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 _____	C 02/16/2023

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 000 ✓ ok/CP	INITIAL COMMENTS Correction date: 3/17/23 The following deficiencies resulted from investigation of Complaints #108491-C, # 109045-C, #109558-C, #109770-C, #109816-C, #110729-C, #110800-C and facility reported Incidents #108098-I and #110836-I conducted February 6, 2023 to February 16, 2023. Complaints #108491-C, #109816-C, #110729-C and #110800-C were substantiated. Facility reported incident #108098-I and #110836-I were substantiated. 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 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care.	F 553	**Description:** F 553 **Plan of Correction:** IDT will be educated to review resident preferences regarding family invitation to care plans. **How residents affected & residents with potential of being affected were identified:** Residents who reside at Centerville Specialty Care have the potential to be affected. **Corrective action taken for resident(s) affected:** Family will be notified of future care conferences per their preferred method, this will be documented in the resident profile under special instructions.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joshua Blackburn | TITLE: Administrator | (X6) DATE: 3/17/23

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.

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 _____	C 02/16/2023

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 553	Continued From page 1 (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident responsible party interviews and staff interviews, the facility failed to permit residents and/or their responsible party's from participation and ongoing contribution in formulation of their care plan development, for 2 of 9 resident records reviewed (Resident's #1 and #5). The facility reported a census of 46 residents. Findings include: 1. The Minimum Data Set (MDS) Assessment tool dated 12/31/22 revealed Resident #1 admitted to the facility from the hospital 12/19/22, at a skilled level of care with diagnoses that included diabetes, pneumonitis due to aspiration, respiratory failure, muscle weakness, intellectual disabilities, severe cognitive impairment with symptoms of delirium present, unclear speech, sometimes able to make herself understood and usually able to understand others, and required extensive assistance, sometimes total dependence, on at least 1 staff to reposition in	F 553	**Measures or systemic changes made to ensure this will not recur and affect others:** Resident #1 no longer resides in the facility. Resident #5 prefers to be contacted via phone. Family preference for notifications will be placed on profile page under special instructions. **Planned monitoring of corrective actions to ensure practice is corrected:** Four audits to be conducted per week for 4 weeks. Then 2 audits per week for 4 weeks to assess for family invitation to care conferences. Results to be submitted to QAPI team for review. **Anticipated Date of Completion for this plan of correction:** 3/17/2023	

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 _____	C 02/16/2023

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 553	Continued From page 2 bed, transfer to and from bed and chair, dressing, eating, toileting, bathing and personal hygiene, non ambulatory, always incontinent of bladder and usually incontinent of bowel. The MDS stated that neither the resident nor the resident's responsible party or Power of Attorney (POA) had participated in the MDS assessment, and the plan for discharge or return to the community was not addressed. POA interviews revealed: POA #1, interviewed 2/8/23 at 3:02 p.m., stated the resident was weak after she had been in the hospital for a few weeks, the physicians anticipated the resident could recover if she received therapy for strengthening at the nursing home, and the resident would be able to return to her former home if she received the therapy that she needed. Shortly after the resident was admitted to the facility they got a call that her therapy would be discontinued, the family didn't understand the facility's action, the resident had special needs due to her intellectual disabilities, and they had to demand a meeting with the facility Social Worker to address their concerns related to her care and strategies to provide the care the resident required in order to return to her home as they had planned. The facility never asked to meet with the family about the resident's care or their concerns otherwise, they only had 1 meeting on 12/29/22, and that was because the resident's POA's demanded it. POA #2 interviewed 2/8/23 at 3:27 p.m., stated the only time they ever met with the staff to discuss her care was when the 2 POA's demanded a meeting, on 12/29/22, and that was after the facility said they were going to stop her	F 553		

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 _____	C 02/16/2023

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 553	Continued From page 3 therapy, they met with the Social Worker, there were no nurses at the meeting, and they tried to address how the resident would get the therapy she required so she could return to her home as they had anticipated. Otherwise, the staff never asked for a meeting or set up anything to go over her care with either of the POA's. 2. The MDS dated 2/2/23 revealed Resident #5 scored 8 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment, that indicated severe cognitive impairment, without symptoms of delirium present, diagnoses included hypertension (high blood pressure), cerebrovascular accident (a stroke), depression, auditory hallucinations, difficulty walking, required extensive assistance of at least 1 staff to reposition in bed, transfer to and from bed and chair, ambulation, bathing, dressing, eating, toileting and personal hygiene, always continent of bladder, frequently incontinent of bowel, usually understood others and usually able to make self understood, and had highly impaired vision. The facility provided documentation that 1 of the resident's POA's participated in a care conference on 12/15/22. Documentation on 9/22/22 stated they were unable to contact the resident's POA for a care conference. During the exit conference on 2/16/23, when asked for further explanation for this, as the resident's POA's were very involved with the resident's life and spent several hours at the facility every day, the facility stated they hadn't always spent as much time at the facility, and did not address why they had not coordinated a care plan meeting with the POA's that were very actively engaged in the resident's care	F 553		

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 _____	C 02/16/2023

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 553	Continued From page 4 POA Interviews: When interviewed 2/13/23 at 2:05 p.m. the resident's POA denied they had ever participated in a care plan meeting or conference, but this Thursday, 2/16/23, they were to come to a meeting for his care, and this was the first time they have had this since the resident has been at the facility (admitted 6/2/22). .	F 553		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §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	F 580	**Description:** F 580 **Plan of Correction:** Education to nursing staff to ensure that if a resident has a change of condition responsible party is to be 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:** Resident #1 is no longer in the facility. Resident #4 first emergency contact is updated and notified of changes. **Measures or systemic changes made to ensure this will not recur and affect others:** Review of change in condition during clinical standup.	

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 _____	C 02/16/2023

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 5 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). §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, and resident responsible party interviews and staff interviews, the facility failed to notify the resident's responsible party of changes in the resident's condition for 2 of 9 resident records reviewed (Resident's #1 and #4). The facility reported a census of 46 residents. Findings include: 1. The Minimum Data Set (MDS) Assessment tool dated 12/31/22 revealed Resident #1 had severe cognitive impairment with symptoms of delirium present, with diagnoses that included	F 580	**Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** Audits will be done 3x weekly for 4 weeks to ensure there is documentation of updating families, Ongoing discussions with our Care plan team during our standard of care meetings to ensure there have been no changes on how families choose to be notified during their care conference meetings. **Anticipated Date of Completion for this plan of correction:** 3/17/23	

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 _____	C 02/16/2023

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 6 diabetes, pneumonitis due to aspiration, muscle weakness, intellectual disabilities, unclear speech, sometimes able to make herself understood and usually able to understand others, and required extensive assistance, sometimes total dependence, on at least 1 staff to reposition in bed, transfer to and from bed and chair, dressing, eating, toileting, bathing and personal hygiene, non ambulatory, always incontinent of bladder and usually incontinent of bowel, and a Stage 1 pressure ulcer present (defined as observable, pressure-related alteration of intact skin with non-blanchable redness of a localized area usually over a bony prominence). Nursing Progress Notes revealed the following entries: 1/22/23 at 5:17 a.m. "Incident, Accident, Unusual Occurrence Note: Certified Nursing Assistant (CNA) requesting this nurse to resident room. This nurse down to room. CNA reports resident right leg is off of the bed and laying on the heat register. Resident laying on bed but air mattress has resident tilted toward register. This nurse and 2 CNA's able to move bed and bring resident leg up. Red area noted. No blisters or open areas noted at this time. Resident shakes head no when inquiring about pain. Bed repositioned away from heat register. This nurse had been in room approximately 15 minutes prior for morning medication and resident was positioned in center of bed." 1/22/2023 at 10:24 a.m. "Patient noted to have a fluid filled blister to her right outer calf, dime-sized, noted redness to be around fluid filled blister that radiates up and down leg, right outer	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 _____	C 02/16/2023

