

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165294	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2024
NAME OF PROVIDER OR SUPPLIER Avoca Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 610 East York Street Avoca, IA 51521	
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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>37074</p> <p>Based on clinical record review, resident interviews, staff interviews, and facility policy review the facility failed to speak in a dignified manner around residents and failed to speak to residents in a dignified manner to 3 of 4 (Resident #5, #6 and #8) residents reviewed. The facility reported a census of 30 residents.</p> <p>Findings include:</p> <p>1. According to the annual Minimum Data Set (MDS) with a reference date of 5/22/24, Resident #5 had a Brief Interview of Mental Status (BIMS) score of 13. A BIMS score of 13 suggested no cognitive impairment.</p> <p>On 6/25/24 at 2:52 PM when Resident #5 was asked how Staff P Licensed Practical Nurse (LPN) was during medication pass and treatments she stated she is a b*tch. When asked to elaborate she stated last week she told her roommate to get up by herself but she only needed a little boost and would not help her. Staff P is just a bitter person. Resident #5 had asked Staff P to shut the over head light in her room, she told her no, she's passing pills, I am busy, I can't help you. Resident #5 stated she sees and hears how testy she gets with the CNAs and nurses.</p> <p>2. According to the admission MDS with a reference date of 5/8/24, Resident #6 had a BIMS score of 15. A BIMS score of 15 suggested no cognitive impairment.</p> <p>On 6/27/24 at 10:35 AM Resident #6 stated Staff P does not take care of him but he can hear her while she's at the nurse's station. His room is located next to the nurse's station. Resident #6 stated she is a rude and not a nice person. She will come to the nurse's station cussing about other residents, while there are residents present. She says the f word a lot and sh*t. He added she talks like this after she leaves a resident's room or helps them. She is just not a nice person. She sits at the computer at the nurse's station and makes rude comments about residents.</p> <p>3. According to the quarterly MDS with a reference date of 3/6/24, Resident #8 had a BIMS score of 14. A BIMS score of 14 suggested no cognitive impairment.</p> <p>(continued on next page)</p>		

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/19/24 at 1:10 PM Resident #8 was lying in bed and used a communication board to communicate. One side of the board has simple phrases, the other side has individual numbers and letters. When the resident is asked a question, he points to the letters to spell out words, making sentences. When asked how staff are with him, he spelled out Staff P is not nice when speaking with him, she's not rough, just not nice.</p> <p>On 6/19/24 at 10:06 PM Staff I Certified Nursing Assistant (CNA) stated Staff P is not the best, to be perfectly honest, when asked how she is to work with. When asked to elaborate he stated every other work is f*ck or sh*t. She cusses and complains about the residents all the time. If the residents need something she will mutter under her breathe, she is just not his favorite nurse to work with. She does not appear happy when she's at work and does not really think she cares about the residents. She is always complaining about them. He has never witnessed her being mean or unkind to residents, just always speaking negatively about them.</p> <p>On 6/21/24 at 3:23 PM Staff E CNA stated that residents have told her that Staff P speaks rudely to them and does not help the residents when they need help. When asked which residents, she stated Resident #5 had reported some concerns today to her; all residents would probably talk about Staff P and how rude she is. Staff E indicated she reported to the Director of Nursing (DON) her concerns on how she speaks rudely to residents, her tone. The DON indicated it was unacceptable and she would speak with her.</p> <p>On 6/26/24 at 12:08 PM Staff H LPN stated Staff P is not a nice person when asked how she was as a co-worker. Staff P will sit at the nurse's station using not so nice words. Residents would be around the nurse's station within listening distance when she would talk like this. They always worked opposite halls so she never saw her being rude or mean to residents. She does know that Resident #5 will not allow Staff P to do her pressure ulcer treatments because how Staff P is.</p> <p>On 6/27/24 at 12:24 PM Staff P acknowledged it was possible for her to be at the nurse's station using that colorful language, and that it's common nowadays. She may cuss but is not bad mouthing the residents.</p> <p>On 7/1/24 at 2:01 PM the Director of Nursing (DON) stated staff are to treat residents with dignity, respect and kindness. The DON stated she's never had issues with Staff P on a respect side of things until they did the self-report. When she was informed of the resident and staff interviews that were completed about Staff P, she stated wow this is new for them. She acknowledged they have to hold staff accountable for being negative and try to create a positive environment at the facility.</p> <p>The facility provided a document titled Resident Rights with a revision date of 12/2016 with a policy statement that read, employees shall treat all residents with kindness, respect, and dignity.</p> <p>Policy Interpretation and Implementation</p> <p>1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:</p> <p>a. a dignified existence</p> <p>b. be treated with respect, kindness and dignity</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility provided a documented titled Dignity with a revision date February 2021 with a policy statement that read, each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.</p> <p>Policy Interpretation and Implementation:</p> <ol style="list-style-type: none"> 1. Residents are treated with dignity and respect at all times. 		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>37074</p> <p>Based on observations, clinical record review, resident, family, and staff interviews, and facility policy review the facility failed to provide baths for 3 of 4 residents (Resident #5, #8 and #9) reviewed. The facility also failed to provide personal hygiene for 2 of 4 residents (Resident #8 and #11) reviewed. The facility reported a census of 30 residents.</p> <p>Findings include:</p> <p>1. According to the annual Minimum Data Set (MDS) assessment tool with a reference date of 5/22/24 Resident #5 had a Brief Interview of Mental Status (BIMS) score of 13. A BIMS score of 13 suggested no cognitive impairment.</p> <p>The Care Plan focus area with an initiation date of 10/9/23 documented Resident #5 required the assistance of 2 staff for bathing.</p> <p>Review of the past 30 days of bathing documentation for Resident #5 revealed her bath days were Mondays and Thursday. Staff documented Resident #5 received a bath on the following dates:</p> <ul style="list-style-type: none"> a. 5/27/24 Monday b. 5/30/24 Thursday c. 6/3/24 Monday d. 6/10/24 Monday e. 6/13/24 Thursday f. 6/17/24 Monday g. 6/20/24 Thursday h. 6/24/24 Monday <p>Staff failed to give Resident #5 a bath on 6/6/24.</p> <p>On 6/23/24 at 6:27 PM Resident #5 was asked how often she received a bath/shower, she stated once a week but is supposed to get two a week. When asked why that is, she stated they tell her they don't have enough staff to get them done. She could get two a week if she hounds staff enough. Her face appeared unshaved and when asked if staff assist her with shaving, she stated they do once week. She is fine with them doing so once a week.</p> <p>2. According to the quarterly MDS assessment tool with a reference date of 3/6/24 Resident #8 had a BIMS score of 14. A BIMS score of 14 suggested no cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Care Plan focus area with an initiation date of 10/9/23 documented he required total assistance of staff for bathing.</p> <p>Review of the past 30 days of bathing documentation for Resident #8 revealed his bath days were Tuesdays and Fridays. Staff documented Resident #8 received a bath on the following days:</p> <ul style="list-style-type: none"> a. 5/28/24 Tuesday b. 5/31/24 Friday c. 6/4/24 Tuesday d. 6/9/24 Sunday e. 6/11/24 Tuesday f. 6/14/24 Friday g. 6/18/24 Tuesday h. 6/21/24 resident not available i. 6/25/24 resident not available <p>On 6/19/24 at 1:10 PM resident was lying in bed and used a communication board to communicate. One side of the board has simple phrases, the other side has individual numbers and letters. When the resident is asked a question, he points to the letters to spell out words, making sentences. Observed his fingernails to be long. When asked if he gets his bath/showers, he spelled out at one time he hasn't had one for a month. When asked if staff ask him if he wants one, he spelled out no. When asked if they tell him why it would not get a bath, she spelled out no. When asked if they cut his nails, he shook his head no then spelled out he has to ask to get them cut. When ask if they complete oral cares for him, he again spelled out he has to ask.