7 inches on each paper chux. Resident #38 observed dressed, sitting up in the wheelchair watching television in the dining room. During a Station 3 Walk through on 8/21/24 at 8:18 AM the following observations were made: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. room [ROOM NUMBER]B17 room door wide open, bed unmade with a fitted bottom sheet on the bed and a turning sheet in the middle of the bed. Resident #38 observed dressed, sitting up in the wheelchair in the dining room. Resident #38 Minimum Data Set (MDS) assessment dated showed a Brief Interview of Mental Status (BIMS) score of 4 out of 15 indicating severe cognitive loss. b. room [ROOM NUMBER]B10 vacant, room door wide open, bed with a fitted sheet and a top sheet thrown over the bed, visible from the hallway. During a station 3 walk through on 8/21/24 at 10:21 AM the following observations were made: a. room [ROOM NUMBER]B18 door wide open to the room with bed unmade, positioning sheet and paper chux visible laying on top of the unmade bed. b. room [ROOM NUMBER]B19 door wide open, bed unmade with fitted sheet only on the bed. c. room [ROOM NUMBER]B17 door wide open, bed unmade with fitted sheet and positioning sheet visible on unmade bed. On 8/21/24 at 1:42 PM the following observations were made on Station 3: a. room [ROOM NUMBER]B20 door wide open with bed not made. b. room [ROOM NUMBER]B18 door wide open, bed with a fitted bottom sheet and a turn sheet on bed only. At 1:45 PM Staff I, left room and stated she would get the aides to lay him down. 1:46 PM staff I, Assistant Director of Nursing (ADON) came down to assist the resident to bed. c. room [ROOM NUMBER]B19 door wide open, bed with a fitted sheet and a turn sheet on the bed. No resident admitted to the room. d. room [ROOM NUMBER]B17 room door wide open, bed with a fitted bottom sheet on the bed with a turning sheet in the center of the bed. The Director of Nursing (DON) walked through the hallway and did not address any of the unmade beds. On 8/21/24 at 4:12 PM Staff H, Certified Nursing Assistant (CNA) reported the beds are to be made up daily. She didn't know why the beds are not being made. Staff H then reported if the resident is independent, they usually make their own beds, then came back and said they will make their beds if the resident asks them to do it. On 8/21/24 at 4:16 PM Staff A, Licensed Practical Nurse (LPN) verbalized the resident beds are to be made when the resident gets up. She reported it is probably not homelike for the beds not to be made, unless the resident does not want their bed made. When asked if there are residents that request not to have their beds made, Staff A responded no. During an interview on 8/21/24 at 4:22 PM the DON voiced that beds are part of Activities of Daily Living (ADLs) services and should be made, unless the bed is going to be stripped due to bath days. She reported that would not support a homelike environment. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Homelike Environment Policy revised February 2021 documented resident's are provided with a safe, clean, comfortable and homelike environment. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include a clean, sanitary and orderly environment.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on observation, clinical record review, policy review, resident and staff interviews, the facility failed to follow physician orders for 1 of 1 resident's reviewed for catheter care (Resident #71). The facility identified a census of 140 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating intact cognition. The MDS documented Resident #71 as dependent upon staff for toileting and utilized an indwelling urinary catheter for diagnosis of neurogenic bladder. The Care Plan dated 7/08/24 detailed the use of a urinary catheter. The Care Plan lacked direction to the staff on changing the urinary catheter per the physician orders. During an interview on 8/20/24 at 7:28 AM Resident #71 reported his catheter had not been changed in at least four weeks. He had brought it to Staff F, License Practical Nurse (LPN) attention, but she no longer worked at the facility. Observation at this time revealed Resident #71 lying in bed with a urinary catheter draining clear yellow urine to a urinary drainage bag that hung from the right side of the resident bed in a privacy bag. Observation on 8/21/24 at 7:38 AM revealed Resident #71 lying in bed with the urinary catheter draining clear yellow urine to a urinary drainage bag that hung off the right side of the bed in a privacy bag. An 8/21/24 review of the Order Summary Report provided by the facility showed the Provider approved Resident #71's order on 6/04/24 which included an order to change the indwelling Foley catheter 14 French bulb size, 10 cubic centimeters (cc) monthly every 28 days on the evening shift. An 8/21/24 review of Resident #71 Treatment Administration Record (TAR) revealed Resident #71 due for the monthly catheter change on the evening shift on 8/02/24. The 8/02/24 catheter change order was signed off of the MAR as U indicating unknown. Review of the Progress Notes on 8/21/24 revealed a Progress Note dated 8/5/2024 at 10:37 PM documenting Resident #71 refused to have his catheter changed requesting the catheter change be moved to the day shift in order for the staff to monitor for complications. The Progress Note detailed the facility submitted a request to Mercy geriatrics for an order change. A 8/6/2024 4:33 PM Communication with Physician Note documented the Provider responded with an order to schedule the Foley catheter change to be changed in the AM per the resident request to begin 8/06/24. Further review of Resident #71 Progress Notes on 8/21/24 revealed no Progress Note documentation since 8/06/24 showing Resident #71 had his Foley catheter changed per the physician's orders. