STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165226	A. BUILDING ______ B. WING ______	07/09/2022

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CENTERVILLE SPECIALTYCARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

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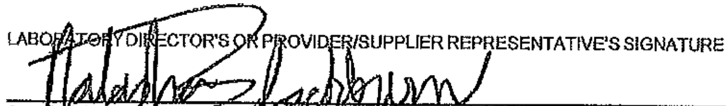
F 000	INITIAL COMMENTS Correction date: 8/3/2022 The following deficiencies resulted from the facility's annual recertification survey and investigation of complaints #103171-C, #103248-C, and #105298-C and facility-reported incidents #101173-I, and #105395-I, conducted 07/05/2022 - 07/09/2022. All of the investigations resulted in facility deficiencies. See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Centerville 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."	
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)	F 554	**Description:** F554 **Plan of Correction:** Education provided to nursing staff regarding medication administration, self-	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE: Administrator

(X6) DATE: 8/3/2022

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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	165225	A. BUILDING ______ B. WING ______	07/09/2022

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F 554	Continued From page 1 A policy on self-administration of medications was requested from the facility and was not provided by the end of the survey. Review of the Admission Record revealed the facility admitted Resident #39 on 05/13/2022 with diagnoses which included congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and anxiety. The resident's Minimum Data Set (MDS) assessment of 05/19/2022 documented Resident #39 scored 15 on a Brief Interview for Mental Status (BIMS) test, which indicated the resident was cognitively intact. The MDS indicated the resident required limited assistance of one person for activities of daily living (ADLs). During an observation on 07/05/2022 at 10:37 AM, three inhalers were observed on the resident's over-the-bed table. Observation on 07/06/2022 at 3:54 PM revealed the three inhalers continued to be on the over-the-bed table in the resident's room. Two of the inhalers were Albuterol (medication used for shortness of breath and wheezing) inhalers and the other was an Anoro inhaler (medication used for chronic obstructive pulmonary disease), which was dated 06/16/2022. Observation on 07/07/2022 at 8:02 AM revealed Resident #39 sitting on the side of the bed. The inhalers were on the over-the-bed table in front of the resident. There was also a plastic medication cup sitting on the table with one pill in it. Resident #39 stated the nurse brought the pill in earlier, but he was not ready to take it at that time, so the nurse left it with the resident. Resident #39	F 554	**Corrective action taken for resident(s) affected:** Order obtained, evaluation completed, and lockbox provided for effected resident. **Measures or systemic changes made to ensure this will not recur and affect others:** Education provided to nursing staff regarding the process of having residents self-administer their own medications per resident wishes. Will discuss in our weekly standard of care meetings any residents who have requested to self-administer. **Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** Weekly discussions in standard of care meetings regarding residents who have expressed preference to self-administer medication **Anticipated Date of Completion for this plan of correction:** 8/3/2022	

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F 554	Continued From page 2	F 554		

indicated he could take pills independently when he was ready. Resident #39 stated the inhalers were the same inhalers he took at home, and that h only used them occasionally, including the Anoro.

A review of the Physician Orders and the July, 2022 Medication Administration Record (MAR) revealed Resident #39's orders included:
a. Anoro Ellipta Aerosol Powder Breath Activated 62.5-25 micrograms/inhalation one inhalation orally one time a day, ordered 05/18/2022.
b. Albuterol Sulfate Aerosol Powder Breath Activated one to two puffs inhaled orally every six hours as needed (PRN), ordered 05/18/2022.

Further review of the current physician's orders revealed Resident #39 did not have orders for these medications to be left at bedside, and no orders for the resident to self-administer medications.

A review of Resident #39's record revealed no assessment for self-administering medications. A copy of Resident #39's assessment for self-administration of medications was requested from the facility on 07/07/2022 and was not provided by the end of the survey.

A review of Resident #39's care plan initiated on 5/13/22 revealed no indication that Resident #9 self-administered medications.

During an interview on 07/07/2022 at 8:04 AM, the Director of Nursing (DON) entered the resident's room and saw the inhalers and the cup with the pill in front of Resident #39, then asked the resident if the nurse left all the medications with him that morning. The resident stated the

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F 554	Continued From page 3 nurse left the pill, but that he kept the inhalers in the room. Resident #39 stated he was missing two pills which was why he had not taken the one pill yet, because he needed to talk to someone about it. The DON took the cup of medication and the inhalers out of the room and approached the nurse on the hall, Staff H, a Licensed Practical Nurse (LPN). Staff H stated the resident had one pill to take in the morning, the resident was not ready to take the pill when she went in the room, and he asked her to leave it. The DON stated Resident #39 could become upset easily if things were not done the way he wanted them done. The DON stated Resident #39 would have to be evaluated to see if he was safe to self-administer medications, and the facility would need to get an order for the resident to do so. The DON stated the medications should not have been left at the bedside. The DON also stated the resident had been known to go out with family and bring medications back, like Tylenol. During an interview on 07/09/2022 at 9:05 AM, Staff V, a Certified Medication Aide (CMA), stated no medications should be left at the bedside, and the resident should be watched to ensure he took the medication. She stated Resident #39 would be able to take his own medications but she was unsure what was required for that to happen. During an interview on 07/09/2022 at 10:33 AM, Staff W, a CMA, stated she was unsure if residents were allowed to self-administer medications. She stated Resident #39 had inhalers at the bedside and was able to use them. During an interview on 07/09/2022 at 2:37 PM, Staff H, LPN, stated residents could not self-administer medications unless there was a	F 554		

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F 554	Continued From page 4 physician order, and a completed evaluation. Staff H stated medications were not allowed at the bedside. Staff H stated Resident #39 could administer his own medications and acknowledged she did leave Resident #39's medications at the bedside at times and did not stand there to watch the resident take them, because the resident thought that was ridiculous. Staff H stated Resident #39 did not have an evaluation to self-administer medication or orders to do so. She stated self-administration of medications should be care planned. During an interview on 07/09/2022 at 3:20 PM, the DON stated residents could self-administer medications if they had an order and had been assessed. The DON stated a locked box would be placed in the room for storage of the medications. The DON stated Resident #39 was known to bring in medications of which staff were not aware. She stated a resident self-administering medication should be care planned. During an interview on 07/09/2022 at 4:53 PM, the Administrator stated a resident would be able to self-administer medications if they were assessed for it, it was part of their care plan, and it was documented properly. The Administrator stated medications should not be left at the bedside for the resident to take independently, but the nurse should witness the resident taking the medications. The Administrator stated leaving medications at the bedside could cause a lot of different issues with the resident, including not taking the medication, or other residents coming in and getting the medication.	F 554		
F 561 SS=D	Self-Determination	F 561		

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F 561	Continued From page 5 CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on facility policy review, clinical record review, observations, resident and staff interviews, and review of resident meal tickets, the facility failed to ensure residents were provided with opportunities to make choices about their meals for 2 (Resident #18 and Resident #42) of two sampled residents reviewed	F 561	**Description: F561-Failure to honor resident Food Choices** **Plan of Correction:** Honor Resident Food choices **How residents affected & residents with potential of being affected were identified:** Residents who reside to Centerville Specialty Care have the potential to be affected. **Corrective action taken for resident(s) affected:** Going forward meal choices will be offered to residents of Centerville Specialty Care by menu daily. **Measures or systemic changes made to ensure this will not recur and affect others:** Education provided to dietary staff regarding daily menus. Menus will be entered into nutrition management everyday by DSS. Menu tally report to be run daily along with scaled recipes. Increase the buffer amount to 4.	

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F 561	Continued From page 6 for choices. The facility reported a census of 53 residents. Findings include: A review of the facility's policy titled, 'Selective Menus,' February 2016 edition, indicated, "Selective menus will provide choices within allowed dietary restrictions and/or modifications. 1. Select menus will be offered to all residents when possible." The policy also indicated, "4. Residents on therapeutic diets will also be offered a select menu between the items on the spreadsheet that corresponds with their therapeutic diet order." Further review of the policy revealed, "7. If a resident does not choose an item from each food group, the Dietary Services Manager or designee will ask the resident if this was their intention or if they would prefer to have a simple-to-prepare substitute to replace the item. A resident may choose to not have an item from a particular food group." 1. Resident #18's Admission Record documented the resident had diagnoses that included diverticulitis (inflammation or infection of pouches formed in the colon), type 2 diabetes mellitus, anxiety disorder, gastro-esophageal reflux disease (GERD), chronic kidney disease, and dysphagia (difficulty swallowing). A review of Resident #18's admission Minimum Data Set (MDS) assessment, dated 04/14/2022, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident with intact memory and cognition. Further review of the MDS revealed the resident had no signs/symptoms of a swallowing disorder, no weight loss/gain, and received a	F 561	**Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** DSS will complete 4 audits per week will be conducted for 4 weeks. Then 3 audits per week will be conducted for 2 additional weeks. Results of the audits will be submitted to QAPI for review and additional recommendations. **Anticipated Date of Completion for this plan of correction: 8/3/2022**	

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F 561	Continued From page 7	F 561		

mechanically altered (change in food texture), therapeutic diet.

Review of Resident #18's care plan, initiated on 04/08/2022, indicated the resident was at an increased nutrition risk related to diverticulitis, type 2 diabetes mellitus, chronic kidney disease, hypertension, cerebral infarction, dysphagia, GERD, and anxiety. The care plan also indicated the resident had a diet order for consistent carbohydrates, soft and bite sized texture, with thin liquids. Interventions included providing meals that were within the resident's diet and to provide double protein portions at breakfast and lunch due to the resident reporting he/she was still hungry after meals.

Review of a Dietary Note, dated 04/11/2022 at 11:53 AM, revealed the Dietary Manager (DM) indicated Resident #18 ate independently and denied any concerns for chewing or swallowing difficulties with soft/bite sized texture. The resident reported he was still hungry after meals and agreed to adding double portions at lunch.

During an observation and interview on 07/05/2022 at 9:09 AM with Resident #18, the DM entered the room with an iPad and asked the resident's roommate what they wanted for the meals for that day. The DM did not ask Resident #18 about meal choices before leaving the room. Resident #18 stated staff did not ask him about meal choices and that this was an issue for him. The resident stated he did not know why staff never asked about his choices. The resident's roommate confirmed that staff only asked the roommate about meal choices and never asked Resident #18.

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F 561	Continued From page 8	F 561		

During an observation and interview on 07/06/2022 at 12:27 PM, Resident #18 sat at a dining room table with three other residents. The resident asked the surveyor to look at the meal ticket, stating he did not know what was being served because it was not indicated on the ticket. Review of the meal ticket revealed carrots, orange dream cake, and coffee were being served. The meal ticket indicated the hot food was to be double protein but did not indicate what protein being served. A review of the other three residents' meal tickets revealed the main dish being served was tater tot casserole. Resident #18 stated staff did not ask him what he wanted for that meal.

During an interview on 07/06/2022 at 12:30 PM, the DM stated Resident #18 was on a regular, consistent carbohydrate diet. The DM stated most meal orders were taken while residents were in the dining room. She stated she came to get Resident #18's roommate's order because the dietary aide did not get that resident's order; subsequently, she did not ask Resident #18 about his meal choice on 07/05/2022. After reviewing Resident #18's meal ticket and noting there was not a main course listed, the DM stated that every resident is asked what they want, and it should be printed out on the meal ticket. However, the DM stated they sometimes ran out of food, or the vendor was out of stock, and the facility had to provide an alternative food option.

Additional interview with Resident #18 on 07/07/2022 at 11:15 AM, revealed on this day, staff asked the resident about meals choices for the first time.

During an interview on 07/08/2022 at 1:29 PM,

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F 561	Continued From page 9	F 561		

the Director of Nursing (DON) stated the facility recently switched to using an iPad to obtain resident meal choices. She stated dietary staff had to ask residents about their meal choices, then the DM printed out residents' meal tickets. The DON stated she was not aware staff had not asked Resident #18 his meal preferences and indicated the resident should be asked.

During an interview on 07/08/2022 at 2:55 PM, the Administrator stated the facility had recently started a new process with meal ordering by using tablets. Staff had to enter and submit the residents' choices prior to the meal. According to the Administrator, there should not be any reason why staff should not ask Resident #18 about their meal preference. The Administrator stated all residents should be asked about their meal choices.

2. A review of Resident #42's Admission Record revealed the facility admitted the resident with diagnoses that included fracture to the left femur, major depressive disorder, diverticulitis, diabetes, and abnormal posture.

Review of Resident #42's significant change MDS assessment, dated 05/16/2022, revealed the resident had a BIMS score of 12, indicating moderate cognitive and memory impairment. The resident required supervision and set-up help with eating.

A review of the resident's Order Summary Report revealed the resident had orders for a consistent carbohydrate diet of regular texture and thin liquids initiated on 5/11/22.

Observations of the lunch meal in the kitchen and

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F 561	Continued From page 10	F 561		

on the tray line on 07/07/2022 from 10:35 AM to 12:48 PM, revealed the Dietary Services Supervisor (DSS), Staff D, a Cook, and Staff Q, a Dietary Aide, prepared and served the lunch meal. The menu listed the meal for the day was a roasted breaded pork tenderloin, cheese broccoli rice, mixed vegetables, and sliced peaches with an alternate meal option of cheese pizza with the same side items. Soups, sandwiches, and salads were always available. At 12:00 PM, Staff D ran out of the breaded pork tenderloins and had three tickets on the current cart that requested them. Those three residents, including Resident #42, received cheese pizza and were not offered another alternative meal option. The remaining half of the cheese pizza was burnt, and Staff D stated it would be thrown out and not served to residents.

A review of Resident #42's meal ticket for the lunch meal on 07/07/2022 revealed the resident requested a breaded pork tenderloin, broccoli cheese rice, mixed vegetables, and peach slices.

Observations of Resident #42's meal on 07/07/2022 at 12:48 PM revealed the resident received a slice of cheese pizza with the cheese broccoli rice, mixed vegetables, and sliced peaches instead of a breaded pork tenderloin with the same side items.

Resident #42 stated during an interview on 07/07/2022 at 12:48 PM that staff did not offer a choice for the lunch meal. The resident stated the pizza was "meh" and shrugged her shoulders. The resident stated they usually really liked pizza, but that pizza did not taste good. Resident #43 stated if given the choice she would have preferred the pork tenderloin to the pizza.

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F 561	Continued From page 11	F 561		

During an interview with Staff L, a Certified Nursing Assistant (CNA), on 07/08/2022 at 3:12 PM, she stated dietary staff took resident meal orders. Staff L stated the only time floor staff took a meal order would be if the resident wanted something different. Staff L stated if a resident wanted something different, she would check with the nurse about the resident's diet first, and then would let the kitchen know.

During an interview with the DSS on 07/09/2022 at 9:57 AM, she stated dietary staff asked each resident what they wanted for the meal the next day and entered the information into a tablet. The DSS stated if a resident could not/did not respond when asked their preferences, dietary staff recorded information for the resident to receive the main meal. Further interview revealed she met with residents on admission to obtain their food preferences, which were entered into the computer and preferences were printed on the meal tickets. However, she stated the computer system used to generate meal tickets and to alert staff how much food to make was down on Thursday, 07/07/2022 before the lunch meal, so dietary staff had to do a manual count of food items needed to provide meal service to all the residents.

During an interview with the DON on 07/09/2022 at 2:39 PM, she stated ideally dietary staff should offer the resident's first food choice and if it was not available, they should offer the alternate menu item. She stated dietary staff should have offered Resident #42 food options, as the resident was very capable of voicing their food preferences.

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	165225	A. BUILDING ______ B. WING ______	07/09/2022

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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 561	Continued From page 12 During an interview with the Administrator on 07/09/2022 at 4:04 PM, she stated dietary staff should follow the meal tickets as written.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the	F 565	**Description: F565** **Plan of Correction:** Call light audits will be completed by the leadership team. Education will be provided to staff regarding the expectation of responding to a call light in a timely manner. **How residents affected & residents with potential of being affected were identified**: Residents who reside to Centerville Specialty Care have the potential to be affected. **Corrective action taken for resident(s) affected:** Call light audits will be completed by the leadership team. **Measures or systemic changes made to ensure this will not recur and affect others:** Call light audits will be completed by the leadership team. Education will be provided to staff regarding the expectation of responding to a call light in a timely manner.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/25
FORM APPRO
OMB NO. 0938-0

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

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F 565	Continued From page 13 families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility policy review, it was determined the facility failed to ensure Resident Council grievances were acted upon and promptly resolved for residents who voiced concerns related to answering call lights in a timely manner for 4 (Resident #16, Resident #19, Resident #49, and Resident #8) of 5 residents who attended the Resident Council meeting. The facility reported a census of 53 current residents. Findings include: A review of the facility's policy titled, "Resident Rights," revised 12/2016, revealed "1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: ... v. have the facility respond to his or her grievances." A Resident Council interview was conducted on 07/06/2022 at 1:45 PM with Resident #34, Resident #16, Resident #19, Resident #49, and Resident #8 present. During the interview, when asked if they had any concerns related to the timeliness of staff answering their call lights. Resident #49 stated it took staff "some time" to answer call lights. Resident #19 stated the facility was short staffed, so it took staff a while to answer the call lights. Resident #8 stated he/she had to wait in the bathroom several times for staff to answer the call light and it could take anywhere from 10 minutes to 40 minutes for them to answer. Resident #8 also stated, "Sometimes you give up." Resident #16 stated it took staff awhile	F 565	**Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** 5 Call light audits per week will be conducted for 4 weeks. Then 3 audits will be conducted for 2 additional weeks. Results of the audits will be submitted to QAPI for review and additional recommendations. **Anticipated Date of Completion for this plan of correction:** 8/3/2022	

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F 565	Continued From page 14 to answer the call lights. A review of Resident Council Minutes dated 11/12/2021, 12/08/2021, 01/10/2022, 02/21/2022, 03/22/2022, and 06/08/2022 revealed the residents in the resident council meeting voiced concerns related to call lights not being answered timely. Review of a Grievance/Concern Investigation Form, dated 12/08/2021, indicated the Resident Council voiced a grievance of, "Call lights not being answered timely. This is happening during mealtimes and after mealtimes most days. It takes 20 minutes or longer and sometimes I have to go turn my bathroom call light on as well." The facility's response was, "Call light audits done and audits to be performed from different department heads." There was no documented evidence of a call light audit for the grievance. The section of the form for, "concerned party advised" was not filled out. A review of a Grievance/Concern Investigation Form, dated 12/30/2021, indicated two Resident Council members had a grievance of, "Call light on for over 15 min [minutes]." The facility's response was, "Call light audit for 3rd shift." Review of a Grievance/Concern Investigation Form, dated 01/10/2022, indicated the Resident Council voiced a grievance of "Call lights. Pts [patients] state it takes over an hour at times." The facility's response was "Call light audits to be done." There was no documented evidence of a call light audit for this grievance. The section of the form for, "concerned party advised" was not filled out.	F 565		

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F 565	Continued From page 15 A review of a Grievance/Concern Investigation Form, dated 02/21/2022, indicated the Resident Council voiced a grievance of "Call lights during the evening taking longer than 15 minutes to answer and staff walk by with heads down. This is not at supper time." The facility's response was, "Audits in place and will be done weekly by department heads." There was no evidence of a call light audit for this grievance. The section of the form for, "concerned party advised" was not filled out. Review of a Grievance/Concern Investigation Form, dated 03/22/2022, indicated Resident #6 voiced a grievance during a resident council meeting of, "Concern that once staff took 20-30 [minutes] to answer a bathroom call light when [Resident #6 had] an accident and CNA came to answer until Housekeeper helped [the resident]." The facility's response was, "Call lights being monitored through audits at this time." A duplicate grievance form for Resident #6 was completed and the facility's response was, "Note placed in communication book to answer call lights in 15 [minutes] for bedroom & [and] 5 for bathroom & call light audit." Resident #6's room was not included in the March 2022 call light audit. The section of the form for, "concerned party advised" was not filled out. A review of a Grievance/Concern Investigation Form, dated 03/22/2022, indicated Resident #27 voiced a grievance during resident council of, "Has concern 2-3 nights weekly that it takes staff 30 [minutes] or more after and before meal on 2-10 [2:00 PM to 10:00 PM] shift for staff to answer [Resident #27's] call light." The facility's response was, "Call light audits continued multiple staff doing audits to monitor problem."	F 565		

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F 565	Continued From page 16	F 565		

Resident #27's room was audited four times from 03/15/2022 to 03/24/2022, with only one of those being on the 2:00 PM to 10:00 PM shift. The section of the form for "concerned party advised" was not filled out.

A review of a Grievance/Concern Investigation Form, dated 06/08/2022, indicated the Resident Council voiced a grievance of, "Call light not being answered in a timely manner. It takes 45 [minutes] to 1 hr [hour] before staff answer my call light. Other times I get put in the bathroom and after turning my light on when finished I sit for over an hour to get off the toilet. This happens multiple times a week." The facility's response was, "Call light audits to continue[.] Education to staff on resident's concern." There were no call light audits provided by the facility for this grievance. The section of the form for, "concerned party advised" was not filled out.

Review of the facility's Call Light Audit Report for March 2022 indicated a call light audit was performed on 03/15/2022 at 1:15 PM; 03/16/2022 at 9:30 AM; 03/18/2022 at 5:39 PM and 5:36 PM; 03/19/2022 at 10:41 AM; 03/20/2022 at 2:15 PM, 2:33 PM, 2:45 PM, 3:04 PM, and 3:05 PM; 03/24/2022 at 8:33 PM, 8:43 PM, and 9:07 PM; and 03/28/2022 at 11:12 AM, 11:14 AM, 11:16 AM, and 11:21 AM.

A review of the facility's Call Light Audit Report for April 2022 indicated a call light audit was performed on 04/14/2022 at 2:40 PM, 3:25 PM, 3:45 PM, and 4:15 PM.

