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	05/28/2026

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 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 observations, staff interviews, and facility policy review, the facility failed to prepare food in accordance with professional standards for food safety to reduce the risk of food borne illness. The facility reported a census of 127 residents.Findings include:During continuous observation on 5/6/25 from 11:00 AM to 11:24 AM, Staff C, Dietary [NAME] washed her hands and used two towels to remove a steam pan of rice and then a steam pan of pork stir fry from the convection oven. The two towels were placed on the preparation table surface. Staff C scooped the proper amount of rice and pork stir fry for 7 pureed meals. Staff C wiped her hand on one of the towels on the preparation table. Staff C opened a bread bag and donned gloves. Staff C (with gloved hands) used tongs to place 5 slices of bread on a cutting board. Staff C operated the robo coupe with gloved hand used a scoop to add more of the liquid from the pork stir fry. With the same gloved hands, Staff C operated the robo coupe. With the same gloved hands, Staff C used tongs to remove 2 additional slices of bread from the bread bag. Staff C, placed her gloved hands on the sides of the stacked bread slices to straighten the stack of bread slices. Staff C held a knife in her right hand placing it in the middle on the stack of bread slices. Staff C placed her left gloved hand with her palm on the top slices and fingers around the edges. Staff C applied pressure to the top of the stack of bread as she pushed the knife down the stack. Staff C, sliced two additional times through the stack of bread while holding the stack of bread with her gloved left hand. Staff C turned off the robo coup and measured out 3 cups of the pureed rice and pork stir fry and left the remaining pureed mixture in the bowl of the robo coupe. Staff C replaced the bowl of the robo coupe back on the base and pushed on the blade touching the pureed mixture with right gloved hand. Staff C removed her right-hand glove and donned a clean glove. Staff C added the bread to the robo coupe using tong. Staff C with gloved hand stopped the robo coupe and measured out an additional 3 cups of the mixture to a second measuring cup. Staff C replaced the bowl to the base of the robo coupe and again pushed the blade down touching the pureed mixture with her gloved hand. Staff C removed her right glove. Staff C donned a glove on her right hand. Staff C used a rubber spatula and scraped the sides of the bowl of the robo coupe. Staff C held the rubber spatula in her right hand used her left hand to scrape off the rubber end of the spatula and again scraped the pureed mixture in the robo coupe. On 5/6/25 at 11:24 AM, Staff C, didn't recall touching the bread or the pureed mixture with gloved hands that touched multiple nonfood surfaces.On 5/6/25 at 11:25 AM, Staff E, Dietary [NAME] reported she observed the staff member cutting bread slices with gloved hands that came in contact with other surfaces. On 5/6/26 at 11:27 AM, the Regional Dietician reported Staff C shouldn't have touched the bread, pushed the robo coupe blade down or scrape off a rubber spatula with gloved hands that had touched nonfood surfaces when preparing pureed meals. Review of the employee file for Staff C contained a Job Description for the position of Cook, which listed Staff C's date of hire as 1/26/26. The Job Description directed staff to handle and prepare food in a sanitary manner, and to maintain strict compliance with established policy/practices/standards for food preparation and storage. Staff C signed the Job Description on 5/6/26. Review of the Order Listing Report with a date of 5/5/26 listed 6 residents with pureed diet texture.Review of the Food Preparation and Service facility policy revised April 2019 directed staff to adhere to proper hygiene and sanitary practices to prevent the spread of food borne illness.