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 7 aspect of calf warm to the touch." 1/24/2023 at 2:21 p.m. "Fax sent to the physician updating on coccyx open area; moderate odor today and yellow/green drainage present." Staff interviews revealed: 2/8/23 at 10:20 a.m., Staff C, registered nurse (RN), stated staff were required to notify family/resident Power of Attorney's (POA's) when there were changes in the resident's condition. Interviews with the resident's responsible party/POA's revealed: POA #1, interviewed 2/8/23 at 3:02 p.m., stated they received phone calls from the nursing home about the resident's condition, staff said she had a bedsore, but there wasn't any concern over it, they acted like it was something minor and they had a treatment for it, they never once said it was serious, they never said the sore had gotten worse, or that it was infected. Staff called, said she fell and had a scrape on her face, but they never called and said she was burned by the heater in her room, they would have remembered that. POA #2 interviewed 2/8/23 at 3:27 p.m., stated they visited the resident twice daily, on 1/22/23 when they arrived to feed the resident her lunch they saw blisters on her leg, it was obvious the resident was burned, the resident's roommate said she'd fallen out of bed the night before, ended up against the wall-mounted heater and how she was burned. They called POA #1 at the time and POA #1 didn't know anything about the burn, POA #2 asked the nurse if it was a burn and how was the resident burned, the nurse said they	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 _____	C 02/16/2023

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 8 weren't the POA and she couldn't provide the information. One day while visiting she saw the bedsore dressing in the resident's trash-can, there was a foul odor and what looked like pus and blood on the dressing, when they asked staff if the bedsore was infected, staff wouldn't answer them. 2. Resident #4's MDS Assessment dated 12/8/22 revealed the resident scored 3 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment, that indicated severe cognitive impairment, without symptoms of delirium present, had diagnoses that included hypertension (high blood pressure), malnutrition and non-Alzheimer's dementia, and required assistance of 1 staff to reposition in bed, transfer to and from bed and chair, ambulation, bathing, dressing, toileting and personal hygiene, usually understood others and usually able to make self understood. the resident received care by Hospice services. Nursing Progress Notes revealed the following entries: 2/9/2023 at 1:24 a.m. "At 8:30 p.m., CNA and CMA reported resident not arousing to verbal or tactile stimuli and unable to give bedtime medications. This nurse down to assess, vital signs: temperature 97.8, pulse 52, respirations 16, blood pressure 115/58, oxygen saturation 90-92% on room air. Lungs clear to auscultation. No cough or dyspnea noted. Resident with eyes closed and not responding. Performed sternal rub, resident raised left arm and attempted to smack this nurse's hand away. Eyes remained closed. At 8:40 p.m. called Hospice nurse , she	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 _____	C 02/16/2023

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 9 was aware." 1/27/2023 at 11:02 p.m. "Vitals: temperature 98.1, blood pressure 106/68, pulse 69, respirations 18, oxygen saturation 95 % on room air. Change in Condition report. Rests in bed. Respirations unlabored. No complaint of pain. Resident continues with increased lethargy. Bedtime meds refused due to resident not wanting to open mouth. Physician updated via fax (facsimile). Blood pressure has increased since earlier today. No respiratory distress noted. Call light in reach." 1/27/2023 at 1:56 p.m. "Vitals: temperature 98.3, blood pressure 75/40, pulse 53, respirations 20, oxygen saturation 99.0 % on room air. Resident appears to be more lethargic than normal, when applying the blood pressure cuff, he did not even hold his own arm up. His hospice aide was in and she thought he was more fatigued. She was going to update his hospice nurse. Resident's blood pressure was low, as was his pulse." The resident's POA was interviewed 2/13/22 at 2:56 p.m. and stated when they arrived at the facility 2/9/23 to visit staff told them something was wrong with the resident, his BP was 70/40 and they couldn't get him awake, it was like he was drunk but he never drank, staff said he had been like that since the day before. Nobody had notified the POA of this, or the resident's other family members. They questioned staff if there had been a medication error or some other reason for his condition. The Hospice nurse came to the facility, assessed the resident and thought he might have been given the wrong medications but said there was no way to prove that and the nurse denied it when they asked about it. Then his blood pressure started to come	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 _____	C 02/16/2023

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 10 up and he started to come around. They found out almost the same thing had happened a couple weeks before (described in nursing progress notes on 1/27/23), and was not notified of that change in his condition either.	F 580		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other	F 582	**Description:** F582 **Plan of Correction:** Families will be notified via our current process of verbal consents and a copy will be mailed to families. **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:** Resident #1 or responsible party was notified of changes in Medicare provided services verbally and in writing.	

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 _____	C 02/16/2023

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 582	Continued From page 11 items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review, and resident responsible party interviews and staff interviews, the facility failed to notify the resident's responsible party, both oral and in writing, of changes in Medicare provided services as required, for 1 of 5 resident records reviewed (Resident #1). The facility reported a census of 46 residents. Findings include: 1. The Minimum Data Set (MDS) Assessment tool dated 12/31/22 revealed Resident #1 admitted to the facility from the hospital 12/19/22, at a skilled level of care with diagnoses that included intellectual disabilities with severe cognitive impairment, pneumonitis due to	F 582	**Measures or systemic changes made to ensure this will not recur and affect others:** A written discharge notice will be mailed out to families regarding their therapy status, along with calling families and reviewing this over the phone and obtaining verbal consents. Education given to staff member who assists with social services when they are out of office. **Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** Audits Bi-Monthly x 1 month then monthly x 1 month **Anticipated Date of Completion for this plan of correction:** 3/17/23	

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 _____	C 02/16/2023

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 582	Continued From page 12 aspiration, respiratory failure and muscle weakness, and required extensive assistance, sometimes total dependence, on at least 1 staff to reposition in bed, transfer to and from bed and chair, dressing, eating, toileting, bathing and personal hygiene and non ambulatory. Therapy services provided and described on the MDS included 1 Speech Therapy (ST) session for 15 minutes, 5 Occupational Therapy (OT) sessions for total of 127 minutes and 3 Physical Therapy (PT) sessions for total of 36 minutes. A Notice of Medicare Non-Coverage form dated 12/28/22 revealed the resident's ST, OT and PT services would end 12/30/22 due to the resident's non-participation, staff reviewed the information over the telephone with the resident's Power of Attorney (POA), Option 3 checked which stated "I don't want the care listed above. I understand that I'm not responsible for paying and I can't appeal to see if Medicare would pay." The form indicated the POA gave verbal consent via telephone, and was signed by the facility's Activity Coordinator. The resident's POA, interviewed 2/8/23 at 3:02 p.m., stated they got a call that her therapy was going to stop shortly after she got there, the facility didn't explain that they could have appealed the decision or how to do that, the family didn't understand the facility's decision as that was the primary reason the resident was admitted there so she could get stronger and return to her home, and they never received any paperwork or information on how to appeal the facility's decision and would have done that if they knew they could have. The facility's Medicare Advanced Beneficiary	F 582		

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 _____	C 02/16/2023

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 582	Continued From page 13 Notice policy, dated April, 2021, directed staff: 1. If the Admissions coordinator or business office manager believes that Medicare will not pay for an otherwise covered skilled service(s), the resident (or representative) is notified in writing why the service() may not be covered and of the resident's potential liability for payment of the non-covered service(s). 2. The resident (or representative) may choose to continue receiving the skilled services that may not be covered, and assume financial responsibility. 3. The Notice of Non-Coverage informs the resident of the pending termination of coverage and of his/her right to an expedited review of service determination. During an interview 2/8/23 at 11:38 a.m., the facility's Activity Coordinator stated she was filling in for the Social Worker when she called the resident's POA on the phone, informed them that therapy under Part A Medicare was going to end. They said they didn't want to appeal the denial, if they wanted to appeal the decision she would have helped them with that, she did not send a copy of the notice to the POA, and stated she had never been instructed to do that.	F 582		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F 686	**Description:** F 686 **Plan of Correction:** Nursing staff will be educated that treatments are to be completed and documented by a licensed nurse. Physicians are to be notified of worsening wounds. Nursing staff will be educated regarding identifying pressure ulcers and their staging.	

