STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165288	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy review, the facility failed to notify the resident's representative in writing and the state ombudsman of a transfer to the hospital for 1 of 2 residents (#8). The facility also failed to provide a bed hold with reserve bed payment information for 2 of 2 residents (#6 & #8). The facility reported a census of 72 residents.Findings include:1.Resident #6's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 05 out of 15 which indicated completely intact cognition. It included diagnoses of cancer, heart failure, and respiratory failure. It revealed the resident was independent with eating, required maximal assistance with toileting, personal and oral hygiene, lower body dressing, and footwear, and required moderate assistance with all other Activities of Daily Living (ADLs) and mobility.The Care Plan dated 1/02/26 included impaired cognitive function related to poor safety awareness and directed staff to keep her routine consistent.The Nurses Note dated 2/03/26 at 1:15 PM revealed the resident was transferred to the hospital due to breathing difficulty. A subsequent Nurses Note at 3:38 PM indicated the resident was admitted to the hospital with a pneumonia diagnosis. The Electronic Health Record (EHR) Standard Evaluations section did not include a documented bed hold authorization with reserve payment information nor did the EHR include family notification in writing of the reason for the resident's hospital transfer.On 4/06/26 at 1:26 PM, Resident #6 stated she did not remember whether or not staff mentioned a bed hold.On 4/07/26 at 2:46 PM, the resident stated she did not remember going to the hospital. The resident's representative stated the facility verbally notified them the resident was going to the hospital for pneumonia but stated the facility did not discuss a bed hold with reserve payment nor did she receive the transfer notification in writing.2. Resident #8's MDS dated [DATE] identified a BIMS score of 03 out of 15 which indicated severely impaired cognition. It included diagnoses of right hip fracture and non-Alzheimer's dementia. It revealed the resident required supervision with eating, maximal assistance with showering and mobility, and was dependent with all other ADLs and shower transfer.An Incident, Accident, Unusual Occurrence Note Progress Note dated 2/26/26 at 5:35 PM revealed the resident sustained a fall but lacked information in the Notifications: section. A Nurses Note Progress Note at 7:07 PM confirmed the resident was transferred to the hospital and the family was made aware.The February 2026 Notice Of Transfer Form To Long Term Care Ombudsman report did not include Resident #8's hospitalization transfer.The Care Plan revised 3/19/26 included a history of a fall with a fracture and a subsequent right thigh surgical incision.The EHR Standard Evaluations section did not include a documented bed hold authorization with reserve payment information nor did the EHR include family notification in writing of the reason for the resident's hospital transfer.On 4/07/26 at 12:18 PM, Staff B, Licensed Practical Nurse (LPN) stated bed hold information is documented under the EHR Evaluations tab and should be available on all residents.On 4/07/26 at 12:26 PM, the Social Services Coordinator (SSC) stated the official Ombudsman notification report did not include Resident #8's hospitalization.On 4/07/26 at 12:38 PM, the Business Office Manager (BOM) stated she was not able to locate documentation that the resident's representative was notified of a bed hold with reserve (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	payment or the reason for the resident's hospital transfer in writing.On 4/07/26 at 12:58 PM, the Regional Nurse Consultant (RNC) stated the facility had not been notifying resident representatives in writing because the transfers were emergent.On 4/07/26 at 1:05 PM, the Director of Nursing (DON) stated she was not able to locate the resident's 2/26/26 hospitalization bed hold.A policy titled Bed-Holds and Returns revised [DATE] indicated:Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail:The rights and limitations of the resident regarding bed-holds;The reserve bed payment policy as indicated by the state plan (Medicaid residents);The facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents); andThe details of the transfer (per the Notice of Transfer).On 4/09/26 at 11:51 AM, the DON stated the nurse should've called the family to inquire about a bed-hold and sent to the family and to notify them why the resident was sent to the hospital. The transfer should have been reported to the Ombudsman.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident interview, staff interviews, and the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0, October 2025, the facility failed to complete and submit the admission Minimum Data Set (MDS) in the required time frame for 1of 19 residents reviewed (Resident #83). The facility reported a census of 72 residents. Findings include: The MDS assessment dated [DATE] for Resident #83 identified a Brief Interview for Mental Status (BIMS) score of 15/15 indicating normal cognition. On 4/8/26 the electronic clinical record MDS page revealed the MDS Admission, dated 3/30/26, was In Progress and the Assessment Reference Date (ARD) was 4/6/26, indicating the MDS admission was 2 days overdue. On 4/9/26 the electronic clinical record MDS page revealed the MDS Admission, dated 3/30/26, was Export Ready. The clinical record's clinical census revealed Resident #83 was admitted on [DATE]. On 4/6/36 at 1:34 PM the resident stated she had been in the facility for 2 weeks. On 4/8/26 at 11:17 AM the MDS Coordinator acknowledged the MDS admission had not been submitted