

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165193	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Dunlap Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673</p> <p>Based on Electronic Health Records (EHR) review, observations, resident interview, family interview, staff interviews, and policy review the facility failed to provide the residents with a comfortable/clean homelike environment by not cleaning resident rooms or common space in a timely manner. The facility reported a census of 33 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) dated [DATE] for Resident #6 documented a Brief Interview of Mental Status (BIMS) score of 5 indicating severe cognitive impairment.</p> <p>On 5/19/25 at 11:17 AM Resident #6's daughter stated there was a spider in the dining room by the nurses station for about a week. The resident's daughter stated her mothers room gets spiders at times. She stated she had told the administration. The daughter stated she killed a large spider in the chapel and explained to look behind the door in the chapel where she killed the spider about a week ago. The daughter stated there were a lot of dead bugs in the chapel when she was there last.</p> <p>On 5/19/25 at 11:40 PM observation of numerous dead bugs in the chapel and in the hallway on center hall. Observation of a large spider dead where Resident #6's daughter described.</p> <p>2. The MDS dated [DATE] for Resident #24 documented a BIMS of 15 indicating no cognitive impairment.</p> <p>On 5/20/25 at 5:02 PM Resident #24 stated the housekeeping rarely comes in to clean the room less then twice a month. Resident #24 stated it did bother her and she has mentioned it to several nurses.</p> <p>3. The MDS dated [DATE] for Resident #27 documented a BIMS of 13 indicating no cognitive impairment. On 5/19/25 at 12:57 PM Resident #27 stated he had to clean his room on his own before on his hands and knees. Resident #27 stated he filed a grievance about how the room was not cleaned in several days. Resident #27 stated he can go days without his room being cleaned. Resident #27 stated it did bother him that his room was not cleaned for days at a time.</p> <p>Observations on 5/19/25 at 11:30 AM of numerous dead insects on the floor around the nurses station and on the center hallway baseboards.</p> <p>(continued on next page)</p>		

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of document Grievance/Concern Investigation Form for the last 3 months documented concern that room had not been cleaned since the resident had admitted to the facility dated 4-7-25. A concern that housekeeping was asked to clean the bathroom because the resident thought the bathroom smelled like urine. The resident wanted it mopped and cleaned. The housekeeper opened the bathroom door, said it was fine and left the room. A concern that the resident's room had not been cleaned for a few days. The resident attempted to clean the floor himself. Actions and follow-up in place for all of the grievances with Staff K, Housekeeping Aide, spot checks for effectiveness, and follow-up inspections.</p> <p>On 5/22/25 at 8:50 AM Staff K, housekeeping aide stated he had worked at the facility since 8/31/23. Staff K stated there were 3 people in the housekeeping then one went to the kitchen and the other became the Manager. Staff K explained about a month ago the Manager moved to Missouri. Staff K stated he worked every day, about 6 hours every day, to keep it under 40 hours. Staff K stated the facility had not allowed overtime in the past. Staff K stated the facility allowed overtime over the last five days since surveyors have been in the facility. Staff K stated on 5/21/25 there were 3 extra housekeeping brought to the facility. Staff K stated they were brought to help out during the survey. Staff K stated the facility had never in the past since he had worked at the facility pulled staff from another building for help at this facility. Staff K acknowledged that he had been spoken to about the grievances. Staff K stated he was the only person in housekeeping and he could not complete all the tasks. Staff K stated the plan that was developed had little to no follow up because there simply was not enough staff at the facility to complete all the tasks. Staff K stated he usually cleaned every single room every day. Staff K stated he usually cleaned the dining rooms and resident rooms daily. Staff K stated in the residents room he would at least sweep the room daily. Staff K acknowledged he did not feel he was completing all the tasks in the housekeeping department because he just simply does not have the time to complete all the required cleaning. Staff K stated he missed areas like the chapel, hallways and the nurses station. Staff K stated he cleaned every bathroom, toilets and the floors every day. Staff K stated he was just thrown into the position and was not oriented to the expectations. Staff K stated he had no orientation besides computer training such as dependent adult abuse. Staff K stated he had spoken to the Administrator about not being able to complete his tasks and he was told they tried to hire staff but the facility never did. Staff K stated he did not remember any follow ups from the management related to grievances.