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 _____	C 02/16/2023

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 686	Continued From page 14 ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, hospital staff, physician and resident responsible party interviews, the facility failed to provide appropriate wound care, by competent nursing staff, consistent with professional standards of nursing practice, to promote healing, prevent infection and worsening of a pressure ulcer for 1 of 2 resident records reviewed with pressure ulcers (Resident #1). The facility reported a census of 46 residents. Findings include: The Minimum Data Set (MDS) Assessment tool dated 12/31/22 revealed the resident admitted to the facility 12/19/22 with diagnoses that included diabetes, pneumonitis due to aspiration and muscle weakness, severe cognitive impairment with symptoms of delirium present, sometimes able to make herself understood and usually able to understand others, and required extensive assistance, sometimes total dependence on staff to reposition in bed, transfer to and from bed and chair, dressing, eating, toileting, bathing and personal hygiene, non-ambulatory, always incontinent of bladder, usually incontinent of bowel, and a Stage 1 pressure sore (PS) present (defined as observable, pressure-related alteration of intact skin with non-blanchable redness of a localized area usually over a bony	F 686	**How residents affected & residents with potential of being affected were identified:** Residents that reside at Centerville Specialty Care. **Corrective action taken for resident(s) affected:** Resident #1 no longer resides to the facility. **Measures or systemic changes made to ensure this will not recur and affect others:** Pressure staging guide will be attached to the treatment cart to assist nurses in appropriately staging wounds. Worsening wounds and wounds without improvement in 2 weeks will be reviewed in standards of care to assure physician has been notified of changes and treatment plan is adjusted accordingly. **Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** 4 audits per week for 4 weeks, then 2 audits per week for 4 weeks to assure licensed nurses are completing and documenting on wounds. **Anticipated Date of Completion for this plan of correction:** 3/13/23	

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 _____	C 02/16/2023

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 686	Continued From page 15 prominence). Physician Orders directed the following skin treatments and wound care: 12/30/22 Apply Calmoseptine Ointment to coccyx topically twice daily. 1/17/23 Fibracol to coccyx area and cover with foam dressing every 3 days, discontinued 1/20/23. 1/20/23 Fibracol to coccyx area and cover with foam dressing daily, discontinued 1/25/23. 1/26/23 Cleanse sacral ulcer with Dakins solution, apply Hydrofera Blue to coccyx wound, cover with foam external pad dressing daily. A Pressure related Injury to Skin Problem initiated on the Nursing Care Plan 12/19/22, with goal the pressure injury would show signs of healing and remain free from infection by the next review date, directed staff to: 1. Utilize pressure relieving/reducing device on bed/chair, initiated 12/19/2022 2. Monitor for pain related to pressure injury, initiated 12/19/2022 3. Monitor/document/report any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length, width and depth), stage, initiated 12/19/2022 Facility wound assessments of the sacral PS, completed by the Assistant Director of Nursing (ADON), identified as the wound nurse, revealed: 12/20/22, Stage 1 PS, present on admission, measured 8.6 centimeters (cm) by 5.7 cm, surrounding skin normal colored, intervention in	F 686		

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 _____	C 02/16/2023

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 686	Continued From page 16 place. 12/22/22, Stage 1 PS, 8.6 cm by 5.7 cm, surrounding skin normal colored, cleansed with wound cleanser, incontinence management implemented, intervention in place. 12/29/22, Stage 1 PS, 1.6 cm by 1.2 cm, scabbed area without drainage, surrounding skin fragile and at risk for breakdown, cleansed with soap and water, treated with Calmoseptine (a barrier cream applied to skin). 1/5/23, Stage 1 PS, 2.5 cm by 0.5 cm, surrounding skin fragile and at risk for breakdown, without induration or swelling, cleansed with soap and water, treated with Calmoseptine, stable. 1/12/23, Stage 1 PS, 10.4 cm by 0.9 cm, depth recorded as "not applicable", wound bed described as granulation tissue without drainage, surrounding skin normal colored without induration or swelling, cleansed with soap and water, treated with Calmoseptine, stable. 1/19/23, Stage 1 PS, 2.6 cm by 1.0 cm, depth "not applicable", light serosanguinous drainage (yellow-pink colored), without indication of infection, surrounding skin fragile and at risk for breakdown, without induration or swelling, cleansed with Wound Cleanser, new order for Fibracol and foam patch applied daily and as needed (PRN), stable. 1/26/23, Stage 1 PS, 4.8 cm by 2.1 cm, depth "not applicable", slough tissue in wound bed, light serosanguinous drainage, faint odor, no indications of infection, surrounding skin normal colored, without induration or swelling, rolled wound edges, wound cleansed with Dakins,Hydroera blue applied to wound bed, cover with foam dressing, changed daily and PRN, stable.	F 686		

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 _____	C 02/16/2023

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 686	Continued From page 17 A physician progress note dated 1/18/23 described the resident's sacral PS as a Stage 2 PS (Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising. May also present as an intact or open/ruptured blister.) The physician directed staff to cleanse the wound with Wound Cleanser, apply Fibracol to the wound bed, cover with a foam dressing changed every 3 days and as needed. A physician progress note dated 1/23/23 described the resident's sacral PS as a Stage 2 PS that measured 1 cm by 0.8 cm and 0.8 cm by 3 cm, wound bed epithelial cells and 50 percent slough tissue, and directed staff to continue cleansing wound with Wound Cleanser, apply Fibracol to the wound bed, cover with a foam dressing changed every 3 days and as needed. A facility wound photo of the resident's sacral PS, dated 1/26/23, revealed wound depth estimated at 1 cm based on resident anatomy in the photo, slough tissue in the wound bed, and reddened skin surrounded the wound opening and extended at least 1 cm from the wound edges that surrounded the wound opening. The wound in the photo appeared as a Stage 3 PS (full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue). The resident's January, 2023 Treatment Administration Records (TAR's) revealed facility Certified Medication Aides (CMA's) documented they completed the resident's sacral PS wound care and dressing changes on the following	F 686		

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 _____	C 02/16/2023

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 686	Continued From page 18 dates: 1/22/23 Staff D, CMA/Certified Nursing Assistant (CNA) 1/23/23 Staff D 1/26/23 Staff P, CMA/CNA 1/28/23 Staff E, CMA/CNA 1/29/23 Staff E Nursing Progress Notes revealed the following entries: 1/29/2023 at 9:53 a.m. "Patient noted to be more sleepy today, difficult to arouse. Patient will open eyes, but no verbal/mumbling noted. Skin pale, warm and dry. Two blisters to right lower extremity, calf area noted to be intact. No redness, swelling, signs or symptoms of infection noted to area, no edema noted to bilateral lower extremities. Dressing to coccyx noted to be dry and intact. Respirations even/unlabored. Lungs clear to auscultation, abdomen soft, bowel sounds present, No symptoms of pain noted. Involuntary muscle twitching to bilateral upper extremities. This RN unable to obtain vital signs after several attempts". 1/29/2023 at 1:23 p.m. "Rests in bed, no verbal response, unable to obtain vitals, fingers with some mottling, lungs diminished, bowel sounds present, no cough or dyspnea, no nausea or vomiting, TLC given, no distress noted." 1/29/2023 at 1:39 p.m. "This RN called and spoke with POA regarding change in condition. POA requesting that patient gets sent out to ER where 'people know more'. This RN attempted to provide education on assessment and status of	F 686		