and was late. The staff stated she had been working on the floor and required assistance from other facilities and Staff A, Registered Nurse (RN)/Travel MDS. The MDS Coordinator stated she had been working on the floor 2-3 times/week for the past couple of months. On 4/8/26 at 11:20 AM Staff A concurred she was assisting with the submission of the MDS's for the facility as when other facilities/staff assist they may not be a RN, which is a requirement for MDS submission. On 4/8/26 at 11:30 AM the Director of Nursing (DON) acknowledged the MDS Coordinator had been working on the floor as a Charge Nurse due to an increase in census and the need for additional staff. The DON expected the MDS's to be completed as required. On 4/8/26 at 11:35 AM the Regional Nurse Consultant stated the facility had been utilizing a Hybrid MDS to assist with the completion and submission of the MDS's. The staff concurred the MDS's needed to be submitted timely according to the RAI Manual. The Regional Nurse Consultant stated the facility did not have a MDS policy but followed the RAI Manual. The CMS RAI Manual Chapter 5: Submission and Correction of the MDS Assessments revealed the admission Assessment can be no more than 14 days from the date of admission.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on clinical record review, staff interview and policy review the facility failed to develop a care plan to address risk factors and interventions for 1 out of 19 residents (Residents #54) reviewed for comprehensive care plans. The facility reported a census of 72 residents.Findings include: The Minimum Data Set (MDS) assessment for Resident #54 dated 1/30/26 identified a Brief Interview for Mental Status (BIMS) score of 03, indicating moderately impaired cognition. The MDS identified Resident #54 required supervision/touching assistance with transfers and ambulation. The MDS included diagnoses of vascular dementia with agitation and restlessness. The MDS documented Resident #54 received antianxiety medication during the last 7 days. A Physician order dated 2/5/26 directed staff to administer Lorazepam (antianxiety) 0.5 mg (milligrams) by mouth twice a day for restlessness and agitation.Resident #54's Wandering Evaluations documented the following scores and wandering risk:11/21/25- 16= High Risk (A score of 12 or above indicated high risk for wandering)12/4/25- 17= High Risk1/20/26=-13= High RiskReview of Resident #54's care plan with target date 5/10/26 revealed the antianxiety medication, potential side effects and what to monitor for while taking the high risk medication was not addressed on the comprehensive care plan. In addition, the care plan did not address Resident #54's risk for wandering and interventions to address the wandering. On 4/8/26 at 7:20 AM, the Director of Nursing (DON) acknowledged Resident #54's antianxiety medication was not addressed on the care plan. The DON reported the care plan was updated on 4/7/26 to include the antianxiety medication and interventions. On 4/8/26 at 7:40 AM, the DON acknowledged Resident #54's wandering was not addressed on the care plan. The DON reported she updated the care plan on 4/8/26 to include interventions for wandering. On 4/8/26 at 9:25 AM, the DON reported she would expect high risk medications to be addressed on the care plan.The facility policy titled Care Plan, Comprehensive Person- Centered revised December 2016 documented the care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being and incorporate risk factors associated with identified problems.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, clinical record review, and policy review, the facility failed to provide appropriate incontinence care for 1 of 1 resident (#49). The facility reported a census of 72 residents.Findings include:Resident #49's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 07 out of 15 which indicated severely impaired cognition. It included diagnoses of non-Alzheimer's dementia, a stroke, multiple sclerosis, and hemiplegia (one-sided paralysis). It indicated he required supervision with eating and was dependent with all Activities of Daily Living (ADLs) and mobility. It also indicated he was always incontinent of bowel and bladder.The Care Plan revised 12/09/25 included bladder incontinence and directed staff to clean the peri-area with each incontinence episode. It revealed the resident was dependent with toileting and required 2-person staff assistance.During a continuous observation on 4/06/26 that began at 11:58 AM, Staff C, Certified Nurse Aide (CNA) and Staff D, CNA provided Resident #49's incontinence peri-care. Both staff performed hand hygiene and put on gloves. Staff C verified the resident had an incontinent episode. After Staff D repositioned the resident on his side, Staff C grabbed a periwipe and wiped the resident's entire perineal area once and discarded the periwipe. Staff C removed her gloves, sanitized her hands, put on a new pair of gloves and turned the resident on his other side. Staff D removed the remainder of the resident's brief, grabbed a periwipe, and wiped the resident's anal area once and discarded the periwipe. Both staff repositioned the resident and fastened the resident's brief.At 12:07 PM, Staff D stated pericare includes removing the resident's brief and using separate periwipes to clean under the resident's belly, the right perineal area, then the left perineal area.At 12:12 PM, Staff C stated a separate periwipe should be used for each perineal sweep and should include retracting the foreskin (if applicable) and cleaning the penis tip. She stated she forgot to use separate wipes or to clean the resident's penis tip.Staff C's Orientation Checklist revealed her skills were reviewed on 3/24/26 and included incontinence care.A policy titled Perineal Care revised [DATE] directed staff to retract foreskin of the uncircumcised male and wash and rinse urethral area using a circular motion.On 4/09/26 at 11:53 AM, the Director of Nursing (DON) stated staff should've followed the facility policy.