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/22/25 at 8:51 AM Staff L, Maintenance Supervisor and Temporary Housekeeping Supervisor stated the previous housekeeping supervisor quit that was why he started being the supervisor. Staff L stated when the residents or staff saw spiders or ants they would report them. Staff L stated it seems when the pest control spray they will try to clean up the dead when the insect is present when sprayed. Staff L stated Resident #7's daughter had reported a spider in the hall and in Resident #7's room. Staff L stated the facility was not cleaned appropriately. Staff L stated there were not enough hours. Staff L stated the halls are not being cleaned daily and the housekeeping staff were limited to 40 hours. Staff L explained the housekeeping department was short 2 full time people and did not have anyone in the laundry either. Staff L stated laundry takes priority over maintenance. Staff L stated maintenance had tasks that took priority as well. Staff L stated it was brought to his attention and he had brought it to the Administrator multiple times requesting more employees in the department or overtime. Staff L stated neither overtime or new hires had been provided. Staff L stated yesterday there were 3 staff from another facility brought in for housekeeping. Staff L stated he had not had any staff from other buildings come help in the housekeeping role. Staff L stated the grievances were written prior to him taking the position and he put together a schedule to ensure the cleaning would have been completed appropriately. Staff L stated the cleaning schedule that was being implemented related to the concerns on the grievances were not being followed because by Wednesday he had too many hours. Staff L stated the Administrator was aware of the concerns. Staff L stated he had that conversation many times with the Administrator. Staff L stated the follow up only happened for 2 days. Staff L stated the Administrator stated he could not have over 40 hours so that was stopped. Staff L stated after the plan was developed there was very little to no followup to how the issues/concerns would be addressed. Staff L stated the resident had very bad incontinence and urinated all over the room and the department was supposed to clean his room [ROOM NUMBER] times a day. Staff L stated he originally cleaned the residents room twice a day but does not think it was currently being cleaned that often.</p> <p>On 5/22/25 at 11:15 AM Staff M, area Administrator stated housekeeping was brought in from other facilities to help out for housekeeping at that facility. Staff M stated there was someone from the department who quit last Tuesday. Staff M stated he would expect the insects would have been cleaned up in a timely manner around the facility.</p> <p>Review of policy revised 8/13 titled, Cleaning and Disinfecting Residents' Rooms documented housekeeping surfaces will be cleaned on a regular basis. Environmental surfaces would be disinfected on a regular basis. Clean personal use items such as lights, phones, call buttons, bedrails etc with disinfectant solution at least twice weekly.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673</p> <p>Based on observation, Electronic Health Record (EHR) review, resident interview, family interview, staff interviews, and policy review the facility failed to follow physician orders for a resident with an ordered breathing treatment and a resident with oral medication for 2 of 4 residents (Resident #6 and #7). The facility reported a census of 33 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) dated [DATE] for Resident #6 documented a Brief Interview for Mental Status (BIMS) score of 5 indicating severe cognitive impairment. The MDS also documented a diagnosis of pneumonia on 4/18/25.</p> <p>Review of Resident #6's EHR titled, Orders documented a physician's order for sodium chloride inhalation nebulization solution 3% to be administered between 7:00 AM and 9:00 AM.</p> <p>Review of the Medication Administration Record (MAR) documented on 4/30/25 the AM dose of sodium chloride inhalation nebulization solution was administered by Staff A, Registered Nurse (RN).</p> <p>The Progress Note with the created date of 4/30/25 entered by Staff H, Director of Nursing (DON), documented Resident #6 did not receive the AM dose of normal saline breathing treatment.</p> <p>On 5/19/25 at 11:17 AM Resident #6's daughter stated her mother was supposed to receive a breathing treatment but did not receive the treatment. The daughter stated there was a change of tubing every Sunday night at the facility for nebulizer's and masks. The daughter stated the nebulizer tubing was new in the package. The daughter stated she asked Staff A if her mother was given a nebulizer treatment that morning. The daughter explained Staff A said she would give Resident #6 another treatment. Resident #6's daughter stated she told Staff A not to give the treatment. The daughter revealed she had not found out the treatment was not given until 5:00 PM.