Review of the facility's Call Light Audit Report for May 2022 indicated a call light audit was performed on 05/19/2022 at 8:30 AM, 9:05 AM,

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F 565	Continued From page 17 9:30 AM, and 10:15 AM. A review of the facility's Call Light Audit Report for June 2022 indicated a call light audit was completed on 06/25/2022 at 9:30 AM, 10:10 AM, and 1:35 PM and on 06/26/2022 at 7:00 AM, 12:40 PM, and 1:25 PM. During an interview on 07/07/2022 at 2:35 PM, the Activity Director (AD) stated that once a resident voiced a grievance during the Resident Council meeting, she typed all the concerns and put them on an individual "Concern Investigation Form" and printed one out for herself, the Administrator (ADM), and the department head related to the concern. For call lights, she would provide a copy to the Director of Nursing (DON). During an interview on 07/08/2022 at 1:49 PM, the DON stated if a resident voiced a concern during the Resident Council meeting, she would go and talk to the resident and/or staff involved. The DON stated she had a huddle meeting and arrived at the facility for the 6:00 AM to 2:00 PM shift so she could huddle with all three shifts. She stated that if she was not present, she had the charge nurse complete the huddle, and they had a communication book at the nurses' desk. The DON stated the main thing is talk to the resident or staff member to come to a resolution to the grievance. The surveyor informed the DON that six out of the last eight months of Resident Council minutes had grievances related to call lights. The DON stated that's something they are trying to improve. She felt like the last couple times, it's gotten better; it's mainly during the 2-10 shift and during meals. The DON stated that call light audits were to be completed every week, and the weekend manager also completed them.	F 565		

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F 565	Continued From page 18 However, she noticed the weekend manager was only completing two room audits. The DON stated the facility was trying to figure out how to do them every shift and on the weekends. The DON stated she would like to see more audits. The DON stated the call light concern was brought to the attention of the Quality Assurance (QA) team but was unsure if it was documented anywhere. During an interview on 07/08/2022 at 3:03 PM, the ADM stated the process for grievances voiced during Resident Council was that the AD would bring all concerns to the ADM in the form of a grievance and would assign the grievance to each respective department. Then, the ADM and the department head would address the concern, bring it up in the morning meeting, complete follow-ups, and reach a resolution. The ADM stated they had a 10-day process for a resolution to ensure everything was resolved in a manner that the resident agreed to. The surveyor informed the ADM that six out of the last eight months of Resident Council minutes included grievances related to call lights. The ADM stated she felt like the residents always brought up the call lights and that it was always addressed. The ADM stated the weekend manager was completing call light monitoring and felt it was being completed on the weekends.	F 565		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be	F 578	**Description:** 578 **Plan of Correction:** Advanced Directives information will be added to resident face sheets if available upon admission and reviewed quarterly during care plan meetings.	

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F 578	Continued From page 19 construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept orrefuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on clinical record, and staff and resident interviews, the facility failed to protect 2 (Residents #18 and #30) of 3 residents' rights regarding an advance directive. Specifically, the	F 578	**How residents affected & residents with potential of being affected were identified:** Residents who reside to Centerville Specialty Care have the potential to be affected. **Corrective action taken for resident(s) affected:** Information has been located and will be uploaded into PCC. **Measures or systemic changes made to ensure this will not recur and affect others:** Advanced Directives information will be added to resident face sheets if available upon admission and reviewed quarterly during care plan meetings. **Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** 4 audits per week will be conducted for 4 weeks. Then 3 audits per week will be conducted for 2 additional weeks. Results of the audits will be submitted to QAPI for review and additional recommendations. **Anticipated Date of Completion for this plan of correction: Ongoing**	

[STATEM]ENT OF DEFICIENCIES [AND PL]AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 578		F 578		

Continued From page 20
facility failed to ensure Resident #18 had the right to formulate an advance directive and failed to ensure Resident #30's advance directive was included in the resident's medical record. The facility identified a census of 53 current residents.

Findings included:

A policy regarding advance directives was requested from the facility, but the facility did not have a policy.

1. Review of Resident #18's Admission Record revealed the resident entered the facility on 04/08/2022.

The resident's admission Minimum Data Set (MDS) assessment, dated 04/14/2022, recorded Resident #18 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact.

A review of Resident #18's care plan, initiated on 04/08/2022, revealed the resident had an advanced directive/code status care plan with a goal for advance directives to be followed per resident/family request. The facility developed interventions included reviewing resident choices quarterly and as needed and honoring the resident's wishes regarding code status. Further review of the care plan revealed staff had visited with the resident regarding the need for a power of attorney (POA), and the resident refused to name a POA.

A review of Resident #18's electronic health record (EHR) on 07/05/2022 at 12:24 PM revealed no documented evidence the resident had an advance directive on file nor evidence the

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F 578	Continued From page 21 facility provided the option to formulate one. During an interview on 07/06/2022 at 12:05 PM, the Social Services Director (SSD) stated the SSD was responsible for completing admission paperwork. The SSD stated a Cardiopulmonary Resuscitation (CPR) status form was completed on admission; however, the facility did not ask residents upon admission about formulating an advance directive. The SSD stated that if the resident already had an advance directive in place, the facility requested a copy. The SSD stated there was nothing in the admission packet related to formulating an advance directive. During an interview on 07/06/2022 at 12:16 PM, the Business Office Manager (BOM) stated the SSD was supposed to provide the option of formulating an advance directive to residents upon admission. According to the BOM, the facility did not have any advance directive information for Resident #18. During an interview on 07/06/2022 at 12:54 PM, the Director of Nursing (DON) stated the SSD was required to speak with a resident upon admission regarding formulating an advance directive. During an interview on 07/06/2022 at 1:02 PM, the Administrator (ADM) stated the SSD was required to ask residents about advance directives upon admission. The ADM stated residents' advance directive should be kept in the residents' electronic health record (EHR) or their accessible medical record. 2. A review of the Admission Record revealed the facility admitted Resident #30 on 09/15/2021.	F 578		

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F 578	Continued From page 22	F 578		

Resident #30's quarterly MDS assessment, dated 05/05/2022, documented the resident had a BIMS score of eight, which indicated the resident was moderately cognitively impaired.

A review of Resident #30's care plan, initiated on 12/29/2021, revealed the facility identified the resident needed a designated power of attorney (POA) for healthcare financial matters to serve in the event of incapacity; to assist with decision making; and to support the resident's health, resource management, and/or safety. The facility developed an intervention that indicated on 04/15/2022, POA documents were completed that would be kept in the business office file throughout the resident's stay. Further review of Resident #30's care plan, initiated on 04/08/2022, indicated the resident had an advance directive/code status care plan. Interventions included the resident's code status was located at the nurse's desk.

A review of Resident #30's electronic health record (EHR) on 07/05/2022 at 12:12 PM revealed no documented evidence the resident had an advance directive, was given the option to formulate an advance director, nor any documented evidence the resident had a POA.

According to an interview on 07/06/2022 at 12:05 PM, the SSD stated Resident #30 did not have a POA and was waiting for the resident's family member to visit. The SSD was not aware POA documents had been completed for Resident #30.

During an interview on 07/06/2022 at 12:16 PM, the BOM stated Resident #30's family member

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F 578	Continued From page 23 completed a POA document a few months previous, and it was in a file in the BOM's office. At that time, the BOM pulled the resident's durable POA form from a drawer in her office and provided a copy to the surveyor. According to the BOM, the resident's durable POA should also be listed in the EHR. At that time, the BOM reviewed the resident's profile in the EHR and stated the advance directive was not in the EHR. The BOM then added 'POA' next to the family member's name listed in the EHR. During an interview on 07/06/2022 at 12:54 PM, the DON stated there should be a copy of Resident #30's advance directive at the nurse's desk and in the resident's medical record. The DON pulled out a binder that contained information about resident code statuses from the nurse's desk; however, the binder did not include advance directives. The DON stated that if a resident's advance directive was in the BOM office, the charge nurse should have a key to access the BOM's office after office hours. The DON stated the key was kept in the medication room; however, the DON and another nurse were unable to locate a key to the BOM office in the medication room. During an interview on 07/06/2022 at 1:02 PM, the Administrator stated that if the advance directives were kept in the business office, the nurse should have a key. The Administrator stated residents' advance directive should be in the residents' electronic health record or their accessible medical record.	F 578		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 580	Continued From page 24 §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580	**Description:** F580 **Plan of Correction:** Nursing staff will be provided education on the importance of completing physician orders as directed, notifying physician on a change of condition, documenting assessments in charts, obtaining vitals as ordered and with a change in condition, notifying the primary care provider on blood sugars outside of parameters, and ensuring the primary care provider and pharmacy are updated on any medications that not available in the E-Kit. **How residents affected & residents with potential of being affected were identified:** Residents who reside to Centerville Specialty Care have the potential to be affected. **Corrective action taken for resident(s) affected:** Orders to be completed as directed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 580

Continued From page 25

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on record review, interviews, and facility policy review, the facility failed to notify the physician of changes in condition and/or the need to alter treatment for two (Resident #311 and Resident #209) of six residents reviewed for medication administration. Specifically, the facility failed to notify the physician when Resident # 311 tested positive for COVID-19, which resulted in a delay in obtaining treatment orders for the resident, who subsequently expired; Resident #311's blood sugars were out of prescribed parameters; Resident #311's medications were unavailable for administration and Resident #209 did not receive medications as ordered. The facility identified a census of 53 current residents.

Findings include:

1. A review of an "Admission Record" revealed Resident #311 had diagnoses which included chronic obstructive pulmonary disease (COPD), chronic viral hepatitis C, diabetes, multiple sclerosis, congestive heart failure (CHF), hypertension, cirrhosis of the liver, and chronic kidney disease. Further review of the admission record revealed the resident expired at the facility on 03/02/2022.

F 580

Measures or systemic changes made to ensure this will not recur and affect others: Nursing staff will be Educated along with continuing education with monthly meetings, Nurse manager and DON will continue this discussion in morning stand up meetings.

Planned monitoring of corrective actions to ensure practice is corrected and will not occur: Nurse manager will complete 3 orders and 3 glucose check audits for 4 weeks. Then 2 order audits will be conducted for 2 additional weeks. DON will complete change of condition audits and vitals for 6 weeks. Results of the audits will be submitted to QAPI for review and additional recommendations.

Anticipated Date of Completion for this plan of correction: 7.25.22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 580	Continued From page 26	F 580		

A review of the admission "Minimum Data Set" (MDS), dated 02/03/2022, indicated Resident #311 scored 12 on a Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. The resident required limited to extensive assistance of two people for activities of daily living (ADLs). The MDS indicated the resident received insulin injections on six out of seven days during the lookback period.

A review of a care plan, dated as initiated on 01/31/2022, revealed Resident #311's goal was to transition back to the community. The facility developed an intervention for the resident to transition home with goals met.

1. a) A review of the facility's policy titled, "Lab and Diagnostic Test Results - Clinical Protocol," revised November 2018, indicated, "The physician will identify, and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility. When test results are report to the facility, a nurse will first review the results." The policy also indicated the following:
- "A nurse will identity the urgency of communicating with the attending physician based on the physician's request, the seriousness of any abnormality, and the individual's current condition."
- "A physician can be notified by phone, fax, voicemail, e-mail, mail, pager or a telephone message to another person acting as the physician's agent (for example, office staff). a. Facility staff should document information about when, how, and to whom the informationwas

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 580	Continued From page 27	F 580		

provided and the response. This should be done in the Progress Notes section of the medical record and not on the lab results report, because test results should be correlated with other relevant information such as the individual's overall situation, current symptoms, advance directives, prognosis, etc. [et cetera]. b. Direct voice communication with the physician is the preferred means for presenting any results requiring immediate notification, especially when the resident's clinical status is unstable or current treatment needs review or clarification."

Review of a facility policy titled, "COVID-19 Testing Policy," revised 03/10/2022, revealed, "Documentation of Testing. Facilities must demonstrate compliance with the testing requirements. To do so, facilities should do the following: For symptomatic residents and staff, document the date(s) and time(s) of the identification of signs or symptoms, when testing was conducted, when results were obtained, and the actions the facility took based on the results."

A review of "Progress Notes" revealed a "COVID-19 Testing" note was entered on 02/26/2022 at 5:55 PM, which indicated Resident #311 had a positive COVID-19 test. The note did not indicate the physician was notified of the positive results.

A review of "Progress Notes" dated 02/27/2022 at 12:21 AM and 02/28/2022 at 12:47 PM, revealed Resident #311 had no signs or symptoms of COVID-19 after testing positive.

A review of "Progress Notes" dated 03/01/2022 at 12:24 AM, revealed Resident #311's oxygen saturation was 86% on room air. Oxygen was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 580	Continued From page 28	F 580		

Continued From page 28

applied, and the resident's oxygen saturation came up to 91% with the oxygen at 2 liters per minute via nasal cannula. There was no indication the physician was notified.

Areview of a focused evaluation "Progress Note," dated 03/01/2022 at 12:30 AM, indicated Resident #311 had an occasional non-productive cough with oxygen in place. The note indicated the resident had no other signs and symptoms and remained in isolation for a recent diagnosis of COVID-19.

A review of "Doctor's Orders and Progress Notes," dated 03/01/2022 at 12:30 PM, revealed, "Apparently, [Resident #311] tested positive for COVID-19 on Friday night [02/25/2022]. No provider was notified." Labs and medications were ordered at this time.

A review of a "Social Service Note," dated 03/02/2022 at 12:59 PM, indicated Resident # 311 expired that morning.

A review of the "Death Record," dated 03/02/2022, indicated Resident #311's time of death was 03/02/2022 at 7:28 AM, and the cause of death was COVID-19 pneumonia.

During an interview on 07/08/2022 at 2:32 PM, Staff T, Nurse Practitioner (NP), stated she was the primary provider for Resident #311. She stated Resident #311 tested positive for COVID-19 on a Friday and she was not notified until she came into the facility to do rounds on the following Tuesday (03/01/2022). She stated the night shift nurse had left a note in her folder requesting an order for oxygen because the resident's oxygen saturation had dropped during

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 580	Continued From page 29	F 580		

the night. She stated she was going to see the resident, and that was when she was told the resident was on the COVID unit. She stated the resident went five days before any COVID treatment was ordered, then died the next day.

On 07/09/2022 at 8:42 AM, the surveyor attempted to call Staff U, the nurse caring for Resident #311 on 03/01/2022 when the physician orders were written. Staff U did not answer, and the surveyor left a message. Staff U did not respond by the end of the survey.

During an interview on 07/09/2022 at 2:37 PM, Staff H, a Licensed Practical Nurse (LPN), stated whenever a resident tested positive for COVID-19, they were put into quarantine and notifications were made to the physician and families and should be documented in the progress notes. She stated the facility did not have standing orders for how to treat COVID-19. After reviewing Resident #311's record, Staff H stated she was unable to find documentation of the provider being notified when the resident tested positive for COVID-19.

During an interview on 07/09/2022 at 3:20 PM, the Director of Nursing (DON) stated whenever a positive COVID-19 test result was obtained, the facility would put the resident in isolation and notify the physician, family, state, and medical director. She stated those notifications should be documented in the progress notes. She stated the facility did not have standing orders for positive COVID-19 residents, but the physician should be updated, and they would provide orders as needed. The DON stated she could not recall the details of Resident #311's death.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 580	Continued From page 30	F 580		

Continued From page 30

During an interview on 07/09/2022 at 4:53 PM, the Administrator, she stated when a positive COVID-19 case was identified the resident was moved to the isolation area and the physician and family should be notified. She stated it should be documented in a progress note.

1. b) A review of the facility's policy titled, "Diabetes," revised September 2017, indicated, "The physician and staff will establish notification parameters related to diabetes monitoring. Based on individualized notification parameters, the staff will inform the practitioner about the status of each patient's glucose control, depending on the situation, goals, and other associated symptoms or conditions."

A review of Resident #311's physician orders and February 2022 Medication Administration Record (MAR) indicated physician orders to check the resident's blood sugar before meals and at bedtime. The order indicated the facility was required to contact the resident's primary care provider (PCP) if Resident #311's blood sugar was over 300 or less than 70.

A review of the February 2022 MAR revealed Resident #311's blood sugar was greater than 300 on 58 occasions out of the 112 times it was checked. On fourteen of those occasions, it was greater than 400; on sixteen occasions, it was greater than 500; and on one occasion, it was greater than 600.

A review of Resident #311's "Progress Notes" for February 2022 revealed the resident's PCP was notified on five of the 58 occasions that the resident's blood sugar was greater than 300.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 580	Continued From page 31	F 580		

Continued From page 31

On 07/09/2022 at 8:42 AM, the surveyor attempted to contact Staff T, Resident #311's PCP, for an interview regarding Resident #311's blood sugars. The surveyor left a message requesting a callback. Staff T did not respond by the end of the survey.

During an interview on 07/09/2022 at 9:05 AM, Staff V, a Certified Medication Aide (CMA), stated the licensed nurses dealt with residents' blood sugars and notifying the physician if the results were out of parameters.

During an interview on 07/09/2022 at 10:33 AM, Staff W, a CMA, stated the physician should always be notified as ordered if a resident's blood sugar was out of parameters, because the physician may want to make changes to the resident's medications.

During an interview on 07/09/2022 at 2:37 AM, Staff H, a Licensed Practical Nurse (LPN), stated staff should document in a progress note or in the MAR notes when a resident's blood sugar was out of physician-ordered parameters and the provider was notified. After reviewing Resident #311's record, she was not able to find documentation that the resident's blood sugars were reported to the physician as ordered, but she stated they should have been. She stated it was important to let the provider know, because they may adjust the resident's medications or diet.

During an interview on 07/09/2022 at 3:20 PM, the Director of Nursing (DON) stated any resident with physician orders to check blood sugars should have parameters ordered as to when to notify the physician, and the nurse should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 580	Continued From page 32	F 580		

document in the computer progress note when the physician was notified. The DON stated notifying the physician when a resident's blood sugar was not within physician-ordered parameters was important, so the physician could make changes if needed.

During an interview on 07/09/2022 at 4:53 PM, the Administrator stated if a resident's blood sugars were out of physician-ordered parameters, the physician and DON should be notified, and it should be documented in a progress note.

1. c) A review of the facility's policy "Pharmacy and Therapeutics Oversight," revised September 2017, revealed "Medications will be ordered, administered, and monitored appropriately and safely." According to the policy, "The medical director will advise the facility on prescribing, handling, dispensing, storing, prescribing, and monitoring medications, including the following: a. Appropriate indications, selection, and prescribing of medications for the facility's resident/patient population. b. Safe procurement, storage, distribution, use and disposal of drugs and biologicals ... d. Contents of emergency and interim medication kits ... i. Monitoring for, identifying, correcting, and preventing medication-related problems including adverse consequences."

A review of the "Physician Orders" and the February 2022 "Medication Administration Record" (MAR) indicated Resident #311 had orders which included:
- Flomax (used of urinary incontinence) 0.4 milligrams (mg) give one tablet by mouthone time a day.
- Fluconazole (used for yeast infections) 50 mg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 580	Continued From page 33	F 580		

give one tablet by mouth one time a day every three days.
- Ranolazine (used for chest pain) 1,000 mg give one tablet by mouth two times a day.
- Isosorbide Mononitrate (used for chest pain) 50 mg give 50 mg by mouth two times a day.
- Prednisone (used for multiple sclerosis) 20 mg give three tablets by mouth one time a day.
- Ropinirole (used for restless leg syndrome) 2 mg give one tablet by mouth one time a day.

Further review of the February 2022 MAR revealed the resident did not receive the following medications due to not being available from the pharmacy for administration:
- Flomax 0.4 mg on 02/22/2022, 02/23/2022, 02/24/2022, and 02/25/2022
- Fluconazole 50 mg on 02/04/2022, 02/16/2022, and 02/22/2022
- Prednisone 60 mg on 02/22/2022, 02/23/2022, and 02/26/2022
- Ranolazine 1,000 mg on 02/22/2022, 02/23/2022, 02/25/2022, 02/26/2022 AM and PM dose, 02/27/2022 AM and PM dose, and 02/28/2022 AM and PM dose
- Isosorbide 50 mg on 02/23/2022, 02/26/2022, 02/27/2022, and 02/28/2022
- Ropinirole 2 mg on 02/23/2022 and 02/25/2022

A review of the "Orders-Administration Notes" for the above medications indicated the medications were either not available or were on order.

A review of Resident #311's record revealed no documentation that the primary care provider (PCP) was notified of the resident not receiving the above medications.

During an interview on 07/08/2022 at 2:32 PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ____ B. WING ____	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 580	Continued From page 34	F 580		

with Staff T, Nurse Practitioner (NP), she stated she could not recall if the facility had notified her of Resident #311 missing medications. She stated she expected to be notified whenever the nurse held a medication so that if the resident ended up having an adverse reaction to not getting the medications, then she would knowthe reason and it would affect how she would treat the resident. She stated having the staff fail to notify her when a medication was being held or not given had been an issue in the past.

During an interview on 07/09/2022 at 9:05 AM with Staff V, Certified Medication Aide (CMA), she stated if a medication was not available during the medication pass, then she would tell the nurse and document that it was notavailable. She stated she was unsure if the physician was notified but thought the nurse did that.

During an interview on 07/09/2022 at 10:33 AM with Staff W, CMA, she stated if amedication was not available, she would tell the charge nurse and document it was not available. She stated the charge nurse should notify the physician.

During an interview on 07/09/2022 at 2:37 PM with Staff H, Licensed Practical Nurse (LPN), she stated if a medication was not available during the medication pass, the physician was notified by fax but admitted it was not done every time.

During an interview on 07/09/2022 at 3:20 PM, the Director of Nursing (DON) stated if a medication was not available during the medication pass, the physician should be notified sometime during the day, and depending on the type of medication, maybe sooner. She stated if a medication was unavailable for multiple days, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 580	Continued From page 35 physician, pharmacy, and DON should be notified. The DON stated the physician should be contacted for clarification whenever a medication was not available to see how the physician wanted to proceed. During an interview on 07/09/2022 at 4:53 PM, the Administrator stated if a medication was not available during the medication pass, the pharmacy and physician should be contacted along with the DON. 2. A review of Resident #209's "Admission Record," revealed the facility admitted the resident on 06/29/2022 with diagnoses that included dementia without behavioral disturbance, major depressive disorder, and Parkinson's disease. A review of Resident #209's admission Minimum Data Set (MDS), dated 07/05/2022, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3, which indicated severely impaired cognitive skills. A review of Resident #209's "Order Summary Report" revealed the resident was admitted with orders for pramipexole dihydrochloride tablet 0.25 milligram (mg). The order was to give one tablet by mouth twice a day related to Parkinson's disease. The order start date was the day of admission, 06/29/2022. A review of the pharmacy receipt revealed Resident #209's pramipexole dihydrochloride tablets were delivered to the facility on 06/29/2022.	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 580	Continued From page 36	F 580		

A review of the resident's June 2022 and July 2022 "Medication Administration Record [MAR]" revealed the pramipexole dihydrochloride tablet 0.25 mg was not administered the evening of 06/29/2022 or the mornings of 07/01/2022, 07/02/2022, or 07/03/2022.

