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	03/27/2025

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 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** 41785 Based on clinical record review, staff interview, hospital document review, staff interviews and facility assessment review the facility failed to implement care and treatment consistent with the resident care plan and physician orders placing the resident at risk for 1 of 16 residents reviewed. Resident #61 required special monitoring of weights and vital signs related to diagnosis of congestive heart failure. Staff failed to consistently monitor the weight and intervene with diuretic medication, and failed to conduct daily vital signs. The facility reported a census of 61 residents. Findings include: The Office/Progress Note from the hospital referral (page 6) to the facility showed that Resident #61 presented to the hospital on 1/27/25 with Shortness of Breath (SOB) and hypoxic respiratory failure. Was taken for cardiac catheterization and stent's were placed in the heart. She had pulmonary edema and required oxygen and diuretics (increases urine production and lowers blood pressure and fluid retention.) She presented with 2+ edema in the extremities. The admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status score of 15 indicating cognition intact. The MDS documented she was admitted from the hospital, had shortness of breath when lying flat and had surgery involving the heart. Her diagnoses included heart failure (CHF), coronary artery disease, renal insufficiency and pneumonia. The Care Plan for Resident #61, dated 2/10/25, documented she was on diuretic therapy related to CHF and chronic kidney disease and has weight fluctuations related to medication. The Care Plan directed staff told administer the diuretic medications as ordered by the physician and to monitor for side effects and effectiveness every shift. The Progress Notes documented the following: -On 2/5/25 at 5:49 PM, the admit note documented that Resident #61 weighed 149 pounds and had edema on the top of her feet/ankle +1 pitting (edema is graded on a scale of 0 to 3, where 0 means the absence of edema and 3 means severe pitting. The grading system is based on how deep the pits are and how long they last after you press the swollen area.) bilateral calves and upper arms. Generalized edema/swelling. (continued on next page)

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	-On 2/6/25 at 12:00 AM the provider encounter note, showed that Resident #61 was admitted with an order for a diuretic, furosemide 20 milligrams (mg) one tab every 24 hours as needed (PRN) for swelling, shortness of breath, or at provider discretion. And give 2 tablets every 24 hours PRN for shortness of breath, leg swelling or at providers discretion. The Progress Notes also documented the following for Resident #61: a. On 2/5/25 at 4:47 PM SOB with minimal exertion b. On 2/7/25 at 9:56 PM SOB while lying flat c. On 2/8/25 at 9:44 PM SOB while lying flat d. On 2/8/25 at 0000 bilateral lower extremities trace edema. e. On 2/9/25 at 7:39 PM SOB while lying flat f. On 2/11/25 at 10:19 PM nursing assessment SOB with minimal exertion edema to top of feet and ankle +1 pitting upper arms with generalized edema/swelling. g. On 2/13/25 at 10:16 PM SOB while lying flat h. On 2/15/25 at 4:11 PM the resident would continue to have daily vital signs as she was skilled. i. 2/17/25 at 3:22 PM generalized edema top of feet and ankle +1 pitting upper arms with generalized edema/swelling. j. On 2/18/25 at 3:50 PM generalized edema +1. The Medication Administration Record (MAR) for February showed that the PRN furosemide had not been used. The Progress Note dated 2/19/25 at 12:00 AM documented the Nurse Practitioner saw Resident #61 on the 19th and found that she had +3 bilateral lower leg edema. She started a scheduled order for furosemide 20 mg daily for edema, and continue PRN dose. Staff were to continue to monitor weight as directed. The Medication Administration Record (MAR) showed that Resident #61 received the first dose of Furosemide 20 mg on 2/20/25. The Progress Note dated 2/28/25 at 12:01 AM showed that the resident had a significant weight increase from 149.1 pounds (lbs.) on 2/6/2025 to 168.4 lbs. on 2/27/2025. She had bilateral +2 pitting edema in the lower extremities. The provider has been notified, and the plan of care includes continuing Lasix 40 mg daily to promote diuresis. Staff were directed to closely monitor the resident's fluid status, strict tracking of daily weights, fluid intake/output, and urine output. Staff had been instructed to carefully assess urine output for adequate response to diuretics and report any concerns regarding decreased output. A pulmonary assessment showed diminished lung sounds bilaterally without distress. The resident reported occasional exertion SOB. