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 _____	C 12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE SPECIALTY CARE	200 CLIVE DRIVE SW CEDAR RAPIDS, IA 52404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
OK/TAG ✓	Correction Date: 12/28/2022 The following deficiencies resulted from an On-Site Revisit of a Focused Infection Control & Complaint Survey ending November 1, 2022 and the investigation of Complaints #108947-C, #108953-C #109215-C and #109493-C, and Facility Self-Reported Incidents #109092-I, #109093-I and #109121-I conducted December 12, 2022 to December 15, 2022. The deficiencies from the Revisit were corrected with new deficiencies cited. Complaint #109215-C was substantiated. Complaints #108947-C, 108953-C were not substantiated. Complaint 109493-C was substantiated with no deficiency. Incidents 109121-C, 109092-I, and 109093-I were not substantiated. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.		"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Heritage Specialty Care does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in	F 609	**F609** *The facility strives to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Andrea K. Zyck, Administrator | 12/29/2022

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.

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F 609	Continued From page 1 serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews, and facility policy review, the facility failed to report an incident of a resident to resident altercation (Residents #15 and #16). The facility reported a census of 139 residents. Findings Include: 1. The Minimum Data Set (MDS) Assessment Tool dated 12/12/2022 revealed Resident #15 with no memory impairment, required extensive assistance to transfer from one surface to another and used a wheel chair for mobility. The Care Plan identified the resident used a mechanical lift for all transfers, had a risk for falls initiated 6/10/2022 and directed staff to provide a safe environment without clutter and encourage to use call light. On 12/1/2022 the Care Plan documented the resident received anticoagulant	F 609	***Corrective action taken for residents found to have been affected by deficient practice:*** State Survey Agency is aware of the resident to resident altercation involving residents #15 and #16. ***How the center will identify other residents having potential to be affected by the same deficient practice:*** Any resident that resides in the facility has the potential to be affected. ***What changes will be put into place to ensure that the problem will be corrected and will not recur:*** Interdisciplinary team was educated on reporting requirements for allegations of abuse, including resident to resident altercations. Administrator or designee will monitor allegations of abuse and resident to resident altercations to ensure they are reported timely and appropriately to the State Survey Agency x4 weeks. ***Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent:*** Identified concerns shall be reviewed by the facility's QAPI Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance.	12/28/2022

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F 609	Continued From page 2 medication and directed staff to monitor for side effects including unusual bruising, bleeding gums, purpura and changes in mental status, and effectiveness. The 11/9/2022 Progress Notes failed to include documentation regarding a resident to resident altercation between Resident #15 and #16. On 12/8/2022, Staff B, Licensed Practical Nurse (LPN) documented in the Progress Notes at 5:04 p.m. an incident involving Resident #15 and Resident #16. On 12/9/2022 at 9:37 a.m., an unidentified staff struck out the Progress Note and labeled it "incorrect documentation". During an interview on 12/13/2022 at 10:40 a.m., Resident #15 reported Resident #16 hit her several times. One incident occurred while Resident #15 spoke to her sister on the phone. Resident #16 wheeled up to her and hit her knee cap. Resident #15 said "ouch" and her sister asked why. Resident #15 indicated Resident #16 had hit her on the arm several times but never left a bruise. The last time, Resident #15 sat near the Nurse's Station with her coat on and the nurse nearby, Resident #16 pinched Resident #15 on the upper arm and she could feel it even though she had her coat on. Sometimes Resident #15 reported, she had to holler to get staff's attention if Resident #16 was getting too close. Resident #15 revealed she did not want it to happen anymore, and she tries to avoid Resident #16, but it happens too fast at times. Observation on 12/14/2022 at 2:45 p.m. revealed Resident #15 had no visible marks or bruises on her left upper arm.	F 609		

