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	10/24/2024

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 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** 49628 Based on interviews, clinical record review, and facility policy review the facility failed to provide dignity by staff swearing in the hallways outside the residents' rooms for 2 of 6 residents (Resident #2 and #5) reviewed. The facility reported a census of 57 residents. Findings Include: 1. Record review of the Minimum Data Set (MDS) for Resident #2, dated 8/8/24 documented a Brief Interview for Mental Status (BIMS) score of 15 indicating normal cognitive functioning. The document revealed the resident had adequate hearing and did not utilize hearing appliances. On 10/22/24 at 12:43 PM Resident #2 stated he had heard staff using swearing when having conversations in the hall. The resident confirmed it was not another resident using swear words. Resident #2 stated the language that he heard did bother him. 2. Record review of Resident #5's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition. The document revealed the resident had adequate hearing, and did not utilize a hearing appliance. On 10/22/24 at 11:53 AM Resident #5 stated she has heard swearing by staff while talking to each other across all shifts. The resident stated she could not identify any specific staff. Resident #5 stated she knew it was staff and not another resident. The resident stated the language was very upsetting to her. On 10/24/24 at 12:35 PM the Regional Nurse Consultant stated that residents should be treated with dignity and that swearing in the hallways would be upsetting to residents. The facility policy, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 4/21, revealed the facility should establish and maintain a culture of compassion and caring for all residents. The document further revealed the facility should provide support to prevent burnout, and stressful working situations. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, Resident Rights, revised 12/16, revealed all employees treat residents with kindness, respect, and dignity. The document provided that residents should have a dignified existence, be treated with respect, kindness and dignity.

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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	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on clinical record review, resident and family interviews, staff interviews and facility policy review the facility failed to provide the needed services in accordance with professional standards by not completing neuroogical assessments after falls for 2 of 2 residents (Resident #1 and #5) reviewed. Resident #1 self reported an unwitnessed fall from bed on 8/24/24 and sustained a hematoma on the right side of his forehead. Resident #5 had a witnessed fall involving a motorized scooter, and sustained a hematoma on the forehead and 3 skin tears on 9/12/24. The facility reported a census of 57 residents. Findings include: 1. Record review of the Minimum Data Set (MDS) assessment for Resident #1, dated 8/29/24 documented a Brief Interview for Mental Status (BIMS) score of 8 indicating a moderate cognitive impairment. The resident was frequently incontinent of bladder and occasionally incontinent of bowel. The MDS documented diagnosis of hypertension, non-Alzheimer's Dementia, seizure disorder or epilepsy. The resident was independent with transfers. The resident used a wheelchair for mobility. The document revealed the resident had 2 falls without injury and 1 fall with injury during the reporting period. The MDS dated [DATE] for Resident #1 documented a BIMS score of 15 indicating intact cognition. The resident was frequently incontinent of bladder and bowel. The resident was independent with transfers. The resident used a wheelchair for mobility. The document revealed the resident had 2 falls without injury during the reporting period. Resident #1's electronic health record (EHR) document: Neurological Eval (multi section)-initiated 8/25/24 at 9:15 PM and locked on 8/29/24 at 3:09 AM, revealed incomplete nursing assessments throughout the document. The document provided for 18 assessments to be completed over the course of several days - initial, (4) 15 minute checks, (2) 30 minute checks, (2) 1 hour checks, and (9) 8 hour checks. The document required staff to enter the date/time vitals were assessed. The documents revealed this occurred 7/18 times. The vitals tab in the EHR provided the documentation for the vitals assessed, and revealed blood pressure (BP) entries for 16 entries, temperature for 7 entries, pulse for 15 entries, respirations for 6 entries, O2 saturations for 7 entries, and pain for 11 entries. The EHR contained the physician fax written on 8/25/24 at 11:32 PM indicated the resident sustained an unwitnessed fall with a hematoma present on the right side, forehead above the right eye. The physician acknowledged the fax on 8/27/24 at 7:28 AM. On 10/22/24 at 3:29 PM Resident #1's Power of Attorney (POA) stated she was notified of the resident's fall a day or so after the fall. The POA stated during the notification she was told the facility had done vitals, and was told the resident did not sustain an injury. The POA stated she visited the resident on 9/16/24 and observed a goose egg and very noticeable black eye. The POA stated the resident indicated he had fallen out of bed. On 10/22/24 at 3:40 PM Resident #1 stated he had been sleeping in bed and he fell out. The resident stated he was able to get off the floor and go to the nurses station to report his fall. Resident #1 was unable to recollect any further details of his fall. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #5's MDS assessment dated [DATE] revealed a BIMS score of 15 indicating intact cognition. The resident was occasionally incontinent of bladder and always continent of bowel. The MDS documented diagnosis of Crohn's disease, difficulty in walking and unsteadiness on feet. The resident was independent with transfers and ambulation up to 50'. Resident #5 utilized a wheelchair for mobility. The document revealed the resident had 0 falls during the reporting period. Resident #5's EHR document: Neurological Eval (multi section)-initiated on 9/12/24 at 7:35 PM and locked on 9/16/24 at 4:42 AM, revealed incomplete nursing assessments throughout the document. The document provided for 18 assessments to be completed over the course of several days - initial, (4) 15 minute checks, (2) 30 minute checks, (2) 1 hour checks, and (9) 8 hour checks. The document required staff to enter the date/time vitals were assessed. The documents revealed this occurred 14/18 times. The vitals tab in the EHR provided the documentation for the vitals assessed and revealed BP entries for 15 entries, temperature for 14 entries, pulse for 15 entries, respirations for 14 entries, O2 saturations for 14 entries, and pain for 9 entries. The EHR contained the physician note written on 9/12/24 and faxed at 5:35 PM that revealed the resident sustained a large goose egg above the left eye and skin tears to the left forearm when her scooter went off the sidewalk and fell . The document further revealed the resident did not want to go to the hospital. The physician acknowledged the fax on 9/12/24, ordered to continue to monitor, and if neuro change, notify the provider, and may need to send out. The fax was returned on 9/12/24 at 7:27 PM. On 10/22/24 at 11:53 AM Resident #6 stated she had been on her scooter on the date of the fall outside with her daughter, when her scooter went off the sidewalk and it tipped over and she fell . The resident stated she bumped her head and had quite the black eye. The resident stated she declined to go to the hospital. On 10/23/24 at 12:10 PM Staff C, Licensed Practical Nurse (LPN), stated neuro assessments were to be completed initially following a fall while the resident was still on the floor. The staff stated the assessment included eyes, range of motion (ROM), and vitals (BP, temperature, pulse, respirations, O2, pain), and if the resident remained in the facility the assessments would continue for 72 hours. Staff C stated each assessment that followed would be completed the same as the initial assessment. The staff stated if a resident had a bump on the head, the physician should be notified via phone for orders of whether to send the resident to the hospital. On 10/23/24 at 1:40 PM Staff D, Registered Nurse (RN), stated if a resident had an unwitnessed fall or witnessed fall while hitting their head, neuro assessments would be initiated. The staff stated neuro assessments included: pupils, strength/ROM for upper extremities (UEs) and lower extremities (LEs), orientation, vitals (pain, temp, BP, pulse, respirations, O2). The staff stated neuro assessments would continue for 15 minutes then graduate up on time. Staff D stated Point Click Care (PCC), EHR, will alert nurses that neuro assessment is due, some will use paper to track and document. The staff stated subsequent assessments for neuro assessments were supposed to be the same as the initial assessment as PCC prompts for filling out. The staff stated they would call a physician if it was urgent, after hours/weekends would call the on-call physician, if critical would send to the emergency room , and notify the physician. The staff stated if the resident had an obvious head injury, they would call the physician. Staff stated if there was not an injury they would send a fax. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/23/24 at 4:22 PM Staff E, RN, stated If the resident is observed to hit their head or the fall is unwitnessed neuro assessments should be completed. The staff stated a neuro assessment included: eyes (pupils, tracking), orientation, and vitals (pain, temperature, BP, pulse, O2 saturations, and respirations) The staff stated all assessments should include the same information. The staff stated a physician should be notified by phone with any sign of significant injury or need for sending to the hospital. The staff stated if the resident was developing a goose egg she would call the physician rather than fax the physician. On 10/23/24 at 3:17 PM the Director of Nursing (DON), stated when a resident has a fall witnessed with hitting their head or an unwitnessed fall she would expect staff to follow the steps in the neuro assessment. The staff stated it was expected that subsequent assessment(s) would be completed the same as the first assessment with data variation dependent upon the resident. The DON stated the time of the assessment would be indicated by the document or could be referenced on the vital entries. The staff stated the staff would complete all the standard vitals. The DON acknowledged that review of the neuro assessments for Resident #1 and Resident #5 did not have complete sets of standard vitals. The staff stated that an abrasion, skin tear, fall with pain, and hematoma would indicate an injury and would tell family of the injury. The DON stated the physician is notified by phone for a significant injury, change in status (neurological, ROM, pain, open injury). The staff stated if the resident had a lower neurological status, it would be up to the nurse whether to notify the physician by phone or fax. The facility policy, Neurological Assessment Level III, revised October 2010, revealed assessment of neurological status always includes frequent vital signs with attention paid to pulse pressure (difference between systolic and diastolic pressures). The document further provided that any change in vital signs should be reported to the physician immediately. The document included steps for assessment of temperature, pulse, respirations, and documentation of the date and time of the assessment.