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The chart lacked documentation of weights from 3/6/25 through 3/17/25. The chart lacked a daily skilled assessment on 2/21/25, 2/27/25, 3/14/25 and 3/16/25. On 3/24/25 at 10:52 AM, Resident #61 was in bed coughing, moaning and appeared uncomfortable as she shifted and tried to move in bed. The resident said the she was not feeling well after her heart surgery. She said that she had been coughing a lot and had phlegm coming up. On 3/26/25 at 3:00 PM, Staff G, Nurse Consultant said that she would have wanted the nurses to call the provider and get clarification with parameters on when to use the diuretic. On 3/27/25 at 10:52 AM, Staff L, Registered Nurse (RN.) acknowledged that Resident #61 had about +1 edema in her feet and ankles. She said that she was not aware of a PRN furosemide order and she would have used it or reached out to the doctor if/when there was a significant weight gain in a day or two. She agreed that parameters with the PRN order should have been clarified so they could've had the guidance on when to use it. On 3/27/25 10:56 AM, the Director of Nursing (DON) said that they did not have a policy on documentation for skilled assessments. They expect that the assessments would be complete daily, including vitals. The DON said that they did not have any policy on edema monitoring related to CHF, or a policy on weight monitoring. She said that they use nursing judgement and go by what was ordered by the doctor. The Facility assessment dated [DATE], included a section titled: Cardiac Services, Metabolic Disorders, Respiratory System, Assessments that showed that the facility would provide early identification of problems/deterioration, management of medical and psychiatric symptoms and condition such as heart failure, diabetes, chronic obstructive pulmonary disease, gastroenteritis, infections such as UTI and gastroenteritis, pneumonia, hypothyroidism.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observations, staff interview and clinical record review the facility failed to implement interventions for the prevention of pressure ulcers for 1 of 3 residents reviewed. Resident #54 was at risk for chronic pressure injuries and was found to be without the treatment dressing or protective boots. The facility reported a census of 61 residents. Findings include: The Minimum Data Set (MDS) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound bed. According to the MDS, dated [DATE], Resident #54 had a Brief Interview for Mental Status (BIMS) score of 0 (severe cognitive ability). She was totally dependent on the help from staff for eating, hygiene, toileting, dressing and turning in bed. Resident #54 had a Stage III pressure ulcer and her diagnoses included renal insufficiency, neurogenic bladder, Bipolar Disorder, schizophrenia, pressure ulcer of the right heel and intellectual disabilities. The Care Plan for Resident #54, updated on 2/3/25, showed that she occasionally rolled out of bed, and had a fall mat placed on the side of the bed. She required maximum assistance of 2 for bed mobility, had poor body positioning and trunk control, and leaned to the right. Resident #54 was at risk for skin impairment, staff were directed to float her heels when in bed, to put sheep skin boots on her feet at all times, and to complete weekly treatments. A Skin Observation dated 12/24/24 at 12:37 PM, showed that the resident did not have any new skin issues on that date. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Skin and Wound Evaluation dated 12/27/24 at 10:15 AM, showed that Resident #54 was found to have an unstageable pressure sore with slough and/or eschar on the right lateral forefoot. The total area measured 8. 1 centimeters (cm) total area, 5.0 cm. length x 2.6 cm. width. The wound contained 100% Eschar (dead tissue that sheds or falls off from the skin, usually tan, brown or black.) The goal of care was to monitor/manage due to wound healing was not achievable because of untreatable underlying condition. An order dated 12/27/24 at 10:48 AM, directed nursing to apply skin prep, covered with high performance foam adhesive dressing to the lateral side of the right foot and the left heel on bath days, every Tuesday and Friday. The Skin and Wound Evaluation dated 3/19/25 documented a pressure ulcer to the left heel stage 3 in house acquired now measures 0.7 cm total area, 1.1 cm in length, 0.9 cm in width and no depth. 