A review of the resident's "Progress Notes", dated 06/29/2022, 07/01/2022, 07/02/2022, and 07/03/2022 revealed the medication was not available for morning administration and no note indicated the physician was called regarding the missing medication.

During a telephone interview with Staff R, a Certified Medication Assistant (CMA), on 07/08/2022 at 1:33 PM, she stated she was able to pass medications as of 05/18/2021 and had worked at the facility for four years as a CNA. She stated if the medication was in stock it was administered. She stated if the medication was not available, she would inform the charge nurse and they would see what was going on. If a medication was not given, it should be documented on the MAR and in a nursing note. She stated she could not find the Parkinson medication for Resident #209 the morning of 07/03/2022. She stated the medication cards were not in the cart that morning and she notified Staff F, a Licensed Practical Nurse (LPN) and charge nurse, who double checked and could not find the medication card either.

An interview with Staff F on 07/08/2022 at 2:28 PM revealed if a medication needed to be given but was not available, she would call the pharmacy to see when it could be delivered. She stated the pharmacy for the facility could be very

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 580	Continued From page 37	F 580		

slow when delivering medications. She stated she was not passing medications on 07/03/2022 and did not recall getting any reports from the CMAs about missing medications.

During an interview with the Director of Nursing (DON) on 07/09/2022 at 2:30 PM, she stated ideally if the medication was not available the nurse would call the pharmacy and check the E-kit (emergency kit; emergency medication box). If the medication was determined to not be sent from the pharmacy, it should be reordered. She stated the physician should be notified the same day when a medication was not available for administration and kept up to date about when the medication could be given. She stated if the medication had not arrived in a few days, the nurses should be following up with pharmacy. She stated there was a "card" issue with Resident #209's medication and the doses not given in the morning should have been reported to the physician.

During an interview on 07/09/2022 at 2:37 PM with Staff H, a Licensed Practical Nurse, she stated she was not sure if the physician was notified that Resident #209's medications were not given.

During an interview with the Administrator on 07/09/2022 at 4:04 PM, she stated the physician, the pharmacy, and the DON should be notified if a medication was not available at medication pass time. She stated the CMAs should report to the nurse if medications were not available.

| F 610 SS=D | Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) | F 610 | | |

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	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

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F 610	Continued From page 38 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 facility policy review, clinical record review, staff interviews, facility document review, the facility failed to complete a thorough investigation of an alleged violation of physical abuse and failed to maintain documentation that an alleged violation was thoroughly investigated for one (Resident #26) of 6 residents reviewed for abuse. Specifically, the facility failed to document and maintain witness statements related to an investigation of an allegation of staff-to-resident abuse involving Resident #26 and Staff B, a Certified Nursing Assistant (CNA) on 11/30/2022. The facility identified a census of 53 current residents. Findings include: A review of the facility's policy titled, "Dependent Adult Abuse Protocols," November 2019 Edition,	F 610	**Description: F610 Investigate/Prevent/Correct Alleged Violation** **Plan of Correction:** Facility will complete outcome summaries on DIA website regarding findings to investigations **How residents affected & residents with potential of being affected were identified:** Residents who reside to Centerville specialty care have the potential to be affected **Measures or systemic changes made to ensure this will not recur and affect others:** Facility will complete outcome summaries on DIA website regarding findings to investigations. Reporting education for DON and Administrator. Abuse education provided for staff. **Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** Each time a report is submitted it will be monitored by the management team to assure compliance. **Anticipated Date of Completion for this plan of correction:** Ongoing when a report is filed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ____ B. WING ____	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 610	Continued From page 39	F 610		

revealed that "Following investigation, the Administrator or designated agent will be responsible for forwarding the results of the investigation to the Department of Inspections & Appeals. This written report shall be forwarded to the Department within five days." The policy also indicated, "Following the completion of the facility investigation, if the facility concludes that the allegations of resident abuse are unfounded, the employee will be allowed to return to job duties involving resident contact, but the employee must maintain separation and have no contact with the resident alleged to have been abused, by reassigning the accused employee to an area of the facility where no contact will be made between the accused employee and the resident alleged to have been abused."

R review of an Admission Record revealed the facility admitted Resident #26 with diagnoses that included congestive heart failure (CHF), dementia with behavioral disturbance, and chronic kidney disease (CKD).

A review of a quarterly Minimum Data Set (MDS) assessment dated 11/04/2021 revealed Resident #26 required extensive physical assistance of two or more people for bed mobility and transfers.

A review of an annual MDS dated 04/21/2022, revealed Resident #26 scored 5 on a Brief Interview for Mental Status (BIMS), which indicated the resident experienced severe cognitive and memory impairment. Further review of the MDS revealed the resident required extensive physical assistance of two or more people for bed mobility and transfers.

A record review of an untitled facility incident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 610	Continued From page 40 report revealed on 11/30/2021, Staff X, Nurse Manager overheard Staff N, Certified Nursing Assistant (CNA) and Staff O, CNA, saying that another CNA had put Resident #26 in an awkward position in the resident's bed intentionally and Staff N and Staff O thought that Staff B, CNA and Staff A, CNA were being mean and hurting Resident #26. Staff N and Staff O reported the concern to the Administrator, stating they had responded to Resident #26's call light and the resident stated they had "roughed up" the resident, referring to the CNAs who had provided care to the resident on the prior shift. Staff N and Staff O reported that the resident was positioned with the head of the bed and foot of the bed both elevated. The resident reported that Staff B and Staff A had placed the resident in that position. The immediate action was to separate the named staff members from the resident. Staff A and Staff B were suspended, pending the investigation. A skin assessment was completed, and two new bruises were found on the resident's left forearm that were not there previously. The resident was on blood thinners. The resident denied being in any pain. The police were notified on 11/20/2021 at 4:00 PM. The officer stated the bruising, in their opinion, did not resemble abuse, due to the color and shape of the bruise. The officer met with the resident at approximately 5:00 PM. The ongoing corrective action included an in-service to be held on 12/14/2021 to address kindness and abuse for all staff members. There was no outcome listed on the facility-reported incident. Review of a Skin and Wound Note dated 11/30/2021 at 4:30 PM revealed the resident had a bruise on the left elbow that measured 4.0 centimeters (cm) high by 4.7 cm in length by 1.6 cm wide.	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 610	Continued From page 41	F 610		

Continued From page 41

A review of a Social Service Note dated 12/02/2021 at 3:56 PM, revealed the Social Service Coordinator (SSC) visited with the resident regarding the incident that occurred on 11/30/2021. The resident denied being in any pain and was in a pleasant mood. The resident inquired why staff would treat them that way and stated that they should not have done that to the resident. The SSC offered reassurance that the facility was completing an investigation.

During an interview on 07/06/2022 at 11:24 AM, the Administrator (ADM) was asked where the facility's findings were documented on the facility incident report since there was no conclusion listed. The ADM stated that one staff was fired, and one was allowed to come back to work. The ADM stated she did not have anything in writing about the staff being allowed to come back or a conclusion to the investigation. The ADM stated the facility did not substantiate or unsubstantiate abuse and waited for the state department to conclude.

During an interview on 07/07/2022 at 4:20 PM, the ADM stated this was the first facility-reported incident she had to complete since becoming the ADM the month prior, and she was unable to access the Iowa Department of Health (IDH) portal to submit the allegation and had to email the IDH for guidance. She stated the facility-reported incident was submitted via email, along with all correspondence. At this time, the surveyor reviewed the binder of information submitted, and the ADM had not provided the facility's conclusion regarding the allegation.

During an interview and record review on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 610		F 610		

Continued From page 42

07/08/2022 at 9:30 AM, the ADM brought in an unlabeled piece of paper that indicated 'Interviews were conducted with staff and residents following the allegation of abuse. It was determined that [Staff B] would not return to work until after the state completed their investigation. Our facility does not try to determine abuse when an allegation occurs. The facility continues to maintain separation with [Staff B] by having her on continued suspension. It is our policy to maintain separation with any allegation of abuse and the facility will continue to follow that policy until this matter is resolved. After the facility investigation/interviews were completed, it was decided that [Staff A] would be able to return to work. Our internal investigation determined that employee [Staff A] did not have contact with [Resident #26] on the day of the allegation, nor did she witness any interactions that could be associated with this incident. At that point, the facility decided to allow [Staff A] to return to her duties as she was deemed safe by the facility's internal investigation.'

On 07/08/2022 at 12:10 PM, an attempt was made to interview Staff N, but the phone number had been disconnected.

During an interview on 07/08/2022 at 12:14 PM, Staff O stated she was not working the hall that Resident #26 resided on during the time of the allegation but was working with Staff N. Staff N told Staff O that the resident was folded up in the bed. Staff O stated she did not physically see Staff B position the resident. Staff N told Staff O that the resident had upset Staff B, and that was why Staff B had folded the resident in the bed. Staff O stated that by the time she arrived in the resident's room, Staff N had already repositioned

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ____ B. WING ____	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 610	Continued From page 43	F 610		

Continued From page 43

the resident in the bed but noted there was a bruise on the top of part of the resident's left arm. Staff O stated the bruise was a couple of inches wide, circle shaped, and purple. Staff O stated the resident did not appear to be in any distress and that the resident was normally very outspoken and angry. The resident told Staff O 'that girl beat me up, the girl with the bun,' but then the resident started talking about their dog. Staff O stated she reported the allegation to the ADM.

On 07/08/2022 at 12:36 PM, an attempt was made to interview Staff A, but the phone number had been disconnected.

In an interview on 07/08/2022 at 3:59 PM, Staff B stated that during the time of the incident, the resident was having a problem with her TV. Another CNA, name unknown, came into the room to try to assist Staff B with fixing the TV. Staff B stated at some point, the other CNA left the room, and Staff B was the only staff member in the resident's room. Staff B stated she transferred the resident, by having the resident place her hands around Staff B's neck. Staff B then assisted the resident to stand and used a stand-to-pivot maneuver to transfer the resident from the wheelchair to the bed. Staff B stated she never touched the resident's arms during the transfer. Once the resident was in bed, Staff B adjusted the resident's position using the draw sheet (sheet placed underneath resident to assist with positioning) and rolled the resident over on the left side, facing the door. Staff B stated the resident had a pressure ulcer around the buttocks and she (Staff B) was trying to prevent the resident from lying directly on it. Staff B then raised the head of the bed and the foot of the bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 610	Continued From page 44	F 610		

to make the resident comfortable. Staff B stated the resident would have said something to her if the resident was uncomfortable because 'that's the type of person' the resident was. Staff B denied folding the resident up like a pretzel. Staff B stated that she was suspended pending the investigation but was never told why she was suspended.

During an interview on 07/08/2022 at 1:39 PM, the Director of Nursing (DON) stated the ADM was responsible for submitting the facility-reported incident regarding allegations of abuse to the state. The DON stated the ADM had to report within 1 to 2 hours of the initial report or within 24 hours on the state website. The DON stated that by day 5, the facility had to submit the completed investigation to the state. The DON stated she was not at the facility during the time of the allegation and did not assess the resident; however, she did see the resident the following day and stated the resident seemed fine and did not provide the DON with any information. The resident had denied being in any pain. The DON stated the outcome of the investigation was that one CNA was no longer employed at the facility. The DON stated she was not aware of any actual abuse, and the incident had remained open with the state department. The DON stated that the facility's practice was to wait for the state's findings before they would have an outcome.

During an interview on 07/08/2022 at 2:32 PM, the ADM stated the regional consultant never told her that the facility had to come to their own conclusion regarding the allegation and that she would be meeting with that person to discuss how to properly complete a facility-reported incident regarding an allegation of abuse. TheADM stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 610	Continued From page 45 that Staff N and Staff O came to her office the day of the allegation and stated that Staff A and Staff B had abused Resident #26 by folding the resident up like a pretzel. Staff A and Staff B were immediately separated from the resident, and the police were called. The ADM stated the resident often referred to a single person as 'they.' The ADM stated there was some bruising and pictures were taken. The ADM stated she spoke to Staff A, who stated she had never worked with the resident that day and had been assigned showers on a different hall. The ADM stated that the Social Services Director (SSC) got statements from other residents and staff that were provided to the state.	F 610		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656	**Description: 656** **Plan of Correction:** Catheters will be added to resident care plans as indicated. **How residents affected & residents with potential of being affected were identified:** Residents who reside to Centerville Specialty Care have the potential to be affected. **Corrective action taken for resident(s) affected:** Catheter added to care plan. **Measures or systemic changes made to ensure this will not recur and affect others:** Catheters will be added to resident care plans as indicated. Nurse education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 656	Continued From page 46 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on facility policy review, clinical record review, and staff interviews, the facility failed to develop a person centered, comprehensive care plan related to a urinary catheter for 1 (Resident #35) of 3 sampled residents reviewed for urinary catheter. The facility reported a census of 53 current residents. Findings include: A review of the facility's policy titled, "Care Plans, Comprehensive Person-Centered," revised on 12/2016, indicated, "8. The comprehensive, person-centered care plan will: ...b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being;	F 656	**Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** Care plans will be reviewed for catheters as indicated weekly during standard of care meeting. **Anticipated Date of Completion for this plan of correction: Ongoing**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 656	Continued From page 47	F 656		

...g. Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems; ...l. Identify the professional services that are responsible for each element of care; ...9. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan."

A review Resident #35's Admission Record revealed the facility admitted Resident #35 with diagnoses that included diabetes mellitus, chronic obstructive pulmonary disease, dementia without behavioral disturbance, anxiety, congestive heart failure, and chronic kidney disease.

The resident's 5-day Minimum Data Set (MDS), dated 05/08/2022, recorded a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident was cognitively intact. At the time of the assessment, the resident did not have a urinary catheter.

A record review of the care plan, revised 05/02/2022, did not indicate the resident had a urinary catheter and no interventions were listed.

A nurse's progress note, dated 06/02/2022 at 5:48 PM. indicated the medical doctor ordered the facility staff to insert a urinary catheter after receiving the results of an ultrasound. A urinary catheter was inserted.

Review of the Medication Administration Record from June 2022, revealed that on 06/02/2022 staff received an an order to insert a 16 French urinary catheter with a 10 cc (cubic centimeter) bulb due to urinary retention.

A nurse's progress note, dated 06/25/2022 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 656	Continued From page 48 4:45 PM documented Resident #35 transferred to the hospital due to vomiting. The resident was still in the hospital during the survey period and unable to be interviewed or observed. During an interview on 07/06/2022 at 8:25 PM, Staff I and Staff J, both Certified Nursing Assistants (CNA), stated the resident had a urinary catheter and they emptied the catheter bag at the end of their shift and provided urinary catheter care at least once a shift. During an interview on 07/06/2022 at 8:27 PM, Staff L, a CNA, reiterated Staff I and Staff J's statement. During an interview on 07/06/2022 at 8:34 PM, Staff M, a Certified Medication Aide (CMA), stated that the resident had a urinary catheter and CNAs provided catheter care. During an interview on 07/06/2022 at 8:43 PM, Staff G, a Registered Nurse, reiterated Staff M's statement. During an interview on 07/09/2022 at 10:07 AM, the Administrator (ADM) stated if a resident had a urinary catheter, it should be added to the care plan. During an interview on 07/09/2022 at 10:14 AM, the Director of Nursing (DON) stated if a resident had a urinary catheter, it should be added to the care plan. During an interview on 07/09/2022 at 3:20 PM, the DON stated the MDS Coordinator was responsible for updating the care plan and if she was not available, it would be the DON's	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 656	Continued From page 49 responsibility. The MDS Coordinator was unavailable for interview during the survey due to an emergency leave of absence.	F 656		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interview, the facility failed to ensure three (Resident #311, Resident #29, and Resident #209) of six sampled residents reviewed for medication administration received care and treatment in accordance with professional standards of practice. Specifically, the facility failed to ensure Resident #311's physician was notified of a positive COVID-19 test on 02/26/2022. Once the provider was aware the resident had COVID-19 on 03/01/2022, the facility failed to ensure physician-ordered medications were provided and tests were obtained as ordered on 03/01/2022. In addition, the facility failed to monitor Resident #311's vital signs for approximately 23 hours prior to the resident's death. Resident #311 expired on 03/02/2022 due to COVID-19 pneumonia; failed to notify the physician when blood sugar levels were outof	F 684	**Description:** F684 **Plan of Correction:** Nursing staff will be provided education on the importance of completing physician orders as directed, notifying physician on a change of condition, documenting assessments in charts, obtaining vitals as ordered and with a change in condition, notifying the primary care provider on blood sugars outside of parameters, and ensuring the primary care provider and pharmacy are updated on any medications that not available in the E-Kit. **How residents affected & residents with potential of being affected were identified:** Residents who reside to Centerville Specialty Care have the potential to be affected. **Corrective action taken for resident(s) affected:** Orders to be completed as directed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 684	Continued From page 50 parameters (too high and/or too low) and failed to conduct and document follow-up blood sugar results and assessments after obtaining abnormal blood sugars for Resident #311 and Resident #29; and failed to administer medications as ordered and/or inform the physician when medications were missed or unavailable for Resident #29 and Resident #209. The facility identified a census of 53 current residents. Findings include: 1. A review of an "Admission Record" revealed Resident #311 had diagnoses which included chronic obstructive pulmonary disease (COPD), chronic viral hepatitis C, diabetes, multiple sclerosis, congestive heart failure (CHF), hypertension, cirrhosis of the liver, and chronic kidney disease. Further review of the admission record revealed the resident expired at the facility on 03/02/2022. A review of the admission "Minimum Data Set" (MDS), dated 02/03/2022, indicated Resident #311 scored 12 on a Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. The resident required limited to extensive assistance of two people for activities of daily living (ADLs). The MDS indicated the resident received insulin injections on six out of seven days during the lookback period. A review of a care plan, dated as initiated on 01/31/2022, revealed Resident #311's goal was to transition back to the community. The facility developed an intervention for the resident to transition home with goals met.	F 684	**Measures or systemic changes made to ensure this will not recur and affect others:** Nursing staff will be Educated along with continuing education with monthly meetings, Nurse manager and DON will continue this discussion in morning stand up meetings. **Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** Nurse manager will complete 3 orders and 3 glucose check audits for 4 weeks. Then 2 order audits will be conducted for 2 additional weeks. DON will complete change of condition audits and vitals for 6 weeks. Results of the audits will be submitted to QAPI for review and additional recommendations. **Anticipated Date of Completion for this plan of correction:** 7.25.22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 684	Continued From page 51	F 684		

1. a) A review of the facility's policy titled, "Lab and Diagnostic Test Results - Clinical Protocol," revised November 2018, indicated, "The physician will identify, and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility. When test results are report to the facility, a nurse will first review the results." The policy also indicated the following:
- "A nurse will identity the urgency of communicating with the attending physician based on the physician's request, the seriousness of any abnormality, and the individual's current condition."
- "A physician can be notified by phone, fax, voicemail, e-mail, mail, pager or a telephone message to another person acting as the physician's agent (for example, office staff). a. Facility staff should document information about when, how, and to whom the information was provided and the response. This should be done in the Progress Notes section of the medical record and not on the lab results report, because test results should be correlated with other relevant information such as the individual's overall situation, current symptoms, advance directives, prognosis, etc. [et cetera]. b. Direct voice communication with the physician is the preferred means for presenting any results requiring immediate notification, especially when the resident's clinical status is unstable orcurrent treatment needs review or clarification."

Review of a facility policy titled, "COVID-19 Testing Policy," revised 03/10/2022, revealed, "Documentation of Testing. Facilities must

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 684	Continued From page 52	F 684		

Continued From page 52

demonstrate compliance with the testing requirements. To do so, facilities should do the following: For symptomatic residents and staff, document the date(s) and time(s) of the identification of signs or symptoms, when testing was conducted, when results were obtained, and the actions the facility took based on the results."

A review of "Progress Notes" revealed a "COVID-19 Testing" note was entered on 02/26/2022 at 5:55 PM, which indicated Resident #311 had a positive COVID-19 test. The note did not indicate whether the physician was notified of the positive results.

A review of "Progress Notes" dated 02/27/2022 at 12:21 AM and 02/28/2022 at 12:47 PM, revealed Resident #311 had no signs or symptoms of COVID-19 after testing positive.

A review of "Progress Notes" dated 03/01/2022 at 12:24 AM, revealed Resident #311's oxygen saturation was 86% on room air. Oxygen was applied, and the resident's oxygen saturation came up to 91% with the oxygen at 2 liters per minute via nasal cannula.

Areview of a focused evaluation "Progress Note," dated 03/01/2022 at 12:30 AM, indicated Resident #311 had an occasional non-productive cough with oxygen in place. The note indicated the resident had no other signs and symptoms and remained in isolation for a recent diagnosis of COVID-19.

A review of "Doctor's Orders and Progress Notes," dated 03/01/2022 at 12:30 PM, indicated Resident #311 tested positive for COVID-19 on 02/25/2022 and no provider was notified. Further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 684	Continued From page 53	F 684		

review revealed the provider ordered a Z-pak (antibiotic), Dexamethasone (a steroid medication) six milligrams (mg) by mouth daily for 10 days, Tessalon pearls (for cough) 200 mg one by mouth four times a day for 72 hours and then as needed (PRN), Robitussin DM 2 teaspoons every six hours as needed for cough, and oxygen to keep saturations greater than 90%. The provider also ordered a chest x-ray, a complete blood count (or CBC, a laboratory test to detect anemia and/or infection), a basic metabolic profile (BMP, a blood test to check for hydration and kidney function), and a d-dimer (test used to rule out blood clots). The ordered labs were to be completed "today [03/01/2022]." There was also an order to test the resident for influenza (flu) A and B if the test had not already been completed. The notes also indicated the facility would be contacted to set up a monoclonal antibody infusion (treatment for COVID-19) for Resident #311.

A review of a "Social Service Note," dated 03/02/2022 at 12:59 PM, indicated Resident # 311 expired that morning.

A review of Resident #311's physician order reports revealed the physician orders for medications and laboratory tests from 03/01/2022 were not entered into the computer until 03/02/2022 and were not implemented prior to the resident's death on 03/02/2022 at 7:28 AM, approximately 19 hours after the orders were written.