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interview, and policy review, the facility failed to lock the wheelchair for 1 of 16 residents dependent on mechanical lift transfers (#49). The facility reported a census of 72 residents.Findings include:Resident #49's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 07 out of 15 which indicated severely impaired cognition. It included diagnoses of non-Alzheimer's dementia, a stroke, multiple sclerosis, and hemiplegia (one-sided paralysis). It indicated he required supervision with eating and was dependent with all Activities of Daily Living (ADLs) and mobility. It also indicated he was always incontinent of bowel and bladder.The Care Plan revised 12/09/25 included bladder incontinence and directed staff to clean the peri-area with each incontinence episode. It revealed the resident was dependent with toileting and required 2-person staff assistance.A continuous observation on 4/06/26 that began at 11:58 AM revealed Staff C, Certified Nurse Aide (CNA) and Staff D, CNA transferred Resident #49 from his bed to a wheelchair. Both positioned the sling under the resident. Staff D positioned the mechanical lift over the resident and both staff connected the sling to the mechanical lift. Staff D raised the resident off the bed and positioned the resident in front of his wheelchair. Staff C stood behind the unlocked wheelchair, grabbed the sling, and used it to position the resident over the wheelchair cushion. Staff D lowered the resident onto the wheelchair cushion. Staff C locked the wheelchair wheels after the resident was seated in the wheelchair.At 12:07 PM, Staff D stated a wheelchair should be locked when lowering a resident onto it.At 12:12 PM, Staff C stated a wheelchair should be locked when lowering a resident onto it. She also stated she forgot to lock the resident's wheelchair during the transfer.A policy titled Lifting Machine, Using a Mechanical revised July 2017 revealed the purpose of the procedure is to establish the general principles of safe lifting using a mechanical lifting device and confirmed the mechanical lift may be used to transfer a resident from a bed to chair.On 4/09/26 at 11:54 AM, the Director of Nursing (DON) stated staff should've locked the wheelchair brakes.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and guidance from the Centers for Disease Control and Prevention (CDC), and policy review, the facility failed to provide the recommended influenza vaccine for 1 of 5 eligible residents (#2) and the recommended pneumococcal (pneumonia) vaccine for 1 of 5 eligible residents (#8). The facility reported a census of 72 residents.Findings include:1.Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated completely intact cognition. It included diagnoses of Parkinsonism (neurological movement disorder), high blood pressure, and respiratory failure. It revealed the resident was admitted [DATE] and had not received the seasonal influenza vaccine.A physician's order dated 11/06/25 indicated the resident may have the annual flu vaccine.The resident's admission Documents included a Vaccination Consent Form dated 11/06/25 that indicated the resident consented to receive the influenza vaccine.The Electronic Health Record (EHR) medication list revealed the influenza medication was never ordered. The EHR Vaccination tab lacked documented influenza vaccination administration.The Care Plan did not include a vaccination focus category.An Encounter Progress Note dated 3/25/26 at 2:00 AM revealed the resident's most recent influenza vaccine was on 10/06/23.A policy titled Influenza Vaccine revised [DATE] indicated Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated or the resident or employee has already been immunized.2. Resident #8's MDS dated [DATE] identified a BIMS score of 03 out of 15 which indicated severely impaired cognition. It included diagnoses of right hip fracture and non-Alzheimer's dementia. It revealed the resident was admitted [DATE], received the influenza vaccine on 9/25/25, but had not received the pneumococcal vaccine.A physician's order dated 6/18/25 indicated the resident may have the pneumococcal vaccine if applicable.A Consent of Declination of the Pneumococcal Vaccine form dated 6/19/25 indicated the resident consented to receive the pneumococcal vaccination.The Electronic Health Record (EHR) medication list revealed the pneumococcal medication was never ordered. The EHR Vaccination tab lacked documented pneumococcal vaccination administration.The Care Plan did not include a vaccination focus category.A SPN-Admit/Re-Admit Progress Note dated 3/02/26 at 6:27 PM included an entry of Pneumococcal Vaccine: Declined (Refused or Historical - Complete Consent Form), Historical pneumococcal administration entered into residents immunization tab.A Center for Disease Control and Prevention (CDC) document titled Pneumococcal Vaccine Timing for Adults dated 3/2025 indicated Resident #1 was eligible to receive the PCV20, PCV21, or the PCV15 followed by the PPSV23 at least one (1) year later.A policy titled Pneumococcal Vaccine revised [DATE] indicated Pneumococcal vaccines will be administered to residents (unless medically contraindicated, already given, or refused) per our facility's physician-approved pneumococcal vaccination protocol. It also indicated Administration of the pneumococcal vaccines or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination.On 4/08/26 at 3:51 PM, the Director of Nursing (DON) stated the residents consented to the vaccinations but the facility had not administered them yet, but will.