100 percent of wound bed covered with epithelial tissue and improving. Observations revealed the following: a. On 3/24/25 at 2:28 PM the door was cracked open and the resident was yelling get up. She was lying on the floor, on a mattress next to the bed. The nurse was preparing to get vitals and told Resident #54 that they would get her up as soon as she got her vitals. The resident was wearing socks on her feet and did not have on the heel protectors. b. On 3/25/25 at 5:56 AM, the resident was in bed, in low position. She was awake and restless. She did not have the protective boots on her feet. c. On 3/25/25 at 8:00 AM, Resident #54 was in her room in the wheel chair. The fall mat is next to the wheel chair. Her feet rested on the foot pedal with her right foot bent and resting on the lateral side of her foot. The heel protectors were on the floor. d. On 3/25/25 at 9:33 AM, the resident was in her wheel chair without the protective boots on. Staff K, Licensed Practical Nurse (LPN) gathered the treatment supplies for her treatment. She did not speak but squealed and said ouch several times throughout the procedure. Staff K encouraged her to stay calm as he removed her socks. Neither one of the feet had adhesive dressings on, and they were dry and scaly. Staff K applied lotion and completed the treatment to the right foot and dated the dressing. The heel of the right foot contained peeling white skin. No open or reddened areas were observed. The lateral area of right foot had a red spot that was not open or swollen. Staff K applied her socks and protective boots. e. On 3/25/25 at 9:43 AM, Staff K said that after completing the treatment on the right heel, he double checked the order, saw there was an order for a dressing to the right foot, then went back and completed that treatment. Staff K acknowledged that the resident did not have a dressing on either foot when he went in to complete that treatments earlier. Staff K thought that there would have been an As Needed (PRN) order to complete the treatment if/when the dressing fell off. f. On 3/26/25 at 11:58 AM, Resident #54 was in the wheel chair, wearing socks on her feet. The left protective boot was on, the right one was on the floor. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/25 at 8:50 AM, an addition had been made to the treatment order and read as follows: Apply skin prep covered with high performance foam adhesive dressing to lateral side of right foot and left heel. Change on bath days every day shift every Tuesday Friday for would and as needed if dressing falls off. On 3/27/25 at 9:06 AM, when asked about the size and description (8.1 cm. total area and 100% eschar) of the pressure discovered on 12/27/24 just 3 days after a Skin Observation showed that Resident #54 had no new skin issues, the Director of Nursing (DON) said she didn't know what the wound may have looked like three days prior. She said that she believed a wound could get to the point of eschar in just 3 days without prior warning signs. The DON said that she would expect the aides to come to nursing staff if/when they discovered that a wound dressings had fallen off. She would then expect the nurses to replace it as soon as it was discovered. A facility policy dated 4/2018, titled: Pressure Ulcers/Skin Breakdown - Clinical Protocol, showed that the staff would examine the skin of newly admitted residents for evince of existing pressure ulcers or other skin conditions. The physician would order pertinent wound treatments, including pressure reducing surfaces, wound cleansing and debridement approaches, dressings and application of topical agents.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 41785 Based on observation, interview and policy review the facility failed to ensure that medications were secured to prevent residents from access. In an observation the survey team found an unlocked, unattended medication cart in the hallway of resident rooms. The facility reported a census of 61 residents. Findings include: In an observation on 3/24/25 at 11:31 AM, it was discovered that an unlocked, unattended medication cart was at the end of a hallway of resident rooms. At 11:33 AM Staff I, Certified Medication Aide (CMA) came around the corner from the nurse's stations at the opposite end of the hallway. She said that she had been in a resident's room administering medications, then went down the hallway to talk to the nurse. She acknowledged that she failed to lock the drawers before she walked away from the cart. On 3/27/25 at 11:59 AM, the Director of Nursing (DON) said that the nurses and CMA's were expected to have the medication cart locked if/when they ever walk away from it and it's not within eye site. According to facility policy titled: Security of Medication Cart, dated April 2007, the medication carts must be securely locked at all times when out of the nurse's view.