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 _____	C 02/16/2023

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 686	Continued From page 19 patient but POA declined education and repeated that they wanted patient sent out to be seen by a doctor who has a 'higher level of education'. This RN verbalized understanding." The resident's record lacked any documentation of sacral pressure sore condition descriptions, type of drainage and amount, symptoms of infection present and other wound conditions as required, between 1/26/23 and 1/29/23. Shower care documented as completed in the resident's record, completed by Staff B, Certified Nursing Assistant (CNA) who worked as a Bath Aide included: 1/12/23, 1/16/23, 1/20/23, 1/23/23 and 1/26/23 One other shower was documented as completed 1/19/23 by Staff E, CNA The facility's Certified Medication Aide (CMA) Job Duties/Job Description policy, dated effective 5/10/21 directed: 1. According to the description of the scope of practice pertaining to CMA's described in Iowa Chapter 58.21(6), CMA's can administer nonparenteral medications if they have taken an approved class and passed a challenge examination. (Parenteral medications are administered via routes other than the digestive tract, such as injection or infusion). 2. There are no limitations on the type of oral solid medications that can be administered. 3. Per Iowa Code 58.19(2)(a), CMA's may not administer injectable medication. The Iowa Board of Nursing regulates practices that Registered Nurses (RN's) and Licensed	F 686		

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 _____	C 02/16/2023

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 686	Continued From page 20 Practical Nurses (LPN's) may delegate to an unlicensed assistive personnel (UAP) by: 1. Ensuring the UAP has the appropriate education and training and has demonstrated competency to perform the delegated task. 2. Ensuring the task does not require assessment, interpretation, and independent nursing judgment or nursing decision during the performance or completion of the task. 3. Verifying that, in the professional judgment of the delegating nurse, the task poses minimal risk to the patient. 4. Communicating directions and expectations for completion of the delegated activity and receiving confirmation of the communication from the UAP. 5. Supervising the UAP and evaluating the patient outcomes of the delegated task. Results of the resident's laboratory blood work obtained in the hospital ER on 1/29/23 revealed: White Blood Cell (WBC) count of 18.8 K/mm3, high value, normal range 4.5 - 11.0 K/mm3. BUN (Blood Urea Nitrogen) 151 mg/dL, high value, normal range 6 to 24 mg/dL. Creatinine 8.96 mg/dL, high value, normal range 0.59 to 1.04 mg/dL. Glomerular Filtration Rate (GFR) 5 ml/min 1.73 m2, low value, normal range 90 to 120 mL/min/1.73 m2. Potassium 5.5 mMole/Liter, high value, normal range 3.6 to 5.2 mmol/L. Sodium 151 mEq/L, high value, normal range 135 to 145 mEq/L. Blood Glucose 424 mg/dL, a high value, critical result value, normal range 99 mg/dL or lower for fasting result.	F 686		

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 _____	C 02/16/2023

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 686	Continued From page 21 The results indicated the resident's septic condition (severe infection that involves the blood), severe dehydration and acute renal failure (kidney shutdown). The resident's Death Certificate, signed by the County Medical Examiner 2/9/23, stated the resident died 2/1/23 at 9:26 a.m. as a result of Sepsis from a pressure ulcer on the sacral region. The resident's responsible party/Power of Attorney (POA) interviews revealed: POA#1, interviewed 2/8/23 at 3:02 p.m., stated the facility notified them she had a bed sore (pressure sore), but not that there was any concern over it, that it was something minor that was being treated, and never once said it was serious, or had gotten worse, or infected. POA #2, interviewed 2/8/23 at 3:27 p.m., stated one day while visiting they saw the soiled dressing in the resident's trash-can in her room, there was a foul odor and what looked like pus and blood on the dressing, when they asked staff if the bedsore was infected, they wouldn't answer them. Staff interviews revealed: Staff A, Registered Nurse (RN), interviewed 2/7/23 at 12:45 p.m., stated she didn't care for the resident very often, had changed her PS dressing, on 1/24/23 she notified the physician of	F 686		

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 _____	C 02/16/2023

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 686	Continued From page 22 wound changes that included yellow-green drainage with foul odor via fax (facsimile), couldn't remember any depth to the wound, the surrounding skin was reddened but blancheable. Staff B, Certified Nursing Assistant (CNA), interviewed 2/8/23 at 9:50 a.m. stated she worked as a Bath Aide, she showered the resident with her dressing on her sacral area, and the nurse never came in the shower room to remove the dressing after it was saturated from the shower, or to apply a new dressing. Staff C, RN, interviewed 2/8/23 at 10:20 a.m., stated when she completed a dressing change, she documented that on the TAR, and no need for any other documentation unless the wound looked different, then would chart that in the progress notes. She changed the resident's dressing a couple of times. When asked to describe the wound the last time she changed the dressing (1/25/23), she stated there was about a quarter-sized "dark spot", but could not provide a color or further description of the area, the "dark spot" hadn't opened yet, there was no drainage and no odor. When instructed that the last time she documented she changed the dressing, 1/25/23, was after yellow-green drainage with odor was noted and the physician informed of that on 1/24/23, Staff C stated she'd had a runny nose, wore a mask, couldn't smell anything, and didn't remember if the wound was opened or not. If she noticed any wound changes she would notify the physician, take a photo of the wound, and would notify family. The facility's Assistant Director of Nursing (ADON), a Licensed Practical Nurse (LPN) interviewed 2/8/23 at 12:22 p.m., stated she was	F 686		

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 _____	C 02/16/2023

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 686	Continued From page 23	F 686		

the facility wound nurse, had special training through Relias (computer based education program for health professionals) and was certified as a wound nurse through the Relias program. The ADON stated nursing should document what they see when they change a wound dressing, and document the treatment was completed in the TAR. If anything abnormal was noted staff should document that in the nursing progress notes. The last time she saw the resident's sacral pressure sore (1/26/23) there was an area that was dark, no depth to the wound but it was open, had light amount of serous drainage, a faint odor that the provider had been updated on. The provider changed the orders to cleanse it with Dakins solution, apply Hydrofera blue to the wound and cover with a foam dressing daily. The ADON stated nurses were expected to complete dressing changes, the CMA's can complete dressing changes if supervised by a nurse, whatever their company policy said. When asked what their company policy directed, the ADON stated she wasn't sure what it said.

The ADON's Certificates of Attendance for wound care education revealed:

1.25 contact hours of continuing education credit for completion of Wound Care for Arterial Ulcers on 11/14/22
1.0 contact hours of continuing education credit for completion of Wound Dressings: Making the Right Choice on 11/14/22

The facility Director of Nursing (DON), interviewed 2/8/23 at 12:55 p.m., stated CMA's could complete dressing changes if the nurse there delegated it to them. Both RN's and LPN's

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 _____	C 02/16/2023

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 686	Continued From page 24	F 686		

could delegate things to the CMA's if they were there. The DON stated she would have to address how the treatments were signed off on the TAR's by the CMA's and was not aware that CMA's completed pressure sore wound care.

Staff D, CMA/CNA, interviewed 2/8/23 at 1:04 p.m., stated she had taken care of the resident, she did "whatever the nurse delegated to her" as far as the resident's sacral PS wound care, and when asked specifically what wound care she provided, or what actions she completed, Staff D abruptly ended the interview and stated she would call the surveyor back in 10 minutes.

Staff E, CMA/CNA interviewed 2/13/23 at 11:48 a.m. stated "she did whatever the nurse delegated to her" when asked if she had provided wound care for the resident's sacral PS. Staff E was advised that was not an acceptable response, she needed to specify what activities the nurse delegated to her, what actions she had taken for the resident's wound care, then Staff E stated "she didn't remember what the nurse delegated to her, but the nurse was present". When asked if she had handled the wound care supplies, or what she did with the supplies, Staff E stated she handed the supplies to the nurse when she needed them, she opened the package of Fibracol for the nurse, removed the Hydrofera blue from the package and handed it to the nurse, the nurse cut the Hydrofera blue with scissors, and helped to keep the resident positioned on her side during the care.