</p> <p>On 5/21/25 at 3:22 PM Staff A stated it was a rough morning on 4/30/25 and the CMA left before 9 am. Staff A explained Resident #6 did not receive the breathing treatment that morning but acknowledged that she had signed off on the MAR that it was given. Staff A stated she did not take the medication down to Resident #6, it was still in her pocket that morning. Staff A stated Resident #6 had a new set up and it was not open at that time. Staff A explained Resident #6's daughter had come down and told her that the treatment was not administered. Staff A stated it was after 10 am on 4/30/25 when Resident #6's daughter notified her the treatment was not administered. Staff A stated Resident #6's daughter did not want Resident #6 to receive the breathing treatment at that point. Staff A stated Resident #6 s daughter was extremely argumentative and demanding. Staff A stated the DON was already aware because Resident #6's daughter had informed her. Staff A stated she spoke to the DON about the incident. Staff A acknowledged it was her mistake Resident #6 did not receive her breathing treatment that morning. Staff A stated she did not receive education of disciplinary actions as a result of the incident.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/21/25 at 3:00 PM the DON stated there was a recent event when Resident #6 did not receive a saline breathing treatment. The DON stated Staff A was asked by Resident #6's daughter if her mother had received the breathing treatment the morning of 4/30/25. The DON stated Staff A stated she had misspoke when she spoke to Resident #6's daughter. The DON stated the saline breathing treatment was a 7 am - 9 am medication. The DON stated she spoke with the physician and there were no new orders. The DON stated she did an investigation and determined that Staff A signed the medication out and the CMA was supposed to turn the nebulizer on.</p> <p>2. The MDS dated [DATE] for Resident #7 documented a BIMS score of 15 indicating no cognitive impairment. The MDS also documented a diagnosis of lymphedema.</p> <p>Review of Resident #7's EHR titled, Orders documented a physician's order for Lasix 40 mg oral tablet one time daily mid morning.</p> <p>The MAR documented on 5/20/25 the mid morning dose of Lasix 40 mg was administered by Staff I, Registered Nurse (RN).</p> <p>On 5/21/25 at 7:27 AM Resident #7 stated she was not given these noon medications. The resident stated she was only given Tylenol so she told the nurse that she was supposed to get eye drops and Lasix and the nurse told her that she was to receive only the Tylenol.</p> <p>Observation on 5/21/25 at 7:40 AM of Resident #7's medication bubble pack for furosemide 40 mg 1 tablet at noon revealed medication present in the bubble with #20.</p> <p>On 5/21/25 at 7:40 AM Staff J, Certified Medication Aide, (CMA) acknowledged the bubble pack revealed that the furosemide 40 mg tablet was not administered yesterday for the noon dose. Staff J stated Staff I, RN administered medication for Resident #7 at noon 5/20/25. Staff J stated when a medication is noted in the bubble pack from the day before she would notify the nurse or the DON. Stated she had not notified anyone of the medication as of that time.</p> <p>On 5/21/25 at 8:10 AM Staff H, DON stated the date should match the number as long as the pharmacy sends a 30 day supply. The DON acknowledged that yesterday's noon dose of furosemide was still in the bubble pack. The DON reviewed other doses of furosemide to ensure it was not given from another card and acknowledged the medication doses were correct on other furosemide bubble packs. The DON acknowledged that the MAR was signed by Staff I that the noon furosemide was given. The DON acknowledged that there was no explanation on the MAR or in Resident #7 EHR that explained the extra dose.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/21/25 at 8:48 AM Staff I, RN stated she spoke with Resident #7 on 5/20/25. Staff I stated Resident #7 liked to self administer her eye drops. Staff I stated Resident #7 was frustrated because she was not allowed to do her eye drops. Staff I stated Resident #7 had 2-3 days worth of Lasix that were not administered. Staff I stated it was not uncommon for days to be left with no explanation. Staff I stated if you look in the center hall cart there were several other medications missed 5/20/25 as well. Staff I stated Staff J and herself had noticed the missed medication 5/20/25. Staff I stated she had never been taught the process of what to do if extra medication were found at the facility. Staff I stated she had administered the Lasix dose to Resident #7 without difficulties. Staff I stated she had also given Resident #7 her 3 eye drops, Tylenol, and furosemide. Staff I stated she did not notify anyone like the DON or anyone else about the extra doses because it is not uncommon to find extra doses at this facility. Staff I stated she had given the dose from the #18 spot on Resident #7's bubble pack.