<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
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<th>TAG</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F000</td>
<td>INITIAL COMMENTS</td>
<td></td>
<td>F000</td>
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<td>F000</td>
</tr>
<tr>
<td></td>
<td>Correction date 2/4/16</td>
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<td>F281</td>
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<td></td>
<td>The following deficiencies relate to the facility's annual health survey. (See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C)</td>
<td></td>
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<td>F281</td>
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<tr>
<td></td>
<td>Incident #57076 was not substantiated.</td>
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<td>F281</td>
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<tr>
<td>S281</td>
<td>483.20(k)(3) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</td>
<td></td>
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<td>F281</td>
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<td></td>
<td>The services provided or arranged by the facility must meet professional standards of quality.</td>
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<td>F281</td>
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<tr>
<td></td>
<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>F281</td>
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<tr>
<td></td>
<td>Based on clinical record review and staff interview, the facility failed to follow physician orders as directed for one of fifteen residents reviewed. (Resident #17) The facility census was 129 residents.</td>
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<td>F281</td>
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<td></td>
<td>Findings include:</td>
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<td>F281</td>
</tr>
<tr>
<td></td>
<td>1. The Minimum Data Set (MDS) Assessment dated 12/7/15, revealed Resident #17 had diagnoses that included Schizophrenia and anxiety and required extensive assistance for transfers, ambulation, toileting, dressing, bathing and personal hygiene.</td>
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<td>F281</td>
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<td></td>
<td>A Physician order dated 4/6/15, documented an order for Risperdal (an anti-psychotic medication) 1 milligram (mg) daily at the hour of sleep.</td>
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<td></td>
<td>The physician ordered the Risperdal dosage</td>
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<td>F281</td>
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</tbody>
</table>

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 patient. (See Instructions.) Except for nursing homes, the findings stated above are disclosed 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 disclosed 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued program participation.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(H1) PROVIDERSUPPLIERS/CLIA IDENTIFICATION NUMBER:
H5310

(H2) MULTIPLE CONSTRUCTION
A. BUILDING ________________
B. WING ________________

(H3) DATE SURVEY COMPLETED
01/04/2016

NAME OF PROVIDER OR SUPPLIER
HERITAGE SPECIALTY CARE

ADDRESS, CITY, STATE, ZIP CODE
290 CLIVE DRIVE SW
CEDAR RAPIDS, IA 52404

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID
PREFIX
TAG

F 281
Continued From page 1
declined to 0.75 mg daily at hour of sleep on
11/9/15, the order was sent to the facility via
facsimile (fax) on 11/11/15.

Review of the November, 2015 and December,
2015 medication administration records revealed
the Risperdal dose reduction was not
implemented.

During interview on 12/31/15 at 2:25 p.m., Staff
N, MDS nurse stated nursing staff were supposed
to note physician orders when they were received
by fax. Staff N stated staff failed to implement the
Risperdal dose reduction as directed.

F 387
483.40(c)(1)-(2) FREQUENCY & TIMELINESS
OF PHYSICIAN VISIT

The resident must be seen by a physician at least
once every 30 days for the first 90 days after
admission, and at least once every 90 days
thereafter.

A physician visit is considered timely if it occurs
not later than 10 days after the date the visit was
required.

This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff
interview, the facility failed to the physician
completed resident visits every 60 days for three
of fourteen resident reviewed. (Resident #1, #4 &
#5) The facility census was 129 residents.

Findings include:
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LCD IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE cross-referenced to the appropriate DEFICIENCY)</th>
<th>DATE COMPLETION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 387</td>
<td>087</td>
<td></td>
<td>Continued From page 2 1. The Minimum Data Set (MDS) assessment dated 11/19/15, documented Resident #1 had diagnoses that included right femur fracture, seizure disorder and dementia and required extensive assistance for dressing, toileting, eating and bed mobility. The clinical record revealed the nurse practitioner visited on 1/23/15. The next visit was completed 3 months and 12 days later on 5/15/15. During interview on 12/31/15 at 9:45 a.m., the Director of Nursing (DON) reported the facility was looking for a physician visit. 2. The MDS assessment completed 10/28/15, documented Resident #4 had diagnoses that included heart failure, ulcerative colitis and Non-Alzheimer's disease and required extensive assistance with all activities of daily living. Review of the physician progress notes revealed no documentation of physician visits for 4 months from 5/15/15 through 9/10/15. 3. The MDS assessment completed 9/21/15, documented Resident #5 had diagnoses that included multi-drug resistant organism, neurogenic bladder, diabetes mellitus and urinary tract infection. Review of the physician progress notes dictated by the nurse practitioner revealed no documentation of physician visits for 4 months from 7/21/15 through 11/10/15.</td>
<td>F 387</td>
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<tr>
<td>F 441</td>
<td>441</td>
<td></td>
<td>483.05 INFECTION CONTROL, PREVENT</td>
<td>F 441</td>
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F 441 | 441 | | 483.05 INFECTION CONTROL, PREVENT |
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<th>ID</th>
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<tbody>
<tr>
<td>F 441</td>
<td>Continued From page 3</td>
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<td>F 441</td>
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<td>01/04/2016</td>
</tr>
<tr>
<td>SS&gt;D</td>
<td>SPREAD, LINENS</td>
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</table>