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/24 at 11:57 AM Staff A, License Practical Nurse (LPN) reported Resident #71 has a physician order to get his Foley catheter changed every 28-30 days. She reported it is scheduled to be done on second shift as he is more awake in the evenings. The August 2024 TAR documented the new physician order dated 8/06/24 to change the Foley catheter monthly, every 28 days on the day shift with the catheter change scheduled for 8/07/24. The 8/07/24 catheter change had not been signed off as completed as of 8/21/24 at 3:00 PM. On 8/21/24 at 3:07 PM Staff A, LPN, reported the charge nurse is responsible for noting physician orders that are returned on their shift. If a fax comes in at the end of shift, the next charge nurse coming on would note the orders. She reported once she notes the physician order, the physician order goes to a folder to go through a double check process. A second nurse is responsible for double noting the physician order. During an interview on 8/21/24 at 3:15 PM Staff G, Assistant Director of Nursing (ADON) reported the charge nurse notes the physician orders as they come in during the shift. As an ADON and support, she will assist with noting the physician orders as needed. She writes a note in the Progress Notes that a new order was received and notifies the family. All physician orders go through a double check system. If the second and third shift nurses have time, they will complete the double noting of the orders. If they don't have time, then she will double note the orders. At 3:18 PM Staff G reviewed Resident #71 August 2024 TAR catheter change order. She voiced according to the TAR Resident #71 catheter had not been changed. Staff G checked with Staff A on the physician order. Staff A reported that the new order in the computer had been entered in the computer by Staff G. After reviewing with Staff A, Staff G confirmed that Resident #71 Foley catheter had not been changed since the new order came in on 8/06/24. During an interview on 8/21/24 at 3:41 PM the Director of Nursing reported she expects the nurses to follow the physician orders. The Medication Orders Policy revised 2014 under recording orders directed treatment order should specify the treatment, frequency and duration of the treatment. The policy lacked direction as to who was responsible to implement the physician orders or oversee the implementation of the physician orders.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40907 Based on observations, interviews, and record reviews, the facility failed to do weekly measurements and assessments on 1 of 2 residents with pressure ulcers (Resident #37). Resident #37 did not receive the weekly assessments between 7/10/24 when he was seen at a wound clinic to 8/20/24 when an assessment was done at the facility. The facility reported a census of 140 residents. Findings include: Staging of a PU/PI is performed to indicate the characteristics and extent of tissue injury, and should be conducted according to professional standards of practice. Determining whether damage to the skin and underlying tissue is a PI or PU depends on the staging of the damaged tissue. See stages below. NOTE: Regardless of the staging system or wound definitions used by the facility, the facility is responsible for completing the MDS utilizing the staging guidelines found in the RAI Manual. Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes of intact skin may also indicate a deep tissue PI (see below). Stage 2 Pressure Ulcer: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Ulcer: Full-thickness skin loss Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the wound bed, it is an Unstageable PU/PI. Stage 4 Pressure Ulcer: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the wound bed, it is an unstageable PU/PI. Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident ' s physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned. The pressure ulcer does not have to be completely debrided or free of all slough or eschar for reclassification of stage to occur. Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure ulcer. Once a deep tissue injury opens to an ulcer, reclassify the ulcer into the appropriate stage. Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. Medical Device Related Pressure Ulcer/Injury: Medical device related PU/PIs result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system. Mucosal Membrane Pressure Ulcer/Injury: Mucosal membrane PU/PIs are found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue, these ulcers cannot be staged. A Treatment Administration Record dated August 2024, directed staff to do the following treatment: Sacrum (tailbone region) Wound: cleanse wound and peri-skin with saline or baby shampoo, prep peri-wound with skin prep. Moisten 2 inches of Kerlix (gauze) with 0.125% Dakins (topical disinfectant), wring out excess solution and pack into the wound. Cover with sacral heart dressing one time a day related to PRESSURE ULCER OF SACRAL REGION, STAGE 4. This treatment had a start date of 06/14/24. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Minimum Data Set, dated dated dated [DATE], documented that Resident #37's diagnoses included heart failure, cancer, depression, and non-Alzheimer's dementia. A Brief Interview for Mental Status documented a score of 11 out of 15, which indicated moderately impaired cognition. This MDS documented that this resident had one Stage 4 Pressure Ulcer and one Unstageable Ulcer. This resident was dependent on staff for bed mobility, transfers, and toileting. On 8/20/24 at 2:02 p.m., Staff G, Assistant Director of Nursing (ADON) stated that she does not think his wounds gets measured weekly, but did not know for sure. She stated he is followed by the wound clinic and his wife wants him to be followed by wound clinic. This ADON stated the wife said it's like their date night time and gives her husband an opportunity to get outside of the facility. The ADON thought this resident goes to the wound clinic every 2 weeks. A Wound Evaluation for a Stage 4 Coccyx dated 7/7/24, was done by the facility. A Healing Center Progress Note dated 7/10/24, was done by the wound clinic. On 8/20/24 at 4:11 p.m., the Director of Nursing (DON), stated they were gathering all the measurements, but it didn't appear that we were doing weekly measurements on his PUs. On 8/20/24 at 4:31 p.m., the DON confirmed the facility had not been assessing and measuring the wound weekly. This DON stated they now have identified the issue and had measured the wounds on this day. A Wound Evaluation for a Stage 4 Coccyx was done on 8/20/24 by the facility. A Ulcers/Skin Breakdown revised September 2017, directed the following: Physicians shall help prevent and manage pressure ulcers, consistent with established guidelines. 1. Incidence of new pressure ulcers will be minimized to the extent possible. 2. Healing of existing pressure ulcers will be optimized to the extent possible. 3. The facility will be able to show that failure of a pressure ulcer to heal was medically unavoidable. Recognition 1. The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility and medical instability. 2. The staff and practitioner will examine the skin of newly admitted residents/patients for evidence of existing pressure ulcers and other skin conditions. 3. The physician will help the staff identify the type (for example, arterial or stasis ulcer) and characteristics (presence of necrotic tissue, status of wound bed, etc.) of an ulcer. 4. The physician will help identify and define any complications related to pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Diagnosis/Cause Identification 5. The physician will help identify factors contributing or predisposing residents/patients to skin breakdown; for example, medical comorbidities such as poorly controlled diabetes or congestive heart failure, overall medical instability, cancer or sepsis causing a catabolic state, and macerated or friable skin. 6. The physician will clarify the status of relevant medical issues; for example, whether there is a soft tissue infection or just wound colonization, whether the wound has necrotic tissue, and the impact of comorbid conditions on healing an existing wound. Treatment/Management 7. 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. 8. The physician will help identify any medical interventions related to wound management; for example, treating a soft tissue infection surrounding an ulcer, removing necrotic tissue, addressing comorbid medical conditions, managing pain related to the wound or to wound treatment, etc. Although poor nutritional status is associated with increased risk of pressure ulcer development, no specific nutritional interventions clearly prevent or heal pressure ulcers. Beyond trying to maintain a stable weight and providing approximately 1.2-1.5 gm/kg protein daily, there are no routine pressure ulcer-specific nutritional measures for those with or at risk for developing a pressure ulcer. Any nutritional supplementation should be based on realistic appraisal of an individual's current nutritional status and minimizing any medications and conditions that may be affecting appetite and weight (see policy on Nutrition (Impaired)/Unplanned Weight Loss or Gain). 9. The physician will help staff identify the likelihood of wound healing, based on a review of pertinent factors; for example: Healing or Prevention Likely: The resident/patient's underlying physical condition, prognosis, personal goals and wishes, care instructions, and ability to cooperate with the treatment plan make wound healing and subsequent wound prevention realistic. Healing or Prevention Uncertain: Healing may be delayed or may occur only partially; wounds may occur despite appropriate preventive efforts. Healing or Prevention Unlikely: The resident/patient is likely to decline or die because of his/her overall medical instability; wounds reflect the individual's overall medical instability; an existing wound is unlikely to improve significantly; additional wounds are likely to occur despite preventive efforts. 10. As needed, the physician will help identify medical and ethical issues influencing wound healing; for example, the impact of end-stage heart disease or decline of artificial nutrition and hydration by the resident/patient or family. (continued on next page)

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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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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Advance directives or current medical orders may limit the scope, intensity, duration, and selection of various interventions. Monitoring 11. During resident/patient visits, the physician will evaluate and document the progress of wound healing-especially for those with complicated, extensive, or poorly healing wounds. This should be based on looking at the wound periodically and on reviewing pertinent information about the patient. 12. 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. Healing may be delayed or may not occur, or additional ulcers may occur because of unmodifiable factors or because of care-related process problems. Current approaches should be reviewed for whether they remain pertinent to the resident/patient's medical conditions, are affected by factors influencing wound development or healing, and the impact of specific treatment choices made by the resident/patient or a substitute decision-maker.

