STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dunlap Specialty Care	1403 Harrison Road Dunlap, IA 51529

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074 Based on observations, record review, resident, staff and family interview the facility failed to ensure 1 of 2 residents (Resident #2) had orders to change his catheter. The facility reported a census of 34 residents. Findings include: According to the admission Minimum Data Set (MDS) assessment tool with a reference date of 9/25/2024, Resident #2 had a Brief Interview of Mental Status (BIMS) score of 15. A BIMS score of 15 suggested he had no cognitive impairment. An admitted [DATE] was documented on the MDS. The MDS documented Resident #2 did not refuse care during the review period. The MDS documented he had an indwelling catheter. The following diagnoses were documented for Resident #2: renal failure, malnutrition, depression, and hypersomnia. According to the quarterly MDS assessment tool with a reference date of 12/25/2024, Resident #2 had a BIMS score of 15. A BIMS score of 15 suggested he had no cognitive impairment. The MDS documented Resident #2 did not refuse care during the review period. Resident #2 had an indwelling catheter. The following diagnoses were documented for Resident #2: renal failure, malnutrition, depression, and hypersomnia. The Care Plan focus area with an initiated date of 12/5/2024 documented he had an indwelling catheter. Staff were directed to: a) monitor for signs and symptoms of discomfort on urination and frequency; b) monitor, document, and report as needed any signs or symptoms or urinary tract infection UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns; c) observe me for acute behavioral changes that may indicate UTI; d) complete ongoing assessment of color, clarity and character of my urine; e) refer him to a urologist for evaluation of incontinence. (continued on next page)

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.

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The following Progress Notes were noted: a) On 9/24/2024 at 12:00 AM an encounter note documented by Advanced Registered Nurse Practitioner (ARNP) noted good urine output via catheter; b) On 12/17/2024 at 2:00 AM an encounter note documented by ARNP noted resident returned from the hospital on 12/13/2024. Resident was treated for acute encephalopathy and started on intravenous (IV) antibiotics. Reviewed hospital notes with the resident. Resident #2 stated that hospital believed the sepsis was due to his catheter not being changed. Reviewed urine sample results which showed contaminant. Noted that resident's catheter change placement was delayed, but not over 6 months as stated in records. His catheter was delayed by a few days. Resident has orders for every 30 days catheter change. He stated he is feeling good today. Review of Resident #2 Medication Administration Records (MARs) and Treatment Administration Records (TARs) from 9/18/2024 through 2/12/2025 revealed the records did not contain orders to change his catheter every 30 days. Review of Resident #2's order history since admission to the facility on [DATE] revealed a standard order that was dated 12/13/2024 to change his catheter monthly. There were no other catheter orders that had been completed, discontinued or struck out in her electronic health record (EHR). On 2/7/2025 at 10:59 AM Resident #2's Power of Attorney (POA) stated his catheter was not changed since he was admitted to the facility until he went to the hospital in December. The POA was not sure what happened or why it was not changed. He added the facility never denied they did not change Resident #2's catheter. On 2/11/2025 at 10:25 AM Resident #2 sat in the dining room filling out his menu for the week. His catheter drainage bag was connected to a hook under the seat of his wheelchair. The drainage bag had a dignity bag present. On 2/11/2025 at 10:25 AM Resident #2 stated he is fairly independent when it comes to taking care of his catheter. He will clean the site, empty the drainage bag and report the output to the nursing staff. When asked if the facility changes the catheter itself, he indicated they have only changed it once since he was admitted to the facility. On 2/11/2025 at 11:59 AM the Nurse Consultant was not able to locate the orders for Resident #2's catheter to be changed. She indicated he was admitted within 24 hours of going to another facility because the admission process was horrible. There were no assessments done and his orders were not put in so when the facility admitted him they had to use the orders from his recent hospitalization or from his referral History and Physical (H&P). She did verify Resident #2 had a Foley catheter. When asked why the ARNP made a note in December 2024 about the catheter being changed a few days late in the readmission note she indicated she would go find out. At 12:28 PM the Nurse Consultant was unable to find out when it was changed prior to his December hospitalization . On 2/11/2025 at 1:05 PM the Administration indicated the facility did not have a policy about the frequency of a catheter and drainage bag needing to be changed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/2025 at 10:13 AM Staff A Licensed Practical Nurse (LPN) stated Resident #2 does all of his own cares throughout the day and the facility changes his catheter when it's ordered to be done. Staff A added he has never had to change it but it's to be changed every 60 days. The staff will change the drainage bag when it needs to be changed. When an order is put in for a certain day to be completed, the staff member that signs in on that day, a pop up will appear that a task needs to be completed. These things never popped up on the days he worked with Resident #2. On 2/12/2025 at 10:27 AM Staff B LPN stated Resident #2 likes to do his own catheter cares because he is independent. Staff B stated she does not change his catheter because it's usually done during the day shift and she works overnights. When asked how often catheters are to be changed, she indicated every month. The orders to do so are on the MAR, when one signs in it pops up as needing to be done that day. Resident #2 will cleanse the catheter site and empty the drainage bag himself. He will then report to nursing staff how much output he has had. She will assist him with changing the drainage bag as needed then she will put a progress note in about doing that. On 2/12/2025 at 12:01 PM the Director of Nursing (DON) stated Resident #2 does his own catheter cares; he will empty the drainage bag, cleans the catheter site and the nursing staff will change it. When asked how often that catheter is to be changed she stated it used to be monthly, but the corporation went to changing the catheters every 60 days, unless the physician orders it more often. The DON was informed the ARNP documented the catheter to be changed every 30 days in a readmission note. She indicated the policy did not change until the beginning of the year and it has not been brought through their Quality Assurance and Performance Improvement (QAPI) meeting yet. She was also informed Resident #2 had no catheter orders on his MAR and/or TARs since his admission in September and there were no progress notes about the catheter being changed. She indicated it needs to be on the TAR so staff know when it needs to be completed. There was an order for it to be changed every 30 days from December but it is not on the TARs since the order was written and there were no progress notes indicating this was completed. She stated unfortunately if it was not documented then it was not done. On 2/12/2025 at 1:54 PM Staff C Registered Nurse (RN) stated Resident #2 will drain his own catheter then let the staff know how much he drained. He will also do his own site cares. Staff C stated he changed the resident's catheter on 1/9/2025 because the resident asked him to. He did a late entry in the record because there was nowhere to document it. When asked when the resident's catheter is to be changed he stated supposed to be done on the night shift because they have more time, every 30 days unless it's a silver tipped catheter then they will do different parameters. He indicated Resident #2 does not have a silver tipped catheter.