</p> <p>3. According to the quarterly MDS assessment tool with a reference date of 5/22/24 Resident #9 had a BIMS score of 15. A BIMS score of 15 suggested no cognitive impairment.</p> <p>The Care Plan focus area with an initiation date of 10/11/23 documented he required assistance of two staff for bathing.</p> <p>Review of the past 30 days of bathing documentation for Resident #9 revealed his bath days were Wednesday and Saturdays. Staff documented Resident #8 received a bath on the following days:</p> <ul style="list-style-type: none"> a. 5/29/24 Saturday b. 6/5/24 Friday c. 6/8/24 Monday <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>d. 6/12/24 Friday-resident not available</p> <p>e. 6/19/24 Friday received two baths</p> <p>The records revealed Resident #9 did not receive a bath from 6/9/24 until 6/19/24, he went 10 days without a bath.</p> <p>On 6/20/24 at 9:21 AM Resident #9 was asked how often he received a bath or shower he stated he gets one 3 times a week. His hair was disheveled and appeared to not have been brushed.</p> <p>On 6/27/24 at 10:20 AM the resident laid in bed with family visiting, hair disheveled.</p> <p>On 6/25/24 at 5:44 PM Resident #9's son stated when they first brought his dad to the facility they were told he would get three baths a week on Monday, Wednesday, and Saturday. If he wanted/needed more he could request it. There are a lot of times they are not giving him his baths and he found out a while ago they somehow changed it to two times a week on Mondays and Wednesdays. There are times his dad would not get a bath at all. When he asks questions they tell him it's because they are short staff and they have no time to do it. They will come in at the beginning of the shift and tell him we will get your bath done today. Later in the day they will come back in a say we are understaffed we can't do it right now. By the end of their shift they will come in a says they will get to it tomorrow. He has been known to not get a bath for two weeks. He asked one of the nurses to look at the logs and she was able to verify that this was accurate. He has filed grievances on his dad's behalf before.</p> <p>4. According to the admission MDS assessment tool with an assessment date of 5/15/24 Resident #11 had a BIMS score of 14. A BIMS score of 14 suggested no cognitive impairment. The MDS documented she required partial/moderate assistance with personal hygiene such as shaving.</p> <p>The Care Plan focus area with an initiation date of 10/11/23 documented Resident #11 required the assistance of one staff for personal hygiene.</p> <p>During continuous observations on 6/18/24, 6/20/24, 6/23/24 and 6/25/24 Resident #11 ambulated throughout the facility with shorts on. It was noted Resident #11's leg hair to be long and in need of being shaved.</p> <p>On 6/25/24 at 3:02 PM Resident #11 stated she gets her baths/showers twice a week. When asked if staff assist with shaving her legs, she stated no. Resident #11 answered yes when asked if she would want staff to shave her legs.</p> <p>Review of Resident Council Meeting Notes revealed during the council meeting on 3/1/24 residents indicated baths are not getting done on time.</p> <p>On 6/18/24 at 11:58 AM Staff F CNA stated baths were not getting consistently completed because they just did not have enough staff on the floor.</p> <p>On 6/19/24 at 10:06 AM Staff I CNA stated he does not do baths on the evening shift, they do not have enough staff to do that. If they do have time and staff is available they will get them done on the evening shift, but it does not happen often.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/21/24 at 10:33 AM Staff M CNA stated she did not believe the baths got done yesterday for 4 residents. Baths are to be completed on the day shift. At times they only have two CNAs on the floor, then management will bring out a note of certain baths that need to be done on the evening shift before they leave most of the time, they are not able to get them done.</p> <p>On 6/21/24 at 12:54 PM Staff N CNA stated she believed residents are getting their baths twice a week. If they had some left over for the evening shift and if they had enough staff they would do them or push the bath to the following day.</p> <p>On 6/21/24 at 1:05 PM Staff O CNA stated there have been a couple occasions where baths are not getting done.</p> <p>On 7/1/24 at 2:01 PM the Director of Nursing (DON) stated residents are to get baths at least twice a week. She added one resident is care planned to receive three a week. If a resident refuses a bath, they will try to offer a bath at another time. If the resident has something going on like an appointment or going out with family on their bath, then they will move their bath to the next day or make sure they get a bath within that same week. The DON indicated residents are getting their baths twice a week unless they are refusing them. When asked when resident's nails are to be trimmed, she stated during their bath time. When she was informed that Resident #8's fingernails were long, she stated he is usually pretty particular about his nails being cut. The DON indicated women's legs are shaved at the resident's discretion. She indicated they would get Resident #11's leg shaved when she was informed her leg hairs were long and the resident stated she wanted them shaved.</p> <p>The facility provided a document titled Resident Rights with a revision date of 12/2016 with a policy statement that read, employees shall treat all residents with kindness, respect, and dignity.</p> <p>Policy Interpretation and Implementation:</p> <p>When assisting with care, residents are supported in exercising their rights. For example, residents are:</p> <p>a. Groomed as they wish to be groomed (hair styles, nails, facial hair, etc.)</p> <p>The facility provided a document titled Activities of Daily Living (ADLs), Supporting with a revision date of 3/2018 with a policy stated that read, residents will be provided with care, treatment and services as appropriate to maintain and improve their ability to carry out ADLs. Residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.</p> <p>Policy Interpretation and Implementation:</p> <p>2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:</p> <p>a. Hygiene (bathing, dressing, grooming and oral care)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074</p> <p>Based on observations, clinical record review, facility investigation review, staff interviews and facility policy review the facility failed to supervise 1 of 3 cognitively impaired residents (Resident #1). Staff were unaware Resident #1 had left the building on 5/26/24 at approximately 4:50 PM. Staff responded to an alarmed door, looked out the door window, disarmed the door alarm and went back to work. The staff member failed to go outside to visually check to see if a resident had left the building. The staff member assumed he saw another staff member in the vicinity. The staff member also failed to initiate a head count to ensure all residents were accounted for. The facility reported a census of 30 residents.</p> <p>Findings include:</p> <p>According to the annual Minimum Data Set (MDS) assessment tool with a reference date of 3/13/24 Resident #1 had a Brief Interview of Mental Status (BIMS) score of 7. A BIMS score of 7 suggested mild cognitive impairment. The MDS documented he did not exhibit wandering behavior during the review period. The MDS documented the following diagnoses: major depressive disorder, dementia and malnutrition.</p> <p>The Care Plan focus area with initiation date of 9/22/23 documented he ambulated with assistance of one staff; utilized a wheelchair for mobility. The Care Plan focus area with an initiation date of 2/23/24 documented he is an elopement risk related to he likes to go outside and forgets to tell staff that he is going outside. The care plan directed staff to alert other staff of his behavior as needed, staff are to approach him positively and, in a calm, accepting manner. Assigned staff to account for his whereabouts throughout the day and distract him from wanting to go outside unassisted by offering pleasant diversions, structured activities, food, conversation, TV shows and books that he prefers.</p> <p>Review of the Wandering Evaluations completed on 12/11/23, 12/19/23, 3/1/24, 5/26/24 revealed he was at low risk of wandering. A wandering evaluation completed on 6/11/24 documented he was at high risk for wandering.</p> <p>A Progress Note on 5/26/24 at 6:30 PM documented the nurse gave Resident #1 his PM medications at 4:40 PM and sent him to the dining room. He was visibly seen wheeling to the dining room at 4:45 PM. Staff H Licensed Practical Nurse (LPN) and Staff I Certified Nursing Assistant (CNA) were at the nurse's station when they heard the staff entrance door alarm go off at 4:50 PM. Staff I went to check the alarm and did not see anyone. At 4:57 PM Staff G Assistant Living (AL) Attendant brought Resident #1 back from Assisted Living. The resident had no injuries and he stated he had just wanted to go outside.