A review of Resident #311's "Progress Notes," dated 03/01/2022 at 2:08 PM, indicated the resident had a non-productive cough but the lungs were clear to auscultation, and respirations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 684	Continued From page 54	F 684		

were even and unlabored. The note indicated the resident's oxygen saturation was 96% on room air on 03/01/2022 at 6:11 AM, approximately eight hours earlier. According to the notes, Resident #311's other vital signs, including temperature (98.5 degrees Fahrenheit), blood pressure (137/56 millimeters of mercury), pulse (71 beats per minute), and respirations (16 breaths per minute) were also obtained at 6:11 AM, approximately eight hours earlier.

A review of "Progress Notes," dated 03/02/2022 at 4:16 AM, indicated Resident #311 did not show any signs or symptoms of COVID-19. The resident's lungs were clear to auscultation and respirations were even and unlabored. Further review of the note revealed the same vital signs obtained on 3/01/2022 at 6:11 AM (the previous day) were also documented on the 03/02/2022 note, oxygen saturation-96%, temperature-98.5 degrees Fahrenheit, blood pressure-137/56 millimeters of mercury, pulse-71 beats per minutes, and respirations-16 breaths per minute. There were no current vital signs documented.

A review of Resident #311's physician orders from the facility's electronic medical records system revealed the resident's "current vitals" were last obtained on 03/01/2022 at 6:11 AM.

A review of the "Death Record," dated 03/02/2022, indicated Resident #311's time of death was 03/02/2022 at 7:28 AM, and the cause of death was COVID-19 pneumonia.

Continued review of Resident #311's "Progress Notes" revealed no documentation of the circumstances surrounding the death of Resident #311 and no documented evidence the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING _____ B. WING _____	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 684	Continued From page 55	F 684		

checked the resident's vital signs, including the oxygen saturation level, for approximately 23 hours before the resident's death.

During an interview on 07/08/2022 at 2:32 PM, Staff T, Nurse Practitioner (NP), stated she was the primary provider for Resident #311. She stated Resident #311 tested positive for COVID-19 on a Friday and she was not notified until she came into the facility to do rounds on the following Tuesday (03/01/2022). She stated the night shift nurse had left a note in her folder requesting an order for oxygen because the resident's oxygen saturation had dropped during the night. She stated she was going to see the resident, and that was when she was told the resident was on the COVID unit. She stated the resident went five days before any COVID treatment was ordered, then died the next day.

On 07/09/2022 at 8:42 AM, the surveyor attempted to call Staff U, the nurse caring for Resident #311 on 03/01/2022 when the physician orders were written. Staff U did not answer, and the surveyor left a message. Staff U did not respond by the end of the survey.

On 07/09/2022 at 11:28 AM, the surveyor attempted to contact Staff C, the nurse who input the orders on 03/02/2022 after the resident expired. Staff C did not answer, and the surveyor left a message. Staff C did not respond by the end of the survey.

During an interview on 07/09/2022 at 2:37 PM, Staff H, a Licensed Practical Nurse (LPN), stated whenever a resident tested positive for COVID-19, they were put into quarantine and notifications were made to the physician and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 684	Continued From page 56	F 684		

families and should be documented in the progress notes. She stated the facility did not have standing orders for how to treat COVID-19. After reviewing Resident #311's record, Staff H stated she was unable to find documentation of the provider being notified when the resident tested positive for COVID-19. She stated when a physician did rounds, they would provide the progress notes at the time of the visit and then the note should go into the resident's chart. Staff H stated the provider would write any new orders on the progress note. She stated she was unable to say why Resident #311's orders were not put into place the day they were ordered.

During an interview on 07/09/2022 at 3:20 PM, the Director of Nursing (DON) stated whenever a positive COVID-19 test result was obtained, the facility would put the resident in isolation and notify the physician, family, state, and medical director. She stated those notifications should be documented in the progress notes. She stated the facility did not have standing orders for positive COVID-19 residents, but the physician should be updated, and they would provide orders as needed. She stated when a provider completed a visit at the facility, the progress notes would be put in the resident's file to be uploaded into the computer. She stated the providers would write any new orders on the progress notes. She stated she expected the orders to be put into the computer right away. After reviewing Resident #311's provider progress note dated 03/01/2022, she stated the orders should have been put in right away and initiated. The DON stated she could not recall the details of Resident #311's death.

During an interview on 07/09/2022 at 4:53 PM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 684	Continued From page 57 the Administrator, she stated when a positive COVID-19 case was identified the resident was moved to the isolation area and the physician and family should be notified. She stated it should be documented in a progress note. The Administrator stated when a physician did a visit and wrote orders, the staff should be putting those orders in when they were received and followed. The Administrator stated Resident #311's orders should have been put in the same day and started and did not know why there was a delay. 1.b) A review of the facility's policy titled, "Diabetes," revised September 2017, indicated, "The physician and staff will establish notification parameters related to diabetes monitoring. Based on individualized notification parameters, the staff will inform the practitioner about the status of each patient's glucose control, depending on the situation, goals, and other associated symptoms or conditions." A review of Resident #311's physician orders and February 2022 Medication Administration Record (MAR) indicated physician orders to check the resident's blood sugar before meals and at bedtime. The order indicated the facility was required to contact the resident's Primary Care Provider (PCP) if Resident #311's blood sugar was over 300 or less than 70. A review of the February 2022 MAR revealed Resident #311's blood sugar was greater than 300 on 58 occasions out of the 112 times it was checked. On fourteen of those occasions, it was greater than 400; on sixteen occasions, it was greater than 500; and on one occasion, it was greater than 600.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 684	Continued From page 58	F 684		

Continued From page 58

A review of Resident #311's "Progress Notes" for February 2022 revealed documentation that the resident's PCP was notified on five of the 58 occasions that the resident's blood sugar was greater than 300.

On 07/09/2022 at 8:42 AM, the surveyor attempted to contact Staff T, Resident #311's PCP, for an interview regarding Resident #311's blood sugars. The surveyor left a message requesting a callback. Staff T did not respond by the end of the survey.

During an interview on 07/09/2022 at 9:05 AM, Staff V, a Certified Medication Aide (CMA), stated the licensed nurses dealt with residents' blood sugars and notifying the physician if the results were out of parameters.

During an interview on 07/09/2022 at 10:33 AM, Staff W, a CMA, stated the physician should always be notified as ordered if a resident's blood sugar was out of parameters, because the physician may want to make changes to the resident's medications.

During an interview on 07/09/2022 at 2:37 AM, Staff H, a Licensed Practical Nurse (LPN), stated staff should document in a progress note or in the MAR notes when a resident's blood sugar was out of physician-ordered parameters and the provider was notified. After reviewing Resident #311's record, she was not able to find documentation that the resident's blood sugars were reported to the physician as ordered, but she stated they should have been. She stated it was important to let the provider know, because they may adjust the resident's medications or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 684		F 684		

Continued From page 59
diet.

During an interview on 07/09/2022 at 3:20 PM, the Director of Nursing (DON) stated any resident with physician orders to check blood sugars should have parameters ordered as to when to notify the physician, and the nurse should document in the computer progress note when the physician was notified. The DON stated notifying the physician when a resident's blood sugar was not within physician-ordered parameters was important, so the physician could make changes if needed.

During an interview on 07/09/2022 at 4:53 PM, the Administrator stated if a resident's blood sugars were out of physician-ordered parameters, the physician and DON should be notified, and it should be documented in a progress note.

2. A review of the "Admission Record" indicated Resident #29 had diagnoses which included diabetes.

A review of the quarterly "Minimum Data Set" (MDS) indicated Resident #29 had moderate cognitive impairment, with a Brief Interview for Mental Status (BIMS) score of 12. The resident required extensive to total assistance of two people for activities of daily living (ADLs). The MDS indicated the resident received insulin injections seven out of seven days during the look back period.

2. a) A review of the facility's policy titled, "Diabetes," revised September 2017 indicated, "The physician and staff will establish notification parameters related to diabetes monitoring. Based on individualized notification parameters, the staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 684	Continued From page 60	F 684		

will inform the practitioner about the status of each patient's glucose control, depending on the situation, goals, and other associated symptoms or conditions."

A review of the physician orders indicated Resident #29 had orders for accuchecks (blood sugar checks) to be completed two times a day and to notify the primary care provider (PCP) if the resident's blood sugar was greater than 300 or less than 70.

A review of the physician orders and June 2022 "Medication Administration Record (MAR)" revealed the resident also had an order (initiated on 12/27/2021) for glucagon (a medication used to treat low blood sugar) one milligram (mg)/0.2 milliliter (ml). The directions were to inject one mg subcutaneously as needed and update the PCP if the resident's blood sugar was over 300 or less than 70.

A review of the May 2022 MAR revealed Resident #29 had a blood sugar below 70 on eleven occasions, with three blood sugar results below 60. There was no documentation the PCP was notified, no documentation that glucagon was administered, nor of any follow-up assessments/checks of the resident's blood sugar.

A review of the June 2022 MAR revealed nine occasions when the resident's blood sugars were below 70, two of which were less than 60. Further review revealed Resident #29's blood sugar was above 300 on occasions. There was no documented evidence the resident's PCP was notified. In addition, there was no documentation that glucagon was administered when the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 684	Continued From page 61	F 684		

resident's blood sugar was below 70, nor of any follow-up/assessments of the resident's blood sugar.

A review of all progress notes dated from 05/01/2022 through 07/08/2022 revealed no documentation Resident #311's PCP was notified as ordered when Resident #29's blood sugars were out of physician-ordered parameters (below 70 or greater than 300). There was also no documentation of the low blood sugars being treated or monitored.

On 07/09/2022 at 8:42 AM, the surveyor attempted to contact Staff T, Resident #29's primary care provider, for an interview regarding the resident's blood sugars. The surveyor left a message requesting a return call. Staff T did not respond by the end of the survey.

During an interview on 07/09/2022 at 9:05 AM, Staff V, a Certified Medication Aide (CMA), stated the nurses dealt with residents' blood sugars and physician notification if results were out of parameters.

During an interview on 07/09/2022 at 10:33 AM, Staff W, a CMA, stated the physician should always be notified if blood sugars were out of physician-ordered parameters, because the physician may want to make changes to the resident's medications.

During an interview on 07/09/2022 at 2:37 AM, Staff H, a Licensed Practical Nurse (LPN), stated staff should document in a progress note or on the MAR notes when a resident's blood sugar was out of physician-ordered parameters and the provider was notified. After reviewing Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 684	Continued From page 62	F 684		

#311's record, she was not able to find documentation that the resident's blood sugars were reported to the physician as ordered, but she stated they should have been. She stated it was important to let the provider know, because they may adjust the resident's medications or diet.

During an interview on 07/09/2022 at 3;20 PM, the Director of Nursing (DON) stated any resident with physician orders to check blood sugars should have ordered parameters for when to notify the physician, and the nurse should document in the computer progress notes when the physician was notified. The DON stated notifying the physician when a resident's blood sugar was not within physician-ordered parameters was important, so the physician could make changes if needed.

During an interview on 07/09/2022 at 4:53 PM, the Administrator stated if a resident's blood sugars were out of physician-ordered parameters, the physician and DON should be notified, and it should be documented in a progress note.

2.b) A review of the facility's policy "Pharmacy and Therapeutics Oversight," revised September 2017, revealed "Medications will be ordered, administered, and monitored appropriately and safely." According to the policy, "The medical director will advise the facility on prescribing, handling, dispensing, storing, prescribing, and monitoring medications, including the following: a. Appropriate indications, selection, and prescribing of medications for the facility's resident/patient population. b. Safe procurement, storage, distribution, use and disposal of drugs and biologicals ... d. Contents of emergency and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 684	Continued From page 63	F 684		

interim medication kits ... i. Monitoring for, identifying, correcting, and preventing medication-related problems including adverse consequences."

A review of "Progress Notes," dated 06/11/2022, indicated Resident #29 was congested and tested positive for COVID-19 twice. The note indicated the provider was notified and new orders were obtained.

A review of Resident #29's "Physician Orders" indicated an order was received on 06/ 11/2022 for dexamethasone six milligrams (mg) give one tablet by mouth one time a day for COVID-19 for seven days, scheduled to start on 06/12/2022.

A review of Resident #29's June 2022 "Medication Administration Record" (MAR) revealed on 06/12/2022 and 06/13/2022, dexamethasone was coded "9", indicating to see the progress notes.

A review of "Progress Notes," dated 06/12/2022 at 3:08 PM and 06/13/2022 at 7:59 AM, revealed the dexamethasone was not available to be administered. The 06/13/2022 note indicated the medication was ordered.

Further review of the MAR revealed dexamethasone was only administered for five days, 06/14/2022 through 06/18/2022, instead of the physician-ordered seven days.

A review of the "Ekit (Emergency medicationkit) Contents" indicated twelve dexamethasone one mg tablets were available in the e-kit.

During an interview on 07/08/2022 at 2:32 PM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 684	Continued From page 64	F 684		

Continued From page 64

Staff T, the Physician Assistant who was Resident #29's primary care provider, stated she expected to be notified if a medication was held. She stated she needed to be aware in case the resident had an adverse reaction due to not receiving the medication. She stated not being notified by facility staff when a medication was held or not given had been an issue in the past.

During an interview on 07/09/2022 at 9:05 AM, Staff V, a Certified Medication Aide (CMA), stated if a medication was not available during the medication pass, she would notify the nurse and document that it was not available. She stated she was unsure if the physician was notified.

During an interview on 07/09/2022 at 10:33 AM, Staff W, a CMA, stated if a medication was not available, she would tell the charge nurse and document it was not available. She stated the charge nurse should notify the physician. She stated if the medication was available in the e-kit, then it should be given. She stated she was unsure why dexamethasone for Resident #29 was not pulled out of the e-kit. She stated the medication should have been given as ordered for seven days, even if it was not available the first two days.

During an interview on 07/09/2022 at 2:37 PM, Staff H, a Licensed Practical Nurse (LPN), stated if a medication was not available during medication pass, the nurse or CMA should check the e-kit to see if it was available there. She stated if the medication was available at the same dose but was with medications ordered at a different time, it could be pulled from those medications and the pharmacy should be notified so the dose could be replaced. She stated if a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 684	Continued From page 65 medication was not available at all, staff should notify the pharmacy. She stated the physician should be notified by fax, but admitted it was not done every time. After reviewing Resident #29's record, she stated the dexamethasone should have been pulled from the e-kit the first two days until it was provided by the pharmacy. Staff H stated Resident #29's dexamethasone should have been given for the full seven days as ordered. During an interview on 07/09/2022 at 3:20 PM, the Director of Nursing (DON) stated if a medication was not available during the medication pass, the cart and the medication room should be double-checked and then the e-kit should be checked to see if the medication was available. The DON stated the pharmacy needed to be called to find out when it was sent and when it would be available. She stated sometimes they could get the pharmacy to deliver medications the same day, even though the pharmacy was hours away. The DON stated the physician should be notified that day, and depending on the type of medication, maybe sooner. She stated if a medication was unavailable for multiple days, the physician, pharmacy, and DON should be notified. She stated dexamethasone was available in the e-kit and could have been used. The DON stated the physician should be contacted for clarification whenever a medication was not available, to see how the physician wanted to proceed. During an interview on 07/09/2022 at 4:53 PM, the Administrator, stated if a medication was not available, the pharmacy, physician, and DON should be contacted.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 684	Continued From page 66	F 684		

3. A review of Resident #209's "Admission Record," dated 06/29/2022, revealed the facility admitted the resident on 06/29/2022 with diagnoses including dementia without behavioral disturbance and Parkinson's disease.

A review of the admission MDS, dated 07/05/2022, revealed the resident scored 3 on a BIMS, which indicated the resident had severely impaired cognitive skills.

A review of the computerized physician's orders, dated 06/29/2022, revealed the facility admitted the resident with physician orders for pramipexole dihydrochloride tablet 0.25 milligram (mg). The directions were to give one tablet by mouth twice a day related to Parkinson's disease.

A review of a pharmacy receipt revealed Resident #209's pramipexole dihydrochloride tablets were delivered to the facility on 06/29/2022.

A review of the June 2022 and July 2022 Medication Administration Records (MARs) revealed the pramipexole dihydrochloride tablet was not administered the evening of 06/29/2022, nor the mornings of 07/01/2022, 07/02/2022, and 07/03/2022.

During a telephone interview on 07/08/2022 at 1:33 PM, Staff R, a Certified Medication Assistant (CMA), stated she was able to pass medications as of 05/18/2021 and had worked at the facility for four years as a Certified Nursing Assistant (CNA). She stated she had passed medications twice on her own. She stated if the medication was in stock, then it was administered. She stated if a medication was not available, she would inform the charge nurse and the charge

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 684	Continued From page 67	F 684		

nurse would see what was going on. If a medication was not given, that information should be documented on the MAR and in a nursing note. She stated she could not find the pramipexole dihydrochloride for Resident #209 the morning of 07/03/2022. She stated the medication cards (pharmacy provided the facility's medications on blister cards) were not in the cart that morning, and she notified Staff F, Licensed Practical Nurse (LPN) charge nurse, who double-checked and could not find the morning medication card either. She stated the medication was available the previous two evenings (07/01/2022 and 07/02/2022) and she administered it.

During an interview on 07/08/2022 at 2:28 PM, Staff F revealed if a medication needed to be given but was not available, she would call the pharmacy to see when it could be delivered. She stated the pharmacy for the facility could be slow when delivering medications. She stated she was not covering the medication cart on 07/03/2022 and did not recall getting any reports from the CMAs about medications missing.

During an interview with the Director of Nursing (DON) on 07/09/2022 at 2:30 PM, she stated, ideally, if a medication was not available, the nurse would call the pharmacy and check the emergency-medication-kit. If the medication was determined to not be sent from the pharmacy, it should be reordered. She stated the physician should be notified the same day when a medication was not available for administration and kept up to date about when the medication could be given. She stated if the medication had not arrived in a few days, the nurses should be following up with the pharmacy. She stated there

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 684	Continued From page 68 was a "card" issue with Resident #209's medication, and the doses not given in the morning should have been reported to the physician. During an interview on 07/09/2022 at 2:37 PM, Staff H, Licensed Practical Nurse, revealed she was not sure if the physician was notified that Resident #209's medication was not given as ordered. During an interview with the Administrator on 07/09/2022 at 4:04 PM, she stated the physician, the pharmacy, and DON should be notified if a medication was not available at medication pass time. She stated the medication assistants should report to the nurse if medications were not available. She stated staff members should have been administering the medication from the medication cards regardless of whether they were AM or PM medication cards.	F 684		
F 689 SS=D	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 facility policy review, clinical record review, and staff interviews, the facility failed to ensure one (Resident #26) of six residents reviewed for abuse/neglect received adequate	F 689	**Description:** F689 **Plan of Correction:** Education provided to nursing staff regarding properly transferring a resident and where to locate transfer status information on the Kardex **How residents affected & residents with potential of being affected were identified:** Residents who reside to Centerville Specialty Care have the potential to be affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 689	Continued From page 69 supervision and assistance to prevent accidents. The facility failed to ensure that Resident #26 was transferred with the number of staff members required, according to the resident's assessed needs and, as a result, the resident sustained a bruise. The facility reported a census of 53 current residents. Findings include: A review of the facility's policy titled, "Safe Lifting and Movement of Residents," revised on 07/2017 indicated, "2. Manual lifting of residents shall be eliminated when feasible. 3. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan." Resident #26's Admission Record documented she had diagnoses including congestive heart failure (CHF), dementia with behavioral disturbance, and chronic kidney disease (CKD). A review of a quarterly Minimum Data Set (MDS) assessment dated 11/04/2021 revealed Resident #26 required extensive physical assistance of two or more people for bed mobility and transfers. The annual MDS assessment dated 04/21/2022 recorded Resident #26 scored 5 on a Brief Interview for Mental Status (BIMS) test, which indicated the resident was severely cognitively impaired. Further review of the MDS revealed the resident required extensive physical assistance of two or more people for bed mobility and transfers. A review of Resident #26's care plan, initiated on	F 689	**Measures or systemic changes made to ensure this will not recur and affect others:** Education provided to nursing staff regarding properly transferring a resident and where to locate transfer status information on the Kardex. **Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** Four audits per week will be conducted to assess nursing staff knowledge regarding transfer status and where to locate transfer status for 4 weeks. Then 2 audits will be conducted for 2 additional weeks. Results of the audits will be submitted to QAPI for review and additional recommendations. **Anticipated Date of Completion for this plan of correction:** 8/3/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ____ B. WING ____	07/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 689	Continued From page 70 04/29/2021, indicated the resident required staff assistance for all care. Interventions included that the resident required assistance of two staff members with toileting, transfers, and bed mobility. Further review of the care plan revealed the resident was taking an anticoagulant (blood thinner) and the interventions included to monitor for unusual bruising. Review of an untitled facility incident report revealed that on 11/30/2021, facility staff reported an allegation of abuse. Staff reported that Staff A, Certified Nursing Assistant (CNA) and Staff B, CNA, put Resident #26 in the bed in an awkward position and were intentionally 'being mean' and hurting Resident #26. The facility immediately suspended Staff A and Staff B pending investigation. A skin assessment was completed, and two new bruises were found on the resident's left forearm. A review of a Skin and Wound Note, dated 11/30/2021 at 4:30 PM, revealed the resident had a bruise on the left elbow that measured 4.2 square centimeters (cm) in area, with a length of 4.7 cm and a width of 1.6 cm. In an interview on 07/08/2022 at 3:59 PM, Staff B stated that during the time of the incident, the resident was having a problem with his/her TV. Another CNA, name unknown, came into the room to try to assist Staff B with fixing the TV. At some point, the CNA left the room and Staff B was the only staff member in the resident's room. Staff B stated she transferred the resident by having the resident place her hands around Staff B's neck, and assisted the resident to stand, then used a stand-to-pivot maneuver to transfer the resident from the wheelchair to the bed. Staff B	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 689	Continued From page 71	F 689		

stated she never touched the resident's arms during the transfer. Once in bed, Staff B adjusted the resident in the bed using the draw sheet (a sheet placed underneath a resident to assist with positioning) and rolled the resident over on her left side, facing the door. Staff B then raised the head of the bed and the foot of the bed to make the resident comfortable. Staff B stated the resident would have said something to her if she felt uncomfortable because 'that's the type of person' the resident was.