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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** 40907 Based on observations, interviews, and record review, the facility failed to ensure residents were smoking in approved areas for 1 of 1 resident reviewed (Resident #184). Resident #184 was observed smoking on facility grounds. The facility was a smoke free campus. The facility reported a census of 140 residents. Findings include: Resident #184 did not have a current MDS as she readmitted to the facility on [DATE]. A Care Plan initiated on 8/8/24, directed staff that this resident used tobacco. The goal was that Resident #184 would adhere to the tobacco/smoking policies of the facility. A Smoking Evaluation was to be done upon admission and as needed. Resident #184 was to be educated on the facility's tobacco / smoking policy(s). On 8/19/24 at 3:34 p.m., Resident #184 wheeled herself down the hall in her wheelchair carrying a pack of cigarettes. Resident #184 stated she does smoke. She said she could smoke whenever she wanted. Resident #184 stated she had asked staff before and they have said they were too busy but this did not happen very often. On 8/19/24 at 1:10 p.m., Resident #184 signed herself out on a sign out book at 1:00 p.m., Staff then let the resident out the exit door on the back side of unit 4. Resident #184 then went to the sidewalk independently, staff did not accompany her. She then wheeled herself to the side walk between the building and the parking lot, lit her cigarette and smoked. When asked how she put her cigarette out, this resident stated she put it out on the sidewalk and then disposed of it in the trash can outside the exit door. On 8/20/24 at 1:48 p.m., the Director of Clinical Operations stated the facility is a non smoking facility. She stated that if residents want to smoke they need to leave the grounds. She clarified that off the grounds means on the opposite side of the facility's parking lots where it becomes the city's property. When asked if the sidewalk nearest the building to unit 4 was considered city property, she stated it was not. When told about the above observation, she said they would need to talk with the resident again. When told there was no receptacle where Resident #184 smoked, this staff stated there wouldn't be a receptacle because this is a smoke free campus. On 8/20/24 at 2:07 p.m., the Administrator stated he would go back down and talk with Resident #184 again. He stated they do smoking assessments on individuals who want to smoke to ensure they are safe to make if off grounds. He stated they do have a smoking policy which essentially directs that this is a non smoking facility/grounds. A Nursing Safe Smoking Evaluation dated 8/8/24, documented the following: 1. Facility Smoking Policy: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Smoke Free A. Vision 1. Does the resident have a visual deficit? (Such as use of glasses, macular degeneration, blindness in one or both eyes) b. No 1a. Specify B. Cognitive 1. Ability to communicate understanding of smoking standard procedure; including: residents are not permitted to keep cigarettes, E-cigarettes, pipes, tobacco or any other smoking articles in their possession. Disposable safety lighters are permitted only, and are stored with smoking articles. Matches or other forms of lighters are prohibited. a. Yes 2. Demonstrates ability to make his/her own decisions in relation to daily activities? a. Yes 3. Comments (no comments) C. Dexterity 1. Demonstrates the ability to hold cigarette safely? a. Yes 2. Demonstrates ability to maintain control of cigarette if physically distracted (i.e. bumped)? a. Yes 3. Demonstrates ability to light his/her cigarette safely? a. Yes 4. Demonstrates appropriate use of an ashtray (i.e. does not drop ashes on self, floor, furniture, ect)? a. Yes 5. Demonstrates ability to let go of cigarette and then retrieve it appropriately? a. Yes (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Demonstrates ability to appropriately extinguish cigarette? a. Yes 7. Comments (no comments) D. Safety 1. Does the resident use O2? b. No 2. Has the resident demonstrated non-compliance with smoking policy requirements? b. No E. Assessment 1. Which one best describes the resident? a. Independent Smoker F. Adaptive Equipment 1. Resident need for adaptive equipment (check all that apply): f. None 1a. Specify G. Care Plan 1. Select the focus, goal and appropriate interventions. Focus: Tobacco Use Goal: I will adhere to the tobacco/smoking policies of the facility. Intervention: Conduct Smoking Evaluation on Admission and PRN. Intervention: Educate Resident/Responsible Party on the facility's tobacco / smoking policy(s). A Smoking Policy-Residents revised in July 2017, documented: Smoking Policy - Residents Policy Statement (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This facility shall establish and maintain safe resident smoking practices. Policy Interpretation and Implementation 1. Upon admission, residents shall be informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. 2. If allowed by the facility, Smoking is only permitted in designated resident smoking areas, which are located outside of the building. Electronic cigarettes are not permitted inside. Otherwise, smoking is not allowed inside the facility under any circumstances. 3. Oxygen use is prohibited in smoking areas. 