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 6/18/24 at 12:07 PM revealed the hall leading to the dining room had a set of fire doors on the left, half way to the dining room. On one of the doors was a sign posted to keep doors closed at ALL times. Once through the fire doors is a door with a box to the left for a code to be entered before opening the door. Once the egress door is engaged an alarm sounds for 15 seconds before the door opens and a louder alarm activates. Once outside there is a white vinyl fence to the left, a garage/building direction in front of the door. To the right is the Assisted Living (AL) building and the staff parking lot. There was a key pad to get back in to the building. Staff T Registered Nurse (RN) came to the door, silenced the alarm, then went outside, walked around and came back through the front entrance.</p> <p>Observation on 6/20/24 at 3:10 PM revealed it is 40 steps from the back entrance that Resident #1 exited the building to the AL building. Once inside the AL building there is a long hall straight ahead and the dining room to the right. If the resident self-propelled approximately 900 feet downhill he would have come to a four-lane highway and a heavily trafficked truck stop exits.</p> <p>The facility's investigative file included the following staff statements:</p> <p>a. Staff J CNA's statement: on Sunday May 26, 2024; I was in a resident's room, assisting the resident to the bathroom. I heard the alarm, was unable to leave the resident's room. I took the resident to the dining room for supper. The Dietary Manager told me that the AL Attendant had brought one of the nursing home residents back to us. I immediately reported this to the charge nurse on duty that day.</p> <p>b. Staff I statement: I believe I had just come out of another resident's room when the alarm went off, and I didn't see which door had opened but I assumed it was the employee entrance as that door alarm tends to set off randomly if another employee leaves and doesn't close it enough. I went to shut off the alarm as it had been going off for around 5-10 seconds, and when I got to the door I looked out the window to see what could have caused it, and I assumed who or what I had seen was Staff J going out for a smoke break, as it looked similar to her height and was around where she typically parks her car. So, I thought nothing of it until someone later came and told me the resident had been brought back from the assisted living side of the facility. That's about what happened, I don't remember much of what happened because it was a hectic time of day trying to get people up and to the dining room for dinner.</p> <p>The facility's investigative file included the following Missing Resident Exercises that had been completed:</p> <p>a. On 3/27/2034 at 1:30 PM staff utilized high risk wandered for missing resident drill by escorting/accompanying resident to the back patio. The dayroom/patio alarm was set off and waited for staff to respond. Staff responded and located the missing resident. The names of people participating did not include Staff I.</p> <p>b. On 4/13/2024 at 11:45 AM the Director of Nursing (DON) set off the door alarm at the end of hall 100 to make it appear a resident exited the building. Staff immediately responded and searched the perimeter and announced overhead. Two other staff went room to room to verify head count to ensure all residents were accounted for. The names of people participating did not include Staff I.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/18/24 at 5:36 PM Staff G stated while on the AL side of the building she got the steam table from the kitchen, plugged it in in the dining room and when she looked to the left she saw a male resident in a wheelchair coming towards her. She said to Resident #1 to come with her and she took him over to the nursing home side of the building. Once on the nursing home side, she told the staff members where he was but they did not seem to know he was out of the building. Staff G stated the fire doors leading down the hall to the dining room on the nursing home side of the building were open and he managed to get out the back-service door. She indicated once outside the door, the maintenance garage is right there, attached to the laundry area. In order to get back in to the nursing home, a code has to be keyed in then the door opens. To exit the building, you have to push the door handle for 15 seconds, as it alarms, then it opens with the alarm still sounding. The day she found Resident #1 he wore tennis shoes, dark pants and a light-colored t-shirt. Staff G stated it was not raining at that time. She assisted Resident #1 back to the nursing home at 4:57 PM that day.</p> <p>On 6/19/24 at 10:06 AM Staff I CNA stated the day Resident #1 left the building, the resident got out the back door that is typically served for employees and staff. He added that door has a tendency for the alarm to go off randomly if it's not shut all the way. Staff I went back there because that is what he thought had happened. He looked out the door window and thought he saw Staff J Certified Medication Aide (CMA) going out for a smoke break. He assumed she had stepped out for a smoke break. He was a little busy at that time and thought she had stepped out. Staff I admitted he did not know if he saw someone, thought he did and thought it was Staff J. When asked how he could have mistaken Staff J a female staff member walking for Resident #1, a male resident in a wheelchair. Staff I stated he was unsure how he thought that, he was just rushing. He rarely gets time to stop to think, he admitted he was not thinking at that time. Later someone had told him that Resident #1 had gotten out and went to the AL side of the building. He was not around when Resident #1 was returned back to the building, he was just informed of what had happened. He stated that's the [NAME] of it, did not think much of it at the time. When asked which door alarmed that day, he stated the door is behind the double doors that are normally shut but they were left open that day. When asked about what time the alarm went off, he stated about 4:30 PM because it was around the time they typically are getting people up for supper. Staff I stated he was coming out of another resident's room when the alarm first sounded. He went to the door and shut the alarm off. The alarm does not shut off unless you enter a code. The alarm sounds throughout the facility and there's a board by the nurse's station that will show them what door is alarming. Another alarm sounds when the door is opened with out the code or after the 15 seconds passes. At the time Resident #1 left the building, he was an assistance of one to do a stand and pivot to his wheelchair. Once he is in his wheelchair, he is independent in the facility. Staff I was asked what the facility's procedure is when a door alarm sounds, he stated typically now we will go to the door, shut off the alarm, check outside to ensure no residents have eloped. If no one is out there, they will go about their business. Before that, there was not anything they did; just do a quick glance outside. He added head counts are done now. Staff I indicated he has worked at the facility for 3 years as of May this year.</p> <p>On 6/20/24 at 9:15 AM Staff K CMA stated that if she heard a door alarm sounding, she would go to the door that is sounding to see if a resident had walked out the door. If she was unable to see a resident, they would complete a head count. When a door alarm sounds, it could be heard throughout the facility and they have a panel that lights up with what door is sounding.</p> <p>On 6/20/24 at 9:26 AM Staff L non-CNA stated that when a door alarm goes off, she would go see where it's alarming then make sure no residents were outside. If she did not see a resident she would make sure all residents were accounted for by completing a head count.