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	05/22/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview the facility failed to change oxygen tubing on 1 out of 1 concentrator for residents with physician orders for oxygen (Resident #14). The facility reported a census of 118 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #14 indicated a Brief Interview for Mental Status (BIMS) score of 15 which indicates no cognitive impairment. It further indicated diagnoses including: chronic obstructive pulmonary disease (COPD), respiratory failure, and anxiety. The MDS indicated Resident #14 required moderate assist from staff for transfers, bathing, dressing, and personal hygiene. Review of the Care Plan dated 4/22/24 revealed Resident #14 altered respiratory status and utilizes oxygen. Observed Resident #14 on 05/20/25 at 10:36 AM with oxygen on in their wheelchair at 1.5 liter per nasal cannula from a tank. The tubing did not have a label with date tubing was changed. The oxygen concentrator in residents room had a label with the date 5/5/25 tubing was changed. On 05/21/25 at 11:26 AM the oxygen concentrator tubing in Resident #14 room date labeled 5/5/25 and the tubing on the tank on the wheelchair still did not have a date. On 05/21/25 at 12:42 PM Staff E, Registered Nurse (RN) stated the oxygen tubing should be changed but unsure how often, I know we have a policy for that. We mark the tubing with the date, time, and initial it has been changed. The concentrator and tank tubing on the wheelchair should be changed. On 05/21/25 at 1:17 PM Staff E, RN clarified the tubing for oxygen should be changed every week. She reviewed the policy and it directs the staff to change it weekly. On 05/22/25 at 11:01 AM the Director of Nursing (DON) states the tanks and the concentrator tubing for oxygen should be changed weekly and it should be labeled with the date and initials. The facility provided a policy titled Departmental (Respiratory Therapy) - Prevention of Infection revised 2011 which directed to change the oxygen cannula and tubing every seven (7) days, or as needed.

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 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. Based on observation, clinical record review, menu review, and staff interview, the facility failed to ensure residents on a pureed diet received the correct portion sizes and food items in accordance with the menu for 1 of 1 meal observed. The facility reported a census of 118 residents. Findings include: The Diet Type Report listed 4 residents with an order for a pureed diet. On 5/20/25 at 10:00 a.m., Staff C, Dietary Services Manager Assistant stated he would prepare puree Salisbury steak for 6 residents but stated he would make 1 extra. Staff C placed 7 steaks, 3 slices of bread, and gravy into the food processor, ground this up, and placed it into a graduate which measured 3 cups. Staff C stated he wanted the total amount to be 5 cups so he added 3 more steaks, hot water, and 2 more sliced of bread. He then poured the mixture into the graduate which measured 6 cups. Staff C then looked at the Pureed Diet Portion Sizes/Scoops poster on the wall and stated he would use a #8 scoop (4 ounce). The Pureed Diet Portion Sizes/Scoops chart directed staff to utilize 2 #8 scoops for 6 cups divided by 6 servings. During the noon meal service on 5/20/25, Staff D, Dietary Staff used 1 #6 scoop (5 1/3 ounce) to serve the pureed meat. Staff D served residents on a pureed diet Salisbury steak, carrots, and bread but did not serve them whipped potatoes. During the service Staff D stated those on a pureed diet did not receive potatoes. The Cycle Day 17 Lunch Menu directed staff to serve the following items to residents receiving a pureed diet: 1 serving whipped potatoes, 1 (3) ounce serving Salisbury steak, half cup serving of pureed roasted carrots. On 5/22/25 at 12:05 p.m. the Registered Dietician stated the facility did not have policies regarding the puree and mechanical soft process. She stated when carrying out the puree process, staff would measure the total volume and then look at the chart to determine the scoop size. She stated the residents on a pureed diet should have received mashed potatoes. On 5/21/25 at 1:17 p.m., the Dietary Manager stated staff should utilize the chart for scoop sizes. He stated he expected residents to receive the correct portion sizes.