4. Metal containers, with self-closing cover devices, are available in smoking areas. 5. Ashtrays are emptied only into designated receptacles. 6. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker, the evaluation will include: a. Ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation). 7. The staff shall consult with the Attending Physician and the Director of Nursing Services to determine if safety restrictions need to be placed on a resident's smoking privileges based on the Safe Smoking Evaluation. 8. A resident's ability to smoke safely will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff. 9. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10. The facility may impose smoking restrictions on a resident at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision. 11. Any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking. 12. Residents who have independent smoking privileges are permitted to keep cigarettes, e-cigarettes, pipes, tobacco, and other smoking articles in their possession. Only disposable safety lighters are permitted. All other forms of lighters, including matches, are prohibited. 13. Residents are not permitted to give smoking articles to other residents. 14. Residents without independent smoking privileges may not have or keep any smoking articles, including cigarettes, tobacco, etc., except when they are under direct supervision. 15. Staff members and volunteer workers are not permitted to purchase and/or provide any smoking articles for residents. 16. This facility maintains the right to confiscate smoking articles found in violation of our smoking policies. 17. Confiscated resident property will be itemized and ultimately returned to the resident, or his or her legal representative. When the property is returned will be determined during a meeting with the resident or representative regarding the circumstances that led to the confiscation.

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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 - 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** 40907 Based on observations, interviews, and record review, the facility failed to provide pain medication when scheduled for 1 of 1 residents that wore a Fentanyl patch (opioid medication) (Resident #109), resulting in this resident reporting being in severe pain. This resident was to have a Fentanyl patch applied on 8/19/24 at 1800. It was not applied until the morning of 8/21/24. The facility reported a census of 140 residents. Findings include: A Minimum Data Set (MDS) dated [DATE] documented Resident #109's diagnoses included Malignant Neoplasm of tongue (cancer), hip fracture, and depression. A Brief Interview for Mental Status score was documented as 12 out of 15, which indicated moderately impaired cognition. This MDS documented that Resident #109 experienced pain almost constantly in the prior 5 days. On 08/19/24 at 10:55 a.m., Resident #109 was sitting on her bed in a private room. This resident stated she was in pain. Stated her mouth hurt and she had a broken hip. A Progress Note dated 8/19/24 at 2:17 p.m., documented that a call was received from the pharmacy concerning the Fentanyl patch order denial by the provider, and the provider wanted to talk with the facility. The ADON (Assistant Director of Nursing) was informed. A Doctor's Order dated 8/19/24 at 7:06 p.m., directed staff to hold the Fentanyl patch for 3 days until 8/22/24. The reason for this hold was documented as the pharmacy would like to speak with physician prior to next order being sent. This Order was written by Staff K, Licensed Practical Nurse (LPN). On 8/21/24 10:06 a.m., Staff G, ADON stated she was not told that pharmacy wanted to talk to the provider regarding the Fentanyl patch. She acknowledged the Progress Note stated that the ADON was notified but stated she was not. This ADON stated she did not know the Fentanyl patch was being held. She looked up the order and verified that it was being held. This ADON said if she would have known about the pharmacy wanting to talk with the provider, she would have called the Hospice physician and not the facility's provider as the Hospice physician manages Resident #109's medications. When told that this resident had complained of pain on 8/19/24, this ADON acknowledged the concern that Resident #109 did not receive her Fentanyl patch at the scheduled time on 8/19/24 at 6:00 p.m., and still had not received the patch. On 8/21/24 at 10:21 a.m., the facility's Physician's Assistant (PA) stated he became aware of the pharmacy sending a request to talk to a physician yesterday morning. He stated he sent a new script for the Fentanyl yesterday morning, 8/20/24. Hospice wanted me to manage Resident #109's Fentanyl patch. This PA stated what happened was the pharmacy had requested the Hospice physician for a new script for the Fentanyl patch, but since this PA is the one who manages the Fentanyl patch he needed to put the new script in. This PA stated he was managing her Fentanyl patch and Hospice was managing her morphine and Haldol, pretty much everything else. He stated the pharmacy called him on the morning of 8/20/24 and that is when he sent the script for the Fentanyl patch to be filled. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 8/21/24 at 10:45 a.m., Staff L, Hospice Social Worker, stated she was in a lot of pain and the nurse came in and gave her some morphine and then put on her regularly scheduled patch. Staff L stated she overheard staff saying something about Resident #109 not having her patch on so they got an order to restart it again today. On 8/21/24 at 11:00 a.m., Resident #109 rated her pain at an 8 out of 10 with 0 being no pain and 10 being the worst pain. She stated the pain was in her mouth and her hip and leg. She had facial grimacing and rubbed her leg. On 8/21/24 at 11:15 a.m., the Nurse Consultant, acknowledged the concern regarding this resident going without her Fentanyl patch from 8/19/24 at 6:00 p.m. to 8/21/24 at 10:30 a.m. She also acknowledged that the facility's provider wrote a prescription for the Fentanyl patch yesterday morning 8/20/24, and it wasn't put in until 10:20 a.m. on this day 8/21/24. On 8/21/24 at 12:14 p.m., Staff K stated the pharmacist sent an electronic request. She stated she did write the order to hold the Fentanyl patch. Staff K stated she did not call the provider. Staff K stated another nurse wrote a fax or a note on the provider's clipboard. Staff K stated she wrote the order to hold the Fentanyl because it showed up in the medication administration record to apply the patch and she did not have the Fentanyl patch to apply. So she wrote the order to hold it until the provider could see the note from the other nurse. When asked if Resident #109 appeared to be in pain that night, Staff K stated that Resident #109 said she was in severe pain that night. Staff K stated she did give her the scheduled morphine but did not give her any PRN (as needed) morphine. Staff K stated Resident #109 has had a lot of pain, since she had fallen and broken her hip. She said her pain had worsened and since she was in Hospice they don't want to fix the fracture. A Pain policy revised on 9/2017 directed the following: Physicians shall help manage individuals with pain, including identification and management of causes. Outcomes 1. Pain will be identified and managed appropriately. 2. Factors that cause or exacerbate pain or increase the risks of having pain will be identified and addressed, to the extent possible. 3. Pain medications will be ordered and used appropriately. Recognition 1. The physician and staff will identify individuals who have pain or who are at risk for having pain. This includes reviewing known diagnoses and conditions that commonly cause pain; for example, degenerative joint disease, rheumatoid arthritis, osteoporosis (with or without fractures), diabetic neuropathy, oral or dental pathology, and post-stroke syndromes. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	It also includes a review of any current treatments for pain, including any complementary and non-pharmacologic treatments. 2. The staff and physician will identify the characteristics (severity, location, intensity, frequency, duration, etc.) of pain. Staff should use a consistent pain assessment approach appropriate to the resident/patient's cognitive level. 3. The staff and physician will evaluate how pain is affecting mood, activities of daily living, sleep, and quality of life, as well as contributing to complications such as deconditioning, gait disturbances, social isolation, and falls. Diagnosis/Cause Identification 4. The physician will help identify causes of pain; for example, by reviewing the patient's history, examining the patient directly, and having a sufficiently detailed discussion with the patient and staff. 5. The physician will help identify the extent to which underlying causes of pain can be addressed or reversed. 6. The physician will order appropriate tests as needed to help clarify aspects of pain (location, cause, etc.). For example, an x-ray may help to identify the cause of joint pain. Treatment/Management 7. With input from the resident/patient to the extent possible, the physician and staff will establish goals of pain treatment; for example, freedom from pain with minimal medication side effects, less frequent headaches, or improved functioning, mood, and sleep. 8. The physician will order appropriate non-pharmacologic interventions and medications to address the individual's pain, consistent with recognized protocols and guidelines. Generally, and to the extent possible, an analgesic regimen should utilize the simplest regimen and lowest risk medications before using more problematic or higher risk approaches. Opioid use-especially, but not solely, related to the management of chronic non-cancer pain-should be consistent with relevant information about the limitations and risks of such medications. 9. Staff will provide the elements of a comforting environment and appropriate physical and complementary interventions; for example, local heat or ice, repositioning, and massage. 10. For the individual who is receiving opioid analgesics, the physician will order measures to prevent constipation. Monitoring (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	11. The staff will reassess the individual's pain and its consequences at regular intervals; for example, at least each shift for unstable or increasing pain or significant changes in levels of chronic pain, and at least weekly for stable chronic pain. Review should include frequency, duration, and intensity of pain; ability to perform activities of daily living (ADLs), sleep pattern, mood, behavior, and participation in activities. 