| 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 11/20/2024 |

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

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| F 000 | INITIAL COMMENTS<br><br>Correction Date 12/13/24<br><br>The following information is related to the investigations of facility reported incident #124899-I and complaints #124900-C, #124845-C, #124865-C, #124800-C, and #124747-C, completed 11/18/24 - 11/20/24.<br><br>Incident #124899-I and Complaints #124900-C, #124865-C, #124800-C, and #124747-C were not substantiated.<br>Complaint #124845 was substantiated.<br><br>See the Code of Federal Regulations (42FR) Part 483, Subpart B-C. | F 000 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, staff and resident interviews, and observations the facility failed to send a resident's medications for an off campus appointment for 1 of 8 residents reviewed (Resident #2). The facility reported a census of 144 residents.<br><br>Findings include:<br><br>According to the Minimum Data Set (MDS) dated 9/13/24, Resident #2 had diagnoses which include debility, cardiac respiratory condition, | F 658 | "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 facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The facility 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."<br><br>**F 658 Services Provided Meet Professional Standards**<br><br>**Corrective action taken for residents found to have been affected by deficient practice:**<br>Resident #2 is no longer a resident at our facility.<br><br>**Continued on next page...** | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12/5/24

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 658 | Continued From page 1<br>heart failure, renal failure, diabetes, and Chronic Obstruction Pulmonary Disease. The resident had a Brief Interview for Mental Status score of 14 which indicated she was alert and oriented. The resident required partial assistance of 1 staff for transfers and ambulation, and substantial assistance for dressing.<br><br>Review of the Care Plan dated 12/22/2023 informed the staff the resident had diabetes mellitus and to administer the diabetic medications according to the physician's orders.<br><br>Review of a Physician's Order dated 7/18/24 directed staff to administer Insulin Aspart Solution 4 units subcutaneous three times a day for diabetes with meals.<br><br>During an interview with Resident #2 on 11/19/24 at 8:30 am, the resident stated she went to visit an adult day care center on 11/13/24, a place she will be attending after her discharge. She stated the staff at the facility did not send her noon insulin for her.<br><br>During an interview with Staff A-RN on 11/18/24 at 2:00 pm, Staff A admitted she didn't send the resident's insulin to the Adult Day Center on 11/13/24, she stated she sent all other medications but forgot the insulin. She stated she was the only nurse working her unit and it was very busy.<br><br>During an interview with Staff C-RN/ADON on 11/18/24 at 1:45 pm, the staff shared she received a call from the Adult Day Center informing they do not have Resident #2's insulin for her noon dose. Staff C told them she would get a one time order to hold the insulin for that | F 658 | **How the center will identify other residents having potential to be affected by the same deficient practice:**<br>Facility residents requiring medication that leave the facility for appointments or outings have the potential to be affected by said deficient practices.<br><br>**What changes will be put into place to ensure that the problem will be corrected and will not recur:**<br>The DON provided education on proper conveyance of medication for residents that are going out to appointments or outings to nursing staff on 12/5/2024. Education will continue to be provided to nursing staff on an ongoing basis. DON or designee will complete weekly audits of 5 residents that leave the facility for appointments for 4 weeks. Audits will be decreased to monthly for 3 months as compliance is maintained.<br><br>**Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent:**<br>Identified concerns shall be reviewed by the facility's QAPI committee. | |

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| F 658 | Continued From page 2<br>time.<br><br>During an interview with Staff B-RN/DON on 11/19/24 at 10:30 am, Staff B stated the nurse should have sent the resident's insulin with her in the morning when leaving but did get an order to hold the noon dose of insulin she missed. | F 658 | **F 695 Respiratory/Tracheostomy Care and Suctioning**<br><br>**Corrective action taken for residents found to have been affected by deficient practice:**<br>Residents #2 is no longer a resident at our facility. | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning<br>CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, staff and resident interviews and observations, the facility failed to provide adequate oxygen services for 1 of 8 residents reviewed (Resident #2). The facility reports a census of 144 residents.<br><br>Findings include:<br><br>According to the Minimum Data Set (MDS) dated 9/13/24, Resident #2 had diagnoses which include debility, cardiac respiratory condition, heart failure, renal failure, diabetes, and Chronic Obstruction Pulmonary Disease. The resident had a Brief Interview for Mental Status score of 14 which indicated she was alert and oriented. The resident required partial assistance of 1 staff for transfers and ambulation, and substantial | F 695 | **How the center will identify other residents having potential to be affected by the same deficient practice:**<br>Facility residents requiring oxygen services have the potential to be affected by said deficient practices.<br><br>**What changes will be put into place to ensure that the problem will be corrected and will not recur:**<br>The oxygen administration policy has been updated to read, "4. If required oxygen use for transport, confirm that the standard e-tank is full prior to transporting to any outside appointment/LOA.<br><br>During the complaint survey and again 12/5/2024 the DON provided education to nursing staff related to the oxygen administration policy update. | |