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/20/24 at 12:57 PM Staff H Licensed Practical Nurse (LPN) stated the day Resident #1 exited the building she gave him his medications at 4:45 PM as he was in bed. They assisted him up to his wheelchair and asked him to start heading to the dining room for dinner. At 4:50 PM Resident #1 by her in wheelchair as she was at her medication cart at the nurse's station. Shortly after she saw him the back-door alarm went out. She had Staff I to go check the door alarm; he did but he did not go outside to look to ensure no one was outside. At about 4:55 PM-4:56 PM the staff AL brought the resident back to the building. After that they ensured all residents were accounted for and initiated one to one supervision on Resident #1. When asked how long after the alarm sounded did Staff I respond, she stated not long. But he just went to the door, put the code in to silence the alarm, looked out the door window but did not physically go outside to see if anyone had gone out the door. When the AL staff member returned Resident #1, Staff H completed an assessment, while in his wheelchair, which revealed no injuries or abnormalities. When she asked the resident what he was doing, she stated he just wanted to go outside. He then ate his supper and went back to his room. When asked if Resident #1 would easily mistaken for a facility staff member, she did not think so. She added she did know of staff members going outside at that time. At the time Resident #1 left the building, the double doors located on the hall leading to the dining room were left open. There are signs on the doors that says to leave them shut. Staff H was asked what the facility's procedure is for when a door alarm sounds, she stated staff are to check the alarm and if you can't verify who went outside, one staff member goes outside to look for anyone that may have left and the other staff member completes a head count. The staff working will go down the halls to make sure all residents are accounted for. But Staff I did not say why he did not do that, that day. If a resident is found outside, staff are to bring the resident back in. Staff H indicated Resident #1 had no behaviors prior to him leaving the building that would indicated he wanted to leave. During a follow-up interview on 6/26/24 at 12:08 PM Staff H stated after she asked Staff I to check the sounding door alarm, she continued to pass medications at the nurse's station. When Staff I returned he said he did not see anyone, so she continued to pass her medications until Staff J let her know Staff G had returned Resident #1 from the AL side of the building. When asked if she initiated a head count after Staff I stated he did not see anyone, she denied starting a head count and added maybe she should have started one.</p> <p>On 6/20/24 at 1:15 PM the Nurse Consultant stated they were unable to find a policy or protocol for staff to follow if they are unable to visualize a resident outside the building after a door alarm has sounded. She has looked through their elopement/wandering policy for this. She acknowledged it is standard of practice to do a head count if staff cannot visualize that a resident has left the building.</p> <p>On 6/20/24 at 1:59 PM Staff J stated she was in a resident's room taking a resident to the bathroom when she heard the door alarm. She could not leave the resident she was with. She could not remember exactly what time but would say it was between 4:15 PM and 4:45 PM. When she was done assisting that resident, she took them to the dining room. The Dietary Manager told her an AL staff member had brought Resident #1 back from their side of the building. He had returned around the same time the alarm had sounded. When asked what staff are to do when they hear a door alarm sound they are to see where the alarm is coming from to see if anyone is outside. If she saw someone she would go get them and bring them back in if it was a resident. She would then let the nurse know. If she did not see anyone outside, she would report to her nurse and assume they would do a head count to ensure all residents were there, are safe and accounted for. At the time Resident #1 left the building he was in a wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/21/24 at 10:33 AM Staff M CNA stated she was taught that if a door alarm was sounding and she was in the middle of assisting a resident, if that task could be stopped she would stop and go see where the alarm was sounding. She would silence the alarm and let the charge nurse know what was going on. She was never taught to go outside and check the surroundings. She added a head count should be completed immediately.</p> <p>On 6/21/24 at 12:34 PM Staff N CNA stated if she heard a door alarm sounding she would look at the board to see what door it was. She would go to the door, check outside to see if she could find anyone that may have left; staff or resident. If she did not see anyone then she would go back inside and do a head count to ensure all residents were accounted for. When asked if she saw a staff member outside what she would do, she stated she would ask if they just went outside. If they said yes, she would silence the alarm.</p> <p>On 6/21/24 at 1:05 PM Staff O CNA stated if an alarm was sounding, she would check the board to see what door it was. She would go to that door, open it to check to see if anyone was outside. If she did not see anyone, no resident in sight or no staff in sight, she would go inside and make sure all residents are accounted for.</p> <p>On 6/21/24 at 3:32 PM Staff E CNA would go check to see what door was alarming, then see if any resident was outside. She went go let the nurse know and do a head count. If she saw a staff member outside she would go speak with that staff member to make no residents were with them. Then she would turn the alarm off.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/25/24 at 10:13 AM the Director of Nursing (DON) stated she was not in the building the day Resident #1 eloped. It happened on a weekend. She received a call from Staff H charge nurse letting her know about an elopement with Resident #1. She was not sure on exact time, it was 4 something that afternoon. From the time the alarm went off and when returned, it was 7 minutes. After talking to all staff, she heard Staff I heard back service door going off and responded to it. Staff I looked out the door window but did not open the door. Staff I said he saw someone he thought was Staff J, the other aide working, who is shorter with short hair. Staff I reset alarm and went back to work. Shortly after, an AL staff member brought Resident #1 back to nursing home side. Apparently, the resident came in the AL building through the door facing the parking lot. Once through that door one could go straight down hall or to the right to the dining room. Resident #1 came through that door and went to the AL dining room, asked staff if they could help him back to his room. Staff then brought him back to the nursing home side. The DON reported they complete multiple elopement drills monthly, started to do them weekly and more. They complete the drills on all shifts and on the weekends. The DON stated the back-service doors are kept closed, with signage up. The day he went out, one was opened and one closed which was not uncommon. When she spoke with Resident #1, he told her he wanted to go outside for some sunshine. She indicated his daughter comes up and takes him outside to get some sun. Keeping them closed and signage does help keep people from trying to get out that way. While doing their drills they have staff initiate a head count to see who went out and who did not. When staff are not sure if a resident had left or not, they still must initiate a head count. Once Resident #1 was back at the facility they immediately placed him on one on one supervision, within line of sight when out of his room. They did that for 3 days to monitor him, talked with him to gauge how he was doing and what he was thinking, to monitor his patterns. Resident #1 did not go towards the doors or wander after that. The next day they did elopement drills on every shift, put out education to all staff. At time of the elopement he was not on increased supervision and had not tried to get out of the building before. Since his elopement there have been no changes in his mental status or need to want to go outside that day. When asked what Staff I should have done differently she stated she did one on one talk with him. He told her he answered the door alarm, and looked out the window. She told him when you respond to an alarm, and you cannot identify who went in or out, you have to initiate elopement protocol and do head count, you have to physically go outside and look. They need to have someone look on the premises, and get the charge nurse right away. Someone should alert all staff right away. Staff I acknowledged he messed up and should have gone outside. They have completed a lot of drills with back service doors. Those back service doors some employee just thinks oh it's an employee that set that alarm off, not a resident. The DON added staff need to take alarms seriously. When asked how he one could assume Resident #1 was Staff J when Resident #1 is a male, with gray/white hair, in a wheelchair and Staff J is an ambulatory female with dirty blonde, brown hair; she stated she said the same thing. [NAME] has dirty blonde brown hair and [NAME] in wheelchair how do you mix that up.</p> <p>On 6/25/24 at 10:40 AM the State's Climatologist reported on 5/26/24 at 4:50 PM at the facility location the temperature was 64-degree Fahrenheit, humidity was 88%, winds were out of the North at 6 miles per hour (mph) with wind guys up to 26 mph, overcast conditions, raining at the time.</p> <p>On 6/27/24 at 12:24 PM Staff P LPN stated if she heard a door alarm sounding she would go to that door, make sure no one was outside. She would come back in and do a head count to make sure everyone was where they were supposed to be.