Staff F, RN, interviewed 2/8/23 at 3:29 p.m. stated she hadn't seen the resident's PS as the dressing change was scheduled on the day shift, dressing changes were something the nurse

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 _____	C 02/16/2023

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 686	Continued From page 25	F 686		

should do and not appropriate for the CMA's, she would never delegate that to a CMA to do. If she thought she saw wound changes, she would communicate with the doctor immediately, document it in the progress notes, inform the wound nurse and would let the family know.

Staff G, LPN, interviewed 2/13/23 at 2:26 p.m., stated she had not seen the resident's sacral PS until the day she was sent to the hospital (1/29/23), it was an opened area, nickel to quarter sized, depth approximately 1 cm, there was serosanguinous drainage, she couldn't tell if there was an odor, the resident was acting differently that day, she thought she was transitioning. She would report any wound changes to the doctor on call and record the changes on the skin sheets. Soiled dressings removed are supposed to go in a red bag and taken to the appropriate container in the soiled utility room, staff should not put a soiled dressing in the resident's trash in their room.

Staff J, RN, agency nurse interviewed 2/12/23 at 12:08 p.m. stated she worked the day shift on 1/28/23 and 1/29/23 and was the nurse who sent the resident to the hospital. On 1/28/23 she felt the resident was transitioning and shutting down, when she assessed the resident at the request of her family she couldn't get a blood pressure reading or pulse oxymetry result, and she had not notified the physician of those findings. She provided her wound care and really couldn't recall what the wound looked like or if there was depth when she changed the dressing on 1/29/23 "as that was so long ago". When asked if a CMA provided her wound care, Staff J stated that wasn't something a CMA could do, that was a nursing responsibility. On 1/29/23 she notified

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 _____	C 02/16/2023

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 686	Continued From page 26	F 686		

the resident's POA by phone that she wasn't doing well, the POA was upset and demanded that she call the doctor and send the resident to the hospital where she would get the care she needed from staff that were more knowledgeable. Staff J notified the doctor, requested an ambulance for transport, the resident was non-responsive at the time she left the facility.

Staff H, hospital Emergency Room (ER) physician (MD), interviewed 2/14/23 at 10:13 a.m., stated she assessed the resident in the ER on 1/29/23, the resident was in critical condition, septic from a wound infection of the sacral pressure sore, the sacral pressure sore was at least grapefruit sized, open, deep, infected and looked horrible. The resident had recently acquired burns on her leg, an unstageable pressure sore on her ear, she was in pain and required Morphine (a strong narcotic opiate analgesic) for pain control. Upon the Resident's presentation to the ER that included a non-responsive state, her hair was matted, very dirty and unkempt. Nursing home staff reported to ER staff that the resident had been up for breakfast and ate some, but she thought that couldn't have been possible given the resident's critical and unresponsive condition when she arrived early in the afternoon to the ER.

Staff I, hospital RN, interviewed 2/15/23 at 2:22 p.m., stated on 1/29/23, the resident's sacral pressure sore measured 10 cm by 10 cm, wound bed described as black eschar, no recorded depth of the wound, scant serosanguinous drainage, surrounding skin red and indurated. The resident required Morphine administration several times for pain control before her death 3 days later on 2/1/23. Her primary diagnosis 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 _____	C 02/16/2023

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 686	Continued From page 27 sepsis from wound infection.	F 686		
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 record review, and staff and resident responsible party interviews, the facility failed to ensure the resident environment remained safe and free of accident hazards, and resulted in a resident's elopement from the facility undetected by staff (Resident #9), and a resident's burn when exposed to extreme heat temperature from a wall heater in the resident's room (Resident #1). The facility reported a census of 46 residents. Findings include: 1. The Minimum Data Set (MDS) Assessment tool dated 8/4/22 revealed Resident #9 scored 10 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment that indicated minimal cognitive impairment, with symptoms of delirium present, diagnoses included diabetes, anxiety, depression, non-Alzheimer's dementia and osteoarthritis of the right knee, required staff supervision or limited assistance of 1 staff for ambulation, dressing, toileting and personal hygiene.	F 689	**Description:** F 689 **Plan of Correction:** • All beds rearranged so that they sit on the adjoining wall from the baseboard heater. • Education provided to staff to ensure beds are not placed against baseboard heaters and rearranged against the adjoining wall. • Routine rounds will occur by IDT to assure that beds are not placed against the baseboard heaters. • Education provided to staff regarding the safety of residents and the baseboard heaters. • Skin evaluations completed on all residents. • Door Alarm audit was completed 9/28/22, a secondary alarm was placed on the back door and a work order placed for the maintenance supervisor to install a sounding alarm and to address all 3 kitchen doors. • Residents evaluated for current wandering evaluations, if not current evaluations were completed. • Residents with wander guards in place had wander guards tested and were checked for placement and functioning. • Secondary alarms were added to facility doors pending review of alarm system by manufacturer scheduled for 9/1/22	

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 _____	C 02/16/2023

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 28 A Wandering Evaluation (elopement risk) completed 5/19/22 revealed the resident scored 20 points, (score 10 or more points identified as high risk for elopement and Wandergard transponder bracelet required), resident scored 31 points on the next Wandering Evaluation completed 9/30/22. Treatment Administration Records (TAR's) indicated staff checked the resident for the presence and function of the Wandergard transponder every shift (3 times every day), the device last checked on 9/27/22 at 7:22 p.m. by Staff O, Licensed Practical Nurse (LPN). An Elopement Risk problem, related to a 7/26/22 elopement attempt, initiated 7/31/22 on the Nursing Care Plan directed staff: 1. Alert staff to my wandering behavior, initiated 7/31/2022 2. Approach resident positively and in calm, accepting manner, initiated 9/18/2022 3. I have a wander guard sewn into the back of my green hat, initiated 8/23/2022 4. Identify pattern of wandering. Is wandering purposeful, aimless, or escapist. Am I looking for something? Does it indicate the need for more exercise? Intervene as appropriate initiated 7/31/2022 5. If I wander away from unit, instruct staff to stay with me, converse and gently persuade me to walk back to designated area with them 9/13/22, initiated: 09/18/2022 An entry transcribed by Staff R, Registered Nurse (RN) in the Nursing Progress Notes on 9/27/22 at 11:23 p.m. stated:	F 689	• Missing resident drills • Education to the staff regarding the door alarm response with resident at risks for wandering and the missing resident procedure including completing a head count if no observation of the reason for the alarm was engaged to inspect the parameter. Once the outside staff member returns the alarm may be silenced at that time and paged all clear by the nurse • Staff education regarding door code to kitchen and expectation of locked door. • Staff education regarding how to check functioning of wander guards. • Postings have been placed on the door as an emergency exit only. • Attention signs placed at all exit doors. • Door alarm and missing resident protocol added to the agency orientation checklist. **How residents affected & residents with potential of being affected were identified:** Residents who reside to Centerville Specialty Care and sleep in beds have the potential to be affected. Also, Residents who are assessed as high risk for elopement have the potential to be affected. **Corrective action taken for resident(s) affected:** All beds rearranged so that they do not sit alongside the baseboard heaters and are now sitting alongside the adjoining wall. Head to toe skin assessment completed to assess for s/s of injury and/or emotional distress. Wander guard checked, in place and functioning. Physician and family aware, resident sent to ER. Care Plan reviewed.	