During an interview on 07/08/2022 at 2:32 PM, the Administrator (ADM) stated that two staff members, Staff N and Staff O, came into her office and made an allegation of abuse. They stated that Staff A and Staff B had abused Resident #26 by folding the resident up like a pretzel. Staff A and Staff B were immediately separated from the resident and the police were called. The ADM stated during the facility's investigation, they identified that Staff A had not worked on that hallway or with Resident #26. The ADM stated that Staff B went into the room by herself with no one in the room, and that the resident was a 2-person transfer, but Staff B had transferred the resident by herself.

During an interview on 07/08/2022 at 3:56 PM, the Director of Nursing (DON) stated if a resident's care plan and MDS stated the resident required the assistance of two staff for transfers and bed mobility, she expected staff to use two people. The DON stated if staff felt the resident did not need two staff for assistance, they would come to her to discuss it.

During an interview on 07/08/2022 at 4:03 PM, the ADM stated if a resident's care plan and MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 689	Continued From page 72 stated the resident required assistance of two staff for transfers and bed mobility, then staff should complete a two-person transfer. The ADM stated there was no reason Staff B should have transferred the resident by herself.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must	F 690	**Description:** F690 **Plan of Correction:** Education will be provided to nursing to review residents with catheters in place upon admission and or placement of new catheters for appropriate diagnosis, and obtain diagnosis from physician if indicated or request to discontinue use of catheter. **How residents affected & residents with potential of being affected were identified:** Residents who reside to Centerville Specialty Care have the potential to be affected. **Corrective action taken for resident(s) affected:** Diagnosis obtained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 690	Continued From page 73 ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on facility policy review, clinical record review, observations, and staff interviews, the facility failed to ensure one (Resident #310) of four residents reviewed for catheter use had the proper justification for the use of an indwelling urinary catheter, failed to assess Resident #310's need for an indwelling urinary catheter and its continued use, and failed to ensure positioning of catheter tubing to reduce the chance for infection. The facility reported a census of 53 current residents. Findings include: A review of the facility's policy titled, "Urinary Incontinence and Catheter Use," dated 09/2017, indicated, "The physician and staff shall use indwelling catheters sparingly, attempt to identify alternatives to catheters for maintaining continence, and monitor for problems and complications related to the use of catheters". Further review revealed "The physician and staff will evaluate the potential for a recently placed indwelling catheter in someone recently admitted from the hospital with a catheter, or who had one placed while in the facility". Continued review indicated "The physician will identify and document clinically pertinent reasons why an indwelling urethral or suprapubic catheter is indicated in certain individuals, including why other alternatives are not feasible." Resident #310's Admission Record recorded he	F 690	**Measures or systemic changes made to ensure this will not recur and affect others:** Education will be provided to nursing to review residents with catheters in place upon admission and or placement of new catheters for appropriate diagnosis and obtain diagnosis from physician if indicated or request to discontinue use of catheter. **Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** Catheter use in facility will be reviewed in weekly standard of care meeting to assess for appropriate diagnosis. Weekly Audit for 6 weeks to assure Care Plan was updated and reflective and that residents have an appropriate diagnosis. **Anticipated Date of Completion for this plan of correction:** Ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 690	Continued From page 74	F 690		

entered the facility on 06/22/2022 with diagnoses which included a right femur fracture and congestive heart failure. The resident did not have a diagnosis related to the use of an indwelling urinary catheter.

Review of the admission Minimum Data Set (MDS), dated 06/28/2022, indicated Resident #310 had no cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Per the MDS, the resident required extensive assistance of two people with activities of daily living (ADLs) including toilet use and personal care. The MDS noted the resident had an indwelling urinary catheter. Further review of the MDS revealed no diagnosis related to the use of an indwelling urinary catheter.

A review of the care plan, dated 06/22/2022, indicated Resident #310 had a urinary catheter. No diagnosis for the use of the catheter was documented on the care plan. Interventions directed staff to provide catheter care every shift .

Review of the resident's June 2022 Physician Orders indicated Resident #310 had an order to the change their indwelling urinary catheter every 30 days and PRN (pro re nata; as needed) with a size 16 French (Fr) with 10 cubic centimeter (cc) bulb. There was no diagnosis for the use of an indwelling urinary catheter.

A review of progress notes from 06/22/2022 through 07/06/2022 revealed almost daily documentation of the catheter being patent and draining yellow urine but no documentation to indicate the need or justification for the urinary catheter.

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F 690	Continued From page 75 A review of Resident #310's record revealed no bladder assessment was completed and no other assessment was completed to determine the ongoing need/justification for the urinary catheter. Observations on 07/07/2022 at 11:43 AM revealed Staff N, Certified Nurse Aide (CNA), came pushed Resident #310 into the hallway from a room with his catheter dragging on the ground under the wheelchair. Staff N then stopped and hung the catheter drainage bag under the wheelchair. During an interview on 07/09/2022 at 9:05 AM with Staff V, CNA and also a Certified Medication Aide (CMA), she stated she provided catheter care but did not know about anything else related to the catheters. Staff V stated she thought Resident #310 had a catheter because they had a broken hip. During an interview on 07/09/2022 at 10:33 AM with Staff W, CMA, she stated she was not sure what needed to be in place when a resident had a catheter. She stated she only provided catheter care if needed. During an interview on 07/09/2022 at 2:37 PM with Staff H, Licensed Practical Nurse (LPN), she stated a resident with a catheter should have an order to change the catheter and the staff should monitor intake and output. She stated no formal assessment was done for residents with catheters to determine the justification for the catheter. Staff H stated if they noticed a resident had urinary retention, then they would contact the physician for an order. There should be a diagnosis and orders that included the size of the catheter and how often to change it, which she	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165226	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

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F 690	Continued From page 76	F 690		

Continued From page 76

noted should be care planned. Staff H stated the purpose for Resident #310's catheter was probably for urinary retention and because the resident had an incision. Staff H stated from reviewing the admission paperwork from the hospital it indicated the resident was not getting up. She stated the resident was getting up now and needed to be assessed for the continuing need for the catheter, but stated that was the physician's responsibility. After reviewing Resident #310's physician orders, she stated the resident had an order for the size of the catheter and when to change it, but she agreed no diagnosis listed. After reviewing the resident's diagnosis, she stated she would say the reason for the catheter was for the fracture and difficulty walking but again agreed the resident did not have an actual diagnosis for the use of the urinary catheter.

During an interview on 07/09/2022 at 3:20 PM, the Director of Nursing (DON) stated a resident with a catheter should have an associated care plan with tasks included on the task list for CNAs to provide care. She stated there should be orders to change the catheter every 30 days and PRN, and the order should include the size of the catheter. The DON stated there should be a diagnosis for the use of the catheter also. She stated staff updated the physician if a resident admitted to the facility with a catheter and no associated order. The DON stated sometimes the physician referred a resident to urology but sometimes a resident wanted the catheter for comfort. She stated in the past, the physician had ordered catheters for irritation due to incontinence. The DON stated Resident #310 admitted with his catheter, but she was not sure of the reason for it. She stated the resident would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

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F 690	Continued From page 77 need to be assessed for the ongoing need for the catheter.	F 690		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on facility policy review, facility document review, and staff interviews, the facility failed to ensure there was sufficient nursing staff to meet the residents' needs as evidenced by not	F 725	**Description: F725 Sufficient Staffing** **Plan of Correction:** Facility assessment will be modified to reflect current resident population. Education to MDS, Admin, and DON. **How residents affected & residents with potential of being affected were identified:** Residents who reside to Centerville specialty care have the potential to be affected. **Corrective action taken for resident(s) affected**: Call light audits will be completed by the leadership team. **Measures or systemic changes made to ensure this will not recur and affect others:** Review in morning stand -up **Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** Review in morning stand -up, education provided Admin, DON, MDS. **Anticipated Date of Completion for this plan of correction:** Ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 725	Continued From page 78	F 725		

following the facility assessment staffing guidelines for 27 of 42 shifts reviewed from 06/25/2022 through 07/07/2022. The facility reported a census of 53 current residents.

Findings include:

A review of the facility's policy titled, "Staffing," revised October 2017, indicated, "Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment.
2. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care."

Review of the Facility Assessment dated 05/30/2022, indicated the average daily census was 43 residents. The Daily Staffing Pattern indicated the following staff were needed for the average daily census:
a. First shift: Two licensed nurses providing direct care, four Certified Nursing Assistants (CNA),one Restorative Aide (RA), one Shower Aide, and one Certified Medication Aide (CMA).
b. Second shift: Two licensed nurses providing direct care, four CNAs, and one CMA.
c. Third shift: One licensed nurse providing direct care and two CNAs.

A review of the Daily Nurse Staffing for 06/25/2022 through 07/07/2022 revealed the following staff worked at the facility:
a. On 06/25/2022, during the day shift (first shift) one licensed nurse, one CMA, and three CNAs worked at the facility; subsequently, based on the facility assessment, the facility was short one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

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F 725	Continued From page 79	F 725		

nurse, one CNA, one restorative aide, and one shower aide.
b. During the evening shift (second shift) on 06/25/2022, two licensed nurses worked four hours each (totaling one eight-hour shift), with one CMA and three CNAs. The facility was short one nurse and one CNA for the shift.
c. On 06/26/2022, one licensed nurse, one CMA, and four CNAs worked the day shift. The facility was short one nurse, one restorative aide, and one shower aide.

Further review of day shift staffing from 06/27/2022 through 07/07/2022, revealed no restorative aide nor shower aide worked the day shift during this time.

Review of the facility's evening shift staffing for 6/26/2022 through 07/07/2022 revealed two 2 licensed nurses worked four hours each (covering one eight hour shift) and one CMA worked each shift, subsequently, the facility was short one nurse on each evening shift based on the facility assessment.

Further review of evening shift staffing revealed on 07/01/2022, one CNA worked a full shift, one CNA worked for four hours, and one CNA worked for six hours, leaving the facility short staffed one CNA for the shift, one CNA for approximately four hours, and one CNA for approximately two hours.

During the evening shift on 07/03/2022, three CNAs worked the full shift, and one CNA worked four hours of the shift (short approximately four hours). Further, during the evening shift on 07/05/2022, three CNAs worked a full shift, and one CNA worked a 6-hour shift. The facility was short one CNA for approximately two hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 725	Continued From page 80	F 725		

Continued review of the facility's Daily Nurse Staffing revealed on the night shift on 07/04/2022 (third shift) one licensed nurse and one CNA worked, leaving the facility without one CNA.

During the Resident Council Interview on 07/06/2022 at 1:45 PM, Resident #34, Resident #16, Resident #19, Resident #49, and Resident #8 were present. The Resident Council members indicated they had concerns related to the timeliness of staff answering their call lights. Resident #49 stated that it took staff 'some time' to answer call lights. Resident #19 stated the facility was short staffed, so it took staff a while to answer the call lights. Resident #8 stated they had to wait in the bathroom several times for staff to answer the call light, stating it could take anywhere from 10 to 40 minutes for staff to respond to the call light. Resident #8 stated, 'Sometimes you give up.' Resident #16 stated it took staff a while to answer the call lights.

During an interview on 07/05/2022 at 9:09 AM, Resident #18 stated the facility did not have enough people to do the job. They don't care about how the residents want to be treated.

During an interview on 07/05/2022 at 9:10 AM, Resident #27 stated the facility can't keep staff and residents get short-changed. Sometimes, he did not get showers. The morale of the staff has really sunk, but they try to help as best they can. Resident #27 concluded you can tell staff are not really happy here.

During an interview on 07/05/2022 at 11:20 AM, Resident #13 stated he was supposed to be repositioned at 9:30 AM but was delayed due to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

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F 725	Continued From page 81 staff assisting other residents during breakfast. Resident #13 stated staff said he would have to wait until 1:00 PM to be repositioned. During an interview on 07/06/2022 at 8:43 PM, Staff G, Registered Nurse, stated that recently, on the 10:00 PM to 6:00 AM shift, there was only Staff G and a CNA working the shift for the entire building. Staff G stated she had to assist the CNA with residents that required two staff members to assist. Staff G stated she notified the Director of Nursing (DON) of the concern related to staffing, but the DON just shrugged her shoulders. During an interview on 07/08/2022 at 1:49 PM, the DON confirmed staffing requirements for nurses and CNAs per the facility assessment. Even though the facility assessment indicated a CMA was required for staffing, the DON stated the facility had CMAs assist nurses when needed. According to the DON, staff, residents, and/or families had spoken with the DON about staffing issues. The DON stated the facility was recovering from a COVID-19 outbreak and some residents required more care than others. The DON stated the facility was currently utilizing two contract agencies for staffing and used the agencies consistently. During an interview on 07/08/2022 at 3:03 PM, the Administrator indicated staffing requirements were different than what was documented on the facility's assessment. TheAdministrator stated on day shift, there should be two licensed nurses and six CNAs; and evening and night shifts should have one licensed nurse and two CNAs for each shift. According to the Administrator, the facility interchanged a CMA and a licensed nurse because a CMA could assist the licensed nurse	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

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F 725	Continued From page 82 with passing medications. However, according to the Daily Nurse Staffing there was no documented evidence a nurse was interchanged with an extra CMA. Further interview with the Administrator revealed the facility recently had a COVID-19 outbreak and a bunch of staff quit on the same day. The Administrator stated to help with staffing, the facility used two contract companies and the facility's management team members had also been working as CNAs to assist with providing resident care.	F 725		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F 755	**Description: F755** **Plan of Correction:** Education to nursing staff to utilize the facility Emergency medication kit if a medication is "not available". A medication should not be documented as "not available" until it is determined the medication is not in the Emergency medication kit, a pharmacy contact note is documented on why there is a delay in that medication, when it will arrive along with a progress note stating the primary care provider was notified. **How residents affected & residents with potential of being affected were Identified:** Residents who reside to Centerville Specialty Care have the potential to be affected.	

Corrective action taken for resident(s) affected: Medication provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 755

Continued From page 83

receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on facility policy review, clinical record review, and interviews, the facility failed to ensure physician-ordered medications were available for administration from the pharmacy for one (Resident #311) of six sampled residents reviewed for medication administration. The facility reported a census of 53 current residents.

Findings include:

A review of the facility's policy "Pharmacy and Therapeutics Oversight," revised September 2017, revealed "Medications will be ordered, administered, and monitored appropriately and safely." According to the policy, "The medical director will advise the facility on prescribing, handling, dispensing, storing, prescribing, and monitoring medications, including the following: a. Appropriate indications, selection, and prescribing of medications for the facility's resident/patient population. b. Safe procurement, storage, distribution, use and disposal of drugs and biologicals ... d. Contents of emergency and interim medication kits ... i. Monitoring for, identifying, correcting, and preventing medication-related problems including adverse consequences."

A review of the Admission Record revealed Resident #311 admitted to the facility on

F 755

Measures or systemic changes made to ensure this will not recur and affect others: Education to nursing staff to utilize the facility Emergency medication kit if a medication is "not available". A medication should not be documented as "not available" until it is determined the medication is not in the Emergency medication kit, a pharmacy contact note is documented on why there is a delay in that medication, when it will arrive along with a progress note stating the primary care provider was notified.

Planned monitoring of corrective actions to ensure practice is corrected and will not occur: Nurse management will complete 4 audits per week for 4 weeks to monitor for medication not administered. Then 2 audits will be conducted for 2 additional weeks. Results of the audits will be submitted to QAPI for review and additional recommendations.

Anticipated Date of Completion for this plan of correction: 8/3/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

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F 755	Continued From page 84	F 755		

01/28/2022 with diagnoses which included atherosclerotic heart disease, hypertension, congestive heart failure, restless leg syndrome, multiple sclerosis, and acute myocardial infarction (heart attack).

A review of the admission Minimum Data Set (MDS) assessment, dated 02/03/2022, indicated Resident #311 had moderate cognitive impairment, with a Brief Interview for Mental Status (BIMS) score of 12 out of 15. The MDS indicated the resident required limited to extensive assistance of two people for their activities of daily living (ADLs) except eating.

A review of the resident's Physician Orders and the February 2022 Medication Administration Record (MAR) indicated Resident #311 had orders which included:
a. Flomax (used of urinary incontinence) 0.4 milligrams (mg) give one tablet by mouth one time a day.
b. Fluconazole (used for yeast infections) 50mg give one tablet by mouth one time a day every three days.
c. Ranolazine (used for chest pain) 1,000 mg give one tablet by mouth two times a day.
d. Isosorbide Mononitrate (used for chest pain) 50 mg give 50 mg by mouth two times a day.
e. Prednisone (used for multiple sclerosis) 20mg give three tablets by mouth one time a day.
f. Ropinirole (used for restless leg syndrome) 2 mg give one tablet by mouth one time a day.

Further review of the February 2022 MAR revealed the resident did not receive the following medications due to not being available from the pharmacy for administration:
a. Flomax 0.4 mg on 02/22/2022, 02/23/2022,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 755	Continued From page 85 02/24/2022, and 02/25/2022 b. Fluconazole 50 mg on 02/04/2022, 02/16/2022, and 02/22/2022 c. Prednisone 60 mg on 02/22/2022, 02/23/2022, and 02/26/2022 d. Ranolazine 1,000 mg on 02/22/2022, 02/23/2022, 02/25/2022, 02/26/2022 AM and PM dose, 02/27/2022 AM and PM dose, and 02/28/2022 AM and PM dose e. Isosorbide 50 mg on 02/23/2022, 02/26/2022, 02/27/2022, and 02/28/2022 f. Ropinirole 2 mg on 02/23/2022 and 02/25/2022 Review of the Orders-Administration Notes for the above medications indicated the medications were either not available or were on order. During an interview on 07/09/2022 at 9:05 AM with Staff V, Certified Medication Aide (CMA), she stated if a medication was not available during the medication pass, then she would tell the nurse and document that it was not available. During an interview on 07/09/2022 at 10:33 AM with Staff W, CMA, she stated if a medication was not available, she would tell the charge nurse and document it was not available. She stated if the medication was available in the E-kit (emergency medication supply) then it should be given. During an interview on 07/09/2022 at 2:37 PM, Staff H, Licensed Practical Nurse (LPN) stated if a medication was not available during the medication pass, the nurse or CMA should check the E-kit to see if it was available to pull from there. She stated if the medication was available at the same dose but was with medications ordered at a different time, it could be pulled from	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 755	Continued From page 86 those medications and then the pharmacy should be notified so the dose could be replaced. She stated if it was not available at all, then the pharmacy should be notified that it was needed. During an interview on 07/09/2022 at 3:20 PM, the Director of Nursing (DON) stated if a medication was not available during the medication pass, the cart and the medication room should be double checked and then the E-kit should be checked to see if the medication was available from there. The DON stated the pharmacy needed to be called to find out when it was sent and when it would be available. The DON stated sometimes they could get the pharmacy to deliver it that day even though the pharmacy was hours away. During an interview on 07/09/2022 at 4:53 PM, the Administrator stated if a medication was not available during the medication pass, the pharmacy and physician should be contacted along with the DON.	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or	F 757	**Description:** F757 **Plan of Correction:** Coumadin logs will be utilized to monitor PT/INR results. Education provided to nursing staff if they are unable to obtain a PT/INR on the scheduled day, they physician will be notified, and a progress note created to reflect any new orders.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

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F 757

Continued From page 87

§483.45(d)(4) Without adequate indications for its use; or

§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.

This REQUIREMENT is not met as evidenced by:

Based on facility policy review, clinical record review and interviews, the facility failed to ensure one (Resident #29) of six sampled residents reviewed for medication administration received adequate monitoring for therapeutic and potential adverse medication effects. Specifically, the facility failed to monitor Resident #29's use of Coumadin (a blood thinner) by ensuring necessary laboratory tests were completed as ordered by the physician. The facility identified a census of 53 current residents.

Findings include:

A review of the facility's policy titled, "Lab and Diagnostic Test Results - Clinical Protocol," revised November 2018, indicated, "The physician will identify, and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility. When test results are report to the facility, a nurse will first review the results." The policy also indicated the following:

a. "A nurse will identity the urgency of

F 757

How residents affected & residents with potential of being affected were identified: Residents who reside to Centerville Specialty Care have the potential to be affected.

Corrective action taken for resident(s) affected: Lab work obtained as ordered

Measures or systemic changes made to ensure this will not recur and affect others: Coumadin logs will be utilized to monitor PT/INR results. Education provided to nursing staff if they are unable to obtain a PT/INR on the scheduled day, they physician will be notified, and a progress note created to reflect any new orders.

Planned monitoring of corrective actions to ensure practice is corrected and will not occur Nurse management to monitor logs and documentation to ensure completion weekly.

