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	12/04/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on clinical record review, policy review, and staff interview, the facility failed to carry out medication consents for residents to make informed decisions with regard to their care for 2 of 5 residents reviewed for medications(Residents #8 and #29). The facility reported a census of 38 residents.Findings included: 1. The Minimum Data Set(MDS) assessment tool, dated 11/19/25, listed diagnoses for Resident #8 which included anxiety, depression, and non-Alzheimer's dementia. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 3 out of 15, indicating severely impaired cognition. The facility policy Antipsychotic Medication Use, revised December 2016, stated the facility would obtain informed consent and document why the benefits of the medications outweighed the risks or adverse consequences.The December 2025 Medication Administration Record(MAR) listed a 12/2/25 order for Abilify(an antipsychotic medication) 2 milligram(mg) one time per day. A 12/2/25 Care Plan entry stated the resident had an order for Abilify. A 12/3/25 11:50 a.m. Nurses Note stated the facility spoke with the resident's representative regarding the reason and benefits of the medication. The facility lacked documentation of the completion of a medication consent prior to the initiation of the medication which included the risks and benefits.2. The MDS assessement tool, dated 10/23/25, listed diagnoses for Resident #29 which included diabetes, heart failure and coronary artery disease. The MDS listed the resident's BIMS score as 9 out of 15, indicating moderately impaired cognition. The December MAR listed a 12/2/25 order for Rexulti(an antipsychotic medication) 0.5 mg one time per day.A Care Plan entry, revised 12/2/25, stated the resident used antidepressant medications related to depression. The facility lacked documentation of the completion of a medication consent prior to the initiation of the medication which included the risks and benefits.On 12/4/25 at 8:28 a.m., the Director of Nursing(DON) stated staff had a conversation with the resident families regarding the initiation of the medications but stated this was not documented in the notes.

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 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. Based on clinical record review, policy review, and staff interviews, the facility failed to carry out assessments and interventions after high blood sugar readings for 1 of 2 residents(Resident #29) reviewed for insulin(an injectable medication used to lower blood sugar). The facility reported a census of 38 residents. Findings included: The Minimum Data Set(MDS) assessment tool, dated 10/23/25, listed diagnoses for Resident #29 which included diabetes, heart failure, and coronary artery disease. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 9 out of 15, indicating moderately impaired cognition. A 6/24/22 Care Plan entry stated the resident used insulin related to diabetes.A 9/5/25 Care Plan entry directed staff to notify the provider if blood sugars exceeded 500 milligrams(mg)/deciliter(dl).The November and December 2025 Medication Administration Records(MARs) directed staff to obtain the resident's blood sugar before meals, at bedtime, and at 12:00 p.m. The MAR directed staff to notify the provider of blood sugars over 500 mg/dl.The resident's Blood Sugar Summary included the following blood sugars for 11/16/25:10:58 a.m. 547.0 mg/dl4:00 p.m. 600.0 mg/dlThe resident's Blood Sugar Summary included the following blood sugars for 12/1/25: 4:31 p.m. 538.0 mg/dlThe facility lacked documentation of provider notification of the above blood sugars and lacked documentation of any follow-up assessments or monitoring following the elevated blood sugars.The facility policy Diabetes-Clinical Protocol, revised 12/3/25, stated the physician would order desired parameters for monitoring and reporting information related to blood sugar management.On 12/3/25 at 3:20 p.m., the Director of Nursing(DON) stated orders included parameters for staff to refer to for provider notification of high blood sugars. She stated staff should follow this. On 12/4/25 at 8:28 p.m., the DON stated she could not locate any further documentation related to the resident's high blood sugars.