</p> <p>Review of the policy revised 4/07 titled, Documentation of Medication Administration documented a nurse or certified medication aide shall document all medication administered to each resident on the residents MAR. Administration of medication must be documented immediately after (never before) it is given. Documentation must include, as a minimum, the signature and title of the person administering the medication.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785</p> <p>Based on observations, interviews and record review the facility failed to ensure a resident does not develop pressure ulcers unless unavoidable and failed to ensure interventions in place for a resident with pressure ulcers for 1 of 3 residents reviewed. On 5/13/25, the Primary Care Provider discovered that Resident #15 had a pressure injury on his heel. Staff documented no new skin issues on the same day. In an observation on 5/22/25, staff failed to have interventions in place. The facility reported a census of 33 residents.</p> <p>The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers:</p> <p>Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.</p> <p>Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister.</p> <p>Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.</p> <p>Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar.</p> <p>Unstageable Ulcer: inability to see the wound bed.</p> <p>Findings include:</p> <p>According to the Minimum Data Set (MDS) dated [DATE], Resident #15 had a Brief Interview for Mental Status (BIMS) score of 14 (intact cognitive ability). He was admitted to the facility on [DATE]. Resident #15 was totally dependent on staff for toileting, dressing, transfers, and rolling over in bed. He was at risk for pressure ulcers and did not have any pressures at the time of the assessment. His diagnoses included: anemia, heart failure, renal insufficiency, malnutrition and asthma.</p> <p>The Care Plan for Resident #15, updated on 2/28/25, showed that he was at risk for nutritional and skin impairment. He was unable to ambulate on his own, staff used the mechanical lift for transfers and he required moderate assistance with showers. A focus area added to the Care Plan on 5/18/25, showed that he had a Stage 1 pressure ulcer on his right heel. Staff were directed to apply a pressure relieving boot when he was in bed.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/19/25 a 10:37 AM, Resident #15 was laying in his bed on his back and was watching television. He said his back hurts because of the mattress on his bed. The resident was wearing a protective boot on his right foot. He said that his heel was sore and was causing him some pain, but he wasn't sure about the treatment plan.</p> <p>According to the Skin Observation Tool dated 5/7/25 at 9:17 AM, Resident #15 did not have any new skin issues.</p> <p>A Wound Evaluation dated 5/13/25 at 3:46 PM, showed that on that date it was discovered that Resident #15 had a new, right heel, deep tissue injury that was in-house acquired. It measured: 3.01 centimeters (cm) total area, 2.18 cm. length and 2 cm. width. The assessment indicated that the resident didn't have any pain and no dressing was applied. The Nurse Practitioner (NP) was present and treatment orders received.</p> <p>On 5/21/25 at 3:21 PM, Staff C, RN, Assistant Director of Nursing (ADON), acknowledged that he had documented the information on the heel pressure discovered on 5/13/25. He said that the NP found the spot when she was doing rounds because the resident told her that he had some pain on his right heel. Staff C maintained that the resident hadn't ever told anyone else about the pain and they were not aware of the developing sore. He was not sure what the heel may have looked like before it was discovered or if staff should have found it sooner.</p> <p>A Wound Care (WC) note dated 5/19/25, showed that Resident #15 was admitted for WC services on 5/14/25 with suspected Deep Tissue Injury (DTI) to his right heel that was found on 5/13/25. The resident was no longer ambulatory or able to bear weight, staff were using a Hoyer (mechanical lift) for transfers. He was chronically bedbound and noticed a deep poking pain in his heel about 2 weeks prior to its discovery. The resident had been sleeping in the recliner and used the bend in the recliner foot rest to push himself up. That routine stopped when they removed the recliner from the room about 2 weeks prior. The wound was described as a smaller area of non-blanching red with a larger surrounding callous. The primary etiology of the ulcer was described as a Stage 1, intact skin with non-blanchable redness of a localized area over a bony prominence with dark pigmented skin, some blue or purple hues. The Plan of Care included cleansing the wound with soap and water, pat dry, scrub the wound bed (mechanically debrided.) and OTA (Open to Air.) At the time of the WC assessment, the resident's foot was appropriately placed in a Prevalon (ulcer protective boot) the wound measured total perimeter of area 5.3 cm. length 1.5 cm x 1.6 cm. The ulcer was consistent with pressure as the primary etiology. Staff were to keep the foot in the Prevalon boot at all times, if resident needed a break, ensure his heel was fully offloaded with use of a wedge or pillows.