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F 609	Continued From page 3 2. The MDS dated 11/7/2022 revealed Resident #16 with severely impaired cognitive skills for daily decision making, required limited assistance of two staff for transfers, supervision or oversight of two staff for locomotion, and used a wheel chair for mobility. The Care Plan revealed the resident had diagnoses including traumatic subarachnoid hemorrhage with loss of consciousness, and identified the potential for a poor mood state due to diagnosis of brain injury after motor vehicle accident, anxiety and depression. The Care Plan had entries documented on the following times: a. On 11/2/2022 the Care Plan added: assist resident to listen to music as needed, it can be calming. b. On 11/9/2022 the resident hit another resident. c. On 11/10/2022 the Care Plan added: Observe for the potential that I may become angry with other residents and want to strike them, redirect me away from others as needed. d. On 12/09/2022 the facility provided the resident with a radio. e. On 12/10/2022 the Care Plan directed staff to observe for mood state and try to locate the source of the poor mood when observed, and report any significant changes in mood state to appropriate staff and/or Medical Doctor (MD). The Progress Notes dated 11/9/2022 at 4:39 p.m., revealed Staff B, LPN received a one time physician order for Seroquel, 25 milligrams (mg), an antipsychotic, and gave Atvian, an antianxiety medication, related to resident hitting other residents on the unit, Physician and Nurse Manager notified.	F 609		

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F 609	Continued From page 4 On 11/10/2022 at 10:49 staff received a new Physician Order to increase the resident's Seroquel to 50 mg two times a day. On 12/8/2022, Staff B, LPN documented in the Progress Notes at 5:04 p.m. an incident involving Resident #15 and Resident #16. On 12/9/2022 at 9:37 a.m., an unidentified staff struck out the Progress Note and labeled it "incorrect documentation". The Incident Descriptions dated 11/9/2022 revealed Resident #16 rolled her wheel chair towards Resident #15, and before Staff U, Registered Nurse (RN) could get down the hall, Resident #16 hit Resident #15 with an open hand on the left forearm. No injuries noted at the time of the incident. Staff separated the residents and Resident #15 stated "this is the last time she is going to hit me?". The Self Report included Resident #15 stated her coat cushioned the hit and although she felt the hit, it was not hard enough to cause injury. Corrective Action Description: The two residents were immediately separated with additional awareness to monitor Resident #16 throughout the next several hours. The Incident Description documented on 12/8/2022 at 3:00 p.m. by Staff B, LPN and struck out on 12/9/2022 at 9:36 a.m. The report included Staff B heard commotion behind her while getting medications ready, and witnessed Resident #16 had her hand wrapped around Resident #15's left biceps and was saying repeatedly "stay out of my house". Staff B immediately separated the residents, assessed the area and found no marks or bruising, Physician, Director of Nursing (DON), Facility Manager, notified.	F 609		

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F 609	Continued From page 5 During an interview on 12/12/2022 at 3:30 p.m., Staff B, LPN reported on 12/8/2022 Resident #16 had her hand around Resident #15's biceps and said "Stay the F--- out of my house". Staff B separated them, assessed the residents, reported it to the director of nursing, assistant director of nursing and completed an incident report regarding the unwanted touch. Staff B indicated this was the second incident between the two residents. Staff B noted the Incident Report and the Progress Note regarding the incident were struck out by Staff V, Interim DON. Staff B indicated any unwanted touching from one resident towards another needed to be reported to the Department of Inspections and Appeals (DIA) and let them determine what needs to be done. On 12/13/2022 at 8:50 a.m. Staff V, RN/Interim Director of Nursing, reported Staff B told her what happened between Resident #15 and Resident #16. Staff B reported Resident #16 was the aggressor and grabbed Resident #15's arm and it left no marks and there was no aggression. Staff V reported to Staff W, Administrator and they decided they were not required to report the incident to DIA. Staff V let Staff B know they would not be reporting it and Staff B indicated she would be charting on the incident. On 12/9/2022 Staff V and Staff W reviewed reports in Point Click Care and Staff W directed Staff V to strike out the Incident Report. When she did that, it also struck out the Progress Note since the two were linked. On 12/13/2022 at 9:10 a.m., Staff W, Administrator reported she directed Staff V to strike out the Incident because it documented	F 609		

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F 609	Continued From page 6	F 609		

"physical aggression" and since the incident did not involve hitting or clawing, she decided it needed to be labeled "other". If Resident #16 would have clawed, slapped or left a mark, the facility would have reported it to DIA.