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Staff I's employee file revealed an Employee Acknowledgement Form-Emergency Preparedness was signed and dated by Staff I on 5/27/21. The form acknowledged that he understands the policy and procedures of the facility Fire Drill, Missing Resident Drill, and Severe Weather Drill. He acknowledged that the emergency preparedness binder is in the large copy room and is available to view at any time.</p> <p>The facility provided a policy titled Wandering and Elopements with a revision date of March 2019. The policy statement documented: the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.</p> <p>The facility provided an Elopement Drill Procedure with an effective date of January 2022. This document sets forth the facility's procedure completing an Elopement Drill/Missing Resident Drill. Staff will be trained on procedures for elopements through quarterly drills.</p> <p>Procedure:</p> <p>4. The ensure search process of the facility and grounds, from the time the resident is missing will be completed within thirty minutes.</p> <p>5. If the search fails to locate the missing resident within thirty minutes from the time the resident is found to be missing, then the Administrator and/or designee places a mock telephone call to the community agency, Administration, the resident's representative and attending physician. Staff will provide the police with all physical identifying information including but not limited to physical appearance, height, weight, age, sex and clothing, if known.</p> <p>The facility provided a document titled Elopement Prevention. The purpose of this document is to maintain resident safety and prevention of injury.</p> <p>Guidelines:</p> <p>9. All staff will respond promptly to all door alarm activation. If immediate reason for the door alarm is not determined, all residents will be accounted for at this time.</p> <p>11. Quarterly Elopement Drills are highly recommended.</p> <p>a. All staff are involved in elopement drills.</p> <p>b. Send a person out to hide where a resident might elope.</p> <p>c. Initiate the search.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074</p> <p>Based on observations, resident council meeting notes, grievance/concerns investigation forms, resident and staff interviews, and facility policy review the facility failed to ensure the facility had sufficient staffing to meet the needs of residents that included answering resident's call lights in a timely manner. The facility reported a census of 30 residents.</p> <p>Findings include:</p> <p>Observations on 6/23/24 from 5:10 PM until roughly 6:30 PM revealed numerous call lights going off on the 200 hall:</p> <ul style="list-style-type: none"> a. room [ROOM NUMBER] call light on at 5:10 PM, off at 5:32 PM; call light was on for 22 minutes b. room [ROOM NUMBER] call light on at 5:40 PM and remained on when checked on at 6:07 PM; at that time call light was on for 27 minutes. c. room [ROOM NUMBER] call light on at 6:07 PM, off at 6:23 PM; call light was on for 16 minutes. d. room [ROOM NUMBER] call light on at 6:00 PM, off at 6:16 PM; call light was on for 16 minutes. e. room [ROOM NUMBER] call light on at 5:36 PM, off at 6:16 PM; call light was on for 40 minutes. <p>Review of Resident Council Meeting Notes revealed during the council meeting on 3/1/24 Resident #9 stated he turns his call light on and it takes quite a while to answer his light. He said it takes quite a while for him to get transferred from his chair to his wheelchair and vice versa.</p> <p>Review of Resident Council Meeting Notes revealed during the council meeting on 5/2/24, residents reported call lights not getting answered timely. Residents stated they come to the resident council meetings but nothing gets done with their complaints and they have brought some of these things up several meetings before.</p> <p>Review of Grievance/Concern Investigation Forms revealed the following grievances:</p> <ul style="list-style-type: none"> a. 3/1/24 Resident #9 indicated his call light was not getting answered very fast. It takes quite a while to get his call light answered and his call light is not always in reach for him to use and ends up yelling for help. b. 5/23/24 Resident #6 indicated he laid in his urine and waited 45 minutes for his call light to be answered. Action and follow-up: resident was immediately cleaned, staff educated on 15-minute timing for answering call lights. <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/18/24 at 11:58 AM Staff F CNA stated call lights could take over 30 minutes to be answered because they did not have enough staff on the floor. They do not have enough staff for the quantity of resident they have. She would have issues getting to her check and changes when she worked overnights because they only had one CNA and one nurse working.</p> <p>On 6/19/24 at 9:49 AM Resident #13 stated it could take up to 20-25 minutes for her call light to be answered. Staff will come in and say they need to go check on something but never come back or don't do what they say. The resident stated communication is bad here. They bring up these concerns during resident council but nothing gets done about it. Observed Resident #13 to be wearing a watch at the time of the interview.</p> <p>On 6/19/24 at 10:06 AM Staff I CNA stated for the most time they can answer call lights timely. If they have three staff on the floor, one staff member will answer call lights and assist those that require one staff for assistance while the other two assist those residents that require assistance of two staff. Staff I stated you can spend roughly 5-10 minutes in a resident's room getting them to bed, once you're done you have 4-5 more lights on. When asked how staffing was he stated it depends on which shift. The day shift usually has 4-5 people working the floor with 1 doing baths. On the evening shift they will have 2-3 on the floor depending on the day of the week. Weekends they will have 2 on the floor, maybe 3 for half the shift. Most weekends worked can be hectic especially with 2 people on the floor; they have a lot of residents that are 2 assists for transfers, plus more residents needed things at once.</p> <p>On 6/20/24 at 9:26 AM Staff L non-CNA smiled when asked how staffing was, then stated it could be better. On the morning shift they usually have two CNAs on the floor and one bath aide doing baths. They will not pull the bath aide to help. With two CNAs on the floor and a lot of residents that are two person assists it's tough. When asked if any tasks get missed or pushed to the side when they only have two CNAs on the floor she stated they don't do it on purpose. Call lights can take along time to get to those. She added when they are short sometimes residents don't get turned every 2 hours, usually every 2.5-3 hours; they get there when they can. When they have more time, they will go around and ask residents if they need anything so they are not on their call lights a lot. At times they don't have time to do that.</p> <p>On 6/20/24 at 1:59 PM Staff J CNA was asked if staff are able to get to call lights timely, within 15 minutes. She stated probably not. You can be in a room busy with another resident and not hear the call lights going off. You don't know how long they have been on, so will go answer them when they can.</p> <p>On 6/21/24 at 10:33 AM Staff M CNA laughed and said she was sure the surveyor knew how staff was. She added it's chaotic. She stated she is not one to berede the office people but they are day they are drowning on the floor but no one will pick up their phones or check messages when they reach out for help. When they need help, they need help. Office staff should be looking out for their own staff. Staff M reported the Administrator told them they could call and call and she would not answer her phone. When they are busy and low staff they will push back when they pass drinks and snacks, so they can answer call lights and get other things done. When they have two people on the floor, one person has to be in the dining room assisting residents with their meals while the other resident is answering call lights and meet those resident's needs by themselves.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/21/24 at 12:54 PM Staff N CNA stated on the evening shift; 2:00 PM-10:00 PM they give two staff. There are a lot of residents that require the assistance of 2 staff. When there are only two CNAs working one has to go to the dining room while residents are in their eating while the other resident is answering call lights, passing room trays, and it's hard.</p> <p>On 6/21/24 at 1:05 PM Staff O CNA stated it can be hard when there's only 2 staff on the floor with a lot of residents that require the assistance of 2 staff. During dinner one aide needs to be in the dining room to help and feed residents while the aide passes trays and answers call lights. When asked if they are able to complete their tasks for their shift she indicated that all depends on call lights and how early/late people want to go to bed. She indicated 9 times out of 10 not everything will get done like not getting all the trash out of resident's rooms, some residents will still be up when the overnight shift staff come in. Also, little things like stockings will not get done. She stated staffing is just really stressful; 30 residents with half of them 2 assistance of staff plus trying to keep any eye on everyone else is stressful.