</p> <p>A review of the Nursing Notes revealed the following:</p> <p>a. On 4/21/25 at 3:42 PM, Resident #15 was an assist of 1 person with the EZ stand for transfers, he had poor nutritional intake, with no current skin concerns. He preferred to sleep in the recliner as he did at home. A bed had been placed in the room and the recliner would be deep cleaned.</p> <p>b. On 4/24/25 at 10:43 AM, the resident was incontinent of urine and soaked through recliner. Housekeeping removed the recliner for cleaning. The resident was no longer able to bear weight, using Hoyer for transfers.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The following 30-day lookback report was found in the Point of Care (POC) Response History, in the electronic chart and printed on 5/20/25 at 3:13 PM:</p> <p>a. Does the resident have any skin injuries? From 4/21/25 through 5/20/25, the twice a day documentation showed no skin issues.</p> <p>On 5/21/25 at 3:09 PM, Staff A, Registered Nurse (RN) said that resident #15 had a recliner in his room that he would sleep in and they removed it out of his room because it was soiled. She said that he wouldn't come out for meals, and she didn't know if he refused showers, and didn't know about what he wore on his feet before the discovery of the pressure ulcer.</p> <p>On 5/22/25 at 7:08 AM, Resident #15 was in bed on his back and was wearing gripper socks. His heels were resting on the bed. The Prevalon boot was on the floor along the side of the bed. At 9:34 AM, he had a blanket over his face, breakfast food was sitting on the bedside tray table. His feet were resting on the bed, Prevalon boot was still on the floor. At 10:46 AM, the resident was still in bed on his back, the boot was on the floor and his heels rested on the bed without a pillow of wedge under his legs to float the heels.</p> <p>On 5/22/25 at 11:15 AM, Staff B, Corporate Nurse Consultant, said that she would expect that the boot would be in place on his right heel unless there was some explanation. She later said that staff had reported that he refused the boot earlier that morning.</p> <p>A facility policy titled: Pressure Ulcers/Skin Breakdown - Clinical Protocol, dated April 2018, showed that the nursing staff and practitioner would assess and document an individuals' significant risk factors for developing pressure ulcers. The physician would order pertinent wound treatments, including pressure reduction surfaces, wound cleaning and debridement approaches, dressings and application of topical agents. The policy lacked reference to staff's responsibility to follow through with orders and/or interventions.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785</p> <p>Based on observation, interview, clinical record review and policy review the facility failed to ensure that medications were given in a timely manner for 1 of 4 residents. On 5/11/25, the morning medication, administered via Percutaneous Endoscopic Gastrostomy (PEG) tube, for Resident #3 were not administered until afternoon. The facility reported a census of 33 residents.</p> <p>Findings include:</p> <p>According to the Minimum Data Set (MDS) dated [DATE] Resident #3 had a Brief Interview for Mental Status (BIMS) score of 8 (moderate cognitive deficits.) She was totally dependent on staff for dressing, hygiene, nutrition and transfers. She had an indwelling urinary catheter and a feeding tube, abdominal always incontinent of bowel.</p> <p>The Care Plan for Resident #3, last updated on 5/14/25, showed that she had a Foley catheter for neurogenic bladder. Staff were to provide catheter care every shift. The resident had a terminal prognosis related to diagnosis of progressive multifocal leukoencephalopathy (damage to the brain white matter.) Resident #3 had a tube feeding related to dysphagia disease. She was at risk for perineal infection related to peg tube site. Staff were to use Enhanced Barrier Precautions (EBP) when performing high contact area activities.</p> <p>On 5/21/25 at 5:22 AM, Resident #3 was in bed with her eyes open. The continuous tube feeding was hooked up to a pump and running. She made eye contact but was unable to respond to questions.</p> <p>A review of a Medication Administration Audit Report showed that on 5/11/25, the 10 morning medications were not administered until 12:20 PM. The 2 medications scheduled for 11:00 AM that day had been administered at 3:37 PM. The chart lacked documentation that the physician had been notified of late administration of medications.</p> <p>On 5/22/25 at 11:15 AM Staff B, Corporate Nurse Consultant, said that she would expect that the administration of medication times would be completed per facility policy. She thought that the nursing staff probably waited for the second administration later because of the late morning medications.</p> <p>According to a document titled: Medication Administration Times, the morning medications would be completed between 7 am-9 am and the later morning medications administered from 11 AM - 1 PM.</p> <p>The policy titled: Documentation of Medication Administration dated April of 2007 the administration of medication would be documented immediately after it was given.</p>		