**The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.**

(a) **Infection Control Program**
- The facility must establish an Infection Control Program under which it -
  1. Investigates, controls, and prevents infections in the facility;
  2. Decides what procedures, such as isolation, should be applied to an individual resident; and
  3. Maintains a record of incidents and corrective actions related to infections.

(b) **Preventing Spread of Infection**
- (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
- (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
- (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) **Linen**
- Personnel must handle, store, process and transport linens so as to prevent the spread of infection.
<table>
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<tr>
<th>F 441</th>
<th>Continued From page 4</th>
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<tbody>
<tr>
<td></td>
<td>This REQUIREMENT is not met as evidenced by:</td>
</tr>
<tr>
<td></td>
<td>Based on observation, clinical record review, facility policy review and staff interview, the facility failed to disinfect the mechanical lift after use for two of three residents in contact isolation. The facility census was 129 residents.</td>
</tr>
<tr>
<td></td>
<td>Findings Include:</td>
</tr>
<tr>
<td></td>
<td>1. The Minimum Data Set (MDS) assessment completed 10/26/15, documented Resident #4 had diagnoses that included heart failure, ulcerative colitis and Non-Alzheimer's disease and required extensive staff assistance with all activities of daily living.</td>
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<tr>
<td></td>
<td>During observation on 12/30/15 at 7:33 a.m., after Staff C, certified nurse aide, CNA and Staff G, CNA used the EZ Way Smart mechanical lift in the resident's room with contact precautions. Staff G did not disinfect the lift after removing it from the room and placing it in the hallway.</td>
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<tr>
<td></td>
<td>During interview on 12/31/15 at 9:35 a.m., the director of nursing reported Resident #4 returned from hospital with MRSA in the nares, asymptomatic. The DON reported she would expect staff to wipe the lift down with Cavi wipes, Century 256 disinfectant spray after use in a resident's room with contact precautions.</td>
</tr>
<tr>
<td></td>
<td>2. The MDS assessment completed 12/8/15, documented Resident #7 had diagnoses that included heart failure, multi-drug resistant organism and neurogenic bladder and required extensive staff assistance with most activities of daily living.</td>
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</tbody>
</table>
Continued From page 5

Observation on 12/30/15 at 12:10 p.m., revealed Staff G, CNA pushing the EZ Way Smart mechanical lift out of the resident's room and into the hallway without disinfecting it after use.

During interview on 12/31/15 at 9:15 a.m., Staff C, CNA reported staff should disinfect the mechanical lift with sanitizer wipes after use in a resident's room with contact precautions.

A review of the infection control policy dated September 2012 titled: standard precautions directed staff to have procedures for routine care, cleaning and disinfection of environmental surfaces (i.e., beds, bedrails, bedside equipment, and other frequently touched surfaces). Ensure procedures are being followed. Contact precautions barriers include: gowns when entering the room if contact with the resident or environmental surfaces, or items in the resident room is anticipated.
Plan of correction for Prefix Tag F281:

Please accept this as the credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law. Professional standards of quality will be provided by:

Resident #17’s physician was contacted by facility designee on 12-31-15 and initiation of the dose reduction was corrected on 1-1-2016. Facility has developed a system to track gradual dose reductions to ensure timely initiation of reductions as indicated by the physician. Monitor by Director of Nurses or designee through quality assurance meeting with a compliance of 2-4-2016.

Plan of correction for Prefix Tag F387

Please accept this as the credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law. Professional standards of quality will be provided by:

Residents #1, #4, #5 have all had recent physician visits. Facility Administrator hired a medical records position on 1-19-2016 to assist with tracking and contacting physicians when required to visit patients per regulatory standards. Monitor through Quality Assurance Processes and periodic audits. Compliance 2-4-2016.

Plan of correction for Prefix Tag F441

Please accept this as the credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law. Professional standards of quality will be provided by:

Director of Nurses or Designee will educate certified nursing assistant staff of the process for disinfecting equipment for residents with contact precautions by 2-4-2016 to assist with preventing contamination. Periodic audits will be performed by Director of Nurses or Designee and report to the Quality Assurance Process with any issues. Compliance 2-4-2016.