Anticipated Date of Completion for this plan of correction: Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 757	Continued From page 88 communicating with the attending physician based on the physician's request, the seriousness of any abnormality, and the individual's current condition." b. "A physician can be notified by phone, fax, voicemail, e-mail, mail, pager or a telephone message to another person acting as the physician's agent (for example, office staff). a. Facility staff should document information about when, how, and to whom the information was provided and the response. This should be done in the Progress Notes section of the medical record and not on the lab results report, because test results should be correlated with other relevant information such as the individual's overall situation, current symptoms, advance directives, prognosis, etc. [et cetera]. b. Direct voice communication with the physician is the preferred means for presenting any results requiring immediate notification, especially when the resident's clinical status is unstable or current treatment needs review or clarification." The Admission Record indicated Resident #29 had diagnoses which included atherosclerotic heart disease (a hardening and narrowing of the arteries) and atrial fibrillation (an irregular heartbeat which can result in formation of a blood clot in the heart). Review of the quarterly Minimum Data Set (MDS) assessment, dated 05/05/2022, indicated Resident #29 had moderate cognitive impairment, with a Brief Interview for Mental Status (BIMS) score of 12. The MDS indicated Resident #29 took an anticoagulant (blood thinner) medication on seven out of seven days during the lookback period.	F 757	**How residents affected & residents with potential of being affected were identified:** Residents who reside to Centerville Specialty Care have the potential to be affected. **Corrective action taken for resident(s) affected:** Lab work obtained as ordered **Measures or systemic changes made to ensure this will not recur and affect others:** Coumadin logs will be utilized to monitor PT/INR results. Education provided to nursing staff if they are unable to obtain a PT/INR on the scheduled day, they physician will be notified, and a progress note created to reflect any new orders. **Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** Nurse management to monitor logs and documentation to ensure completion weekly. **Anticipated Date of Completion for this plan of correction:** Ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 757	Continued From page 89 A review of a care plan, dated as initiated 06/22/2021 and last revised 05/20/2022, indicated Resident #29 required anticoagulant/blood thinning therapy related to atrial fibrillation. Interventions included monitoring for side effects. A review of the Resident #29's current Physician Orders indicated the resident had orders for the following: a. Coumadin 4 milligrams (mg) give two tablets (8 mg) by mouth one time a day every Monday, Tuesday, Thursday, Friday, Saturday, and Sunday, and one tablet (4 mg) by mouth onetime a day every Wednesday, ordered on 06/22/2022. This dose was increased from the previous dose of Coumadin 4 mg by mouth daily. b. PT/INR (prothrombin time/international normalized ratio - lab tests to monitor blood clotting) to be completed monthly on the first of the month, ordered 01/26/2022. c. Monitor for side effects of anti-coagulant use, ordered 10/15/2019. A review of Resident #29's discontinued orders indicated an order received on 04/28/2022 for PT/INRs to be completed on day 3 (05/02/2022) and day 7 (05/06/2022) while the resident was taking the antibiotic Keflex twice a day for seven days. A review of a laboratory report dated 05/02/2022 revealed Resident #29's PT results were 42. 4 and the INR measured 4.18. A therapeutic INR level is between 2.0 and 3.0. Resident #29's lab values were considered critical. The report indicated the results were called to the facility nurse. A review of a Focused Evaluation progress note,	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING _____ B. WING _____	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

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F 757	Continued From page 90	F 757		

dated 05/03/2022, indicated that on 05/02/2022 at 6:20 PM, the facility received a call from the laboratory with a high critical INR of 4.18. The note indicated the Nurse Practitioner (NP) was called and orders were obtained to hold the Coumadin for two days, recheck the PT/INR on the morning of 05/03/2022, and update the NP. The note indicated orders were also obtained for Vitamin K 20 mg to be given intramuscularly (IM) at that time. The note indicated the Vitamin K was administered in the left hip.

A review of Resident #29's medical record revealed no documentation that the PT/INR was drawn the morning of 05/03/2022 as ordered.

A review of the May 2022 Lab Administration Report indicated the order for the INR to be redrawn the AM of 05/03/2022 was blank and not initialed as being completed.

A review of laboratory results revealed the PT/INR was not obtained until 05/04/2022 with results of PT 17.4 and INR 1.66. This was a subtherapeutic level, since the INR did not fall between 2 and 3. A review of physician orders obtained 05/04/2022 indicated the PT/INR to be rechecked on 05/09/2022.

A review of a Nurses Note, dated 05/10/2022, indicated the PT/INR was drawn with one attempt to the right hand (this was one day after the lab was ordered).

A review of the laboratory report for the PT/INR drawn on 05/10/2022 indicated results of PT 14.6 and INR 1.38. A review of physician orders obtained 05/10/2022 indicated the PT/INR to be redrawn on 05/13/2022.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 757	Continued From page 91 The Nurse's Note, dated 05/13/2022, indicated labs were drawn from the right hand after one attempt. A review of the resident's medical record revealed no laboratory results for the PT/INR that was ordered to be drawn on 05/13/2022. A copy of the lab report was requested from the facility on 07/07/2022 at 9:17 AM and was not received prior to the end of the survey. A review of the June 2022 Lab Administration Report indicated the PT/INR was signed off as being completed on 06/01/2022. A review of the resident's record revealed no laboratory results for the PT/INR that was to be done on 06/01/2022. A copy of the lab report was requested from the facility on 07/07/2022 at 9:17 AM and was not received prior to the end of the survey. A review of a Nurse's Note, dated 06/10/2022, indicated the facility attempted to obtain blood for labs that included a PT/INR, but they were unsuccessful after two attempts. A review of Resident #29's discontinued orders revealed an order was received on 06/11/2022 for a PT/INR to be done and it was scheduled to be done on 06/14/2022. A review of the resident's medical record revealed the PT/INR ordered to be done on 06/14/2022 was not collected until 06/15/2022. The INR measured within therapeutic range at 2.43. A handwritten note on the report indicated the PT/INR was to be rechecked on 06/17/2022.	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165225	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 07/09/2022
NAME OF PROVIDER OR SUPPLIER: CENTERVILLE SPECIALTY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE: 1208 EAST CROSS STREET, CENTERVILLE, IA 52544	

(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 757	Continued From page 92	F 757		

A review of a nurse's note, dated 06/15/2022, indicated the PT/INR results were received and the primary care provider (PCP) was notified with orders to recheck the PT/INR on 06/17/2022.

A review of the resident's discontinued orders indicated an order was received on 06/15/2022 for the PT/INR to be rechecked and scheduled for 06/17/2022.

A review of the laboratory report, dated 06/17/2022, indicated Resident #29's PT measured 34.3 and INR was high at 3.36. There was no indication the PCP was notified of the results at that time.

A review of the resident's discontinued orders indicated an order was received on 06/19/2022 to recheck the PT/INR on 06/21/2022.

A review of the Orders-Administration Note, dated 06/22/2022, indicted the PT/INR was obtained from the right hand after the third attempt (this was a day after it was ordered to be rechecked).

A review of the laboratory report, dated 06/22/2022, indicated Resident #29's PT measured 44.2 and INR was 4.38. The report indicated the critical INR results were called to the facility on 06/22/2022 at 4:04 PM.

A review of the resident's discontinued physician orders indicated an order was received on 06/22/2022 for the PT/INR to be rechecked on 06/29/2022.

A review of the resident's current physician orders revealed Resident #29's Coumadin was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 757	Continued From page 93	F 757		

Continued From page 93

increased (see above) even though the INR results were reported to be a critical level.

A review of the June 2022 Lab Administration Report indicated the PT/INR that was to be rechecked on 06/29/2022 was blank and was not initialed as being completed.

A review of the resident's medical record revealed no laboratory results for the PT/INR that was ordered to be drawn on 06/29/2022. A copy of the lab report was requested from the facility on 07/07/2022 at 9:17 AM and was not received prior to the end of the survey.

A review of the July 2022 Lab Administration Report revealed the PT/INR scheduled to be completed on 07/01/2022 was not signed off as being completed.

A review of the resident's record revealed no laboratory results on 07/01/2022 for the routine PT/INR that was ordered to be drawn monthly on the first. A copy of the lab report was requested from the facility on 07/07/2022 at 9:17 AM and was not received prior to the end of the survey.

During an interview on 07/08/2022 at approximately 9:29 AM, the facility's regional nurse stated she had called Staff U, Licensed Practical Nurse (LPN) to inquire about the recent missing labs. She stated the nurse reported trying to do a blood draw on 07/05/2022 but was unsuccessful and Staff U was supposed to come into the facility to do a late entry Nurse's Note. She stated she assumed the attempted draw on 07/05/2022 was for the routine order due on 07/01/2022.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 757	Continued From page 94	F 757		

An attempt was made to contact Staff T, a Nurse Practitioner (NP), who was Resident #29's primary care provider (PCP), on 07/09/2022 at 8:35 AM. A message was left with no response by the end of the survey.

An attempt was made to contact Staff U on 07/09/2022 at 8:42 AM, for an interview, and a message was left with no response by the end of the survey.

During an interview on 07/09/2022 at 9:05 AM, with Staff V, a Certified Medication Aide (CMA), she stated Staff C, a nurse supervisor, monitored all the labs and Coumadin use.

During an interview on 07/09/2022 at 10:33 AM, Staff W, a CMA, stated Staff C monitored the residents on Coumadin and the labs and followed up on them.

An attempt was made to contact Staff C on 07/09/2022 at 11:28 AM, and a message was left with no response by the end of the survey.

During an interview on 07/09/2022 at 2:37 PM, Staff H, LPN, stated when an order for labs was obtained, it was put directly into the computer. If it was ordered STAT (immediate), then they would draw it right away. Otherwise, if it was routine, then they would do it as the physician ordered. She stated the facility drew their own blood for labs and sent it to the lab. Staff H stated if she was unable to get the blood, she would ask another nurse to do it or pass it on to the next shift. She stated if all else failed, they would send the resident to the hospital lab to have it drawn. She stated if they were unable to get the lab, the physician should be notified. Staff H stated when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 757	Continued From page 95	F 757		

the lab results were faxed to the facility, the nurse on duty should follow up on them; the nurse should notify the physician and document it in a nurse's note. Staff H stated Staff C, the nurse manager, monitored residents on Coumadin.

During an interview on 07/09/2022 at 3:20 PM, the Director of Nursing (DON) stated residents on Coumadin were managed by the nurse supervisor, Staff C, and it was her responsibility to keep track of the Coumadin and labs associated with the use of Coumadin. The DON stated when a lab was ordered it should be drawn within one to three days of the order unless it was a stat order and then it should be gotten that day. The DON stated when the order was received, the nurse should enter the order into the computer and draw the blood that day. She stated the laboratory requisition was filled out right away sometimes but may not be done until the lab was due. If the blood was unable to be obtained, depending on the lab, they may send the resident out if needed or if the physician requested. The physician should be notified if the lab was not able to be obtained. If the lab ordered was routine, then they would get the lab when they could, but if it was a stat order or an order like a PT/INR and they could not get it, then they would send the resident out. The DON stated Resident #29 sometimes refused lab draws so they would get another person to try and the attempts should be documented in progress notes. The DON stated once a lab report was obtained, the charge nurse or nurse supervisor should follow up on it. The DON stated not all labs needed to be called to the physician, but they should be scanned in and uploaded to the resident's record. She stated this was an issue at the facility. She stated if they needed, they would call and let the physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 757	Continued From page 96 know the results verbally and then document it. During an interview on 07/09/2022 at 4:53 PM, the Administrator stated the DON and Staff C were responsible for ensuring all labs were being obtained and followed up on and should be documented in progress notes.	F 757		
F 800 SS=D	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on facility policy review, clinical record review, observations, and interviews, the facility failed to provide a diet that met the resident's nutritional and special dietary needs for 1 (Resident #18) of 4 residents reviewed for nutrition. The facility identified a census of 53 current residents. Findings include: Review of the facility's "General Food Preparation and Service" policy, updated February 2016, revealed, 'The facility shall provide each resident with food prepared and served by methods that conserve nutritive value and flavor. The food should also be palatable, attractive and at the proper temperature. The Dietary Services Manager and/or cook is responsible for seeing that all menu items are prepared, the menu followed, and for ensuring resident diet orders are	F 800	**Description:** F-800- Failure to provide diet that meets residents needs **Plan of Correction:** Provide a diet that meets the residents needs. **How residents affected & residents with potential of being affected were identified:** Residents who reside to Centerville Specialty Care have the potential to be affected. **Corrective action taken for resident(s) affected:** Affected residents have been provided with appropriate diet per physicians orders. **Measures or systemic changes made to ensure this will not recur and affect others:** DDS will run a diet type report twice weekly on Mon/Thurs. Will Audit diet orders to match tray tickets and adjust as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 800	Continued From page 97 served correctly.' Resident #18's Admission Record documented the resident had diagnoses that included diverticulitis, type 2 diabetes mellitus, anxiety disorder, gastro-esophageal reflux disease (GERD), chronic kidney disease, and dysphagia (difficulty swallowing). Resident #18's admission Minimum Data Set (MDS) assessment, dated 04/14/2022, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident possessed intact memory and cognition. Further review of the MDS revealed the resident had no signs/symptoms of a swallowing disorder, no weight loss/gain, and received a mechanically altered (change in food texture), therapeutic diet. Review of the Order Summary Report for Resident #18 revealed a physician's order, with a start date of 04/08/2022, for the resident to have a consistent carbohydrates diet. The order indicated, "Level 6 Soft & [and] Bite Sizedtexture, Level 0 Thin consistency [liquids], double proteins at lunch." Observations on 07/07/2022 from 10:35 AM to 12:48 PM of the lunch meal revealed the Dietary Services Supervisor (DSS), Staff D, a Cook, and Staff Q, a Dietary Aide, prepared and served the lunch meal. Food for the lunch meal consisted of a roasted breaded pork tenderloin, cheese broccoli rice, mixed vegetables, and sliced peaches. The alternate menu option was cheese pizza, cheese broccoli rice, mixed vegetables, and sliced peaches. Nearing the end of meal service, Staff D ran out of the roasted breaded pork tenderloin.	F 800	**Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** Auditing Mondays and Thursdays x 4 weeks and then on Mondays x 2 weeks. 2 audits per week will be conducted for 4 weeks. Then 1 audit per week will be conducted for 2 additional weeks. Results of the audits will be submitted to QAPI for review and additional recommendations. **Anticipated Date of Completion for this plan of correction: 8/3/2022**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 800	Continued From page 98	F 800		

A review of Resident #18's meal ticket for lunch on 07/07/2022 revealed the resident was to receive one slice of cheese pizza cut into bite sized pieces (documented on the main menu as a regular serving), one 4 ounce (oz) scoop of broccoli cheese rice, and 1 1/2 cup diced peaches, with double protein indicated on the ticket.

Observation on 07/07/2022, at 12:17 PM, revealed Staff D plated Resident #18's meal, which included a whole quarter of the cheese pizza (two servings of protein). Staff D put the whole piece of pizza onto a plate along with 4 oz of broccoli cheese rice, 4 oz mixed vegetables, and 4 oz peach slices. The pizza, per the meal ticket, should have been bite sized. Staff D stated nursing staff should be the ones to cut up the pizza. Further observation revealed at 12:20 PM, an unknown certified nursing assistant (CNA) returned Resident #18's pizza to the kitchen, telling the cook the resident would like the pork.

Continued observation on 07/07/2022 at 12:39 PM revealed Resident #18's meal was prepared and included one microwaved pork patty that still looked frozen, 8 oz. (2 scoops) of the cheese broccoli rice, 4 oz. mixed vegetables, and 1/2 cup sliced peaches. Staff D stated since the pork looked nasty, she gave the resident double broccoli rice casserole, claiming the cheese was the protein the resident would receive double of.

During an interview on 07/08/2022 at 1:29 PM, the Director of Nursing (DON) stated Resident #18 came to the facility with a diet that was different than most, including small bites with some mechanical soft.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

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CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

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F 800 — Continued From page 99 — F 800

During an interview on 07/09/2022 at 9:56 AM the DSS stated the main protein during Thursday's (07/07/2022) meal was the pork patties or the cheese pizza. She stated there was little protein value in the broccoli cheese rice and it would not count as double protein. She stated the computer program generated the meal tickets and provided the dietary staff with the number of meals needed; the computer was down on Thursday, 07/07/2022, so they had to manually count the meals needed and did not count accurately.

During a follow-up interview with the DON on 07/09/2022 at 2:39 PM, she stated that she would not think broccoli was an acceptable protein alternative, and that the broccoli cheese casserole from lunch would not be sufficient to serve as a double protein.

During an interview on 07/09/2022 at 4:04 PM the Administrator stated dietary staff should follow the meal tickets as written.

F 804 SS=D — Nutritive Value/Appear, Palatable/PreferTemp
CFR(s): 483.60(d)(1)(2)

§483.60(d) Food and drink
Each resident receives and the facility provides-

§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;

§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, policy review,

F 804 (Provider's Plan of Correction):

Description: F804- Failure to provide a palatable meal

Plan of Correction: Provide palatable meals

How residents affected & residents with potential of being affected were identified: Residents who reside to Centerville Specialty Care have the potential to be affected.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 804	Continued From page 100 and review of cooking instructions, the facility failed to serve palatable meals to residents during one of one meal observation. The facility identified a census of 53 current residents. Findings include: A review of the "General Food Preparation and Service" policy, updated February 2016, revealed, "The facility shall provide each resident with food prepared and served by methods that conserve nutritive value and flavor. The food should also be palatable, attractive and at the proper temperature. The Dietary Services Manager and/or cook is responsible for seeing that all menu items are prepared, the menu followed, and for ensuring resident diet orders are served correctly." Observations of the of the lunch meal on 07/07/2022 from 10:35 AM to 12:48 PM revealed the Dietary Services Supervisor (DSS), Staff D, a Cook, and Staff Q, a Dietary Aide, prepared and served the lunch meal. Food for the lunch meal consisted of a roasted breaded pork tenderloin, cheese broccoli rice, mixed vegetables, and sliced peaches. The alternate menu option was cheese pizza, cheese broccoli rice, mixed vegetables, and sliced peaches. Nearing the end of meal service, Staff D ran out of the roasted breaded pork tenderloin. Observation on 07/07/2022 at 12:26 PM, revealed after Staff D ran out of the prepared pork tenderloin, she retrieved breaded pork chop patties from a box in the freezer. Staff D placed the pork chop patties on a plate and put them into the microwave. At that time, Staff D stated she usually did not run out of food when the computer	F 804	**Corrective action taken for resident(s) affected:** Affected residents will receive palatable food that meets the temperature required by policy. **Measures or systemic changes made to ensure this will not recur and affect others:** Reeducation provided to dietary staff on appropriate temperatures for meals. Competency audits done on cooks. Meal audits will rotate between breakfast, lunch, and dinner. **Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** 4 meal audits per week will be conducted for 4 weeks. Then 3 meal audits per week will be conducted for 2 additional weeks. Results of the audits will be submitted to QAPI for review and additional recommendations. Competency audits done on cooks twice per week on Monday and Thursday x4 weeks. Then Once per week on Monday x 2 weeks. **Anticipated Date of Completion for this plan of correction: 8/3/2022**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 804	Continued From page 101	F 804		

provided her the count for meal service. Staff D stated she had to do a manual count of resident meals herself before the meal service and she did not make enough of the main protein for all the residents.

Further observation and interview on 07/07/2022 at 12:34 PM, revealed Staff D pulled the breaded pork chop patties out of the microwave and took a temperature of the pork patties which measured 188 degrees Fahrenheit (F). The four pork patties looked the same as when they were frozen and put into the microwave. Staff D stated the meat looked 'nasty' and 'not cooked', and placed the pork patties into the steam table tray to be served to residents.

Observation on 07/07/2022 at 12:40 PM, revealed an unknown certified nursing assistant (CNA) returned with an unknown resident's plate of the microwaved pork patty and stated the resident was 'not going to eat this' and they requested a soup and sandwich instead. Also at this time, Staff D pulled a second plate of microwaved breaded pork chop patties out of the microwave and added them to the steam table for meal service. As she was plating the microwaved pork patties, the DSS stated the pork 'looked nasty'.

A review of the cooking instruction on the box of the breaded pork chop patties revealed two instructions for cooking the pork: The instructions included:
a. Deep fryer: preheat oil to 360 F, place frozen patties in oil for three to five minutes or until internal temperature was 165 F.
b. Grill: add small amount of oil to medium heat (360 F), cook frozen product for four minutes on each side or until the internal temperature was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

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F 804	Continued From page 102 165 F, turning often to avoid burning. During an interview with Staff L, a Certified Nursing Assistant, on 07/08/2022 at 3:12 PM she stated meal orders were completed by dietary staff and the only time floor staff took an order was if the resident wanted something different. Staff L stated if the resident wanted something different, she would check with the nurse first and then would let the kitchen know. During an interview on 07/09/2022 at 9:35 AM, Staff Q stated dietary staff took meal orders on the tablet from residents. She stated they either went room to room or took the residents' orders in the dining room. Staff Q stated if the residents could not respond when asked what they wanted, they received the regular meal. Staff Q stated choices were always offered, and an alternate menu was always available to residents if they did not like the menu options. During an interview on 07/09/2022 at 9:56 AM, the DSS stated the microwaved pork patties should have been baked, grilled, or fried. She stated the residents who received the microwaved pork patties should have been offered another option altogether, such as soup, salad, or sandwich. She stated she saw the microwaved pork patties left on plates and had a second unknown resident return the microwaved pork patty and requesting a sandwich. She stated resident meal preferences were taken on the tablets, and each resident was asked what they would like the day before. The DSS stated if a resident could not respond, they would receive the regular meal unless their preferences documented otherwise. She stated she interviewed the residents about their preferences	F 804		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

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F 804	Continued From page 103 when she initially met them and kept the preferences documented in the computer. The DSS stated the computer program generated the meal tickets and provided the dietary staff with the number of meals needed. She stated the computer was down on Thursday, 07/07/2022, so they had to manually count the meals needed and did not count accurately. During an interview on 07/09/22 at 2:39 PM, the Director of Nursing (DON) stated she would not expect the kitchen to microwave meat to be served. She stated she would expect them to offer the resident a palatable alternative. The DON stated if two staff members said the pork looked disgusting, it should not be served to the resident. During an interview on 07/09/2022 at 4:04 PM, the Administrator stated if kitchen staff were commenting that the food looked nasty, it should not be served to residents, and other, more palatable, options should be offered.	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 812	**Description: F812-** Failure to maintain dish machine temps, Failure to serve food in a sanitary manner, Failure to obtain food temps for service, Failure to cover meals going to outer dining room	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