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| F 695 | Continued From page 3<br>assistance for dressing. The resident utilized oxygen therapy.<br><br>Review of the Care Plan dated 12/22/2023 informed the staff the resident utilizes oxygen therapy related to ineffective air exchange. The Care Plan directed the staff to administer oxygen to the resident as ordered.<br><br>During an interview with Resident #2 on 11/19/24 at 8:30 am, the resident stated she went to visit an adult day care center on 11/13/24 that she will be attending after her discharge. She stated the staff at the facility did not send enough oxygen with me and they had to call an ambulance and send me to the hospital. The resident said her husband informed the staff that she would be leaving at 7:30 am and return approximately at 2:30 that day on 11/13/24. The resident stated they said her oxygen dropped low that day but stated she could not tell and thought maybe she had some tightness in her chest.<br><br>On 11/18/24 at 3:20 pm an interview with a staff member from the Adult Day Care Center indicated that during her visit the staff noted the resident's oxygen saturation levels were trending down into the 70's. Upon examination the oxygen tank the resident brought to the visit was empty. The Day Center called the facility to report she had low oxygen levels and reported they do not stock oxygen for resident use at the facility, each resident is responsible to bring their own with them. The Adult Day Care staff called 911 to get assistance for the resident.<br><br>Review of a local hospital report dated 11/13/24 at approximately 3:00 pm revealed the following: | F 695 | The DON or designee will conduct audits of residents utilizing oxygen who are going out on appointments to ensure they have a full oxygen e-tank on departure. Audits will be conducted weekly for 4 weeks. Audits will be reduced to monthly for 3 months as compliance is achieved and maintained.<br><br>**Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent:**<br>Identified concerns shall be reviewed by the facility's QAPI committee. | |

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Patient is a 63-year-old female presenting today via EMS from Heritage care facility because she ran
out of oxygen. Staff reported to EMS that she did not have enough oxygen in her tank to supply her with her chronic 2 L that she is on, and she desatted to 75% on room air. They then called EMS.
There seems to be a lot of logistical confusion between EMS, patient and her husband, and Heritage
regarding why she was sent to the emergency room, and why she did not have her oxygen adequately supplied. Currently, patient reports she feels fine and is just a little bit tired.

During an interview with Staff A-RN on 11/18/24 at 2:00 pm, the staff stated she thought the resident would be leaving at 7:30 am and returning between 12:30-1:00 pm. The nurse stated she checked the oxygen when she left and the resident had approximately 1/2 of a tank, she used E tanks running at 2 liters per minute. She reported the Adult Day Center called about 1:00 pm to inform the facility of her condition and they sent her to the emergency room. When asked Staff A-RN how long a full E size oxygen canister would last running at 2 liters, Staff A stated she didn't know.

During an interview on 11/18/24 at 3:39 pm with the facilities oxygen supply company, the spokesman stated an E size canister would last approximately 5 hours running at 2 liters, it could vary slightly depending on the resident's respiration rate but not affect it drastically.

During an interview with Staff B-RN/Director of Nurses on 11/18/24, the D.O.N. stated the

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| F 695 | Continued From page 5 | F 695 | | |

resident's husband made almost all of her appointments and then alerts the staff to provide transportation. Staff B stated she received a phone call from the Adult Day Center and informed the D.O.N. that Resident #2 ran out of oxygen, her oxygen levels were low and could the facility bring another tank for her. The D.O.N. stated they could not get there fast enough, to hang up and call 911 so she could get oxygen.

During an interview with Staff C-RN/Assistant Director of Nurses on 11/18/24 at 1:45 pm. Staff C stated she got a call sometime around lunch from the Adult Day Center that Resident #2 ran out of oxygen and they had to call 911. Staff C stated she thought the resident was going to a psychiatric appointment and didn't know she was going to an Adult Day Care Center on 11/13/24. Staff C/RN asked how long a full E size canister would last running at 2 liters stated she did not know.

The Oxygen Administration Policy dated October 2010 failed to instruct staff how to prepare a resident prior to leaving the facility to assure their oxygen needs are met.