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 02/09/2023

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 000	INITIAL COMMENTS	F 000		
x DC	Correction Date: 2/23/2023 The following deficiency resulted from the investigation of Complaints #109520-C, #109618-C, #110611-C and #110714-C and Facility Self-Reported Incidents #109517-I, #109592-I and #109647-I conducted February 02, 2023 to February 09, 2023. Incidents #109517-I, #109592-I and #109647-I and complaint #109618-C were substantiated. Complaints #109520-C, #110611-C and #110714-C were not substantiated. (See Code of Federal Regulation (42CFR), 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 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews and observations the facility failed to provide appropriate supervision to prevent 5 falls which resulted in 3 fractures for 1 of 7 residents sampled (Resident #7). The facility reported a census of 147. Findings include:	F 689	**F689** *The facility strives to ensure that the resident environment remains as free of accident hazards as is possible; and that each resident receives adequate supervision and assistance devices to prevent accidents.* ***Corrective action taken for residents found to have been affected by deficient practice:*** Resident #7 is receiving appropriate supervision, and interventions are in place to prevent falls. ***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.	

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

Admin | 3/1/2023

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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HERITAGE SPECIALTY CARE	200 CLIVE DRIVE SW CEDAR RAPIDS, IA 52404

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F 689	Continued From page 1 According to the admission Minimum Data Set (MDS) dated 10/12/2022, Resident #7 had diagnoses which included; diabetes-type 2, dementia, chronic kidney disease, thyroid disorder and arthritis. The resident ambulated about the unit independently without assistive devices, could toilet themselves and perform hygiene tasks independently. The Resident had a Brief Interview for Mental Status (BIMS) score of 7 which indicated severe cognitive impairment. The resident resided on the locked CCDI unit (Chronic Confusion and Dementing Illness Unit). Review of the Care Plan initiated on 10/7/2022 informed the staff Resident #7 had a risk for falls upon admission. The Care Plan directed the staff to encourage the resident to use his call light and obtain a Physical and Occupational Therapy consultation and treat as necessary. Further review of the Care Plan noted the following changes: On 11/2/2022 the care plan indicated staff should encourage wearing appropriate footwear and review for antiemetic use (anti nausea medications), on 11/15 the care plan directed the staff to assist the resident to the bathroom before laying down in bed and on 12/4/22 the care plan directed staff to add auto locking brakes to the residents' wheelchair. Review of an undated care plan obtained from Staff A-RN on 2/8/2023 indicated on 1/18/2023 the staff moved the resident closer to the nurses station but failed to indicate which unit. Review of the Progress Notes revealed Resident #7 had an admission date of 10/6/2022 to the CCDI unit within the facility. Review of the Progress Notes revealed the resident had the following falls:	F 689	***What changes will be put into place to ensure that the problem will be corrected and will not recur:*** Nurses were educated on root causing falls and putting interventions in place related to the root cause. DON or designee will monitor falls for root cause and appropriate interventions related to the root cause 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.	2/23/2023

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F 689	Continued From page 2 a. On 11/2/2022 the resident had 2 unwitnessed falls, the second fall of the day, the resident lost his balance in the bathroom, fell to the floor and complained of severe left hip pain. The staff called Emergency Medical Services (EMS) and transported resident to a local hospital. The resident sustained a left greater trochanter fracture of left hip (hip fracture) and admitted to the hospital. The resident returned to the facility on 11/10/2022. b. On 11/10/2022 the resident returned from the local hospital after being treated for a hip fracture, within 45 minutes of his return the resident had an unwitnessed fall and complained of left hip pain. EMS summoned and transported the resident to a local emergency room for evaluation. The resident sustained an extension to the greater trochanteric fracture, which involved the intertrochanteric region extending toward the less trochanter fracture. The resident admitted to the hospital and had surgical repair of the fractured left hip. c. On 12/4/2022 the resident had an unwitnessed fall, complaining of left hip pain. d. On 12/15/2022 the resident had an unwitnessed fall in his room. The resident complained of severe left hip pain. EMS summoned and transferred the resident to a local emergency room. Upon assessment the resident found to have a new, acute fracture of the left proximal femur in the subtrochanteric region and further distally in the proximal 3rd of the femoral diaphysic near the distal portion of the hardware. The resident had surgical repair of fracture on 12/16/2022 and returned to the facility on 12/21/2022. The resident returned to the facility on a no weight bear status and used a wheelchair to move about the unit.	F 689		