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review, facility document review, and staff interview, the facility failed to notify the Long-Term Care Ombudsman of a discharge for 3 of 6 residents reviewed (Resident #13, Resident #122, and Resident #126). The facility reported a census of 127 residents.Findings include:1. Review of the electronic health record (EHR) Clinical Census information for Resident #13 revealed an entry of hospital paid leave effective 3/28/26. A Progress Note dated 3/29/26 at 6:34 AM documented Resident #13 had been admitted to the hospital. Review of the Notice of Transfer Form to Long Term Care Ombudsman lacked Resident #13's 3/28/26 hospitalization. 2. Review of the EHR Clinical Census information for Resident #126 revealed an entry of hospital paid leave effective 2/24/26 and an entry of stop billing effective 2/28/26. A Progress Note dated 2/24/26 at 1:56 PM documented Resident #126 had been sent to the emergency room for surgical opinion. The Progress Notes lacked documentation Resident #126 had been admitted to the hospital. A Progress Note dated 2/27/26 at 12:00 PM documented Resident #126 was being discharged . Review of the Notice of Transfer Form to Long Term Care Ombudsman lacked Resident #126's 2/24/26 hospitalization and the 2/28/26 discharge. During an interview on 5/6/26 at 9:42 AM, Staff A, Interim Social Services reported Resident #13 and Resident #126 had not been included on the Notice of Transfer Form to Long Term Care Ombudsman. During an interview on 5/6/26 at 12:05 PM, the Administrator revealed the facility lacked a policy and acknowledged Resident #13 and #126 should have been included in the notifications to the LTC Ombudsman. 3. Review of the EHR Clinical Census information for Resident #122 revealed an entry of hospital unpaid leave effective 3/26/26. A Progress Note dated 3/26/26 at 6:50 PM documented Resident #122 had been admitted to the hospital. The Notice of Transfer Form to Long Term Care Ombudsman lacked Resident #122's 3/26/26 hospitalization.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and facility policy review the facility failed to complete the Minimum Data Set (MDS) assessments to accurately reflect resident condition for a feeding tube, and to accurately reflect Preadmission Screening and Resident Review Level II for 2 of 4 residents reviewed (Resident #3 and Resident #105). The facility reported a census of 127 residents.Findings Include:1. The Minimum Data Set (MDS) assessment for Resident #3 dated 8/23/25 showed Resident #3 was not considered by the state level II Preadmission Screening and Resident Review (PASRR) process to have serious mental illness and/or intellectual disability or a related condition. The MDS listed diagnoses of depression and Post Traumatic Stress Disorder (PTSD). Resident #3's chart held the Notice of PASRR Level II Outcome dated 3/27/25. The Level II directed Resident #3 needed the level of services provided in a nursing facility and needed specialized services for behavioral health and/or developmental condition. On 5/07/26 at 12:10 PM, Staff G, MDS Coordinator confirmed according to the MDS dated [DATE] for Resident #3, not considered by the state level II Preadmission Screening and Resident Review (PASRR). Staff G confirmed the MDS failed to show serious mental illness, intellectual disability or other related conditions. Staff G confirmed the assessment failed to show the completion of the Level II. Staff G opened the Level II dated 3/27/25. Staff G reported the facility expected the MDS accurate. 2. The Care Plan Report for Resident #105 with a revision date of 2/27/26 identified a Focus Area for tube feeding. Staff were directed to check for placement and gastric contents/residual volume per facility protocol and record (initiated 2/26/26). Resident #105's MDS assessment dated [DATE] included a Brief Interview for Mental Status (BIMS) of 5 out of 15, indicating severe cognitive impairment. MDS Section K Swallowing/Nutritional Status for Resident #105 lacked documentation of a feeding tube. MDS Section Z Assessment Administration documented, in part, [staff who completed the assessment] certified the accompanying information accurately reflects resident assessment information for this resident. Staff B, Registered Nurse (RN) signed the completed Section K Swallowing/Nutritional Status on 4/9/26. Review of the Hospital Progress to Discharge summary dated [DATE], documented Resident #105 had a Left PEG tube (a flexible feeding tube inserted through the abdomen into the stomach to deliver nutrition, fluids, and medications directly) with site c/d/i (clean, dry, intact). The Order Review History Report electronically signed by the Physician on 4/1/26 included the following: a. Enteral Feed Order every shift Flush feeding tube with at 50ML of water before and after administration of feedings on hold from 04/06/2026 11:08 AM to 04/06/2026 4:51 PMb. Enteral Feed Order five times a day Formula Type / Strength: 1.5 Osmolyte 290 ML 5 times dailyc. Enteral Feed Order three times a day Check Residual every shift if less than 30ML note in progress note. On hold from 04/06/2026 11:08 AM to 04/06/2026 16:51 During an observation on 5/6/26 at 9:57 AM, Staff C, Registered Nurse (RN) provided Resident #105 with 50 ML of water before and after administration of feeding and 290 ML of Osmolyte feeding. Staff C acknowledged Resident #105 had the feeding tube since admission. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/26 at 1:16 PM, Staff B, MDS Coordinator Registered Nurse (RN) verbalized she was responsible for completing the MDS. Staff B acknowledged Resident #105 has had a feeding tube since his original admission on [DATE]. Staff B verbalized the MDS assessment dated [DATE] was inaccurately coded. On 5/6/26 at 1:21 PM, the Administrator voiced the expectation was the MDS should accurately reflect the resident condition. The MDS Completion and Submission Timeframes facility policy revised July 2017 revealed the Assessment Coordinator or designee is responsible for ensuring that resident assessments are submitted to [redacted] system in accordance with current Federal and State Guidelines.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview, and record review, the facility failed to ensure post dialysis assessments and fistula assessments were consistently completed in accordance with physician orders, facility policy, and the comprehensive care plan for 1 of 2 residents reviewed for dialysis (Resident #84). The facility reported a census of 127 residents.Findings include:Review of the Minimum Data Set (MDS) assessment for Resident #84 dated 2/27/26 revealed a Brief Interview for Mental Status score of 15 out of 15, which indicated intact cognition. Per this assessment, the resident had a diagnosis of dependence on renal dialysis, and received dialysis while a resident. Review of Resident #84's Care Plan focus area dated 5/6/25 revealed the resident received hemodialysis related to end stage renal disease (ESRD), and had an arteriovenous (AV) fistula to the left upper extremity (LUE). The Intervention dated 5/6/25 revealed staff to listen to and feel the dialysis site (the fistula) to ensure it was functioning correctly. This was required before dialysis, after dialysis, and on days without dialysis.During an observation and interview on 5/5/2026 at 8:17 AM, Resident #84 explained that while nurses checked her vital signs before she left for dialysis, they often failed to check her afterward or on days when she didn't have an appointment. Resident #84 pulled up her left sleeve and showed the fistula site. She expressed that this worried her because she was afraid of medical complications. In a follow-up interview the next day on 5/6/2026 at 8:32 AM, she noted that no one had checked her dialysis access site at all the previous day. She felt ignored.Review of Resident #84's electronic medical records showed the following present on the resident's April 2026 Supplemental Documentation Record: a. Complete the Dialysis Evaluation prior to dialysis, post dialysis and on non-dialysis days. every day shift every Tues, Thurs, Sat, Sun.b. Complete the Dialysis Evaluation prior to dialysis, post dialysis and on non-dialysis days. two times a day every Mon, Wed, Fri. Records revealed the following: On 4/16/2026 and 4/26/2026 (non-dialysis days), nurses signed off the assessment was done, but the actual evaluation data was missing. On 4/17/2026 (dialysis day), the facility failed to perform the required check after the resident returned from treatment.During an interview on 5/06/2026 at 9:11 AM Staff F, LPN (Licensed Practical Nurse) confirmed that staff were expected to evaluate dialysis residents every day. This included checking the dialysis site for a thrill and bruit (the vibration and sound that indicate the site was working properly) and vital signs. Staff F stated that these checks were supposed to happen before and after every dialysis appointment.During an interview on 5/06/2026 at 12:25 PM, the Director of Nursing (DON) stated that all staff had received online training for dialysis care. The DON acknowledged that while nurses were supposed to assess residents both before and after their appointments, the post-dialysis checks did not always happen. The DON also mentioned that daily checks on non-dialysis days only occurred if a doctor specifically ordered them, and any missed checks should have been documented as refused or noted if the resident was out of the buildingReview of the facility policy titled End-Stage Renal Disease, Care of a Resident with last revised September 2010 revealed staff caring for residents with ESRD, including residents receiving dialysis care outside of the facility, shall be trained in the care and special needs of these residents. Education and training of staff includes, specifically the type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. Based on observation, clinical record review, and interviews the facility failed to address trauma history, PTSD triggers, signs of distress, non-pharmacological interventions, or medication in assessments and care plans for 1 of 1 residents reviewed for Post Traumatic Stress Disorder (PTSD) (Resident #112). The facility reported a census of 127 residents.Findings include:admission paperwork for Resident #112 scanned to the facility on 2/20/2026 documented the resident took 1 milligram (mg) of prazosin at bedtime for chronic PTSD with trauma related nightmares. Resident #112's care plan with an admission date of 3/02/2026 did not include focus areas, goals, or interventions for PTSD, nightmares, trauma, or prazosin.The Minimum Data Set (MDS) for Resident #112 dated 3/08/2026 documented a Brief Interview for Mental Status score of 3/15 which indicated severe cognitive impairment. MDS diagnoses included non-Alzheimer's dementia, anxiety disorder, and depression. The box for PTSD was not checked.A document titled Progress Notes dated 4/07/2026 revealed the resident's provider conducted a regulatory visit at the facility. The past medical history did not include PTSD.The task section of the Electronic Health Record (EHR) included monitoring behavior symptoms. A 30 day look back revealed that on 4/13/2026 the resident was documented crying, yelling, pushing, and grabbing. On 04/16/2026 the facility documented the resident yelled/screamed.The