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	08/22/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22506 Based on clinical record review, staff interviews, and policy review the facility failed to ensure each resident was treated with respect and dignity while interacting with 1 of 3 residents reviewed. (Resident #1) The facility reported census was 40. Findings include: According to a Minimum Data Set (MDS) with a reference date of 7/11/24, Resident #1 had long and short term deficits and severely impaired cognitive abilities. Resident #1 was independent with transfers and mobility, moderate assistance with dressing, toilet use and personal hygiene needs. Resident #1's diagnosis included Non-Alzheimer's dementia, aphasia, coronary artery disease, renal insufficiency, chronic obstructive pulmonary disease. According to Resident #1's Care Plan, he is at risk for aggression and wandering behavior with interventions to approach and speak calmly, offer food or drink, ice cream or Mountain Dew. Remind resident that his behavior is inappropriate. Offer a pleasant diversion or structured activity such as food, conversation or TV. In an interview on 8/22/24 at 8:45 a.m. Staff D, Housekeeper, stated she was unsure of the date (7/31/24), but that morning she heard Resident #1 mumbling, so she stepped out into the hall and saw Resident #1 walking down the [NAME] hall. Staff D stated this was usual behavior for Resident #1 as he liked to wander. The nurse, Staff A, headed down the hall way to redirect him. Staff A stood in front of Resident #1 with her arms outward. Staff A's voice was raised as she was telling Resident #1 he could not go in that direction. Staff D stated Resident #1 started to get physical and Staff A was escalated, so she offered to take over, but Staff A continued to interact with Resident #1, so she walked away. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/22/24 at 9:10 a.m. Staff E, Housekeeper, stated on Wednesday, July 31st at around 6:15 a.m. to 6:30 a.m., she and Staff D were sweeping and cleaning the outer dining room. Resident #1 was wandering as usual and he has history of exit seeking. Resident #1 was just looking around and Staff A, Licensed Practical Nurse, apparently thought he was getting too close to the front door. Staff A came over and grabbed Resident #1 by the arms as she stood behind him, saying we're not going to do this today, you need to sit down. Staff A was pushing Resident #1 away from the door, trying to redirect him. Things settled down after that and Resident #1 continued to hang around the housekeeping staff. Staff E stated she and Staff D went to the [NAME] hall shower room to clean. Resident #1 also moved into the [NAME] hall and was standing outside of room [ROOM NUMBER], looking in, when Staff A came into the hall demanding Resident #1 stay out of the room, then again grabbed his arms from behind and started redirecting him, but this time more aggressively than before. Resident #1 started hitting Staff A and at one point Staff A pushed Resident #1 so hard he stumbled and almost fell . Staff A maintained contact with Resident #1 and prevented the fall. Staff E stated she was able to intervene and get Resident #1 involved in an activity. Staff E stated she didn't believe Staff A had any malicious intent to harm Resident #1. In an interview on 8/22/24 at 10:12 a.m. Staff C, Housekeeping Supervisor, stated on the morning of Wednesday, July 31st, they (housekeeping staff) had came in early due to a power outage. At shift change (6:00 a.m.) she overheard discussion that Staff A had been assigned skin assessments and this seemed to upset her. Staff C stated she was in the outer dining room with Staff E. Resident #1 was wandering and stepped towards the front door. Staff C told Staff E to grab a magazine in an attempt to distract Resident #1 with an activity. Staff C positioned herself in front of the door. At that time Staff A walks over saying we're not doing this today, then pushes Resident #1 in the chest with open hands, away from the door. Staff C stated she stepped in encouraging Resident #1 to look at the magazine. Resident #1 responded and Staff C left the area. The facility policy dated April 2021 documented the following: 1. Abuse of any kind against residents is strictly prohibited. 2. Abuse prevention includes recognizing and understanding the definitions and types of abuse that can occur. 3. It is understood by the leadership in this facility that preventing abuse requires staff education, training, and support, and a facility-wide culture of compassion and caring.