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NAME OF PROVIDER OR SUPPLIER Dunlap Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673</p> <p>Based on observations, staff interview, and policy review the facility failed to store food in accordance with professional standards by not dating open food items or disposing of expired food items. The facility reported a census of 33 residents.</p> <p>Findings include:</p> <p>On [DATE] at 8:24 AM an observation during the initial kitchen tour revealed a 3 door refrigerator with 3 bags of lettuce (one bag open) with the expiration date of [DATE]. A second 3 door refrigerator had a bag containing 8 hard boiled eggs that were open and undated, 8 individual yogurt containers with expiration of [DATE] and cheese in a large clear plastic container with an open date of [DATE]. Dry storage contained a bag of gravy mix, a bag of lemonade mix, a 2 pound bag of gluten free flour, a 5 pound bag of egg noodles, a 10 pound bag of tri colored noodles and a 5 pound bag of white cake mix open and undated.</p> <p>On [DATE] at 10:23 AM Staff E, Certified Dietary Manager (CDM) stated the facility's expectation was that all open food items would be dated with the date the item was opened. Staff E stated she would have expected the cheese with the date of [DATE] would have been discarded before [DATE]. Staff E stated all expired food should have been discarded once it was expired. Staff E explained the yogurt and lettuce should have been discarded before [DATE].</p> <p>During a continuous observation on [DATE] from 11:17 AM - 12:15 PM of the lunch meal service revealed Staff F, CDM using metal tongs to remove buttered bread from a metal container. Observation revealed Staff F moving between the tongs and bare hands to replace the lid using the handle of the lid to cover the bread throughout the entire lunch service. Observation on [DATE] at 11:44 AM revealed Staff E, CDM complete hand hygiene, open the 3 door refrigerator, remove a plastic bag with 2 foil wrapped sandwiches, retrieve one sandwich from the bag, open the foil with bare hands, grasp one sandwich from the foil with bare hand and place the sandwich on a plate that was taken out to the dining room for a resident.</p> <p>On [DATE] at 12:32 PM Staff G, Registered Dietitian (RD) acknowledged that she had observed Staff E handle food with bare hands. Staff G stated her expectation was that food would not be handled with bare hands. Staff G stated her expectation was that expired food would be discarded once expired. Staff G stated she expected opened items of food would be dated. Staff G explained tongs should not have been utilized for handling the handle of the metal lid and placing the bread on a plate for a resident. Staff G expressed concerns related to cross contamination when bare hands and tongs contacted the same item that bread was being served with.</p> <p>Review of policy revised ,d+[DATE] titled, Food Receiving and Storage documented dry foods that are stored in bins will be removed from original packaging, labeled and dated (use by date). All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by).</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785</p> <p>Based on observation, staff interviews and record review the facility failed to complete accurate resident records for 3 of 13 residents reviewed (Residents #3, #24 and #30.) Documentation on dialysis residents #30 and #24 had been completed up to 12 days after the date of the assessment. Staff entered a late nursing note for Resident #3 that indicated catheter care had been completed the previous evening when it had not been done. The facility reported a census of 33 residents.</p> <p>Findings include:</p> <p>1. According to the Minimum Data Set (MDS) dated [DATE] Resident #3 had a Brief Interview for Mental Status (BIMS) score of 8 (moderate cognitive deficits). She was totally dependent on staff for dressing, hygiene, nutrition and transfers. She had an indwelling urinary catheter and a feeding tube, abdominal always incontinent of bowel.</p> <p>The Care Plan for Resident #3, last updated on 5/14/25, showed that she had a Foley catheter for neurogenic bladder. Staff were to provide catheter care every shift. The resident had a terminal prognosis related to diagnosis of progressive multifocal leukoencephalopathy (damage to the brain white matter.) Resident #3 had a tube feeding related to dysphagia disease. She was at risk for perineal infection related to peg tube site. Staff were to use Enhanced Barrier Precautions (EBP) when performing high contact area activities.</p> <p>On 5/20/25 at 12:09 PM, Resident #3 was in bed on her back. There was a urinary catheter hanging on the bed frame, light color urine. The resident made eye contact but was unable to respond to questions.</p> <p>A Nursing Note dated 5/10/25 at 2:20 PM showed that the resident was started on an antibiotic for a urinary tract infection.