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, clinical record review, policy review, and resident and staff interviews, the facility failed to carry out fall interventions(the use of a gait belt) in order to prevent a fall for 1 of 4 residents reviewed for falls(Resident #5). The facility reported a census of 38 residents.Findings included:The Minimum Data Set(MDS) assessment tool, dated 11/4/25, listed diagnoses for Resident #5 which included restless leg syndrome, Alzheimer's disease, and non-Alzheimer's dementia. The MDS stated the resident was dependent on staff for toilet transfers and required partial to moderate assistance for walking. The MDS listed a Brief Interview for Mental Status(BIMS) score as 5 out of 15, indicating severely impaired cognition. The facility policy Safe Lifting and Movement of Residents, revised 2017, stated the facility would incorporate resident safety, dignity, comfort, and medical conditions into the goals and decisions regarding the safe lifting and moving of residents. The facility stated staff were trained in the use of gait belts.Care Plan entries, dated 11/1/25, stated the resident was at risk for falls and required the assistance of 1-2 staff for walking and transfers. An 11/8/25 Witnessed Fall report, completed by Staff C Registered Nurse(RN), stated the resident walked to the bathroom with an assist of one. The resident stated she wanted to use the commode but the bucket was not in the commode. Staff C grabbed the commode with one hand and held onto the resident with the other hand. The resident staggered backwards and Staff C helped her land.An 11/8/25 Nurses Note, completed by Staff C, stated the resident had to use the bathroom and Staff C asked another staff member if the resident was an assist of 1 or 2 and staff reported she was an assist of 1. Staff C assisted the resident out of her chair and walked to the bathroom when the resident stated her bathroom was broken and she wanted to use the commode. The bucket was not in the commode so Staff C reached with one hand to fix the commode and her other hand was on the left arm of the resident who held onto the walker. As Staff C reached for the commode, the resident stepped backwards and fell to the floor.An 11/11/25 Encounter Note stated the resident had a fall on 11/8/25 and reported hip pain. On 12/2/25 at 9:41 a.m., Resident #5 stated she had a fall and it hurt her. On 12/2/25 at approximately 5:00 p.m., the resident walked in the hall with 2 staff members and her walker. The resident wore a gait belt that one staff held onto and another staff followed behind with a wheelchair. On 12/4/25 at 9:26 a.m., Resident #5 stated when she fell, staff did not use a gait belt but stated they typically did.On 12/4/25 at 9:57 a.m., Staff C stated the resident reported she had to use the bathroom. Staff C stated she was a travelling nurse so she asked two staff members if the resident could get up by herself and they said yes. She walked with the resident to the bathroom and when they were halfway there, the resident stated she wanted to use the commode. The commode was about 3 feet away and the bucket was not inserted. She stated they had to walk back toward the commode and the resident stepped back and fell. Staff C stated she did not have a gait belt on the resident and this was her(Staff C's) fault. Staff C stated she learned her lesson. On 12/4/25 at 10:20 a.m., the Director of Nursing(DON) stated staff should utilize a gait belt if a resident was an assist of 1 or 2. She stated staff would use the Kardex(a document containing resident information) to determine how to transfer the resident.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, policy review, and staff interview, the facility failed to ensure residents on a mechanical soft and pureed diet received the correct portions for 5 of 5 residents and failed to follow the menu for 3 of 3 residents reviewed. The facility reported a census of 38 residents. Findings include:Observations on 12/03/2025 starting at 11:00 AM revealed the following:a. Staff B, [NAME] placed 2 unweighted sections of ham in the food processor and processed to a mechanical soft (ground) texture. She measured out 5 green scoops (1/3 cup) of the processed ham and stated was for the mechanical soft diets. Staff B added 1 cup of gravy to the remaining ham and processed to a pureed consistency. She measured the pureed ham as 2 cups. During the subsequent meal service, Staff B served the mechanical soft ham to 2 residents and the pureed ham to 3 residents with a 1/3 cup scoop. After serving, she measured 1 cup of mechanical soft ham and 1/3 cup of pureed ham remaining. Interview on 12/03/2025 at 1:15 PM, Staff B stated she did not measure the ham sections before processing to mechanical soft and puree. Staff B stated she estimated the portion size of ham for the number of residents on altered diets and did not weigh the portion sizes for the menu requirements of 5 ounce serving of ham for each resident with mechanical soft and puree diet. Staff B stated the mechanical soft and pureed meat serving size is always the green scoop (1/3 cup). Staff B stated did not provide