Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165288	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlantic Specialty Care	1300 East 19th Street Atlantic, IA 50022

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on observations, clinical record review, and staff interviews, the facility failed to protect residents from possible accidents and injuries for 2 of 3 residents (#3, #9). The facility reported a census of 63 residents. Findings include: 1. Review of Resident #3's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating normal cognitive function. The resident used a manual wheelchair (w/c) and could propel up to 150 feet independently. Resident #3's care plan revealed the resident used a w/c for mobility. On 8/12/24 at 1:06 PM Staff B, Certified Medication Aide, pushed Resident #3 from the dining room to her room without the use of foot pedals. On 8/12/24 at 2:36 PM the resident stated she normally self propels her w/c. On 8/13/24 at 11:15 AM Resident #3 self propelled her w/c in the hallway. 2. Review of Resident #9's MDS assessment dated [DATE] revealed a BIMS score of 11/15 indicating moderate cognitive impairment. The resident utilized a w/c and self propelled the w/c up to 150 ' independently. Resident #9's Care Plan revealed the use of a w/c for mobility and the resident self propelled. On 8/13/24 at 10:50 AM observed the Assistant Director of Nursing (ADON) pushing Resident #9's w/c to the medical clinical office. The resident did not have a leg rest on the right side. On 8/13/24 at 11:15 AM the resident self propelled her w/c around the dining room using her right upper extremity and right lower extremity. The left foot plate was in place. On 8/13/24 at 11:00 AM Staff G, Certified Nursing Assistant (CNA), stated a resident must have foot pedals on their w/c to be pushed. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/13/24 at 11:14 AM Staff D, Certified Medication Aide (CMA), stated foot plates have to be on the w/c for pushing. On 8/13/24 at 11:25 AM Staff H, CNA, stated staff cannot push residents without foot pedals. If a resident needed a push and there were no pedals on the w/c they would look in the resident's room. If there were no pedals there staff would look in the spare parts room. On 8/13/24 at 11:28 AM Staff C, Registered Nurse/Charge Nurse, stated resident's must have foot plates on the w/c to push to prevent injury. On 8/13/24 at 12:58 PM the Director of Nursing (DON) stated residents are required to have foot pedals on their w/c's to be pushed. On 8/13/24 at 1:25 PM the Administrator stated residents must have foot pedals on their w/c's to be pushed. Review of the facility provided document, Wheelchair (Use of) dated 1/15 taken from the Nursing Guidelines and Procedure Manual, foot rests should be folded up out of the resident's way for safety and not removed. When pushing residents lower footrests and place resident's feet on the footrests.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on observations, clinical record review, staff interviews and policy reviews the facility failed to implement appropriate hand hygiene and infection control practices to mitigate the spread of pathogens during medication administration (Resident #8, #7, and #3). The facility reported a census of 63. 1. During continuous observation of medication administration on 8/12/24 at 11:40 AM Staff A, Certified Medication Aide (CMA) did not consistently complete hand hygiene between 4 residents. 2. During continuous observation of medication administration on 8/12/24 at 11:55 AM Staff B, CMA, did not complete consistent hand hygiene between 16 residents. 3. Review of Resident #8's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating normal cognitive function, and the resident independent with toileting and transfers. Resident #8's Care Plan revealed the resident would transfer to the floor and independently use the toilet. At 12:55 PM on 8/12/24 Staff B placed Resident #7's eye drops in her pocket with gloves and a tissue. Staff B then obtained Resident #8's oral medication. Staff B entered Resident #8's room and provided the oral medication. Staff B then donned gloves and picked up a basin that was sitting on the floor. Resident #8 stated I squatted to use the toilet and left you a present. Staff B took the basin to the bathroom, emptied it, flushed the toilet, and rinsed the basin before returning it to the room. Staff removed gloves, washed hands, tied the trash and removed it from the room. Staff B discarded the trash and used hand sanitizer. 4. Review of the MDS assessment dated [DATE] revealed Resident #7 had an indwelling catheter, received more than 51% of total calories through parenteral feeding, and had a BIMS score of 00 indicating severe cognitive impairment. The Clinical Physician Orders dated 8/13/24 revealed Resident #7 required enhanced barrier precautions (EBP) related to a PEG tube/Foley catheter. Resident #7's Care Plan revised on 8/8/24 revealed the resident had EBP related to a urinary catheter and a Peg Tube. At 1:03 PM on 8/12/24 Staff B used hand sanitizer, donned gloves, and entered Resident #7's room. Staff provided eye drops to each eye per order and removed gloves from her pocket for wiping around the resident's eyes. Gloves were removed as the staff left the room. Staff B did not use additional personal protective equipment (PPE). On 8/13/24 at 9:20 AM Resident #7's catheter bag was observed to be hanging from a low bed touching the floor without a cover. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of Resident #3's MDS assessment dated [DATE] revealed a BIMS score of 15 indicating normal cognitive function. The resident used a manual wheelchair and could propel up to 150 feet independently. Resident #3 had an ostomy. Resident #3's Clinical Physician Orders dated 8/13/24 revealed the resident had EBP related to a colostomy. Resident #3's Care Plan revealed the resident had EBP related to a history of colectomy with ileostomy. On 8/12/24 at 1:06 PM Staff B pushed Resident #3's wheelchair into her room, donned gloves and provided eye drops per physician orders. Staff removed gloves upon exiting the room. Resident #3 had a sign posted on her door indicating EBP. Staff B only used gloves. On 8/13/24 at 12:58 PM the Director of Nursing (DON) stated hand hygiene should be completed between each resident during medication administration. Hand hygiene should also be completed before and after glove use. The DON stated best practice would be to keep eye drops in the box prior to administration. The DON stated staff would find out who has EBP by referring to the Kardex as it is the best place for information. The staff stated individuals who may have EBP include those with Foley catheters, ostomies, wounds. The DON provided a document, Enhanced Barrier Precautions Everyone Must, that provided instructions on what should be worn during resident care activities. On 8/13/24 at 1:25 PM the Administrator stated staff need to follow recommendations for PPE for those with EBP. The facility document Enhanced Barrier Precautions Everyone Must indicated staff and providers must clean their hands when entering and exiting the room, wear gloves and gowns during high contact resident care activities. The facility policy, Handwashing/Hand Hygiene, revised August 2019 instructed staff to perform hand hygiene prior to applying and upon removing non-sterile gloves. The document also revealed hand hygiene should be completed before and after direct contact with residents. The facility policy, Administering Oral Medications, revised October 2010, revealed staff are to complete hand washing prior to administration of medications and hand antisepsis upon completion. The facility policy, Catheter Care Urinary, revised September 2014 revealed the catheter tubing and drainage were to be kept off the floor.