</p> <p>An order Audit Report printed on 5/22/25 at 7:51 AM, showed an order Acetic Acid irrigation solution 0.25% use 60 ml. via irrigation every night shift for prevent blockage and Urinary Tract Infection (UTI) irrigate Foley catheter.</p> <p>A review of the Medication Administration Record/Treatment Administration Record (MAR/TAR) showed that on the evening of 5/19/25 the catheter flush had not been completed and referred to the nursing notes.</p> <p>The following was found in the Nursing Notes:</p> <p>a. On 5/19/25 at 10:44 PM, solution not available. For the flush.</p> <p>b. On 5/19/25 at 11:07 PM (entered on 5/20/25 at 10:10 AM) the flush was completed with Normal Saline and the primary care physician was aware.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/21/25 at 5:15 PM, the Director of Nursing (DON) said that the overnight nurse had called and told them that there was no acetic acid available for the catheter flush, so she was told to call the doctor and get an order for Normal Saline (NS.) The DON said that she talked to the Nurse Practitioner (NP) and verified that the nurse did get an order but she did not know for sure if the nurse completed the flush. She said she assumed and that was why she documented the next day that it had been completed.</p> <p>2. According to the MDS dated [DATE], Resident #24 was admitted to the facility on [DATE]. He had a BIMS score of 15 (intact cognitive ability). She was totally dependant on staff for dressing, hygiene and toilet transfers. The resident had dialysis treatments and diagnoses that included; end stage renal disease, morbid obesity, chronic pain and liver disease.</p> <p>The Care Plan updated on 4/29/25, showed that Resident #24 had chronic kidney disease that required dialysis three days a week. Staff were to monitor the shunt for patency, document peripheral edema, document and report symptoms of infection, or renal insufficiency such as changes in lung and heart sounds.</p> <p>A Dialysis Evaluation (DE) dated 5/4/25 at 12:04 PM, (entered on 5/16/25 at 12:05 PM) showed in Section 3, that the vital signs (vs) had been obtained on 5/4/25 at 8:00 AM and a reference made to see vs A review of the Weights and Vitals (W&V) tab lacked a Temperature (T) Blood Pressure (BP) or Heart Rate (HR) on 5/4/25.</p> <p>The DE dated 5/12/25, (entered on 5/16/25 at 12:14 PM) showed that the resident returned to the facility on [DATE] at 5:00 PM and had no edema, shortness of breath or nausea and the lung sounds were clear. The document showed that the date and time the vitals had been obtained was 5/12/25 at 4:00 PM, referenced to see vs. The W&V showed just one set of vitals taken on 5/12/25, and that was at 9:25 AM.</p> <p>3. According to the MDS dated [DATE], Resident #30 was admitted to the facility on [DATE] and had a BIMS score of 15 (intact cognitive ability) He was independent with hygiene, dressing, toileting and transfers. He received dialysis treatments and had diagnoses that included: anemia, renal insufficiency, diabetes mellitus, end stage renal disease,</p> <p>The Care Plan for Resident #30 updated on 4/22/25, showed that he was receiving hemo-dialysis three days a week, staff were to monitor for shunt patency, edema and signs of infection.</p> <p>The DE form dated 5/4/25 at 3:12 PM, (entered on 5/15/25 at 9:33 PM) showed that he had no edema or shortness of breath, clear lung sounds and the fistula/graft site looked normal. The date and time of vitals obtained was 5/4/25 at 9:00 AM, referenced to see vs. The W&V lacked a BP, HR or T for that day.</p> <p>The DE form dated 5/12/25 at 5:18 PM (entered on 5/16/25 at 12:20 PM) indicated that the resident returned to the facility at 4:00 PM, with no fluid overload, no shortness of breath and clear lung sounds. The date and time vitals were obtained indicated it was 5/12/25 at 4:00 PM and referenced to see vs. The W&V showed that the T had been taken just one time that day at 8:30 AM, and HR was taken at 9:04 AM.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/22/25 at 11:15 AM, Staff B, Corporate Nurse Consultant, said that she would expect to see that documentation of assessments and vitals completed per policy</p> <p>Facility Policy titled: Charting and Documentation July of 2017, showed that documentation in the medical record would be objective, complete and accurate. Documentation of procedures and treatment would include care specific details including date and time procedure treatment was provided.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673</p> <p>Based on observations, Electronic Health Record (EHR) review, policy review, and staff interviews the facility failed to provide appropriate infection prevention practices when providing care to a resident with an enteral feeding tube and stage 2 wound with one that had a care plan for Enhanced Barrier Precautions (EBP) for 2 of 3 reviewed (Resident #3 and #6). The facility reported a census of 33 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) dated [DATE] for Resident #6 documented a Brief Interview of Mental Status (BIMS) score of 5 indicating severe cognitive impairment. The MDS also indicated Resident #6 had one or more unhealed pressure ulcers. The MDS had described the pressure ulcer as a stage 2.