</p> <p>On 6/23/24 at 5:35 PM Staff I stated they had one call-in for this shift. He stated he sent a text out to everyone to see if they could come in but no one was available. At 6:15 PM overheard Staff I state this is when I wish our 3rd CNA was here.</p> <p>On 6/23/24 at 6:27 PM Resident #5, who resided in room [ROOM NUMBER], sat in her wheelchair in her room with her call light on. The surveyor acknowledged the resident's call light had been on for a long time this evening. When asked if this was normal during the evening shift, she acknowledged it was. She added she wants to go to bed but she has to wait and it happens a lot on this shift. Resident #5 stated she has to wait a long time to go to bed at this time during the day on the weekends. The resident stated she requires the assistance of two staff and a mechanical lift. When she has to wait this long it results in her not wanting to get out of bed because she does not know when she will be able to get back to bed. Resident #5 stated right now I am waiting for Staff I to find another staff member to assist him with her transfer. At 6:31 PM Staff I came in and informed Resident #5 he was trying to find Staff J CMA to help him.</p> <p>On 6/24/24 at 8:55 AM the Administrator sent an email that indicated the facility has nine residents that required the assistance two staff for transfers, bed mobility and ambulation.</p> <p>On 6/27/24 at 10:35 AM Resident #6 indicated it could take up to an hour and half for his call light to get answered. He has a clock on his wall by his TV and a digital clock on his motorized wheelchair. He added he always knows what time it is.</p> <p>On 6/27/24 at 2:00 PM Resident #14 stated it usually takes up to 30 minutes for staff to answer his call light. Observed a call on his wall to the left of his TV.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 7/1/24 at 2:01 PM the DON stated the facility's staffing is good and they staff based on their census. When their census is below 30 they will have 2-3 CNAs and a nurse on the floor. When they can, they will have another CNA come in from 6:00 PM to 10:00 PM to help get residents to bed for the night. Herself and the Assistant Director of Nursing (ADON) will fill vacancies on the overnight shift if they need to. She acknowledged they try to increase staff but when they do, staff will call in. When asked if they take in account the acuity of their residents to help with staff, she indicated they do not; they look at their census. When discussing call light concerns, she stated she expected staff to answer resident call lights within 15 minutes. She was informed this was not the case on 6/23/24 when the surveyor came to the building that Sunday. When Staff T Registered Nurse (RN) called her to let her know a surveyor was in the building, she had no idea how crazy it was. She came in to the facility and assisted until about 8:00 PM or so. When asked if she felt call lights were getting answered within 15 minutes, she stated typically yes, with some outliers absolutely. Their leadership team can still answer call lights to see what the resident needs, then go from there. Any clinical staff can answer the call light and assist the resident.</p> <p>The facility provided a document titled Answer the Call Light with a revision date of 3/2021 with a purpose that read the purpose of this procedure is to ensure timely responses to the resident's requests and needs.</p> <p>Steps in the Procedure</p> <ol style="list-style-type: none"> 1. Identify yourself and politely respond to the resident by his/her name. <ol style="list-style-type: none"> a. If the resident needs assistance, indicate the approximate time it will take for you to respond. b. If the resident's request requires another staff member, notify the individual. c. If you are uncertain as to whether or not a request can be fulfilled or if you cannot fulfill the resident's request, ask the nurse supervisor for help. 		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>37074</p> <p>Based on grievance/concern investigation forms, staff interviews, employee file review, and review of job descriptions the facility failed to ensure qualified staff assisted in the kitchen when they did not have adequate staff working. The facility reported a census of 30 residents.</p> <p>Findings include:</p> <p>Review of Grievance/Concern Investigation Forms revealed the following grievances:</p> <p>a. 4/23/24 a resident expressed frustration with staffing in the kitchen. Stated she's sick of not getting what she orders and the Administrator needed to figure it out. Action and follow-up: dietary manager was out unexpectedly. Administrator pulling staff from other departments to help cook and serve meals.</p> <p>b. 5/3/24 a resident asked for a peanut butter sandwich and they brought her the bread and the peanut butter packet, told her to make her own sandwich. She said for what she pays to stay here, her sandwich should be made for her. Action and follow-up: dietary manager spoke to all cooks about making the sandwich. This was done by a nursing staff that filled in as a cook. Education was provided.</p> <p>On 6/18/24 at 11:24 AM Staff D Registered Nurse (RN) stated she has noticed Certified Nursing Assistants (CNAs) and nurses in the kitchen cooking and working as a dietary aide without trainings or being certified. Staff D stated she has witnessed Staff E CNA in the kitchen cooking. She indicated any staff member would be willing to speak of this too as well as residents.</p> <p>On 6/18/24 at 11:58 AM Staff F CNA stated she would see CNAs in the kitchen cooking if they did not have a cook for that day. When asked how often this happened she stated it just depended on kitchen staffing for the day. She acknowledged she assisted in the kitchen by serving the meal and setting up room trays. She denied receiving training from the facility prior to assisting with kitchen duties.</p> <p>On 6/19/24 at 10:48 AM Staff Q Maintenance stated he has helped with meal service before but only as a dietary aide. He would deliver drinks and food trays, he cannot cook because there are different diets and orders. He just helps when they need it because they can't keep kitchen staff right now.</p> <p>On 6/20/24 at 9:15 AM Staff K CMA stated they have asked her to help in the kitchen but she declines. She works on the floor not in the kitchen.</p> <p>On 6/20/24 at 9:26 AM Staff L non-CNA stated they have asked her to help in the kitchen, but she has refused to do so because she was not hired for that.</p> <p>On 6/20/24 at 12:57 PM Staff H Licensed Practical Nurse (LPN) stated she has never helped in the kitchen but has noticed CNAs and other nurses helping. She added Staff E CNA has gone in the kitchen to cook before. She has also noticed the Activity Director assisting as well.</p> <p>(continued on next page)</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/20/24 at 1:59 PM Staff J CMA state she had been asked to help in the kitchen and she does help. When asked what she helped with she stated delivered trays to residents, set drinks out on tables, set up trays, picked up trays, did dishes and makes sure the kitchen and dining room was tidy. She denied cooking in the kitchen and did not have any extra training to help with dietary tasks or certifications.</p> <p>On 6/21/24 at 10:33 AM Staff M CNA stated they ask her to help in the kitchen all the time but she refuses to help. When asked if she has noticed other CNAs or nurses in the kitchen helping, she stated Staff P LPN will go back to the kitchen when not doing medication pass. Staff E CNA will be in the kitchen cooking as well. Staff M indicated the Dietary Manager will send her texts asking her to work as a dietary aide or a cook but that's not her job. She is not certified to do any of that. The others that have assisted in the kitchen are also not certified to do what they do. The Administrator will tell them they need to go in the kitchen to help. Staff M acknowledged she knows she can help pass meals to the residents but knows she is not to help in the kitchen.</p> <p>On 6/21/24 at 12:47 PM Staff R previous [NAME] stated they have had CNAs and nurses help in the kitchen with no training. Those staff people don't know what they are doing as they cooked or did dietary aide stuff. They had to help because the facility could not keep kitchen staff, the whole facility can't keep help.</p> <p>On 6/21/24 at 12:54 PM Staff N CNA stated if there are enough CNAs she will help the kitchen staff, if there is not enough CNAs she will not help. When asked what kind of things she does to help the kitchen staff she stated she will get drinks ready, wrap silverware, serve food, and get room trays ready. She has noticed Staff P in the kitchen cooking after she is done with her nursing staff. Staff N is not sure if Staff P has been trained or certified but has cooked a few times.