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F 812	Continued From page 104 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observations, staff interviews, and facility document review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, the facility failed to maintain safe dishwashing wash temperature of 120 degrees Fahrenheit (F) or above for a low temp machine; to serve foodto residents in accordance with sanitary professional standards; to check the temperature of foods heated and reheated in the microwave; to cover meals that were sent to the outer dining area; and record, clean, and monitor a resident nourishment refrigerator. The facility identified a census of 53 current residents. Findings include: 1. A review of the "Sanitization" policy, revised October 2008, revealed for "Low Temperature Dishwasher (Chemical Sanitization), a. Wash temperature (120 [degrees] F [Fahrenheit])." A review of the "ES-2000 Dishmachine" specification sheet revealed the incoming water temperature should measure 120 degrees F minimum up to 140 degrees F. Observations on 07/07/2022 from 10:35 AM to 12:48 PM of the of the lunch meal revealed the	F 812	**Plan of Correction:** To maintain dish machine temperature and when it is not tempting Ecolab to be contacted and dishes not to be used for meal service. Food will be served in a sanitary manner and temperatures obtained for service. Food going to outer dining room to be covered. **How residents affected & residents with potential of being affected were identified:** Residents with the potential to be affected if dish machine is not at the appropriate temperature, and if foods temperature is not obtained for service, served in a sanitary manner or taken to the outer dining room without a cover.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 812	Continued From page 105 Dietary Services Supervisor (DSS), Staff D (a cook), and Staff Q (a dietary aide) prepared and served the lunch meal. Food for the lunch meal consisted of a roasted breaded pork tenderloin, cheese broccoli rice, mixed vegetables, and sliced peaches. Observation on 07/07/2022 at 10:47 AM, revealed Staff D blended pureed consistency meals. At 10:51 AM, Staff D rinsed and placed the food processor bowl into a dish rack and pushed it through the dish machine. The thermometer displayed a wash cycle temperature of 90 degrees F, and a rinse cycle temperature of 110 degrees F. A note on the thermometer displayed wash/rinse 120 degrees F. However, Staff D did not attempt to check the temperature of the dish machine or re-run the food processor bowl through until temperature reach 120 degrees F for both cycles. Staff D stated the dish machine was a chemical machine and should rinse at 120 degrees F. Further observation on 07/07/2022 at 10:55 AM, revealed Staff D retrieved the cleaned food processor bowl and lid that had a wash temperature of 90 degrees F to blend the mechanical soft breaded pork patties in. At 11:05 AM, Staff D rinsed and loaded the food processor bowl, lid, and utensils onto a dish rack, opened the dishwasher, pushed the previous clean rack out of the wash bay, and replaced it with the dirty rack. The thermometer displayed a wash temperature of 97 degrees F and a rinse temperature of 110 degrees F. The DSS came over and checked the temperature of the machine. The DSS noticed the low temperature, she ran the dishes through again. The second wash temperature measured 108 degrees F with	F 812	**Measures or systemic changes made to ensure this will not recur and affect others:** New booster heater to be installed on the machine. Scheduled with Ecolab for 8/3/2022. Dishes will not be used until the machine runs at temp to meet the requirements. 5-minute meeting reeducating staff on dish machine temps, usage and when to report temperatures. 5-minute in-service re-educating staff on proper sanitary usage of tongs and other utensils	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 812	Continued From page 106 a rinse temperature of 120 degrees F. At this time, the DSS stated the machine was new, serviced monthly, and the rinse temp should be 120 F. She stated Ecolab serviced the machine monthly since the machine was installed in April 2022. The DSS ran the same dishes through a third time. The thermometer displayed a wash temperature of 115 degrees F and a rinse temperature of 122 degrees F. The DSS stated the dietary staff had a h*** of a time doing dishes in the morning and would have to run the same dishes through multiple times until the temperature reached 120 degrees F. Continued observations on 07/07/2022, at 11:12 AM, revealed Staff D retrieved the clean food processor bowl to puree the peaches. At 11:25 AM, Staff D rinsed and loaded the food processor bowl, lid, and utensils onto a dish rack, opened the dishwasher, pushed the previous clean rack out of the wash bay, and replaced it with the dirty rack. The thermometer displayed a wash temperature of 115 degrees F and a rinse temperature of 120 degrees F. Further observations in the kitchen of the dishwasher on 07/09/2022 at 9:35 AM revealed a wash temperature of 115 degrees F and a rinse temperature of 120 degrees F. Staff Q was observed to check the thermometer and stated both the wash and rinse cycle were supposed to run at 120 degrees F for their dish machine. At 9:40 AM, Staff Q ran the dish machine, and the thermometer displayed a wash cycle temperature of 110 degrees F and a rinse cycle temperature on 118 degrees F. Staff Q stated the dishes should be continually run through the dish machine until the temperature got to 120 degrees F. A third wash cycle temperature displayed 118	F 812	**Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** Staff will be audited for sanitary usage of utensils, recording of appropriate dishwasher temps, covered food, 4 times per week will be conducted for 4 weeks. Then 3 per week will be conducted for 2 additional weeks. Audits of food being covered 4 times per week will be conducted for 4 weeks. Then 3 per week will be conducted for 2 additional weeks. Food Temp audits 4 times per week will be conducted for 4 weeks. Then 3 per week will be conducted for 2 additional weeks. **Anticipated Date of Completion for this plan of correction: 8/3/2022**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

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CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

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F 812	Continued From page 107	F 812		

Continued From page 107
degrees F and a rinse cycle temperature of 120 degrees F.

Review of an Ecolab Regular Service Call Receipt, dated 06/24/2022, revealed a wash temperature of 115 degrees F.

During an interview with the DSS on 07/09/2022 at 9:56 AM, she stated the hot water for the dishwasher was from a shared water tank, so Ecolab installed a temperature booster to the dishwasher serviced by Ecolab. She stated she was not present during their last check on the dishwasher in June, 2022.

During an interview with the Director of Nursing (DON) on 07/09/2022 at 2:39 PM, she stated she was not sure what the dish washer wash cycle temperature should be. She stated the dietary staff should follow the provided manufacturer training and guidelines for temperature. She stated that Ecolab was who serviced the dishwasher. She stated dietary staff should call the manufacturer if something was not right so the manufacture could come to the facility and look at the machine.

During an interview with the Administrator on 07/09/2022 at 4:04 PM, she stated the dishwasher was supposed to be at 120 degrees F for the wash and rinse cycles. She stated staff should notify the service provider if temperature was not reaching 120 degrees F and the dishes should be re-run when temperature had been established. She stated if the machine was not up to temperature, the dishes should not be used.

2. A review of the "General Food Preparation and Service" policy, updated February 2016, revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ____ B. WING ____	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

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F 812	Continued From page 108	F 812		

"Utensils, cups, glasses, and dishes are handled in such a way as to avoid touching surfaces that food and drink will come in contact with". Further review of the policy revealed "If a foreign object comes into contact with food, the food item much be discarded. An equivalent food replacement will be offered".

Observations on 07/07/2022 from 10:35 AM to 12:48 PM of the of the lunch meal revealed the Dietary Services Supervisor (DSS), Staff D (a cook), and Staff Q (a dietary aide) prepared and served the lunch meal. Food for the lunch meal consisted of a roasted breaded pork tenderloin, cheese broccoli rice, mixed vegetables, and sliced peaches

Observation on 07/07/2022 at 12:21 PM, revealed the handle of the serving tongs used for the breaded pork tenderloin fell into the serving tray, resting on the two remaining tenderloins in the pan. Staff D picked up the tongs and plated one of the patties under the handle of the tongs. At 12:32 PM, Staff D stated the handle of a serving utensil should not touch a food item. She stated if the handle did touch a food item, the soiled utensil should be replaced. She stated they were not supposed to serve food after a utensil handle had touched it. Staff D served the remaining two pork patties to residents.

During an interview on 07/09/2022 at 9:56 AM, the DSS stated utensil handles should not touch food items in the steam table and should realistically be thrown out and new food made.

During an interview on 07/09/2022 at 2:39 PM, the Director of Nursing (DON) stated if a contaminated utensil touched a food item, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 812	Continued From page 109	F 812		

food should not be served to residents.

During an interview on 07/09/2022 at 4:04 PM, the Administrator stated if a food item was contaminated by a dirty utensil handle, the food should be tossed out and not given to residents.

3. A review of the "General Food Preparation and Service" policy, updated February 2016, revealed, "The dietary services manager and/or cook is responsible for seeing that all menu items are prepared, the menu followed, and for ensuring resident diet orders are served correctly'.Further review of the policy revealed "All hot foods will be cooked or reheated to a safe minimum internal temperature and will be held about 135 degrees F [Fahrenheit]".

Observations on 07/07/2022 from 10:35 AM to 12:48 PM of the of the lunch meal revealed the Dietary Services Supervisor (DSS), Staff D (a cook), and Staff Q (a dietary aide) prepared and served the lunch meal.

Observation on 07/07/2022 at 11:57 AM, revealed Staff D poured a can of chicken noodle soup into a bowl and put it into the microwave. At 11:58 AM, Staff D pulled the soup out of the microwave and placed the soup onto a meal tray for room service. When asked what the temperature of the soup was, Staff D stated usually one minute was all the soup needed, and she usually did not take the temperature of foods from the microwave before sending it out to the residents. Staff D retrieved her thermometer, took the temperature of the soup and it displayed a temperature of 98 degrees F. Staff D was not aware of the safe microwave food temperatures, but found out food should be heated to 140 degrees F. Staff D put

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 812	Continued From page 110 the soup back in the microwave. At 12:05 PM, the second soup temperature displayed 157 degrees F, was covered, and put on the tray for room service delivery. Further observation on 07/07/2022 at 12:43 PM, revealed Staff Q retrieved the bowl of soup from the microwave for a resident and moved to leave the kitchen without taking the temperature of the soup. When asked what the temperature of the soup was, she stated she did not know and never took the temperature of microwaved foods before serving them to the residents. Staff D provided a thermometer which displayed the soup's temperature at 144 degrees F. During an interview on 07/09/2022 at 9:56 AM, the DSS stated dietary staff should take the temperature of microwaved foods before giving it to the residents. She stated food should be the proper temperature to prevent foodborne illness. The food could also be cold by the time it gets to the resident and would be sent back. She stated taking food temperatures was included in dietary staff training. During an interview on 07/09/2022 at 2:39 PM, the Director of Nursing (DON) stated she was not sure of safe serving temperatures but would expect dietary staff to take the temperature of the food reheated or heated in the microwave and make sure they are within safe serving range. Dietary staff should know the safe serving temperatures. During an interview on 07/09/2022 at 4:04 PM, the Administrator stated the temperature should be taken of food microwaved before being given to the resident.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 812	Continued From page 111	F 812		

4. A review of the "General Food Preparation and Service" policy, updated February 2016, revealed, "Food will be transported to other areas in covered containers".

Observations on 07/07/2022 from 10:35 AM to 12:48 PM of the of the lunch meal revealed the Dietary Services Supervisor (DSS), Staff D (a cook), and Staff Q (a dietary aide) prepared and served the lunch meal. Food for the lunch meal consisted of a roasted breaded pork tenderloin, cheese broccoli rice, mixed vegetables, and sliced peaches.

Observation on 07/07/2022 at 12:05 PM, revealed the food service began for the outer dining area, across a main hallway from the inner dining area and the kitchen. Four resident meals were placed directly on the cart with no cover and were transported to the outer dining area. At 12:11 PM, observation revealed a second cart with four more resident meals was plated and sent to the outer dining area. None of the four meals were covered for transport. At 12:14 PM, Staff D stated meals served to the dining area had never been covered for meal pass service.

During an interview on 07/09/2022 9:35 AM, Staff Q stated they had always delivered meals to the back dining room uncovered and had not thought of potential contamination happening in the distance between the kitchen and the outer dining area.

During an interview on 07/09/2022 at 9:56 AM, the DSS stated meal delivery had always been uncovered to the dining areas, both inner and outer. She stated the food going to the outer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 812	Continued From page 112	F 812		

dining area could become contaminated in transit because of the main hallway and the distance from the kitchen.

During an interview on 07/09/2022 at 2:39 PM, the Director of Nursing (DON) stated the facility had never covered the outer dining room meals before delivery, and room trays were the only meals covered for delivery. She stated the outer dining area meals should be covered for delivery, as there was no other way to ensure food safety or to ensure food was not contaminated.

During an interview on 07/09/2022 at 4:04 PM, the Administrator stated the food should be covered in transport for safety.

5. A review of the "Personal Food Storage" policy, dated February 2016, revealed, "Food or beverage brought in from outside sources for storage in designated resident refrigeration units, or personal room refrigeration units will be monitored by designated facility staff for food safety. Individuals will be educated on safe food handling and storage techniques by designated facility staff as needed. Staff will examine food for quality (visual, smell, packaging) to identify potential concerns." Continued review of the policy revealed "Designated facility staff will be assigned to monitor individual room storage and refrigeration units for food and beverage disposal. All refrigeration units will have internal thermometers to monitor for safe food storage temperatures. Units must maintain safe internal temperatures in accordance with state and federal standards for safe food storage temperatures. Staff will monitor and documents unit refrigerator temp (temperatures)."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 812	Continued From page 113 Observations of the C-Hallway nourishment refrigerator, on 07/07/2022 at 2:30 PM, revealed the temperature logs had not been completed since 05/04/2022. All documented temperatures between 5/01/2022-05/04/2022 measured below 40 degrees F. During an interview on 07/07/2022 at 2:30 PM, Staff H, LPN (Licensed Practical Nurse) stated the refrigerator was for resident food and drinks. She stated the night nurse was supposed to tend to the resident refrigerator. Staff H stated the night nurse was supposed to record the temperature, and throw out old stuff, concluding that staff can all pitch in and throw out gross stuff if they see it. Further observation of the nourishment refrigerator on the C-Hallway on 07/07/2022 at 2:30 PM revealed the contents of the refrigerator included: a. 4 squares of prepackaged cheeseexpired 04/14/2022. b. 1 cheddar cheese stick expired 04/18/2022. c. 1 Mozzarella stick with no exp date. d. 6 pack of rice pudding expired 06/10/20222 During an interview on 07/07/2022 at 2:40 PM, Staff W, a certified medication/nursing assistant, stated night shift was supposed to check the C-Hallway refrigerator daily and clean it out. Temperatures should be taken daily and expired items thrown out. She stated all the items in the refrigerator were resident foods and drinks and should all be labeled with names and dates. She stated they knew what each resident usually got by way of soda or food items as they usually got the same thing.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 812	Continued From page 114 During an interview on 07/07/2022 at 2:45 PM, the Director of Nursing (DON) stated night shift was supposed to check the C-Hall refrigerator temperatures daily, clean out the refrigerator, and make sure everything in the refrigerator had a name and date. The DON stated there should be no expired foods in there. During an interview on 07/09/2022 at 4:04 PM, the Administrator stated the third shift nurse was supposed to monitor and clean the refrigerator in the C-Hallway. She stated all food items in the refrigerator should not be expired food, and the refrigerator temperature should be taken nightly and logged.	F 812		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observations and staff interviews, the facility failed to ensure the lids on one of two dumpsters were closed when not in use. The facility reported a census of 53 current residents. Finding include: A review of the policy titled, "Food-Related Garbage and Refuse Disposal," revised 10/2017, revealed "1. All food waste shall be kept in containers. 2. All garbage and refuse containers are provided with tight-fitting lids or covers and must be kept covered when not in continuous use ...7. Outside dumpsters provided by garbage pickup services will be kept closed and free of	F 814	**Description: F814 Garbage Disposal** **Plan of Correction:** Close dumpster lids when not in use. **How residents affected & residents with potential of being affected were identified:** Residents who reside to Centerville Specialty Care have the potential to be affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 814	Continued From page 115 surrounding litter." Observations of the dumpsters on 07/07/2022 at 3:54 PM with the Dietary Services Supervisor (DSS), revealed two of the four dumpster lids were open on one dumpster. The second dumpster's lids were closed. Flies swarmed around both dumpsters. The DSS stated the lids to the dumpsters were kept open all the time and she did not know if the dumpster lids needed to be closed or not. During an interview with Staff Q, Dietary Aide, on 07/09/2022 at 9:35 AM, she stated the dumpster lids should be closed when not in use. During a follow-up interview on 07/09/2022 at 9:56 AM, the DSS stated dumpster lids should be closed when not in use. She stated she was not aware of fly control measures being put into place out back by the dumpsters. During an interview on 07/09/2022 at 2:39 PM, the Director of Nursing stated the lids of the dumpsters should be closed when not in use. She stated sometimes at end of shift the lids had been left open. During an interview on 07/09/2022 at 4:04 PM, the Administrator stated the dumpster lids should be shut when not in use.	F 814	**Measures or systemic changes made to ensure this will not recur and affect others:** Bright colored signs placed on dumpsters stating that lids must be always closed 7/9/2022. Dumpsters moved to furthest edge of back parking lot the week of 7/11/2022. Dumpster to remain there during the Spring Months through the Fall months. Ecolab provided dumpster fly spry and will treat pests now and in the future. **Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** Ecolab to treat. 7/29/22 they provided 5 fly lights and 1 fly panel. Maintenance will perform 4 audits per week for 4 weeks. Then 3 audits will be conducted for 2 additional weeks, assuring dumpster lids are closed with signs and in the correct location staff/resident questionaries. Results of the audits will be submitted to QAPI for review and additional recommendations. **Anticipated Date of Completion for this plan of correction:** Ongoing	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is	F 842	**Description: F842**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 842	Continued From page 116 resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.	F 842	**Plan of Correction:** Education to nursing staff to ensure intervention is offered, administered and documented as indicated if resident expresses pain. **How residents affected & residents with potential of being affected were identified:** Residents who reside to Centerville Specialty Care have the potential to be affected. **Measures or systemic changes made to ensure this will not recur and affect others:** Education to nursing staff to ensure intervention is offered, administered, and documented as indicated if resident expresses pain. **Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** Nurse management will audit pain scales 2 times per week for 4 weeks. Then 1 audits will be conducted for 2 additional weeks. Results of the audits will be submitted to QAPI for review and additional recommendations. **Anticipated Date of Completion for this plan of correction:** 8/3/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 842	Continued From page 117	F 842		

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on facility policy review, interviews, and clinical record review, the facility failed to ensure the medical record was complete and accurately documented for 1 (Resident #26) of 1 sampled resident reviewed for pain. Specifically, the facility failed to ensure Resident #26's medications were documented as administered on the medication administration record (MAR). The facility identified a census of 53 current residents.

Findings include:

A review of the facility's policy titled, "Pain," revised 9/17, revealed, staff would "report the resident/patient's use of standing and PRN [as needed] analgesics."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 842	Continued From page 118	F 842		

A review of the Admission Record revealed the facility admitted Resident #26 with diagnoses that included congestive heart failure, anxiety, muscle wasting, age related physical debility, chronic kidney disease, and chronic embolism and thrombosis of deep veins of the left lower extremity.

Resident #26's annual Minimum Data Set (MDS) assessment, dated 04/21/2022, documented the resident had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident was severely cognitively impaired. The MDS indicated the facility did not attempt to conduct an interview with the resident regarding pain because the resident was rarely/never understood. The assessment documented staff saw no indicators or pain or possible pain (IE: non-verbal sounds, facial expressions, etc.) in the last 5 days of the assessment period. The MDS recorded the resident received no scheduled pain medication nor pain medication as needed. According to the MDS, Resident #26 received non-medication interventions for pain.

A review of Resident #26's current Order Summary Report revealed the resident had physician orders for acetaminophen (Tylenol) tablets 325 milligrams (mg). The order directed staff to give two tablets by mouth every four hours as needed for an elevated temperature or pain and had a start date of 06/19/2019. The report also indicated an order to apply two grams of Voltaren Gel 1 % (diclofenac sodium) to the right shoulder topically, four times a day for pain. The start date was 05/26/2022.

During an observation on 07/05/2022 at 10:16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING _____ B. WING _____	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 842	Continued From page 119	F 842		

AM, Resident #26 yelled, 'Nurse. Help me. Help me. Nurse' in a low audible tone. At 10:18 AM, the MDS Coordinator went into the resident's room and stated the resident was annoyed and in pain. The MDS Coordinator stated she would notify the nurse. At 10:24 AM, the resident was still saying "nurse." The MDS Coordinator entered the resident's room again and stated the nurse was coming with medication.

During an interview on 07/06/2022 at 4:12 PM, the MDS Coordinator stated they notified Staff H, a Licensed Practical Nurse, that Resident #26 was in pain on 07/05/2022, and Staff H stated they would provide the resident with Tylenol.

A review of Resident #26's Medication Administration Record [MAR] for July 2022 indicated the resident did not receive any acetaminophen on 07/05/2022 and did not receive the routinely scheduled Voltaren gel on the morning nor mid-day/afternoon of07/05/2022.

During an interview on 07/07/2022 at 10:23 AM, Staff H stated she had administered Resident #26's acetaminophen and Voltaren gel on 07/05/2022. Initially, Staff H stated she documented that the medications were administered. However, after reviewing the resident's MAR, Staff H stated the medication was administered but they did not document it was given.

During an interview on 07/08/2022 at 1:35 PM, the Director of Nursing (DON) stated if a medication was administered to a resident as needed, the nurse should document the medication given.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 842	Continued From page 120 During an interview on 07/08/2022 at 2:29 PM, the Administrator stated that if a resident was in pain, the nurse should complete an assessment and provide any scheduled and as needed medication to the resident. The Administrator stated if a medication was given, it should be documented.	F 842		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on facility policy review, facility document review and staff interviews, the facility's Quality Assurance Performance Improvement Program (QAPI) failed to maintain a program that developed and implemented effective improvement plans to correct identified areas of concern, which included answering resident call lights in a timely manner. The facility identified a census of 53 current residents. Findings include: A review of the facility's policy titled, "Quality Assurance and Performance Improvement (QAPI) Program - Governance and Leadership," revised in 03/2020, indicated, "4. The responsibilities of the QAPI Committee are to: a. Collect and analyze performance indicator data and other information; b. Identify, evaluate, monitor and improve facility systems and	F 867	**Description: F867 QAPI** **Plan of Correction:** QAPI to maintain a program that develops and implements an effective improvement plan identifying areas of concerns which includes answering call lights in a timely manner. **How residents affected & residents with potential of being affected were identified:** Residents who reside to Centerville Specialty Care have the potential to be affected. **Measures or systemic changes made to ensure this will not recur and affect others:** Grievances will be referenced in QAPI planning.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

(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 867	Continued From page 121 processes that support the delivery of care and services; c. Identify and help to resolve negative outcomes and/or care quality problems identified during the QAPI process; d. Utilize root cause analysis to help identify where identified problems point to underlying systematic problems." Resident Council Minutes dated 11/12/2021 indicated in both Old Business and New Business sections, residents voiced concerns that call lights were not answered timely on the 2:00 PM to 10:00 PM (evening) shift. A record review of Resident Council Minutes for 12/08/2021 indicated in both the Old Business and New Business that residents voiced concerns that call lights were not answered timely. The Grievance/Concern Investigation Form, dated 12/08/2021, indicated the Resident Council voiced a grievance of, "Call lights not being answered timely. This is happening during meal times and after meal times most days. It takes 20 minutes or longer and sometimes I have to go turn my bathroom call light on as well." The facility's response documented a response of 'Call light audits done and audits to be performed from different department heads'. The facility failed to provide a call light audit for this grievance. Review of Grievance/Concern Investigation Form, dated 12/30/2021, indicated a grievance of a 'Call light on for over 15 min [minutes]'. The facility's recorded a response of 'Call light audit for third shift'. The Grievance/Concern Investigation Form, dated 01/08/2022, indicated Resident #13 voiced	F 867	**Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** QAPI meetings will be conducted for 4 weeks. Then monthly or as needed thereafter. Results of the audits will be submitted to QAPI for review and additional recommendations. **Anticipated Date of Completion for this plan of correction:** Ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING ______ B. WING ______	07/09/2022

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F 867	Continued From page 122 a grievance of, 'call light was on for 45 [minutes]. Staff were dealing with emergencies at the time. Two staff were at meal break. The nurse was outside with smokers'. The facility's response recorded 'Nurse stated call light was not on for 45 min. Nurse stated it could have been on longer than usual as they were assisting others at this time but got to resident as soon as they could'. Review of Resident Council Minutes for 01/10/2022 indicated residents voiced concerns that call lights were not answered timely in both the Old and New Business sections. Review of the Grievance/Concern Investigation Form, dated 01/10/2022, indicated the Resident Council voiced a grievance of, Call lights. Patients state it takes over an hour at times'. The facility's documented a response of call light audits to be done. The facility failed to provide a call light audit for this grievance. A record review of Resident Council Minutes for 02/21/2022 indicated in the Old Business that residents voiced concerns the call lights were not answered timely and in the New business residents voiced concerns that call lights were taking longer than 15 minutes to be answered. The Grievance/Concern Investigation Form, dated 02/21/2022, indicated the Resident Council voiced a grievance of, 'Call lights during the evening taking longer than 15 minutes to answer and staff walk by with heads down. This is not at supper time.' The facility's documented a response that 'Audits in place and will be done weekly by department heads'. The facility failed to provide a call light audit for this grievance.	F 867		

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	165225	A. BUILDING ______ B. WING ______	07/09/2022

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F 867	Continued From page 123	F 867		

The Resident Council Minutes of 03/22/2022 indicated in Old Business the continued concern the call lights were not answered timely and in the New Business that residents voiced concerns the call lights were taking longer than 30 minutes to be answered and the call lights in the bathroom were taking 20 to 30 minutes to be answered.