12. The staff will evaluate and report the resident / patient's use of standing and PRN analgesics. Depending on the characteristics of pain, the physician may start with PRN doses or supplement standing doses with PRN doses for breakthrough pain. If there are more than occasional analgesic requests, the physician will consider changing to regular administration of at least one analgesic with another medication for PRN use, increasing the standing dose of an existing analgesic, switching to another analgesic, and/or adding non-pharmacological measures. 13. Periodically the physician will evaluate and summarize the status of an individual with pain, including active conditions that exacerbate pain, consequences or complications of pain, and effectiveness of current interventions for pain. 14. The staff and physician will monitor for adverse effects of pain medications such as gastrointestinal bleeding from non-steroidal anti-inflammatory drugs (NSAIDs), or anorexia, confusion, lethargy or severe constipation related to opioids. The physician will adjust medications accordingly, based on effectiveness and side effects. 15. If the resident/patient's pain is complex or not responding to standard interventions, the attending physician may consider additional consultative support. If a consultant is involved in managing pain, the attending physician will maintain an active role by reviewing the consultant's recommendations, addressing medical issues that affect pain, monitoring for complications related to treatment, and evaluating subsequent progress. The physician should not simply defer to the consultant for all pain-related issues. 16. If pain is stable and the underlying cause is resolved or it is unclear whether a source of pain remains, the physician will consider a trial reduction or elimination of analgesic medication; for example, reduce the standing dose of an analgesic and see if there is any increase in pain-related symptoms or increased use of PRN analgesics. Reductions in opioid analgesics are especially important in light of their limited efficacy in the treatment of chronic non-cancer pain and their many diverse significant side effects. Based on results of attempted dose reductions, the physician should document a clinically significant rationale for not attempting further analgesic reduction. It should not just be assumed that the absence of pain symptoms implies the need for indefinite analgesic administration. Sometimes a trial tapering or discontinuation of analgesics is indicated to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165310	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Heritage Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Clive Drive SW Cedar Rapids, IA 52404	

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F 0697 Level of Harm - Actual harm Residents Affected - Few	determine if current medications or doses are still needed.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on observation, clinical record review, document review, resident and staff interviews, the facility failed to honor resident choice of meal items for 1 of 1 resident sampled (Resident #113). The facility identified a census of 140 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating intact cognition. The MDS identified Resident #113 with a significant weight gain and a diagnosis of lupus, anemia, and end stage renal disease. During an interview on 8/20/24 at 8:49 AM Resident #113 reported she has chosen to eat a vegetarian diet and the staff are not supporting her choice of diet. They served her an Italian club sandwich the other day with meat sauce. Other days they served her a hot dog or a hamburger. She related her physician ordered diet is a low sodium diet, but she has made it clear to the staff that she doesn't want to eat meat as she isn't digesting the meat well. On 8/21/24 at 7:45 AM Resident #113 reported they usually bring her scrambled eggs for breakfast and she has told them she cannot eat eggs. She usually just eats fruit loops and drinks chocolate milk. Resident #113 voiced she had not eaten breakfast yet. During an interview on 8/21/24 at 9:29 AM Staff C, Dietary Aide (DA) reported she was aware that Resident #113 voiced she didn't want to eat meat since she had returned from the hospital. She verbalized Resident #113 had not eaten meat for about six weeks, then last week she asked for chicken at one of the meals, which she gave her. She was aware that the resident had requested no meat. Staff C reported she served Resident #113 oatmeal, fruit loops, sausage links, and chocolate milk on her breakfast tray. On 8/21/24 at 9:31 AM Staff D, DA reported she also knew that Resident #113 had requested no meat since she had come back from the hospital. On 8/21/24 at 9:40 AM Resident #113 sat in her motorized wheelchair in her room getting ready to eat breakfast. She had a meal tray of oatmeal, fruit loops cereal, two glasses of chocolate milk, and scrambled eggs. She stated she will not eat the scrambled eggs and they know not to send her any eggs. She stated she doesn't recall ever requesting to eat chicken in the past few weeks. She stated the staff could have her confused with other residents as there are a lot of residents here. Her stomach couldn't handle digesting chicken. Resident #113 stated at least she could eat her fruit loops and chocolate milk. A 8/21/24 review of Resident #113 Care Plan lacked documentation of Resident #113 request to eat a vegetarian diet or not to be served meat and eggs. (continued on next page)