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on observation, document review, staff interview, and policy review the facility failed to provide a well balanced diet that meets nutritional and special dietary needs by use of incorrect serving size portions for meals for 1 of 61 residents reviewed. The facility reported a census of 61 residents. Findings include: Continuous observation on 3/25/25 at 12:05 AM of Staff C, Cook, prepared modified barbeque (BBQ) pork for the noon meal. Staff C indicated needed 8 ground servings of BBQ pork. The staff removed 8 servings of the BBQ pork and placed 4 servings twice in the lid of the Robot Coupe food processor to transfer to the bowl of the Robo Coupe. The staff placed the lid on the processor, turned the machine on, and walked away. Staff C removed the BBQ pork from the processor and poured it into a measuring cup. The Registered Dietitian (RD) intervened as the BBQ pork appeared as pureed consistency rather than mechanical soft. The RD instructed Staff C to place it back in the processor, add BBQ sauce to complete the puree process. Staff C referred to the [NAME] Brothers Pureed Diet Portion Sizes/Dishes for the serving size, the temperature taken at 138 degrees, and placed the uncovered pureed BBQ pork in the steamer. Staff C measured 3 servings for pureed baked beans, and placed them in the Robo Coupe for processing. The staff poured the processed food in a measuring cup and was moving to return to the steam table, when the Certified Dietary Manager (CDM) intervened, and instructed the staff to place the food in the steamer due to the temperature decreasing. Staff C placed the uncovered pureed baked beans in the steamer. Staff C began serving the final pureed meal, and noted there was an incomplete serving of the pureed baked beans. The staff stated there was a shortage of the pureed baked beans as they had dried up in the steamer. Staff C proceeded to place the plate with the incomplete serving on the room service tray for delivery. The staff failed to provide the resident with a full serving as required. On 3/27/25 at 10:55 AM the RD stated the facility followed the [NAME] Brothers Pureed Diet Portion Sizes/Dishes for determining serving size. The RD expected if there was a shortage on a serving size, the cook would stop and prepare additional food to provide a full serving. On 3/26/25 at 1:56 PM the Administrator stated she expected residents to receive full servings as required. The facility's Therapeutic Diets Policy did not specifically address the preparation and portion sizes of the mechanically altered diets.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 49628 Based on observations, documentation review, resident interviews, staff interviews, and policy review the facility failed to prepare, serve and distribute food in accordance with professional standards. The facility failed to take and document temperatures of food in the kitchen prior to distribution. The facility reported a census of 61 residents. Findings include: Continuous observation on 3/25/25 at 11:15 AM found Staff C, cook, began placing items on the steam table with temperatures taken upon removal from the stove or steamer. At 12:17 Staff C began the meal service without taking temperatures at the steam table. Staff B, Dietary Services Manager Assistant, delivered plates to the dining room, and the room tray carts to the nurses station for the nursing staff to deliver to the rooms. At 1:30 PM the meal service concluded with the last of the room trays leaving the kitchen to be delivered with a sample tray included. The staff did not obtain food temperatures from the steam table at the completion of the meal service. Observed food items moving to the steam table 1 hour before service began, and the meal service took 1 hour and 15 minutes. Observed a room tray delivery cart with 6 meal trays sitting at the nurses station waiting for delivery that had left the kitchen prior to 1:30 PM. Staff B stated they had notified nursing of the need for delivery of the room trays. At 1:39 PM the sample tray returned to the kitchen for temperature checks with the CDM, Staff D, and RD. The CDM obtained a BBQ pork temperature of 142 degrees, carrots 109 degrees, and fried potatoes of 107 degrees. The CDM, Staff D, and RD concurred the temperatures were below the serving temperature requirements. Review of the Food Temperature Logs for January, February, and March provided opportunities for data entry for before and after each meal. The January log revealed 62/93 opportunities completely documented. The February log revealed 67/84 opportunities completely documented. The March log revealed 37/69 opportunities completed documented. The facility failed to completely document 80/246 (33%) food temperature entries for before, after, or complete meal. On 3/24/25 at 11:10 AM Resident #32 stated food was not served at appropriate temperatures. The resident indicated she ate both in the dining room and her bedroom. Resident #32 stated the temperatures were not correct in both locations, but the room trays were worse. On 3/24/25 at 1:55 PM Resident #25 stated she ate in the dining room and the food was often cold. On 3/26/25 at 1:32 PM the Registered Dietitian expected temperatures would be taken before and at the end of meal service from the steam table and the temperatures would be logged. The RD expected the facility to have food service completed within 45 minutes. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/26/25 at 1:56 PM the Administrator expected temperatures to be taken at the steam table prior to and after the meal service with logs kept for all cooking/serving temperatures. The facility's Food Preparation and Service Policy, revised 4/19, revealed specific temperatures/times required for specific foods, as well as the temperatures required for modified consistency diets, to be reached to inactivate pathogenic microorganisms. The document indicated temperatures of foods held in steam tables were to be monitored throughout the meal. The document further revealed dietary staff would adhere to proper practices to prevent the spread of foodborne illness. The Food and Drug Administration Food Code 2022 revealed the person in charge of the kitchen provides daily oversight of the employees ' routine monitoring of the cooking temperatures.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49628 Based on observations, staff interviews, and policies reviewed the facility failed to store, prepare, serve, and distribute food in accordance with professional standards. The facility reported a census of 61 residents. Findings include: Observation on 3/24/25 at 9:28 AM revealed the walk in cooler did not have an interior thermometer. The walk-in cooler contained opened and undated food items of a cake, canned fruit in dessert cups, and a jug of Half and Half. The Half and Half liquid had an aluminum foil covering and a best if used by date of 3/8/25. The walk-in freezer contained an opened bag of ravioli, not sealed and undated. The milk cooler contained thick darkened frost inside along the right side of the cooler. The reach-in refrigerator contained an undated opened jug of milk and a container containing a yellow substance that was undated. The pantry contained opened and undated packages of Oreo Medium Cookie Pieces and pasta. The bottom shelf of the large food preparation counter in the main part of the kitchen revealed food remnants, crumbs, and was dirty in appearance. Continuous observation on 3/25/25 at 11:15 AM revealed Staff D, Travel Certified Dietary Manager, and the facility Certified Dietary Manager (CDM) wore gloves while preparing oranges and placing them in dessert cups. Staff C, cook, removed fried potatoes from the steamer and obtained temperatures of 165 degrees, 176 degrees, and 179 degrees. Staff C placed the potatoes in a metal container and placed them on the steam table at 11:20 AM. Staff C obtained a temperature of the baked beans of 179 degrees and moved them to the steam table. Staff C removed a tray of pork from the steamer with various temperatures observed ranging from 151 degrees to 161 degrees. Staff C added the pork to a container of pork with barbeque (BBQ) sauce, and placed it uncovered in the steamer. Staff C initiated making mashed potatoes, and placed the opened container of mashed potato mix under the prep table. Observed the mashed potato mix was not dated and put on the shelf under the prep table which had remnants of other food items. Staff C removed the BBQ pork and obtained temperatures from 155 degrees to 161 degrees. Staff D assisted Staff B by providing education on stirring food items before temperature check; with stirring the BBQ pork the temperature measured 165.8 degrees. Staff C moved the BBQ pork to the steam table. Staff A, cook, wearing gloves touched packaging and food items (lettuce, hard boiled eggs, cheese, meat) while making chef salads. Staff C indicated needed 8 mechanical soft servings of BBQ pork. The staff removed 8 servings of the BBQ pork and placed 4 servings twice in the lid of the Robot Coupe food processor to transfer to the bowl of the Robo Coupe. The staff placed the lid on the processor, turned the machine on, and walked away. The Registered Dietitian (RD) intervened as the mechanical soft BBQ pork had processed to a pureed consistency. Staff C obtained a temperature of 138 degrees, placed the uncovered pureed BBQ pork in the steamer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:17 PM Staff C initiated the meal service without taking temperatures at the steam table. The CDM prepared the mechanical soft BBQ pork, covered, and placed in the steamer. The CDM checked the temperature of the puree BBQ pork, stated it needed to be covered and placed back in the steamer. Staff E, Cook, donned gloves without hand hygiene, and obtained supplies to prepare a grilled cheese sandwich. The staff touched the packaging and the bread. The CDM stopped the process, provided education to Staff E to not touch food items and packaging with gloves. The CDM indicated did not feel gloves were necessary for preparing a grilled cheese as the sandwich was not a ready to eat product as it was going to the stove. At 12:40 PM Staff stopped the meal service to prepare 3 servings of pureed baked beans. Upon completion of the puree process Staff C attempted to return them to the