The Grievance/Concern Investigation Form, dated 03/22/2022, indicated Resident #6 voiced a grievance that staff took 20-30 minutes to answer their bathroom call light when Resident #6 had an accident and a housekeeper helped Resident #6. The facility documented a response that 'Call lights being monitored through audits at this time.' A duplicate grievance form for Resident #6 was completed and the facility's response was, 'Note placed in communication book to answer call lights in 15 [minutes] for bedroom [and five] for bathroom [and] call light audit'. Resident #6's room was not included in the March, 2022 call light audit.

Review of Grievance/Concern Investigation Form, dated 03/22/2022, indicated Resident #27 voiced a grievance of '2-3 nights weekly it takes staff 30 [minutes] or more after and before meal on 2-10 [evening] shift for staff to answer [Resident #27's] call light'. The facility's response was, 'Call light audits continued multiple staff doing audits to monitor problem'. A duplicate grievance form for Resident #6 was completed and the facility's response was, 'Note placed in CNA communication book & call light audit'. Resident #27's room was audited four times from 03/15/2022 to 03/24/2022, with only one occurrence for the 2:00 PM to 10:00 PM shift.

The Grievance/Concern Investigation Form,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

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F 867	Continued From page 124 dated 03/25/2022, indicated a previous resident voiced a grievance of, 'Call light not working. Staff needs to slow down and be compassionate ([Staff M])'. The facility documented the response of 'Call light replaced with a working one. Spoke with ([Staff M]) about slowing down and being kind in her approach'. The Call Light Audit Report for March 2022 indicated the following: a. 03/15/2022, Room 12. The call light was turned on at 10:13 AM and was answered by 10:28 AM b. 03/15/2022, Room 17. The call light was turned on at 1:10 PM and was answered by 1:15PM. c. 03/16/2022, Room 13. The call light was turned on at 9:30 AM and was answered by 9:42AM. d. 03/16/2022, Room 24. The call light was turned on at 10:00 AM and was answered by 10:05 AM. e. 03/16/2022, Room 4. The call light was turned on at 2:30 PM and was answered by 2:39PM. f. 03/18/2022, Room 21. The call light was turned on at 5:39 PM and was answered by 5:51PM. g. 03/18/2022, Room 24. The call light was turned on at 5:46 PM and was answered by 6:00PM. h. 03/19/2022, Room 13. The call light was turned on at 10:41 AM and was answered by 10:46 AM. i. 03/20/2022, Room 15. The call light was turned on at 2:15 PM and was answered by 2:15PM. j. 03/20/2022, Room 21. The call light was turned on at 2:33 PM and was answered by 2:46PM. k. 03/20/2022, Room 9. The call light was turned on at 2:45 PM and was answered by 2:54PM. l. 03/20/2022, Room 13. The call light was turned on at 3:04 PM and was answered by 3:04PM. m. 03/20/2022, Room 31. The call light was turned on at 3:05 PM and was answered by 3:05 PM. n. 03/24/2022. Room 14. The call light was turned on at 8:33 PM and was answered by 8:36	F 867		

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	165225	A. BUILDING ____ B. WING ____	07/09/2022

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CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

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F 867	Continued From page 125	F 867		

PM.
o. 03/24/2022. Room 20. The call light was turned on at 8:43 PM and was answered by 8:45 PM.
p. 03/24/2022. Room 24. The call light was turned on at 9:07 PM and was answered by 9:11 PM.
q. 03/28/2022. Room 13. The call light was turned on at 11:14 AM and was answered by 11:17 AM.
r. 03/28/2022. Room 14. The call light was turned on at 11:16 AM and was answered by 11:18 AM.
s. 03/28/2022. Room 20 bathroom. The call light was turned on at 11:21 AM and was answered by 11:34 AM.
t. 03/28/2022. Room 5. The call light was turned on at 11:12 AM and was answered by 11:30 AM. Note indicated, "during lunch time, staff was addressed."

A record review of Resident Council Minutes for 4/13/2022 indicated in the Old Business that residents voiced concerns the call lights were not answered timely on the 2:00 PM to 10:00 PM (evening) shift. There was no call light concern for the New Business.

A record review of Call Light Audit Report for April 2022 indicated the following:
a. 04/14/2022, Room 20. The call light was turned on at 11:03 AM and was answered by 11:08 AM.
b. 04/14/2022, Room 16. The call light was turned on at 2:40 PM and was answered by 2:49 PM.
c. 04/14/2022, Room 13. The call light was turned on at 3:25 PM and was answered by 3:36 PM.
d. 04 14/2022, Room 25. The call light was turned on at 3:45 PM and was answered by 3:52 PM.
e. 04/14/2022, Room 17. The call light was turned

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F 867	Continued From page 126	F 867		

on at 4:15 PM and was answered by 4:22 PM.

Review of Resident Council Minutes for 5/16/2022 did show any concerns related to call lights.

The Call Light Audit Report for May 2022 indicated the following:
a. 05/19/2022, Room 13. The call light was turned on at 8:30 AM and was answered by 8:38 AM.
b. 05/19/2022, Room 17. The call light was turned on at 9:05 AM and was answered by 9:12 AM.
c. 05/19/2022, Room 31. The call light was turned on at 9:30 AM and was answered by 9:43 AM.
d. 05/19/2022, Room 17. The call light was turned on at 10:15 AM and was answered by 10:30 AM.

The Resident Council Minutes for 06/08/2022 indicated in New Business that residents voiced concerns related to call lights not being answered within 15 minutes.

A review of the Grievance/Concern Investigation Form, dated 06/08/2022, indicated the Resident Council voiced a grievance of their 'Call light not being answered in a timely manner. It takes 45 [minutes] [to] 1 [hour] before staff answer my call light. Other times I get put in the bathroom and after turning my light on when finished I sit for over an hour to get off the toilet. This happens multiple times a week'. The facility's response was 'Call light audits to continue[.] Education to staff on resident's concern.' There were no call light audits provided by the facility for this grievance.

The Call Light Audit Report for June 2022 indicated the following:
a. 06/25/2022, Room 11. The call light was turned

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	165225	A. BUILDING ______ B. WING ______	07/09/2022

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CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

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F 867	Continued From page 127	F 867		

on at 9:30 AM and was answered by 9:39 AM.
b. 06/25/2022, Room 5. The call light was turned on at 10:10 AM and was answered by 10:20 AM.
c. 06/25/2022, Room 22. The call light was turned on at 1:35 PM and was answered by 1:40PM.
d. 06/26/2022, Room 12. The call light was turned on at 7:00 AM and was answered by 7:13AM.
e. 06/26/2022, Room 10. The call light was turned on at 12:40 PM and was answered by 12:50 PM.
f. 06/26/2022, Room 21. The call light was turned on at 1:25 PM and was answered by 1:35PM.

During the Resident Council interview on 07/06/2022 at 1:45 PM, Resident #34, Resident #16, Resident #19, Resident #49, and Resident #8 were present. Due to a complaint made and review of the Resident Council minutes, the Resident Council members were asked if they had any concerns related to the timeliness ofstaff answering their call light. Resident #49 stated it took staff 'some time' to answer call lights. Resident #19 stated the facility was short staffed, so it took staff a while to answer the call lights . Resident #8 stated they had to wait in the bathroom several times for staff to answer the call light and it could take anywhere from 10 minutes to 40 minutes for them to answer. Resident #8 stated that 'sometimes you give up'. Resident #16 stated it took staff a while to answer the call lights.

During an interview and record review on 07/08/2022 at 4:17 PM, the DON brought in the QA minutes for 04/06/2022, which were for February and March 2022. The QA document indicated that in Resident Council, 'Call lights continue to be an issue - call light audits done weekly'. The DON stated call lights would be brought to QA and a plan would be made.

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CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

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F 867	Continued From page 128 During the QA with the DON and Administrator on 07/09/2022 at 5:36 PM they stated QA grievances were brought to them from staff or residents or from observations. The DON stated she had input and the QA committee included the department heads, pharmacy representative and the medical director all met to go over issues and things that need to be addressed, with priority given to major medical conditions and care issues. The DON stated some identified issues currently being addressed by the QA committee included showers for residents and falls. The DON stated the facility had designated a shower aide on the schedule to meet the needs of residents. The DON stated the shower concern was brought to their attention during a resident council meeting and after the plan was put into place the reports of residents no receiving a shower began decreasing. The DON stated when an identified concern was being resolved through the QA process it is revisited over several QA meetings before being resolved. The DON stated after an issue has been resolved it would be periodically reviewed for any new issues. The Don stated the shower concern from residents was resolved. They stated the QA committee meets at least quarterly and at times more often. The Administrator stated the department heads had five-minute QA meetings daily in the morning and again with floor staff in the afternoon meetings . They stated deviations were monitored and caught through audits. They stated the facility monitored their staffing in QA on an ongoing basis. The Administrator stated staff and residents can bring concerns to the QA committee via a concern form, but most communication of issues was verbal and brought to the attention of the DON.	F 867		

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F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed andthe results of each staff test; and (ii) Document in the resident records that testing	F 886	**Description: F886 Covid Testing** **Plan of Correction:** Follow guidelines required by CMS regarding county rate testing and Up-To-Date vaccine requirements. **How residents affected & residents with potential of being affected were identified:** Staff and Residents of Centerville Specialty Care have the potential to be affected. **Measures or systemic changes made to ensure this will not recur and affect others:** Notice placed on door stating testing guidelines for staff in relation to county transmission rates. Staff will be reeducated regarding COVID testing.	

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	165225	A. BUILDING ______ B. WING ______	07/09/2022

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CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

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F 886	Continued From page 130 was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on facility policy review and document review, and interviews, the facility failed to perform routine COVID-19 testing for all staff and residents per guidelines from the Centers for Medicare and Medicaid Services (CMS) QSO -20-38-NH memorandum. Specifically, the facility failed to perform routine COVID-19 testing per current guidelines when the facility was in a county with a moderate community transmission rate. This had the potential to affect all staff and residents in the facility. The facility identified a census of 53 current residents and over 48 staff members. Findings include:	F 886	**Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** Administrator will audit COVID testing biweekly for 4 weeks. Then weekly for 2 additional weeks. Results of the audits will be submitted to QAPI for review and additional recommendations. **Anticipated Date of Completion for this plan of correction:** Ongoing	

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F 886	Continued From page 131 A review of the CMS QSO -20-38-NH memorandum, revised 03/10/2022, revealed, "Routine testing of staff, who are not up-to-date, should be based on the extent of the virus in the community. Staff who are up-to-date, do not have to be routinely tested. Facilities should use their community transmission level as the trigger for staff testing frequency". Further review of the policy revealed "Up-to-date means a person has received all recommended COVID-19 vaccines, including any booster dose(s) when eligible." A review of the facility's policy titled, "Care Initiatives COVID-19 Testing Policy," last updated 03/15/2022, revealed it reflected the QSO-20-38-NH memo guidance and indicated, "The facility should test all staff, who are not up-to-date at the frequency prescribed in the Routine Testing table based on the level of community transmission reported in the past week". Further review of the policy revealed "If the level of community transmission decreases to a lower level of activity, the facility should continue testing staff at the higher frequency until the level of community transmission has remained at the lower activity level for at least two weeks before reducing testing frequency." A review of the report of COVID-19 level of community transmission available on the CDC COVID-19 Integrated County View site (COVID-19 by County CDC) viewed 07/06/2022, indicated that Appanoose County, where the facility was located, was in a yellow/moderate transmission rate, indicating that anyone that was not up to date with all COVID-19 vaccine doses was required to test once a week. The county had been at yellow/moderate transmission rate since	F 886		

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F 886	Continued From page 132 06/23/2022. A review of testing logs from 06/01/2022 through 07/09/2022 of five random staff members (Staff Y, Staff Z, Staff AA, Staff BB and Staff E) revealed one nursing staff member had not been tested weekly as required. Staff Z was not tested the week of 06/20/2022-06/26/2022. A review of the COVID-19 Staff Vaccination Status for Providers indicated Staff Z had an exemption from the COVID-19 vaccine. During an interview on 07/09/2022 at 8:56 AM with Staff Y, Certified Nursing Aide (CNA), she stated the facility was testing all staff twice a week. Staff Y stated she was not sure if she missed testing at any time. During an interview on 07/09/2022 at 9:05 AM with Staff V, Certified Medication Aide (CMA), she stated the facility tested twice a week while in outbreak, but she was unsure of the testing frequency now. During an interview on 07/09/2022 at 10:33 AM, Staff W, CMA, stated staff were being tested twice a week. During an interview on 07/09/2022 at 2:37 PM with Staff H, Licensed Practical Nurse (LPN), she stated they were being tested twice weekly while in outbreak status, but was unsure now that the facility was out of outbreak status. She stated the Administrator kept up with the testing frequency. During an interview on 07/09/2022 at 3:20 PM, the Director of Nursing (DON) stated the county transmission level was yellow, meaning the	F 886		

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F 886	Continued From page 133 facility was testing once a week. The DON stated all residents and staff needed to test unless they were up-to-date with their vaccines, including boosters, or if they had COVID-19 recently. She stated the staff should be tested before they were allowed to work. The DON stated the Administrator and the Minimum Data Set (MDS) nurse, who was also the infection control preventionist (ICP), were responsible for monitoring the testing of the staff. During an interview on 07/09/2022 at 4:53 PM, the Administrator stated the current community transmission rate was moderate and they were testing weekly on Mondays. She stated staff should not be working if they had not been tested. She stated she was responsible for monitoring the tests and was taking the staff's word that they were testing as needed but did not follow up on it. The Administrator stated she needed a new process because she was doing everything herself and it was too overwhelming. The Administrator stated she gave the resident testing responsibilities to the MDS nurse to handle. The MDS nurse/ICP was not available for an interview due to being on medical leave.	F 886		
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on facility policy review, resident and staff interviews, observations and facility document review, the facility failed to maintain an effective	F 925	**Description: F925 Pest Control** **Plan of Correction:** When there are flies the maintenance man will kill them outside with spray and inside with a flyswatter sanitizing indoors afterwards. He will reach out to Ecolab to voice concern and for further assistance.	

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	165225	A. BUILDING ______ B. WING ______	07/09/2022

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F 925

Continued From page 134
pest control program throughout the entire facility and in one of one kitchen. The facility identified a census of 53 current residents.

Findings include:

A review of the "Pest Control" policy, revised May 2008, revealed "Policy statement: Our facility shall maintain an effective pest control program . Policy Interpretation and Implementation: 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. 2. Pest control services are provided by [company name] and [company name]. 3. Windows are screened at all times. 4. Only approved "FDA [Food and Drug Administration]" and "EPA [Environmental ProtectionAgency]" insecticides and rodenticides are permitted in the facility and all such supplies are stored in areas away from food storage areas. 5. Garbage and trash are not permitted to accumulate and are removed from the facility daily. 6. Maintenance services assists, when appropriate and necessary, in providing pest control services."

During an interview on 07/05/2022 at 11:06 AM, Resident #42 stated the facility needed to do something about the flies in their room and in the facility. They stated the flies liked to stick around their room and in the hallways. Upon exiting the resident's room, multiple flies were observed in the C-Hallway.

On 07/05/2022 at 12:30 PM, an unknown female entered the beauty shop where surveyors were working and sprayed a few spots along the base board but did not spray along the window or the door. She stated she was spraying for spiders

F 925

How residents affected & residents with potential of being affected were identified: Residents who reside to Centerville Specialty care have the potential to be affected.

Corrective action taken for resident(s) affected: Follow up with Residents #19 and #42 on 8/1/2022, after Ecolabs for pest control visited on 7/29/2022 and dumpsters were moved the week of 7/11/22, indicated that the issue with the flies has gotten better.

Measures or systemic changes made to ensure this will not recur and affect others: Brightly colored signs attached to the dumpsters. Dumpsters moved to furthest end of back parking lot 7/11/2022 to be moved back by the building in the Winter months for safety reasons. Ecolabs provided SSI-50 Insecticide for the flies to be used outside as well as Dumpster Fair powder to cut the smell. Ecolab provided us with 6 bait stations, 5 fly lights, one fly panel placed in dining interior, hallways interior, kitchen interior, and by the rear door on 7/29/2022. Maintenance man will kill flies with flyswatter and sanitize after killing the flies.

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F 925	Continued From page 135 that day. Observations on 07/06/2022 at 11:30 AM revealed flies buzzing around the dining areas and in C Hallway. During a Resident Council meeting on 07/06/2022 at 1:45 PM, held with five cognitively intact residents, all of them reported they had a fly issue in the facility, stating they were in the dining room, and Resident #19 mentioned them being in their room. During C-Hallway observations on 07/06/2022 between 2:36 PM and 3:15 PM, multiple flies buzzed around the back end of the hallway and in and out of residents' rooms. During dining room observations on 07/06/2022 at 3:36 PM, flies buzzed throughout both dining areas. Dining room observations on 07/07/2022 at 8:57 AM, flies were seen at breakfast buzzing around residents as they ate. Observations of the lunch meal were conducted in the kitchen and on the tray line on 07/07/2022 from 10:35 AM to 12:48 PM. The Dietary Services Supervisor (DSS), Staff D, a Cook, and Staff Q, a dietary aide, prepared and served the lunch meal. During meal service observations revealed multiple flies in the kitchen, landing on the carts and trays to be delivered to resident rooms, and buzzing around the steam table during meal service. A review of the Pest Control invoices revealed the pest control technician sprayed for flies on	F 925	**Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** Maintenance will perform 4 audits per week for 4 weeks. Then 3 audits will be conducted for 2 additional weeks, assuring dumpster lids are closed and in the correct location and with signs attached (the rear entry by where the dumpster was previously located was identified as the point of entry for the flies), and 3 staff/resident questionaries completed. Results of the audits will be submitted to QAPI for review and additional recommendations. **Anticipated Date of Completion for this plan of correction:** Ongoing during months outside of Winter	

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F 925	Continued From page 136 05/03/2022, 04/05/2022, 11/04/2021, 10/18/2021, and 08/04/2021. The invoice dated 07/05/2022 did not include pest control for flies. Observations of the dumpsters with the DSS on 07/07/2022 at 3:54 PM revealed two of the four dumpster lids were open on one dumpster. The second dumpster's lids were closed. Flies swarmed around both dumpsters. During an interview at this time, the DSS stated the lids to the dumpsters were kept open all the time and she did not know if the dumpster lids needed to be closed or not and did not know if they contributed to the flies. During an interview on 07/08/2022 at 12:37 PM, the Maintenance Supervisor (MS) stated he identified the issue outside with the dumpsters and flies. The MS stated the facility had no other place to put them on the property and had not brought up ideas to manage the flies. He stated he could not say if the dumpster lids being open contributed to the fly issue. The MS stated he was able to order one bug zapper a month as budget allowed for the fly problem in the resident hallways. The facility could try a bug zapper out back, but they were very expensive. The MS stated the Administrator was aware of the fly issue and recommended the zappers and was on board with mitigation. He stated he knew of no specific fly treatment for the kitchen and the facility was in the process of changing to a different pest control company for pest control services. During an interview with Staff L, a Certified Nursing Assistant (CNA), on 07/08/2022 at 3:12 PM she stated the flies had gotten worse over the last month. Staff L stated it was so hot outside,	F 925		

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F 925	Continued From page 137	F 925		

people open the doors and the flies come flying in. Staff L had not heard about any mitigation efforts and was not sure about measures being taken to prevent the flies.

During an interview with Staff Q on 07/09/2022 at 9:35 AM, she stated the dumpster lids should be closed when not in use. She stated she had not seen any flies in the kitchen or come in from the back door.

During an interview on 07/09/2022 at 9:56 AM, the DSS stated she would see a few flies in the kitchen but not that many. She stated she was not aware of fly control measures being put into place out back by the dumpsters or in the kitchen or dining rooms. She stated she had not reported the flies to anyone.

During an interview on 07/09/2022 at 2:39 PM, the Director of Nursing (DON) stated she was aware of the fly issue at the dumpsters, and it could be a source of the fly issue in the facility. The DON stated flies were also out front and were bad in the area this year. She knew a pest control company would visit, and she had inquired about the flies specifically to maintenance andthe Administrator about solutions. The DON stated the facility was working on the fly problem and it had been challenging to manage. The DON stated she had not heard about flies being in the kitchen, but the residents had mentioned it and some carry fly swatters.

During an interview on 07/09/2022 at 4:04 PM, the Administrator stated the dumpster lids should be shut when not in use. She stated she checked the dumpsters for flies, and they were everywhere around the dumpsters. No staff had brought itto

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F 925	Continued From page 138 her attention that the flies were a problem by the dumpsters.	F 925		