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F 689	Continued From page 3 e. On 12/27/2022 the resident had an unwitnessed fall and complained of severe left hip pain. EMS personal summoned and transferred the resident to a local emergency room. The emergency room x-rays revealed a nondisplaced oblique fracture of the medical mid left femoral shaft that could be acute and the resident is noted to have stable mild osteoarthritis of both hips. The resident returned to the facility the same day with an order for a orthopedic consultation as soon as possible. The resident stated to staff he had been up walking and fell onto the floor. Review of the Primary Care Provider note dated 1/10/2023 indicated Resident #7 has a history of left femur fracture on 11/2/22, worsened after a fall on 11/10/22 which required surgical repair. The resident again hospitalized on 12/15/2022 with a new acute fracture and underwent another surgical repair. The resident discharged back to the facility for therapies and fell again on 12/27/22. The images of 12/27 showed a concern for another acute fracture, the resident discharged back to the facility with a follow up visit ordered with an orthopedic specialist. The resident remains no weight bear on the left leg and requires assistance of 2 staff for transfers. During an interview with Staff A-RN/MDS Coordinator on 2/8/23 at 10:15 am, Staff A stated she is responsible for the care plan changes and interventions for Resident #7. She stated he has had a lot of falls with fractures. Review of the residents falls and interventions completed with Staff A-RN, she stated the resident has had a total of 6 falls since admission. The following interventions were added to the resident's care plan:	F 689		

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F 689	Continued From page 4 a. The resident had a fall on 11/2/22 which resulted in a fracture. The intervention put in place for the resident included a medication review for nausea. b. The resident had a fall on 11/10/22 which resulted in a fracture. The intervention put in place is to offer him to use the bathroom prior to laying down in bed. c. The resident had a fall on 12/4/22, the intervention put in place included adding auto lock breaks on his wheelchair. d. The resident had a fall on 12/15/22 which resulted in a fracture, the staff failed to put additional interventions in place. e. The resident had a fall on 12/27/22, the intervention included to move the resident to a different room in the facility. During the interview regarding the lack of interventions after the 12/15/2022 fall, Staff A stated she didn't put any new interventions in place for the resident, she guessed she missed that. During an interview with Staff B-Director of Nurses on 2/8/23 at 11:00 am, Staff B stated the care plan interventions were not effective as the resident continued to fall. The D.O.N. stated she does not think offering a resident to go to the toilet prior to laying down is an effective interventions as the staff should have already been doing this. During an interview with Staff C-LPN Unit Manager on 2/8/23 at 8:30 am, Staff C stated Resident #7 had frequent falls. He has fallen many times and has had 3 fractures as a result of the falls. She stated the resident was independent prior to this first fracture and has not walked independently since. She stated the	F 689		

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F 689	Continued From page 5 resident has dementia, is impulsive and cannot remember to ask for help as per a care plan intervention. Observation on 2/7/23 at 11:50 am revealed the resident sitting on his bed in his room. The resident stated he cannot remember his falls but did state he cannot get up any more by himself and said his legs are not any good anymore. Review of a facility generated list of falls from 11/1/2022 thru 2/3/2023 revealed the facility had a total of 135 falls during this time frame, 42 were witnessed falls and 93 unwitnessed falls reported. Review of a Falls and Fall Risk policy dated 2017 directed staff to assess the resident to identify and implement pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling.	F 689		