</p> <p>On 6/21/24 at 1:05 PM Staff O CNA stated they have asked her to help in the kitchen but when they have asked her she has been in rooms doing cares. A couple weeks ago, she noticed a nurse had been in the kitchen serving food and CNAs acting as dietary aides.</p> <p>On 6/21/24 at 3:32 PM Staff E CNA stated she has helped in the kitchen as a dietary aide and a cook a few times. When asked if she has been trained or had any dietary certification she denied having been trained or having any certifications. This did not happen very often within a week's time. She complained about helping and they took her out of the kitchen. During a follow-up interview on 6/25/24 at 10:01 AM Staff E was asked how she knew what to do when making the mechanical soft and puree meals when she helped in the kitchen. She stated she looked at a chart that's in the kitchen. She added she previously worked at an adult day care center where she cooked, so she knew the different diets and how to do the different consistencies.</p> <p>On 6/23/24 at 6:00 PM Staff B [NAME] stated kitchen staffing had been rough for a bit because herself and the Dietary Manager were off at the same time due to medical reasons.</p> <p>(continued on next page)</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/27/24 at 12:24 PM Staff P LPN stated she has worked in the kitchen before. The Dietary Manager had prepped the food, sat right there as Staff P served the meals. She would follow their slips when serving the meals. Staff P denied cooking, she only plated the food. When asked why the Dietary Manager watched her serve instead of serving herself, she stated because she just had surgery so she sat in a chair and watched her. Staff P denied having training from staff but worked in another facility's kitchen so she knew how to use the dishwasher and knew certain diets. Staff P stated she does not have any certifications or trainings to work in the kitchen. The Dietary Manager did show her how to obtain food temperatures, makes sure it was hot and how to keep it hot.</p> <p>On 6/27/24 at 12:12 PM the Activities Coordinator indicated she was asked to work in the kitchen for kitchen staff but out on the floor was just passing out trays and drinks. She denied ever going into the kitchen to cook. She provided that Staff E CNA did work as a cook one day as she passed out drinks to the residents. She added all the kitchen staff called in that day so they had no choice but to go back there to work as kitchen staff. This was roughly two months ago.</p> <p>On 7/1/24 at 2:01 PM the Director of Nursing (DON) laughed when asked if nursing staff had assisted in the kitchen. She stated it was accurate but not recently, in the last two months. The DM had to go on medical leave abruptly, had staffing issues with call-ins along with vacancies. When nursing staff was overstaffed Staff E and Staff P would go help in the kitchen. The DON indicated the DM completed orientation checklists with them but is unsure of the entire protocol for this. She knows staff have to complete serve safe training. When asked if Staff E and Staff P got all the training a normal dietary staff would do, she stated no. She acknowledged she has helped as a dietary assistant before.</p> <p>Review of the job description for a cook listed the purpose of this position under general supervision of the Dietary Services Manager, the cook position assures the resident meals and other nourishments are properly prepared/cook and apportioned according to authorized menus and individual care plans, and are served according to established schedules, consistent with regulations and starts of practice. Functions within strictly defined procedures with little latitude for variation or change. Under the qualifications portion of the job description there is a section for education/certifications/license: staff must be willing to complete the following during new hire orientation: food, safety, and sanitation study courses and modified diet training. Experience needed for this position includes demonstrating skills in quantity food preparation and service.</p> <p>Review of the job description for a CNA listed the purpose of this position under on-site supervision of the charge nurse, the CNA provides personal care and supervision to residents in a manner conducive to their safety, comfort, security and the greatest degree of independence possible. Operates within the parameters of each resident's care plan and daily schedule as determined by the interdisciplinary team and within the practice of limitations of certification. The primary functions and responsibilities of this position are as follows: additional duties may be added as necessary to meet the needs of the facility. Staff will be evaluated on their ability to perform these functions competently with minimal supervision and/or reminders. Review of the essential functions section revealed it did not list kitchen duties or responsibilities. Review of the general functions section revealed it did not list kitchen duties or responsibilities.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>37074</p> <p>Based on observations, staff interviews, and facility policy review the facility failed to store and serve food in a sanitary manner. The facility also failed to maintain infection control practices while in the dish area when going from the dirty area to the clean area. The facility reported a census of 30 residents.</p> <p>Findings include:</p> <p>On 6/18/24 at 10:23 AM observed three tubes of hamburger meat in a gray hard plastic bin with a tape label that indicated the hamburger was for Thursday 6/19/24 (Thursday was actually 6/20/24). Red, bloody looking, fluid gathered at the bottom of the gray hard plastic bin. This bin sat on the second to last shelf in the walk-in cooler with two cardboard boxes of stripped bacon on the shelf below. Also noted in the walk-in cooler, a box that contained 4 green peppers with what appeared mold on them (black and white fuzzy areas throughout). While speaking with the Dietary Manager, Staff A Dietary Aide, had gloved hands while in the dish area. With gloved hands he moved a trash can closer to the dish room, removed dishes (bowls, cups, small plates) from the clean area of the dish room and placed them in their proper areas in the kitchen. With the same gloved hands, he began cleaning the dirty side with a squeegee. He then opened the dishwasher, removed more clean dishes with the same gloved hands. He took those clean dishes (bowls and cups) to their proper place.</p> <p>On 6/20/24 at 11:17 AM observed two tubes of hamburger meat in a gray hard plastic bin. The bin also had an opened zip lock bag that contained one raw hamburger patty. The zip lock bag was not labeled and opened to air. The zip lock bag and two tubes of hamburger rested in red, bloody looking, fluid at the bottom of the gray hard plastic bin. This plastic bin now rested on the bottom self in the walk-in cooler. The four moldy looking green peppers remained in a card board box in the walk-in cooler.</p> <p>On 6/23/24 at 5:08 PM Staff B [NAME] was in the kitchen behind the food service window holding a cell phone with both hands. Observed Staff B plating sandwiches with her bare hands for 16 residents. During the meal service she would handle the meal tickets that are filled out by the residents, plates, individual ice cream containers, a bag of chips, and soup bowls. Observed Staff B scratching her hair line with her index finger on her right hand and pull at her t-shirt. The same ungloved hand she used to plate the sandwiches. At 5:21 PM Staff B walked by the service area where the food was and coughed into the area without covering her mouth.</p> <p>On 6/20/24 at 11:19 AM the Dietary Manager (DM) was made aware of the raw hamburger patty in an opened zip-lock, she indicated she would throw it away. When informed the gray hard plastic bin that had the raw hamburger in it was on a shelf above two boxes of stripped bacon on 6/18/24, she stated it shouldn't have been. She was also shown the four green peppers that contained what looked like mold (black and white fuzzy areas throughout) had been in there since 6/18/24 she again indicated she would get rid of them.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/23/24 at 6:00 PM Staff B was asked why she handled the ready to eat sandwiches with her bare hands, she indicated she was taught she had to wear gloves while making them. As long as she washed her hands before services and did not leave the service line she could serve the sandwiches with her bare hands. So, she always stays at the service line until all meals are served. To clarify, asked Staff B if she did not have to wear gloves when touching ready to eat food as long as she washed her hands and stayed in the service area. She acknowledged that was accurate.