steam table when the CDM intervened and indicated a temperature was required due to the processing. Following the temperature check, Staff C placed the uncovered puree baked beans in the steamer. Observed the CDM make a special order peanut butter and jelly sandwich using butter/margarine, peanut butter, grape jelly, and bread that were all opened and undated sitting on the counter. The meal service concluded at 1:30 PM with the last tray leaving the kitchen. The staff did not take completion temperatures of the steam table. The continuous observation revealed inconsistent hand hygiene between kitchen tasks, and donning/removal of gloves. Review of the kitchen temperature logs for the milk cooler, walk-in cooler, walk-in freezer, reach-in refrigerator and reach-in freezer for the months of January, February, and March revealed January was the only month for data for all of the appliances with data for 25/31 days. Review of the March log for the reach-in freezer temperatures revealed 17/23 days with data. Record review of the March log for the reach-in refrigerator revealed 15/23 days with data. The facility failed to record temperatures for the milk cooler, walk-in cooler, and walk-in freezer for the months of February and March. The facility failed to record temperatures for the reach-in the freezer for the month of February and 6 days in March. The facility failed to record temperatures for the reach-in refrigerator for the month of February, and 8 days in March. The sanitizing solution logs for January, February, and March for the triple sink revealed opportunities for data entry at each mealtime for each date of the month. The documents revealed 217/246 data points obtained. The facility failed to record data for 29 opportunities The dish machine temperature logs for the months of January, February, and March revealed 3 opportunities per date for data entry. The logs revealed data entry for 219/246 possible entries. The facility failed to record data for 27 opportunities. On 3/24/25 at 9:50 AM the CDM stated she had been in the position approximately 2 weeks, and was not sure if logs were kept at all for the walk-in cooler and walk-in freezer. The CDM acknowledged there should be complete logs for all cooling appliances, the dish machine, and sanitizer for the triple sink. (continued on next page)

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	03/27/2025

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/25/25 at 11:35 AM the RD completed a walk through of the walk-in cooler, walk-in freezer, and review of the milk cooler. The RD concurred items in the kitchen should have dates when received, opened, and sealed appropriately. The RD removed the previously observed Half and Half in the walk-in cooler, and ravioli in the walk-in freezer. The RD also noted the cookie dough uncovered and stated it would need to be discarded. The RD concurred the milk cooler should not have discolored frost in it, as well as wrappers from other food items. On 3/25/25 during the meal preparation the RD concurred the bread, peanut butter, butter/margarine, and grape jelly on the counter should be dated, and as it was not it should be discarded. The RD stated food items should be covered when placed in the steamer. On 3/26/25 at 1:32 PM the RD expected that food items should be dated with date received, date opened and to be stored in airtight containers. The staff stated if items were not in airtight containers, not dated or outdated they needed to be discarded. The RD stated at a minimum hand hygiene should be completed upon entry into the kitchen, between tasks, and prior to and removal of gloves. The staff stated gloves were for single use only, and staff could not touch containers and food items. The RD expected logs for cooler temperatures, dish machine, and triple sink sanitizer to be maintained. On 3/26/25 at 1:56 PM the Administrator expected there to be logs kept for all refrigerators, freezers, cooking/serving temperatures, dishwasher and sanitizer use. The Administrator expected all food items to be dated upon receiving and opening, and to be placed in sealed containers if not completely used. The Administrator expected hand hygiene to be completed in the kitchen at all times including before/after glove use, and staff not to touch food with their bare hands. The facility's Food Receiving and Storage Policy, revised 10/17, revealed dry foods be stored in bins and would be removed from the original packaging, labeled, and dated with use by date, and rotated with the first in - first out system. The document revealed wrappers of frozen foods must stay intake until thawing. The document indicated the refrigeration and food temperatures will be monitored and documented. The facility's Refrigerators and Freezers Policy, revised 12/14, revealed monthly tracking sheets for all refrigerators and freezers would be posted to record temperatures. The document revealed the supervisor or designee would check and record the temperatures at the beginning and end of each day. The document indicated all food should be dated to ensure proper rotation by expiration dates with the received dates marked on the cases and if individual packages were removed from the case that they would have used by dates marked on the package. The facility's Sanitization Policy, revised 10/08, revealed the surfaces should be cleaned on a regular basis with oversight by the Food Services Manager. The facility's Food Preparation and Service Policy, revised 4/19, revealed bare hand contact with food was prohibited, gloves were for single-use items, worn when handling food directly, and discarded after each use.