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, clinical record review, policy review, and staff interview, the facility failed to consistently monitor the functioning of the dishwasher and failed to ensure adequate kitchen sanitation for 2 of 2 kitchen observations. The facility reported a census of 118 residents. Findings include: 1. The initial kitchen tour on 5/19/25 at 10:05 a.m. revealed the following concerns: a. A fan above the hand washing sink was covered with mesh and a thick layer of dust covered the mesh and the fan blades. The fan blew toward the left hand side of the dishwasher where clean dishes emerged. b. Staff B, Dietary Staff washed dishes and when requested to test the functioning of the dishwasher she obtained a strip but then stated she did not know how to complete the test. Staff B stated she did not test the machine that morning before doing breakfast dishes. The Dietary Manager was present and could not locate a log of dishwasher function tests. c. The top of the dishwasher was covered with yellow chunks of debris. d. The fire suppression system spigots had dust particles hanging from them. The Dish Machine Temperature Log for May 2025 directed staff to check the wash and rinse temperatures and parts per million (PPM) sanitizer concentration prior to each meal. The log lacked documentation staff carried this out for breakfast, lunch, and dinner from 5/15/25 to 5/17/25, for lunch and dinner on 5/18/25, and for breakfast on 5/19/25. A follow-up up visit to the kitchen on 5/20/25 at 12:57 p.m. revealed the following concerns. a. Dust remained on the fire suppression system spigots. b. Dust remained on the fan which blew toward the clean side of the dishwasher. The facility policy Sanitization, revised October 2008, stated the facility would maintain food service areas in a clean and sanitary manner and directed staff to wash all equipment to remove debris using hot water or chemical sanitizing solutions. The facility policy Dishwashing Machine Use, revised March 2010, stated the operator would check temperatures with each dishwashing cycle. On 5/21/25 at 1:17 p.m., the Dietary Manager stated moving forward, staff would check the dishwasher every day. He stated they would train all staff regarding this. He said he did not like the fans blowing toward the clean side of the dishwasher and agreed this was not a good set up.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and staff interview the facility failed to follow the Center for Disease Control and Prevention (CDC) 2025 Adult Immunization Schedule for pneumococcal vaccination for 1 of 5 residents sampled (Resident #41). The facility identified a census of 118 residents. Findings include: Resident #41 Electronic Healthcare Record (EHR) Census documented admission to the facility on 1/09/23. The EHR Immunization Record documented Resident #41 received a pneumococcal 23 vaccination on 10/15/2017 at the age of 54. A Consent for Pneumococcal Vaccination signed by Resident #41 on 1/09/23 showed the Resident circled she accepted to receive the vaccination. An Order Summary Report signed by the Provider on 10/08/24 showed an active order as of 1/09/23 for a pneumococcal vaccination to be administered if applicable. A 11/30/2024 9:31 Pharmacy Consultant Review Progress Note recommended a Prevnar 20 vaccination. A 12/28/2024 4:49 PM Pharmacy Consultant Review Progress Note recommended for nursing to get the consents for the vaccines and enter them into the EHR. The CDC 2025 Adult Immunization Schedule for Pneumococcal Vaccination for adults age [AGE] or over directed when the pneumococcal 23 is the only pneumococcal vaccination received, then one dose of PCV15, PCV20, or PCV21 should be offered at least 1 year after the last PPSV23 dose. On 5/20/25 at approximately 4:00 PM Staff A, Administrator reported Resident #41 had not received an updated pneumococcal vaccination. An Email dated 5/20/25 at 3:50 PM from the Pharmacist documented she had completed vaccination screening in December 2024. Resident #41 was under the age of 65 and had received a prior pneumococcal vaccination which was sufficient at that time. The Pharmacist further noted with the latest Association for Professionals in Infection Control and Epidemiology (ACIP) recommendations that came out in October 2024, it (updating pneumococcal vaccination) had been overlooked and she took responsibility for the oversight. The Pharmacist documented Resident #41 was eligible for a Capvaxive 21 or Prevnar 20 vaccine at that time. During an interview on 5/21/25 at 4:18 PM the Infection Preventionist verbalized she wasn't sure who was responsible for the pneumococcal status review as part of the admission process. The pharmacy had documented Resident #41 as not eligible for pneumococcal vaccination based on the 2024 CDC Immunization schedule the last time she reviewed the vaccinations. The pneumococcal vaccinations didn't happen, but should have. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Pneumococcal Policy revised October 2019 documented all residents would be offered the pneumococcal vaccine to aide in preventing pneumonia/pneumococcal infections. The Policy Interpretation and Implementation directed the following: a. Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. b. Assessments of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission. The Policy failed to address who was responsible for assessing resident eligibility for pneumococcal vaccinations.