</p> <p>Review of document titled, Resident Matrix revealed Resident #6 had a stage 2 pressure ulcer that was not present on admission.</p> <p>On 5/21/25 at 9:06 AM an observation of Resident #6's transfer onto the shower chair by Staff N, Certified Nursing Assistant (CNA) and Staff O, Observation revealed Staff N and Staff O completed hand hygiene, applied gloves, did not apply gowns, applied lift cloth to sit to stand mechanical lift, Staff N ran the mechanical lift controls, Staff O removed Resident #6's brief, Staff N lowered Resident #6 into the shower chair, Staff O removed gloves, Staff O completed hand hygiene, Staff N removed gloves and completed hand hygiene, both staff applied gloves, Staff N removed the lift sling, Staff N positioned Resident #6 in the shower, Staff N removed socks and night gown, and Staff N started the shower.</p> <p>On 5/21/25 at 9:16 AM Staff N stated because Resident #6 had a wound on her buttocks because of the wound she now got a shower. Staff N stated Resident #6 usually got a whirlpool.</p> <p>On 5/21/25 at 9:55 AM an observation of Staff C, Registered Nurse (RN) / Assistant Director of Nursing (ADON) and Staff O, CNA of dressing change to pressure area on coccyx. Observation revealed both staff completed hand hygiene, applied gloves, no gown applied, area cleansed with normal saline by Staff C, Staff C removed gloves, Staff C completed hand hygiene, Staff C mixed collagen with normal saline, Staff C mixed the collagen with cotton tip applicator, Staff C completed hand hygiene, Staff C applied gloves, Staff C applied skin prep around the wound, Staff C removed gloves, Staff C completed hand hygiene, Staff C applied gloves, Staff C applied collagen to the wound bed, Staff C applied the dressing, Staff C dated the dressing, gloves removed by both and hand hygiene completed by both staff.</p> <p>On 5/21/25 at 10:10 AM Staff C, RN / ADON acknowledged he was familiar with EBP. Staff C stated a gown would be worn with any resident with an MDRO, catheters, enteral feeding tube, or dialysis resident. Staff C stated when care was completed a gown and gloves should be worn. Staff C stated he believed if the wound was open and draining a gown should be worn. Staff C stated it was discussed with the nurse practitioner and it was determined that EBP was not required for Resident #6's wound. Staff C stated EBP was not required for wound care on Resident #6. Staff C acknowledged that Resident #6 had a pressure area that was covered with a border gauze.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/21/25 at 10:17 AM the DON stated EBP should be required with anyone with a catheter, anyone with a draining wound, and a resident with any external devices. The DON stated if the wound had drainage it would require EBP. The DON acknowledged that Resident #6 was on EBP when she had ESBL. The DON stated EBP was removed when Resident #6 no longer had ESBL. The DON stated Resident #6 did not require EBP at this time.</p> <p>41785</p> <p>2. According to the Minimum Data Set (MDS) dated [DATE] Resident #3 had a Brief Interview for Mental Status (BIMS) score of 8 (moderate cognitive deficits.) She was totally dependent on staff for dressing, hygiene, nutrition and transfers. She had an indwelling urinary catheter and a feeding tube, abdominal always incontinent of bowel.</p> <p>The Care Plan for Resident #3, last updated on 5/14/25, showed that she had a Foley catheter for neurogenic bladder. Staff were to provide catheter care every shift. The resident had a terminal prognosis related to diagnosis of progressive multifocal leukoencephalopathy (damage to the brain white matter). Resident #3 had a tube feeding related to dysphagia disease. She was at risk for perineal infection related to peg tube site. Staff were to use Enhanced Barrier Precautions (EBP) when performing high contact area activities.</p> <p>On 5/21/25 at 7:10 AM, Staff A, Registered Nurse (RN) disconnected the continuous feeding from the pump for Resident #3. She clamped off the tube, then flushed the tubing with water. Staff A failed to wear gloves or a gown throughout the procedure. She talked to the resident, checked around the peg site, adjusted the gauze under the tubing, then exchanged a high five and fist bump with the resident.</p> <p>On 5/21/25 at 10:17 AM, the Director of Nursing (DON) stated the EBP should be required with anyone with a catheter, anyone with a draining wound, or external devices.</p> <p>According to an undated facility policy titled: Enhanced Barrier Precautions; the facility would implement EBP for the prevention of transmission of multidrug-resistant organisms. The facility would have an order for EBP initiated for residents with any of the following: wounds (chronic wounds such as pressure ulcers) and/or indwelling medical devices (feeding tubes) even if the resident was not known to be infected or colonized with a MDRO (Multidrug-resistant organism).</p>		