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 _____	C 02/16/2023

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 29 "At 10:10 p.m., Staff M called facility and alerted this nurse that resident was outside in gravel. This nurse, other nurse and 2 Certified Nursing Assistants (CNA's) out to assess resident. Noted resident sitting on bottom in gravel. Resident stating wanting to go home. Range of Motion (ROM) to all extremities per normal. Resident uncooperative with assessment. Resident not wanting to come back into facility. Did get resident back into facility. Staff K, CNA sent into facility to assess door and opened East hall door since resident so close to door. Noted door alarm on East hall door sounded at this time. Did not note alarm going off at time of resident exit. Staff M, CNA, stated rounds were completed at approximately 9:40 p.m. Other LPN on staff noted she had just left resident's room after his treatment. During that time, no door alarms noted going off. Once inside building, resident with comments like "I might as well just die." Resident also made threatening statements. Other nurse did note some scrapes to arm, resident still uncooperative with assessment. Call to physician at 10:30 p.m., orders to send to the hospital Emergency Room (ER) for evaluation. Called for ambulance at 10:45 p.m., arrived at 11:00 p.m. and took the resident to the ER. Did check residents Wandergard in hat before leaving, appeared to work, but Wandergard alarm did not sound when exited front door with ambulance." A written statement transcribed by the facility Administrator on 9/28/22 at approximately 8:00 a.m., obtained during a telephone interview with Staff O, LPN, (Staff O worked the evening shift on 9/27/22) stated: "Saw the resident on the ground on buttocks, walker still upright. Helped him inside, then	F 689	**Measures or systemic changes made to ensure this will not recur and affect others:** Education to staff and ongoing reinforcement of monitoring bed arrangements. Education to staff completed regarding door alarm response, residents at risk for wandering, and missing resident procedure. Attention signs placed at exit doors. **Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** Education to staff and routine IDT rounds to ensure beds are not sitting alongside baseboard heaters. Discussions will be brought to Qapi with any concerns. Routine audits of door alarms to assess for functionality weekly. Missing resident drills monthly per shift and then quarterly per shift. Results of the audits will be submitted to QAPI for review and additional recommendations. **Anticipated Date of Completion for this plan of correction:** 03/17/23	

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 _____	C 02/16/2023

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 30 checked all alarms. Resident was not in pain, scratch on arm. Front door alarm was canceled before Paramedic took resident out. Resident had his green hat on with the Wandergard sewn in the back. All other alarms sounded. Resident just wanted to go somewhere besides here." The facility's self-reported incident described the resident found outside near east hall exit door 9/27/22 at approximately 10:10 p.m., the time of the resident's exit unknown but estimated between 10:00 p.m. and 10:10 p.m. based on facility's investigation, that also revealed no door alarms sounded, including Wandergard alarmed exit doors. The facility hypothesized the resident exited through 1 of the 2 Kitchen service doors from the Dining Room, the doors swollen, did not close and latch completely, and could have been opened without the required security pass-code. From the Kitchen, the resident could have entered the service hall and exited through the service hall exit door without sounding any alarms. A Nursing Note transcribed by a hospital RN in the resident's ER record on 9/28/22 at 1:08 p.m. stated: "Administrator from Care Center present to look for patient's Wandergard. Patient very irritated, stated "get your hands off my stuff". Patient kept stating "he didn't know what box she was talking about". After Administrator left the room, patient stated "Ya, I know what box she's talking about, they used to keep it right here on my wrist. I threw that away a long time ago". Found trauma shears in patient's pants pocket from the Care Center.	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 _____	C 02/16/2023

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 31 Asked patient what he was doing with the scissors, patient stated "that's his business"." Staff Interviews revealed: Staff K, CNA interviewed 2/7/23 at 5:51 p.m., stated when he worked the night shift (10 p.m.. to 6 a.m.) on 9/27/22 they were at the Nurse's Station getting report per usual, probably between 9:55 p.m. and 10:05 p.m., while there he didn't see the resident, several staff were there for report and nobody saw him up by the Nurse's station or in the Dining Room area. Staff K stated he did not hear any alarms while at the Nurse's Station for report, then Staff M found him outside as she left after she worked 2nd shift (2 p.m. to 10 p.m.). Staff K thought the resident went out the East hall exit door, the door was supposed to alarm when opened, but didn't that night. Staff K stated nobody had seen the resident walking around in the area, and didn't think the resident could walk from his room (near the end of the East hall) to the kitchen and out the service entrance, then walk all the way back to the area outside by the East door where he was found. The resident said he hated it there and wanted to leave. Staff L, CNA, interviewed 2/7/23 at 6:07 p.m. stated she worked the night shift on 9/27/22, was at the Nurse's Station for report with her coworker Staff K, they didn't hear any door alarms go off, and she had not seen the resident up and around at anytime while at the Nurse's Station. Staff M called into the building from her phone about 10:10 p.m. - 10:15 p.m. and said the resident was outside and needed help to get him up. Both nurses went out and they brought the resident in	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 _____	C 02/16/2023

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 32	F 689		

through the front door, sat him at a table until the ambulance came and took him to the hospital. The resident could walk independently with his walker.

Staff M, Certified Medication Aide (CMA) and CNA, interviewed 2/13/22 at 6:12 p.m. stated she punched out and left after she worked the evening shift on 9/27/22, she talked to a coworker by their car for a few minutes, then went to her car that was located towards the east end in the parking area in front of the facility and thought she heard someone say "help me". It was dark so she moved her car in a way that the headlights shone in that direction and could tell someone was on the ground at the east end of the building, went there and found the resident seated on the ground, his walker was upright, he had a hold of his cane and the remote control for his television, he said he was leaving and just needed help getting back up on his feet. She believed he came out the East door, as she didn't think he could have navigated the back gravel parking lot, full of pot-holes in the dark with his walker, and made it all the way around the building to the East door where he was seated near. She called the facility for help with her cell phone, 2 nurses and 1 of the aides came out, checked him over, he wasn't hurt, they got him up and walked him back into the building through the front door. The resident didn't have a Wandergard on his wrist, he had a habit of removing them. As a CMA she'd checked for the function and placement of Wandergard's on all residents that had them, they did that every shift. The resident didn't like it there and frequently said that, usually ambulated with a walker. Staff M stated sometimes the East hall exit door would stick, wouldn't go all the way shut, and if it wasn't latched you could open it

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 _____	C 02/16/2023

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 33 without the alarm going off and thought that's how the resident eloped without sounding an alarm. Staff M stated she had not heard any door alarms going off before she left work that night, between 10:00 p.m. and 10:05 p.m. The facility Administrator, interviewed 2/13/22 at 3:08 p.m., stated the resident exited through 1 of the 2 kitchen doors from the Dining Room (both with pass code required), at the time of the elopement both of the dietary doors were "swollen" so didn't close completely unless forced, if unlatched the resident could have pushed the door open without the pass code, no alarm would have sounded and how the resident was able to leave undetected. Once in the Kitchen, the resident could have entered the service hall and exited through the service hall exit door. An employee found him outside at the East end of the building when she left work after 10 p.m. The employee used her cell phone and called into the building for help. The resident had his Wandergard on him, but no door alarms had sounded. Both nurses responded and assessed the resident, there were no injuries, he was assisted back into the building, they sat him in the front room/living room area while they called the physician, Director of Nursing (DON) and herself. It must have been while he sat there that he got dressing scissors from a treatment cart and cut his Wandergard bracelet off. He was sent to the hospital by ambulance within a half hour of the elopement. Since then, both of the Kitchen doors were sanded down the day after the elopement so they latched easily, and a second alarm was added to each Kitchen door located near the top of the door. They added a pass-code key pad to enter	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 _____	C 02/16/2023

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 34	F 689		

the service hall from the Kitchen exit door, and an alarm was added to the service hall exit door that alarmed whenever the door was opened. All door alarms were checked at the time of the elopement and all worked, if the Kitchen doors were latched they alarmed. All staff were re-educated on procedures for elopement.

Staff P, CNA, interviewed 2/13/23 at 1:28 p.m. stated the resident always said he wanted to get out of there, he'd pack his things up in his room and would say he's leaving. She was not surprised to hear he eloped, he ambulated independently.

Staff Q, CNA, interviewed 2/14/23 at 8:18 a.m., stated she never heard the resident say he wanted to leave but heard he said that to other staff, he missed his home and just wanted to go back to it. He had a Wandergard bracelet on but he got it off. When he came back from the hospital after he eloped they had to check him every 15 minutes for his whereabouts.