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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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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 8/07/24 2:30 PM Dietary Note documented Resident #113 on a low sodium diet, regular texture, thin liquids diet. The note lacked documentation of Resident #113 choice or preferences to be served vegetarian food items or that she requested not to be served meat or eggs. During an interview on 8/21/24 at 12:07 AM Staff A License Practical Nurse (LPN) reported she talked to the Dietician and Dietary Services Manager (DSM) both about Resident #113. She doesn't know if there is a designated person that goes over the menu with the residents, but dietary staff take the menu's out and go over it with the residents to see what they want. Staff A reported Resident #113 stated multiple times she wanted to be served a vegetarian diet. The kitchen generally does not serve her meat, but they do serve her eggs and she will not eat eggs. Resident #113 has requested a vegetarian diet for the past month. Staff A voiced she talked to the DSM that Resident #113 did not like scrambled or poached eggs. Staff A couldn't remember if the Dietician was there at the time, but she is in the facility weekly. A review of Resident #113 meal cards from 9/19/24 to 8/21/24 revealed the following: a. 8/19/24 breakfast meal card, 2 fried eggs. b. 8/19/24 lunch meal card, 3 ounces (oz.) homemade meatloaf c. 8/19/24 dinner meal card, 4 oz. roast beef sandwich d. 8/20/24 breakfast meal card, 2 scrambled eggs e. 8/20/24 lunch meal card, 3 oz baked fish f. 8/20/24 dinner meal card, 1 turkey sandwich g. 8/21/24 breakfast meal card, one 1 fried egg. h. 8/21/24 lunch meal card, 4 oz. roasted turkey. The Alerts on the meal cards was blank and the meal cards lacked documentation of Resident #113 food choices/preferences. During an interview on 8/21/24 at approximately 1:18 PM the Administrator reported part of the problem is the Housekeeping Manger is transitioning into the kitchen as the Dietary Manager and so residents are not getting asked about food choices prior to each meal. He reported Resident #113 is not being asked about her food choices prior to the meal. He reported a small group of residents are trialing a new process and only a small amount of residents are being asked about food choices. On 8/21/24 at 1:22 PM Staff E, Food Service Director reported she was aware that Resident #113 had requested no meat. She talked to Resident #113 about her breakfast meal and Resident #113 requested fruit loops and chocolate milk as she will not eat eggs. Staff E reported she had not added the preference to not serve meat or eggs on Resident #113 meal ticket as the resident had requested chicken before, but she was aware the resident had recently requested no meat. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/24 at 1:23 PM the Administrator reported he had not been made aware of Resident #113 request to not have meat served for her meals. On 8/21/24 at 2:20 PM Resident #113 reported she had been served the turkey as part of her lunch meal. Observation revealed an approximate 3-4 ounces portion of turkey on a piece of bread with mashed potatoes on the resident's plate. Resident #113 reported she could not eat the turkey. During an interview on 8/21/24 at 4:33 PM the Dietician reported that she had just been informed today (8/21/24) that Resident #113 didn't want meat. Prior, she heard Resident #113 would only take certain kinds of meat, but not that she wouldn't eat meat. When a resident is admitted , she fills out the dietary assessment and the DSM fills out the dietary preferences. Since the facility has a gap in the DSM position, the activity coordinator had been filling out the dietary preferences. The Dietician pulled up Resident #113 dietary slip and confirmed her dietary preference did not include no meat or eggs. She confirmed that Resident #113 admitted to the facility in March 2024. She expects staff to fill out a dietary communication form to inform the kitchen or the dietary staff to inform her if a resident has requested dietary changes. Once informed, she would update the residents meal card. If there is not enough information, she will go collect the information once she is back in the facility or have the DSM go get the information updated. She expressed the communication has been difficult due to the gap in the DSM position. The Food and Nutritional Services Policy dated 2001 documented each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. The Policy Interpretation and Implementation further directed the following: 1. The multidisciplinary staff, including nursing staff, the attending physician and the dietician will assess each resident's nutritional needs, food likes, dislikes and eating habits, as well as physical, functional, and psychosocial factors that affect eating and nutritional intake and utilization. 2. Reasonable efforts will be made to accommodate resident choices and preferences. 3. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive. 4. If an incorrect meal is provided to a resident or a meal does not appear palatable, nursing staff will report it to the food service manager so that a new food tray can be issued.