resident's Medication Administration Record (MAR) for May 2026 retrieved 5/04/2026 at 1:47 PM documented the resident received prazosin HCl oral capsule 1 mg by mouth one time a day for chronic PTSD with night terrors. The MAR did not include behavior monitoring.On 5/04/2026 at 11:04 AM observed the resident call out from her bed with the sound ah ah ah ah ah ah. Her speech was mostly garbled then she clearly stated her head hurt. The resident closed her eyes and called out again in a higher pitch. Her head moved back and forth on the pillow.On 5/06/26 at 7:42 AM heard resident hum then call out with a loud, repetitive sound. After about a minute she yelled, ahhhhhhhh.At 9:12 AM on 5/07/2026 Staff I, Licensed Practical Nurse (LPN) indicated staff monitor for agitation, aggressive behavior, and residents seeking a lot of attention. She reported Resident #112 yelled and screamed sometimes when she was out of her room and called out when she was in bed, and she didn't really know what caused it. She stated it was addressed with scheduled and as needed medications. She was not aware of a PTSD diagnosis or nightmares/night terrors. She would address it by sitting with a resident and reassure them if she knew it was happening.During an interview on 5/07/2026 at 9:23 AM Staff J, Certified Nurses Aide (CNA) stated she watched residents for threatening, combative, sexual, emotional, and health changes and reported them to the nurse. Staff J reported it was normal for this resident to call out. She wasn't sure what caused it. When asked if she was aware of the resident's PTSD diagnosis or night terrors, she stated she didn't know about that because she didn't work at night. She didn't think it happened during the day, only when she did that 'screaming out thing' maybe.On 5/07/2026 at 10:04 AM Staff K, Assistant Director of Nursing (ADON) confirmed the resident's EHR did not include a diagnosis of PTSD. Because the resident was on a medication for PTSD, the ADON stated she would expect it to show on the list of diagnoses, the care plan, the MDS, and hospice information. She thought the facility would be responsible for identifying triggers, monitoring mood and behaviors, would have regular behavior documentation, should know what led to the PTSD diagnosis, and have a plan for non-pharmacological interventions. She was unable to find that in the resident's EHR.On 5/07/2026 at 10:38 AM the DON confirmed the resident was on prazosin for chronic PTSD with night terrors. She reported the resident admitted to the facility from home and coordination could be difficult. She wasn't sure about the cause of the PTSD or triggers, and stated the social worker who would have addressed that was no longer there. At 12:22 PM, she stated they did locate the diagnosis on the admission orders and confirmed it did not get transferred to the resident's EHR.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interviews, record review, and policy review the facility failed to maintain documentation of staff screening and education regarding COVID vaccination, or maintain records of staff vaccination status. The facility reported a census of 127 residents.Findings include:On 5/07/2026 at 10:16 AM Staff K, Assistant Director of Nursing (ADON), stated she was the facility's infection preventionist. When asked when staff received education regarding COVID testing and vaccination, she stated the same provider who vaccinated residents could give the education to staff. Staff K did not have documentation of who received that education. She indicated she would have to see if there was COVID training in (redacted) their training platform or during orientation because she wasn't involved in all of that. During an interview on 5/07/2026 at 10:38 AM the Director of Nursing (DON) reported the staff received COVID education through (redacted) their training provider. The DON directed back to Staff K for documentation regarding COVID based on her role as infection preventionist. A document titled 2026 Annual CNA (Certified Nurses Aide) Training Schedule updated 02/16/2026 documented staff training by quarter. The list did not include COVID education. An email from the Administrator, dated 05/07/2026 at 11:39 AM included a COVID-19 fact sheet dated 1/31/2025. She indicated that was their COVID education. She did not include information about when staff were provided the education, who received it, how often, or how staff were screened. During an interview on 5/07/2026 at 12:19 PM Staff H, Certified Medication Aide (CMA) stated she had worked at the facility for about 2 years. She reported she was not asked by the facility for her vaccination status, was not offered the COVID vaccine or told where to get one, and the facility did not provide COVID education to her on paper or in person. She thought there might have been a training online but she couldn't remember when. During a follow up interview with Staff K on 5/07/2026 at 12:23 PM she stated she couldn't say if they had any additional documentation that staff were screened for vaccination eligibility, provided COVID education, were offered the vaccine or told where to get it, or if the facility administered the vaccine to any staff through their vaccination partner. A policy titled Coronavirus Disease (COVID-19) - Vaccination of Residents and Staff dated February 2021 indicated staff eligible to receive the COVID-19 vaccine were strongly encouraged to do so. Staff consent would be documented in the employee health record. Staff would be provided a fact sheet specific to the vaccine he or she will receive that explained risks and benefits, contraindications, and potential side effects or adverse reactions.