2. The Minimum Data Set (MDS) Assessment tool dated 12/31/22 revealed Resident #1 had severe cognitive impairment with symptoms of delirium present, with diagnoses that included diabetes, pneumonitis due to aspiration, muscle weakness, intellectual disabilities, unclear speech, sometimes able to make herself understood and usually able to understand others, and required extensive assistance, sometimes total dependence, on at least 1 staff to reposition in bed, transfer to and from bed and chair, dressing, eating, toileting, bathing 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 _____	C 02/16/2023

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 35 personal hygiene, non ambulatory, always incontinent of bladder and usually incontinent of bowel, A skin-impairment related to blister problem initiated on the nursing care plan 1/22/23 directed staff: 1. Educate resident, family, and caregivers of causative factors and measures to prevent skin injury. 2. Monitor for and document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection to physician. 3. Resident bed was moved away from the heater on 1/22/23. 4. Weekly treatment documentation to include, measurement of each area of skin breakdown, type of tissue and exudate, and any other notable changes or observations. Nursing Progress Notes revealed the following entries: 1/22/23 at 5:17 a.m. "Incident, Accident, Unusual Occurrence Note: Certified Nursing Assistant (CNA) requesting this nurse to resident room. This nurse down to room. CNA reports resident right leg is off of the bed and laying on the heat register. Resident laying on bed but air mattress has resident tilted toward register. This nurse and 2 CNA's able to move bed and bring resident leg up. Red area noted. No blisters or open areas noted at this time. Resident shakes head no when inquiring about pain. Bed repositioned away from heat register. This nurse had been in room	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 _____	C 02/16/2023

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 36 approximately 15 minutes prior for morning medication and resident was positioned in center of bed." 1/22/2023 at 10:24 a.m. "Patient noted to have a fluid filled blister to her right outer calf, dime-sized, noted redness to be around fluid filled blister that radiates up and down leg, right outer aspect of calf warm to the touch." The facility Skin/Wound assessment forms stated: 1/22/23 at 9:16 p.m., Staff F, RN, described a 2.3 centimeter (cm) by 0.7 cm blister on the resident's right calf. 1/23/23 at 10:59 a.m., the Assistant Director of Nursing (ADON) and facility wound nurse described a 1.6 cm by 1.4 cm blister on the right thigh. A physician Progress Note related to the physician's assessment on 1/23/22 stated: A new blister wound on right lateral calf first noted 1/22/23 measured 4 cm by 1.8 cm, and directed staff to continue cleansing blistered areas to right lower extremity with wound cleanser, apply xeroform gauze, cover with non adherent gauze pad, wrap with rolled gauze daily and as needed (PRN). Monitor for signs or symptoms of infection. Physician orders directed staff: 1/5/23 - May have bed against the wall. 1/26/23 - Apply Xeroform Petrolatum Patch to right leg topically daily (a treatment for burns). Iowa Chapter 58 Administrative Code regulation	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 _____	C 02/16/2023

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 37 58.35(4)j specifically directs: Beds shall not be placed in such a manner that the side of the bed is against the radiator or in close proximity to it unless it is covered so as to protect the resident from contact with it or from excessive heat. Staff interviews revealed: Staff K, CNA interviewed 2/7/23 at 5:51 p.m. stated he worked the night shift, on 1/22/23 the resident started to slide out of bed and when he found her she was between the bed and the heater on the wall (her bed was up against the wall). The nurse had been in her room around 5 a.m. to give her medication, and when he found her it was between 5:15 and 5:20 a.m. and he called out for help. The 2 other staff on duty responded, they had to work together to get the resident back in bed. The resident had not really fallen, her leg was hanging off the side of the bed and it was up against the heater, her skin was red but there wasn't a blister. The nurse knew it and had looked at it. Staff L, CNA interviewed 2/7/23 at 6:07 p.m., stated she worked the night shift on 1/22/23 when the resident slid off the side of the bed, they had just put an air mattress on top of her bed, she didn't really fall, but the mattress had started to slide off the right side of the bed, where the legs would be, her bed was up against the wall so the resident's right leg was between the bed and the wall, and up against the heater but it was wrapped in her sheet, her bottom and the rest of her were still on top of the bed. It took the 3 staff on duty to get the resident's bed moved away	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 _____	C 02/16/2023

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 38	F 689		

from the wall and the resident positioned back in the bed. Her leg was red but she didn't see any blister at the time.

Staff F, RN, interviewed 2/8/23 at 3:29 p.m. stated she worked night shift , on 1/22/23 she gave the resident her thyroid pill at 5 a.m., the resident was in her bed per usual. Around 5:15 a.m. Staff K found her leg over the side of the bed and she went in to help him and the other CNA on duty to get the resident back on the bed and the bed moved away from the wall. The resident had not fallen, the air mattress was sort of tilted off the edge of the bed and her right leg was between the bed and the wall, against the heater. She checked her for injuries, the leg was red where it had been against the heater, warm, but there was no open areas or blistering, she filled out an incident report and notified the oncoming nurse and the Director of Nursing (DON). They had her bed up against the wall because of her attempts to get up on her own, that she frequently did after she woke her up for her 5 a.m. medication.

Staff H, physician (MD), interviewed 2/14/23 at 10:13 a.m., stated the resident had recently acquired burns on her leg when she assessed her 1/29/22. (Staff H was the physician on duty in the hospital Emergency Room on 1/29/23.)

Resident responsible party/Power of Attorney (POA) interview revealed:

2/8/23 at 3:27 p.m., the resident's POA stated on 1/22/23, when they arrived at the facility to feed the resident lunch they saw blisters on her leg and could tell the resident was burned. 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 _____	C 02/16/2023

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 39 resident's roommate told them she'd fallen out of bed the night before, was up against the wall-mounted heater and how she was burned. When they asked the nurse if it was a burn and how the resident was burned, the nurse said she couldn't tell them that.	F 689		

Natasha Blackburn

From: Natasha Blackburn
Sent: Friday, March 17, 2023 5:41 PM
To: Gina Anderson
Subject: Training for Centerville Specialty Care

We would like for you to provide some pressure ulcer development prevention and treatment education to our staff. Would you be able to come to one of our in services in the future? We hold them on the second Tuesday of each month at 2 pm. Please let me know if this would work for you. Thanks.

Sincerely,

Natasha Blackburn | Administrator
Centerville Specialty Care, 1208 East Cross Street, Centerville, Iowa 52544
C: (5150 393-9465 | F: (641) 865-3460
nblackburn@careinitiatives.org
careinitiatives.org

F553

Care Initiatives

In-Service

5-minute meeting

Date: 2/27/23

IDT team is to review family/resident's preference in regards to invitations for care plan conference.

How family wishes to be notified will be documented in the chart and will be notified in this fashion for further care conferences.

Thank you & please see me with any questions.

Teri Garr, LPN MDS

NURSING/CP TEAM

Print Name		Position	Signature
[redacted]	[redacted]	Administrat	[redacted]
		Certified Med (CMA)	
		Certified Med Ai (CMA)	
		Certified Nurse Aide (CNA) - Nursing	N/A
Mis	C	Certified Nurse Aide (CNA) - Nursing	N/A
	Davis	Certified Nurse Aide (CNA) - Nursing	N/A
		Certified Nurse Aide (CNA) - Nursing	N/A
		Certified Nurse Aide (CNA) - Nursing	N/A
A		Certified Nurse (CNA) - Nursi	
Teri		Charge Nurs	
L		Social Servi Coordinator	
		Certified Med (CMA)	
		Certified Nurse A (CNA) - Nursing	N/A
R		Certified Nurse Aide (CNA) - Nursing	
		Certified Nurse Aide (CNA) - Nursing	
	M	Charge Nurse - RN	
	N	Certified Nurse Aide (CNA) - Nursing	
	Pe	Charge Nurse - LPN	
Al	Ponse	Restorative Aide/ CMA	N/A

Care Initiatives

F580

In-Service

5-minute meeting

Date: 2/22/23

If the resident has a change in medications, fall, new skin/wound area, or any changes of condition the families MUST be notified.