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 41785 Based on observation, resident interview, clinical record review, staff interview and policy review the facility failed to maintain accurate medical records for 1 of 16 residents reviewed. Staff documented that the vital signs for Resident #61 had been completed and the chart lacked documentation of those vitals. The facility reported a census of 61 residents. Findings include: The Care Plan for Resident #61, updated on 2/5/25, showed that she had diagnoses that included Congestive Heart Failure (CHF), acute respiratory failure, and weight fluctuation due to diuretic use and document signs and symptoms of Coronary Artery Disease (CAD) such as dependent edema. The Progress Note dated 2/5/25 at 4:47 PM, showed that Resident #61 was admitted for skilled nursing services from the hospital after Atrial fibrillation (AFib) with rapid ventricular response RVR (condition characterized by an irregular heartbeat with a rate exceeding 100 beats per minute.) The Progress Note dated 2/5/25 at 6:38 PM, showed that Resident #61 had a Brief Interview for Mental Status (BIMS) score of 15 (intact cognitive ability.) On 3/24/25 at 10:52 AM, Resident #61 was in bed coughing, moaning and appeared uncomfortable as she shifted and tried to move in bed. The resident said the she was not feeling well after her heart surgery. She said that she had been coughing a lot and had phlegm coming up. A review of the clinical record revealed that on 2/15/25, 2/24/25 and 2/28/25 the chart lacked documentation of vital signs. Nursing notes included the following documentation: a. On 2/15/25 NN at 12:47 AM, obtain new vital signs: completed b. On 2/24/25 at 10:42 PM, obtain new vital signs: completed c. On 2/28/25 at 12:01 AM, obtain new vital signs: completed On 3/27/25 at 10:56 AM, the Director of Nursing (DON) said that she expected that skilled assessments would be completed daily, including a complete set of vital signs. A facility policy titled: Charting and Documentation dated July 2017, showed that documentation in the medical record would be objective, complete, and accurate. Documentation of procedures and treatments would include care-specific details, including; assessment data.

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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** 41785 Based on observation, staff interview and facility policy review the facility failed to ensure that staff used appropriate infection control practices to prevent the spread of pathogens for 1 of 3 residents reviewed. Staff failed to change gloves after adjusting a soiled brief for Resident #27 she then touched other surfaces with the same gloved hand. The facility reported a census of 61 residents Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #27 had an indwelling catheter and a colostomy. He was totally dependent on staff for transfers, showers and personal hygiene. The resident had diagnoses that included: heart failure, renal insufficiency, multiple sclerosis and benign prostatic hyperplasia. The Care Plan last updated on 7/29/24 showed that Resident #27 had a Foley catheter and was at risk for a potential skin and soft tissue infections. Staff were instructed to use enhanced barrier precautions when performing high-contact care activities. On 3/25/25 at 7:04 AM, Resident #27 was sitting in the shower room and Staff H, Certified Nurse Aide (CNA) said that she was waiting for the nurse to come in and take a look at the catheter site. With gloved hands, she pulled back the brief to reveal a copious amount of blood around the penis and under the abdominal fold. The CNA then touched the arm of the mechanical lift and resident's shoulder with same gloved hand. On 3/27/25 at 10:40 AM, the Director of Nursing (DON) said that the staff were taught to change gloves after they become soiled. She would expect them to also use hand hygiene before applying clean gloves. According to facility policy titled: Handwashing/Hand Hygiene, dated August 2019, the use of gloves did not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene was recognized as the best practice for preventing healthcare-associated infections.