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 49628 Based on clinical record review, interviews, and facility policy reviews, the facility failed to provide adequate nursing staff to assure residents safety by not responding to call lights in a timely manner for 4 of 6 residents (Resident #2, #3, #5, and #6). The facility reported a census of 57. Findings include: 1. Record review of the Minimum Data Set (MDS) assessment of Resident #2 dated 8/8/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15, indicating normal cognitive functioning. The resident had diagnoses of displaced intertrochanteric fracture of left femur with routine healing, osteoarthritis, difficulty in walking, and low back pain. Resident #2 required partial/moderate assistance with transfers, lying to sitting on the edge of bed, and dressing. The resident was dependent on toileting. Resident #2 utilized a manual wheelchair (w/c) for mobility. The resident was always continent of bowels and bladder. On 10/22/24 at 12:43 PM Resident #2 stated he has waited longer than 30 minutes for a call light to be answered. The resident stated if he had to wait for longer than 30 minutes, he would have incontinence episodes. Resident #2 stated he had incontinence episodes. The resident stated longer call lights do not correlate to any specific shift. The resident stated he will yell for assistance if necessary, and has self transferred to prevent incontinence episodes. The resident stated he has fallen as a result of self transfer. 2. Record review of the MDS of Resident #3 dated 10/9/24 revealed a BIMS score of 15/15, indicating normal cognitive functioning. The resident had diagnoses of pressure ulcer to the left heel, right below the knee amputation, osteomyelitis of the left ankle and foot, and peripheral vascular disease. Resident #3 required total assistance/dependency on staff for transfers, bed mobility, dressing, and toileting. The resident utilized a wheelchair for mobility. The document revealed the resident was always continent of bowel and had a catheter. On 10/22/24 at 2:05 PM Resident #3 stated call lights have lasted up to 30 minutes before being answered. The resident stated it was felt to be due to low staffing. The resident did not relate the call lights to a specific shift. 3. Record review of the MDS of Resident #5 dated 9/5/24 revealed a BIMS score of 15/15 indicating intact cognition. The MDS documented diagnoses of Crohn's disease, difficulty in walking and unsteadiness on feet. The resident was independent with transfers and ambulation up to 50'. Resident #5 utilized a wheelchair for mobility. The resident was occasionally incontinent of bladder and always continent of bowel. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/24 at 11:53 AM Resident #3 stated sometimes it can take a long time for staff to answer call lights. The resident stated there had been times where both she and roommate had turned on the call light, and staff would only acknowledge her and not the roommate. Resident #3 stated she has had to wait for an hour or longer for a call light to be answered. The resident stated when necessary she will transfer to her w/c, and will go chase the staff down to get assistance for herself or roommate. 4. Record review of the MDS of Resident #6 dated 9/12/24 revealed a BIMS score of 14/15 indicating intact cognition. The MDS documented diagnoses of non-Alzheimer's dementia, depression, epilepsy, and essential tremor. Resident #6 was independent with transfers, required partial/moderate assistance for ambulation up to 10', and was independent with toileting and dressing. The resident utilized a wheelchair for mobility. The resident was occasionally incontinent of bladder and always continent of bowel. On 10/22/24 at 1:25 PM Resident #6 stated call lights can take longer than 20 minutes. The resident stated on 1 occasion she got tired of waiting for her call light to be answered, she left her room to go eat, and when she came back the staff finally came and answered her light. On 10/23/24 at 11:43 AM Staff A stated that call lights can be longer than want, longer than 15 minutes. The staff stated that it can occur when there are multiple lights going off. On 10/23/24 at 11:55 AM Staff B stated call lights can be longer than 15 minutes, especially between the hours of 6 and 10 as many residents want to go to bed as soon as they are finished with supper. On 10/23/24 at 3:17 PM the Director of Nursing (DON) stated call lights were supposed to be answered in less than 15 minutes. Review of facility grievances since 6/24 revealed 2 grievances for call lights not being answered in a timely manner. Review of Resident Council Minutes since 6/24 revealed 2 meetings where call lights were not being answered timely. The minutes on 6/5/24 further revealed the need to check on both residents when a call light is turned on. A further document, an unidentified date of minutes, revealed resident concerns of call lights going off and staff at the nurses station on their phones, laughing, and joking rather than assisting residents. Review of the facility policy, Answering the Call Light Level I, revised 3/21, revealed the purpose of that procedure was to ensure timely responses to the resident's requests and needs.