On 12/13/2022 at 1:30 p.m., Staff U, Interim Assistant Director of Nursing (ADON) reported on 11/9/2022 as she walked down the hall, she observed Resident #16 grab Resident #15's forearm before she could reach her. Resident #15 went to her room and reported she would tell her family. Staff U made out an Incident Report because it was a resident to resident altercation. A facility must report all resident to resident incidents to DIA. Music calms Resident #16, and if someone rolls past her, crossing her line of vision, she will roll towards them, cuss at them and possibly grab them. If a resident hits or pinches another resident, staff need to complete an Incident Report.

Review of the facility Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating Policy dated April, 2021 and received 12/13/2022 at approximately 2:30 p.m. included:
a. All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management.
b. Findings of all investigations are documented and reported.
c. The policy failed to include resident to resident altercations/abuse.

Review of the Weekly Risk Meeting Worksheet dated 11/17/2022, revealed the facility reviewed

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F 609	Continued From page 7 the resident to resident altercation between Resident #15 and Resident #16 with no further concerns. Review of the All Staff Meeting conducted on 11/17/2022, included Abuse Reporting of all potential incidents to the On-Call Nurse and Administrator. All abuse allegations will result in an investigation of all parties involved. The revised Abuse Policy received 12/13/2022 at 3:30 p.m. from Staff W included: Policy Interpretation and Implementation: The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: B., other residents.	F 609	**F676** *The facility strives to ensure that residents are given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. Including: Hygiene-bathing, dressing, grooming, and oral care; Mobility-transfer and ambulation, including walking; Elimination-toileting; Dining-eating, including meals and snacks; and Communication including speech, language, and other functional communication systems.* ***Corrective action taken for residents found to have been affected by deficient practice:*** Residents #8, #10, #11, #12, and #15 are offered and provided 2 baths per week. ***How the center will identify other residents having potential to be affected by the same deficient practice:*** Any resident that resides in the facility has the potential to be affected. ***What changes will be put into place to ensure that the problem will be corrected and will not recur:*** Nursing staff were educated on offering baths to residents according to their scheduled bath days, and documenting if the bath was completed or if it was refused. Administrator or designee will randomly audit completion and documentation of baths 3 times per week for 4 weeks. ***Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent:***	
F 676 SS=E	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b)	F 676		

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F 676	Continued From page 8 of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews and policy review, the facility failed to provide 2 baths a week for 5 of 11 residents reviewed (Resident #8, #10, #11, #12 and #15). The facility reported a census of 139. Findings Include: 1. According to the Minimum Data Set (MDS) dated 11/20/2022, Resident #8 with diagnoses which included renal sufficiency, diabetes mellitus, hip fracture and Non-Alzheimer's Dementia. The resident had a Brief Interview for	F 676	Identified concerns shall be reviewed by the facility's QAPI Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance.	12/28/2022

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F 676	Continued From page 9 Mental Status (BIMS) score of 7 out of 15, which indicated impaired cognitive ability. The resident required extensive assistance of 2 staff for transfers, bed mobility, walking in the room, dressing and toilet use. The MDS indicated the resident required physical help in parts of the bathing activity with staff assistance. Review of the Care Plan dated 10/7/2022 directed staff to provide assistance with activities of daily living due to limited mobility and to assist the resident with bathing. Review of the Documentation Survey Report (Bath Sign-Off Sheets) for Resident #8 directed staff to provide assistance with bathing on Saturday and Wednesdays. Review of the November 2022 Bath Sign-Off Sheets revealed the staff failed to give the resident 1 bath out of 8 bathing opportunities. Review of the December 2022 Bath Sign-Off Sheets revealed the staff failed to give the resident 2 out of 3 bathing opportunities. Review of the resident's Progress Notes from 11/1-12/13/2022 failed to include documentation the resident refused their baths at any time during this time frame. 2. Review of the Admission Record dated 8/31/2022, Resident #10 with diagnoses which included Unspecified Dementia, diabetes, schizophrenia disorder and anxiety. According to the MDS dated 11/22/22 the resident had severe cognitive ability and required	F 676		