rolls, per the menu, for the 3 residents with puree diets, as she forgot to puree the rolls with the ham. Facility Diet Spread Sheet for 12/3/25 revealed lunch for mechanical soft and pureed diet as 5 ounces of ham and included a roll for pureed diets. Facility's undated Pureed Food Preparation Policy directed all residents on a pureed diet shall receive the correct portions of pureed meat, fruit, starch, fat, vegetables and dessert. The policy directed staff to pureed the correct number of portions (plus 1-2 extra servings), bread as planned on the menu may be added to the mixture, determine the total volume, and determine the scoop size. Interview on 12/3/25 at 1:45 PM, the Dietary Manager (DM) stated all residents should receive the portion size per menu. The DM stated the process was to measure the meat portions, then process the meat to mechanical or puree consistency and use the chart to determine the serving size per total volume. The DM stated residents should receive all food items on the menu. the roll should have been pureed with the meat.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and policy review, the facility failed to implement the Infection Prevention and Control Program (IPCP) by staff wearing Personal Protective Equipment (PPE) in the hall after resident care and by allowing the indwelling catheter tubing to contact the floor during resident transport in a wheelchair. The facility reported a census of 38 residents. Findings include:On 12/02/25 at 9:56 AM, Staff A, Physical Therapy Assistant (PTA) transported Resident #7 in a wheelchair from his room to the shower room. Staff A was observed wearing PPE while assisting Resident #7 reposition in his wheelchair in his room. She exited Resident #7's room, did not remove the gown, and transported the resident to the shower room. The resident's indwelling catheter tubing was in contact with the floor during transport.The Minimum Data Set (MDS) dated [DATE] for Resident #7 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated completely intact cognition. It included diagnoses of atrial fibrillation (irregular heartbeat), heart failure, diabetes mellitus, thyroid disorder, arthritis, cerebrovascular accident (stroke), urinary tract infection (UTI), and acute cystitis with hematuria (bladder inflammation with blood in the urine). It also indicated the resident was dependent with all Activities of Daily Living (ADLs) and mobility. It also revealed he had an indwelling catheter upon admission.The Care Plan revised 11/18/25 included the resident's urinary (indwelling) catheter and directed staff to provide Enhanced Barrier Precautions (EBP).On 12/03/25 at 2:58 PM, Staff A stated the resident being transported in his wheelchair was not part of his therapy. She also stated the facility provided PPE education and evaluated staff appropriately putting on and removing PPE. She said she understood EBP requirements directed staff to enter the resident's room, put on PPE before touching the resident, perform hand hygiene, don gloves, and provide resident care or a transfer within the resident's room. She confirmed PPE was not required once the staff and resident were in the hallway. She admitted she kept it on because she was going to continue working with the resident in the bathroom and knew she would need another gown. She further stated she was not aware the resident's indwelling catheter bag was on the floor when she transported the resident.The EBP sign directed staff to wear gloves and a gown for the followingHigh-Contact Resident Care Activities.a. Dressingb. Bathing/Showeringc. Transferringd. Changing Linense. Providing Hygienef. Changing briefs or assisting with toiletingg. Device care or use: central line, urinary catheter, feeding tube, tracheostomyh. Wound Care: any skin opening requiring a dressingOn 12/04/25 at 8:32 AM, the Infection Preventionist stated staff should remove PPE prior to exiting residents' rooms.On 12/04/25 at 10:52 AM, the Director of Nursing (DON) stated staff should have removed the PPE before leaving the resident's room.A policy titled Catheter Care, Urinary dated [DATE] directed staff to be sure the catheter tubing and drainage bag are kept off the floor.A policy titled Enhanced Barrier Precautions revised April 28, 2024 indicated EBP should be followed outside the resident's room when performing transfers and assisting during bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility. In general, gowns and gloves would not be recommended when performing transfers in common areas such as dining or activity rooms, where contact is anticipated to be shorter in duration. Examples: Walk to Dine Restorative program, assisting residents with feeding, transfers from w/c to stationary chair in common areas.