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	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centerville Specialty Care	1208 East Cross Street Centerville, IA 52544

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 22506 S 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on clinical record review and staff interviews, the facility failed to ensure residents are appropriately assessed and provided interventions to maintain their optimal health and well being for 2 of 4 residents reviewed. (Resident #5, #6) The facility reported census was 45. Findings include: 1. According to a Minimum Data Set (MDS) with a reference date of 3/28/24, Resident #5 had a Brief Mental Status (BIMS) score of 15 indicating an intact cognitive status. Resident #5 dependent to maximal assistance with transfers, mobility, dressing, toilet use and personal hygiene needs. Resident #5 was coded as having a catheter and continent bowel functioning. Resident #5's diagnosis included renal insufficiency, arthritis and hip fracture. According to a progress note dated 3/24/24 at 1:15 p.m. communication with primary care physician noted blood tinged urine observed in Resident #5's catheter bag. Progress note at 10:22 p.m. indicated an order to discontinue the catheter on a trial basis was granted and Resident #5 stated he would prefer to have it removed in the morning. On 3/25/24 at 5:07 a.m. the progress note indicates the catheter was removed. A progress note written by Staff E, Licensed Practical Nurse, at 10:55 a.m. stated Resident #5 was alert and normal self with no complaints of pain or discomfort and had still not voided this shift. This is the only progress note written regarding Resident #5 by Staff E during her 6:00 a.m. to 2:00 p.m. shift. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/29/24 at 4:33 p.m., Staff A, Registered Nurse, stated she was working a 6:00 a.m. to 6:00 p.m. shift on 3/25/24. Staff A stated Staff E was responsible for the care of Resident #5 during her shift. Staff A stated Staff E left early that day at 1:00 p.m. and upon leaving stated Resident #5 had voided. At around 2:00 p.m. Resident #5's family voiced concern that Resident #5 indicated he had not voided since his catheter was removed early that morning. Staff A stated she questioned the aides which affirmed Resident #5 had not voided that day. Staff A stated she contacted the physician and received an order for a catheter and when inserted she got 400 milliliters returned. Resident #5 stated he felt much better afterward. In an interview on 7/31/24 at 11:34 a.m. Staff D, Certified Nurse Aide, stated she recalled the day (3/25/24) in which Resident #5 had his catheter removed. Staff D stated she remembers he was a no void that day and she informed the nurse, Staff E. According to Bladder Elimination records dated 3/25/24 at 12:21 p.m., Staff D indicated Resident #5 Did Not Void. In an interview on 7/31/24 at 12:07 p.m. Staff E, Licensed Practical Nurse, stated she remembered the morning (3/25/24) Resident #5 had his catheter removed. Staff E stated she left early (1:00 p.m.) that day, but remembers visiting with Resident #5 before she left. Staff E stated she asked Resident #5 if he had voided and he stated a little. Staff E stated she palpated his abdomen and Resident #5 denied any discomfort. 2. According to a Minimum Data Set (MDS) with a reference date of 5/3/24, Resident #6 had a Brief Mental Status (BIMS) score of 15 indicating an intact cognitive status. Resident #6 was independent to set up assistance with transfers, mobility, dressing, toilet use and personal hygiene needs. Resident #6 was coded as continent bowel and bladder functioning. Resident #6's diagnosis included pneumonia, diabetes mellitus and chronic obstructive pulmonary disease. According to an incident report dated 3/8/24, Resident #6 had an unwitnessed fall without injury. Facility protocol requires neurological assessments to be conducted every 15 minutes times 4, every 30 minutes times 2, every one hour times 2 and every 8 hours times 9. Neurological assessments are to include vital signs. According to the Neurological Eval's Second 8 hour check, Staff E indicated vital signs were completed at 12:30 p.m. Review of PointClickCare vital sign records for Resident #6, found no vital signs recorded at or around that time by Staff E. According to the Neurological Eval's Fifth 8 hour check, Staff E indicated vital signs were completed at 12:30 p.m. Review of PointClickCare vital sign records for Resident #6, found no vital signs recorded at or around that time by Staff E. According to the Neurological Eval's Ninth 8 hour check, Staff F indicated vital signs were completed. Review of PointClickCare vital sign records for Resident #6, found no vital signs recorded by Staff F on or around the time the Ninth 8 hour check was due.