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F 676	Continued From page 10 supervision of 1 staff for baths. The MDS indicated the resident required physical help in part of the bathing activity with help of 1 staff. Review of the Care Plan dated dated 9/6/2022 directed the staff to cue/assist the resident with dressing, bathing and personal hygiene cares. Review of the Documentation Survey Reports (Bath Sign-Off Sheets) directed the staff to bathe the resident Tues and Friday on the day shift and required assistance of 1 staff. Review of the November 2022 Bath Sign-Off Sheets revealed the staff failed to provide the resident a bath 3 out of 8 opportunities. Review of the December 2022 Bath Sign-Off Sheets revealed the staff failed to provide the resident 2 out of 3 bathing opportunities. Review of the resident's Progress Notes from 11/1-12/13/2022 failed to include documentation the resident refused their baths at any time during this time frame. 3. According to the Admission Record dated 12/31/2021, Resident #11 with diagnoses which included metabolic encephalopathy, dementia, alcohol dependence, major depressive disorder. Review of the MDS dated 10/6/2022 revealed the resident with a BIMS score of 99 which indicated severe cognitive ability. The resident requires supervision of 1 staff for ambulation and extensive assistance of 1 staff for personal hygiene. Resident #11 requires physical help for transfers only.	F 676		

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F 676	Continued From page 11 Review of the Care Plan dated 12/14/2021 revealed the resident requires assists of staff for activities of daily living related to cognitive loss. The Care Plan directed staff to assist the resident with bathing and informs them she likes to wear bilateral ear plugs to avoid getting water in her ears. Review of the resident's Progress Notes from 11/1-12/13/2022 failed to include documentation the resident refused their baths at any time during this time frame. Review of the Documentation Survey Report directed staff to provide bathing assistance on Tuesday and Fridays on the day shift. Review of the November 2022 Documentation Survey Report (Bath Sign-Off Sheets) revealed the staff failed to provide a bath for the resident 2 out of 9 bathing opportunities. Review of the December 2022 Documentation Survey Report (Bath Sign-Off Sheets) revealed the staff failed to provide 1 out of 3 baths for the resident. 4. According to the Admission Record dated 11/15/2022, Resident #12 with diagnoses which included Vascular Dementia. Review of the MDS dated 10/6/2022, revealed the resident with a BIMS of 10 which indicated impaired cognitive ability. The resident independently walked about the unit and could take herself to the toilet. The resident had total dependence with bathing with supervision of 1	F 676		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 12 staff. Review of the Care Plan dated 2/14/2022 revealed the resident requires staff assistance for bathing and directed the staff to provide cues/assistance with bathing. Review of the resident's Progress Notes from 11/1-12/13/2022 failed to include documentation the resident refused their baths at any time during this time frame. Review of the Documentation Survey Report (Bath Sign-Off Sheets) informed the staff the resident is scheduled to have a bath on Monday and Thursday evening with assist of 1 staff. Review of the November 2022 Documentation Survey Report (Bath Sign-Off Sheets) revealed the staff failed to give the resident a bath 2 out of 8 bathing opportunities. 5. According to the Admission Record 12/13/2022, Resident #15 with diagnoses which included fracture of left tibia, diabetes, kidney disease. Review of the MDS dated 10/12/2022, Resident #15 with a BIMS of 15 which indicated she is alert and oriented and gives accurate information. The resident utilizes a wheel chair for movement about the facility, requires extensive assistance of 2 staff for toilet use and limited assistance of 2 staff for personal hygiene and has total dependence on staff for showering. Review of the Care Plan dated 6/2/21 revealed the resident required staff assistance with	F 676		

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 _____	C 12/15/2022

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F 676	Continued From page 14 Practical Nurse (LPN) on 12/14/2022 at 11:30 a.m., Staff X stated if baths are not completed on the assigned day, they staff will try to do them the next day but not always. Review of the Bath, Shower-Tub Policy dated February 2018 states the purpose of this procedure was to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. The policy directed the staff to date and time when the shower was performed and to inform the nurse if the resident refuses.	F 676		