When updating families please ensure this is documented with who you speak with regarding the changes.

Thank you & please see me with any questions.

Chanda Willingham Rn DON

CMA & NURSING

Print Name		Position	Signature
Natasha	Bla	Administration	
An		Certified Med Aide (CMA)	
		Certified Med Aide (CMA)	
		Certified Nurse Aide	
		Aide	
Apri		Aide	
Che		Aide	
		Aide	
		Nurse Aide (CNA) - Nursing	
		Charge Nurse - LPN	
Lo	Graham	Social Services Coordinator	
Sia		Certified Med Aide (CMA)	
		Nurse	
		Nurse - L	
A		Restorative Aide/ CMA	

F582

Care Initiatives

In-Service Form

Date: 2/16/23

Education Description (Attach copy of education to this form)

A written discharge notice will be mailed out to families regarding their therapy status, along with calling families and reviewing this over the phone and obtaining verbal consents.

Print Name	Position	Sign
[redacted]	Admin	[redacted]
[redacted]	SS	
[redacted]	Activities	
[redacted]	BOM	
[redacted]	LPN, MDS	[redacted]

Care Initiatives

F686

In-Service

5-minute meeting

Date: 2/22/23

Treatments are to be completed and documented on by a licensed nurse and physician is to be notified of worsening in wounds. Attached is education identifying pressure ulcers and their staging.

CMA/Nursing

Heather Wells LPN - ADON

Print Name		Position	Signature
[redacted]	Blackburn	Administration	
		Certified Med Aide (CMA)	
		Certified Med Aide (CMA)	
Heat[redacted]		Certified Nurse Aide (CNA) - Nursing	
		Certified Nurse Aide (CNA) - Nursing	
		Certified Nurse Aide (CNA) - Nursing	
		Certified Nurse Aide (CNA) - Nursing	
Melissa		Certified Nurse Aide (CNA) - Nursing	
		Certified Nurse Aide (CNA) - Nursing	
		Charge Nurse - LPN	
		Social Services Coordinator	
	Kroeger	Certified Med Aide (CMA)	
		Certified Nurse Aide (CNA) - Nursing	
		Certified Nurse Aide (CNA) - Nursing	
		Certified Nurse Aide (CNA) - Nursing	
	Moorman	Charge Nurse - RN	

Care Initiatives

In-Service

5-minute meeting

Date:

Treatments are to be completed and documented on by a licensed nurse and physician is to be notified of worsening in wounds. Attached is education identifying pressure ulcers and their staging.

CMA's & Nursing

Heather Wells LPN - ADON

Print Name		Position	Signature
[redacted]	[redacted]	Administration	
		Certified Med Aide (CMA)	
		Certified Med Aide (CMA)	
	Benjamin	Certified Nurse Aide (CNA) - Nursing	
		Certified Nurse Aide (CNA) - Nursing	
		Certified Nurse Aide (CNA) - Nursing	
		Certified Nurse Aide (CNA) - Nursing	
		Certified Nurse Aide (CNA) - Nursing	
Adrianna		Certified Nurse Aide (CNA) - Nursing	
		Charge Nurse - LPN	
		Social Services Coordinator	
		Certified Med Aide (CMA)	
		Certified Nurse Aide (CNA) - Nursing	
		Certified Nurse Aide (CNA) - Nursing	NA - CNA
		Certified Nurse Aide (CNA) - Nursing	NA - CNA
		Charge Nurse - RN	NA - CNA

Care Initiatives

F689

In-Service

5-minute meeting

Date: 01/31/23

Residents' beds cannot be pushed or be sitting alongside the baseboard heaters. Beds are to be positioned along the adjoining wall as the baseboard heaters can put the residents at risk for burns. If the resident refuses to move their bed, please ensure the residents bed is at a safe distance from the baseboard heater and are educated.

Thank you

Chanda Willingham Rn DON

ALL STAFF

Print Name		Position	Signature
[redacted]	[redacted]	Administration	
		Certified Med Aide (CMA)	
		Certified Med Aide (CMA)	
Heather		Certified Nurse Aide (CNA) - Nursing	
[redacted]	[redacted]	Certified Nurse Aide (CNA) - Nursing	
		Certified Nurse Aide (CNA) - Nursing	
		Certified Nurse Aide (CNA) - Nursing	
Christina	Kady	RN	Read & Acknowledged NB 2-1-23

Care Initiatives

F689

In-Service Form

Date: 9/28/22

Education Description

The South kitchen entrance door code is 1234 but will be changed to 1650. This door must remain locked and should ONLY be used for deliveries/contract and to dispose of garbage. The same holds true for the other two services doors (the one that provides entry and exit to South Hall as well as the one to exit the building). Signs are now posted.

The front doors to the kitchen entry have been sanded down to assure they will close and latch. In the future we will be using a key for entry for the dinning room East and West Kitchen doors. These doors are to always remain locked except for when meal service is occurring (at that time use the chain to hold open). Codes for these doors are West: 1234 East 8251. Only the kitchen staff should be accessing these South, East and West kitchen doors.

The doors will be audited everyday for 2 weeks then biweekly for 2 weeks and then weekly for 2 weeks.

Staff may be held accountable for residents who are injured due to elopement, which may result in fines/the loss of license/certifications! I do not want this happening to any of my staff.

Print Name	Position	Signature
[redacted]ng	DSM	
Lor[redacted]beem	Dietary	
Ka[redacted]nald	Dietary	
Mich[redacted]nald	Dietary	
G[redacted]d	Dietary	
[redacted]vitt	Dietary	
[redacted]nnn Mitch[redacted]	Dietary	

F689

Care Initiatives

In-Service Form

Date: 9/28/22

Education Description

The South kitchen entrance door must remain locked and should ONLY be used for deliveries/contract and to dispose of garbage. Only Kitchen Staff should be using this door! The same holds true for the other two services doors (the one that provides entry and exit to South Hall as well as the one to exit the building). Signs are now posted.

The front doors to the kitchen entry have been sanded down to assure they will close and latch. In the future we will be using a key for entry for the dinning room East and West Kitchen doors. These doors are to always remain locked except for when meal service is occurring (at that time use the chain to hold open). Only the kitchen staff should be accessing these South, East and West kitchen doors.

The doors will be audited everyday for 2 weeks then biweekly for 2 weeks and then weekly for 2 weeks.

Staff may be held accountable for residents who are injured due to elopement, which may result in fines/the loss of license/certifications! I do not want this happening to any of my staff.

Thanks,

Natasha

F689

Care Initiatives

In-Service Form

Date: 9/28/22

Education Description

If a resident is reported missing notify the administrator and Don, and organize a thorough search of the facility to include all residents rooms, including bathrooms one by one, and surrounding buildings and grounds. Be sure to open all closed doors locked and unlocked and thoroughly search each room.

If you hear a door alarm its important to act immediately to the alarm, checking all exit doors and completing a head count if no observation of the reason for the alarm was engaged to inspect the parameter.

Attached are the high-risk residents for elopement and Wanderguard check list and a binder is kept at the nurses station with the missing resident profile.

When a resident first admits to the facility a wandering evaluation is to be completed to determine if the resident is at risk for elopement, if resident is at high risk then the resident needs added to the Wanderguard list

When placing a Wanderguard on a resident make sure that the tester reads 000 and flashes a green light 3 times, this reading confirms that the Wanderguard is working correctly.

Nursing staff is responsible for checking every shift with the Wanderguard tester. If the Wanderguard is not working, please ensure the activation button is pressed in all the way and recheck if its still not working, then the nurse is responsible for replacing that Wanderguard.

New Wanderguards are stored in the med room.

Thank you

Chanda Willingham & Natasha Blackburn

F689

9/29/2022

ATTENTION

No staff is to be in the kitchen at any time other than dietary. If you need something, please radio the kitchen and let them know so they can get it for you. The snack cart is to be left in the inner dining room at night as no staff is to enter the kitchen after dietary staff have left!