</p> <p>On 6/25/24 at 1:22 PM the DM stated Staff B said something to her about touching ready to eat foods. Staff B told her she had gloves on when she made the sandwiches but did not wear them when she served them. The DM told her she has to wear them when serving ready to eat food or use tongs to serve the item. The DM indicated Staff B has been working at the facility for two years and should have known this. The DM was made aware of Staff A in the dish room completing dirty and clean tasks with the same gloved hands. She stated he should be washing his hands between tasks. Staff C [NAME] added that's why it's nice to have extra people working in the kitchen. They will have one staff member on the dirty side of the dish area and one on the clean side.</p> <p>Review of the Job Description for a cook listed the purpose of this position under general supervision of the Dietary Services Manager, the cook position assures the resident meals and other nourishments are properly prepared/cook and apportioned according to authorized menus and individual care plans, and are served according to established schedules, consistent with regulations and starts of practice. Essential functions include to handle and prepare food in a sanitary manner.</p> <p>The facility provided a document titled Food Receiving and Storage with a revision date of 10/2017 documented foods shall be received and stored in a manner that complies with safe food handling practices.</p> <p>Policy Interpretation and Implementation</p> <p>13. Uncooked and raw animal products and fish will be stored separately in drip-proof containers and below fruits, vegetables and other ready-to-eat foods.</p> <p>The facility provided a document titled Food Storage-Refrigerated Foods, February 2016 edition. The policy statement read, perishable foods shall be refrigerated in a manner which optimizes food safety, nutrient retention and aesthetic quality.</p> <p>The facility provided a document titled Generalized Food Preparation and Service, February 2016 edition. The policy statement read the facility shall provide each resident with foods prepared and served by methods that conserve nutritive value and flavor. The food should also be palatable, attractive and at the proper temperature.</p> <p>Procedure</p> <p>3. Food Storage</p> <p>a. Food is covered/sealed.</p> <p>4. Food Preparation</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>i. Bare hands should never touch ready to eat food directly.</p> <p>5. Food Service</p> <p>f. Never touch food directly with bare hands.</p>

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>37074</p> <p>Based on observations, resident and staff interviews and facility policy review the facility failed to properly dispose of room trays with left-over food in a timely manner. The facility reported a census of 30 residents.</p> <p>Findings include:</p> <p>On 6/20/24 at 11:17 AM Staff S Dietary Aide stated when she comes in after having the weekend off she will find dishes still in resident's room from who knows what meal since she was gone all weekend.</p> <p>On 6/23/24 at 5:53 PM observed on Resident #12 entry table a white plate with a slice of wheat bread on it, bowl with milk in it, biscuit, egg, sausage sandwich on the plate as well. Also observed two drinking glasses, 1 of the glass was 1/2 full of milk. When asked how long those dishes has been there she stated breakfast and lunch. This happens all the time on the weekends, when staff not picking up her dishes. She indicated she went to the dining room this evening for dinner.</p> <p>On 6/27/24 at 3:39 PM observed on Resident #7's bedside table a white plate on top of a plate cover. A set of silverware lying on top of the plate, an empty sour cream packet and a coffee mug on top of the plate. At 4:15 PM the dishes remained on her bedside table. At 4:45 PM the plate, silverware and coffee mug were not on her bedside table.</p> <p>On 7/1/24 at 2:01 PM the Director of Nursing (DON) indicated it's a shared effort when it comes to picking up room trays from resident's rooms; it can either be dietary or nursing staff. They are already looking at the policy a little further and will create an action plan for that. She added some residents will have their meals delivered to their rooms and eat off them for a while. Those trays will get picked up late or left in there. When asked when trays should be removed from resident rooms, she indicated it's at the discretion of the resident, when the meal is completed or when the resident is done eating. There's some gray area in the policy it stated 30 minutes to an hour after the meal is served. When asked what the facility's meals times are she stated breakfast is served at 7:30 AM, lunch is served at 11:45 AM, and supper is served at 5:00 PM.</p> <p>The facility provided a document titled Room Service, February 2016 edition. The policy statement read residents who are unable to come to the dining room or who desire to dine in their own room shall be provided with room service.</p> <p>Procedure:</p> <p>6. Nursing and/or Dietary Services will be responsible for collecting soiled trays in the following manner:</p> <p>d. Collect soiled tray only after the resident has completed meal or indicates the same.</p> <p>8. All soiled trays will be returned to the Dietary Services Department within an hour of completion of the tray.</p>		

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<p>F 0926</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have policies on smoking.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074</p> <p>Based on observations, clinical record review, resident and staff interviews, and facility policy review the facility failed to ensure 2 of 2 residents' (Resident #6 and #7) vape pens were properly stored. The facility also failed to ensure 1 of 2 residents (Resident #7) used her vape pen outside in the designated smoking areas. The facility reported a census of 30 residents.</p> <p>Findings include:</p> <p>1. Review of Resident #6's clinical record revealed no documentation related to him being able to smoke with or without supervision.</p> <p>On 6/18/24 at 11:45 AM observed three vape pens in Resident #6's room on his dresser.</p> <p>On 6/23/24 at 5:32 PM observed Resident #6 outside with staff. Staff were assisting Resident #6 with his vape pen.</p> <p>2. Review of Resident #7's clinical record revealed no documentation related to her being able to smoke with or without supervision. Clinical record revealed Resident #7 was admitted to the facility on [DATE].</p> <p>On 6/18/24 at 11:24 AM Staff D Registered Nurse (RN) stated she has been around vape pens before and knew that's what Resident #7 had in her room. Staff D acknowledged Resident #7 would use her vape pen in her room. She added residents like Resident #7 have told her the pens have THC in the pen. Staff D suggested talking with other nurses and Certified Nursing Assistance (CNAs) about this because a lot of staff knew about the vape pens.</p> <p>On 6/18/24 at 2:25 PM observed Resident #7 lying in bed watching television. She held a red vape pen throughout our conversation, and her room smelt fruity. The resident let me look at the vape pen; at the base of the pen, but the mouth piece is a compartment that contained what appeared to be an oily substance. On the side of the pen is a name Batch. Resident #7 was asked what the red vape pen was for, she stated it was prescribed to her to help with pain management. She indicated it helps her tolerate her sciatic nerve pain. Resident #7 was asked what was in the pen to help manage her pain, she indicated CBD (cannabidiol) and THC (tetrahydrocannabinol). She added a friend brings in the oil cartridge, he brings them in a paper sack. Resident #7 stated that's just so weird that people can bring this stuff out in public and that she is used to smoking it but not through a pen. She stated she is not used to smoking it in public or people bringing it in for her. Resident #7 stated she has a medical card to use it and has been using marijuana since she was [AGE] years old. She again stated it's weird to be smoking it in public like this. She indicated she has had the pen since she came to the facility and it really helps her. Throughout the interview the resident's eyes were glassy and would not maintain eye contact.</p> <p>On 6/20/24 at 1:59 PM Staff J CNA stated she knew Resident #7 had a vape pen in her hand a lot, so she was capable of using it herself.</p> <p>(continued on next page)</p>

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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)		
<p>F 0926</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/25/24 at 1:02 PM during a follow- up interview with Resident #7, she stated the Administrator and DON told her she could have her pen if she got in the mechanical lift, in her wheelchair and went outside off the facility's property. The resident indicated she is unable to do this because of the sores she has on her bottom. She had told them she also had two jars of THC gummies in her night stand. They removed those and her vape pen from her room when a police officer came to the facility.</p> <p>On 7/1/24 at 2:01 PM the DON stated if a resident wishes to smoke, they need to have a smoking evaluation completed. If a resident wished to utilize a vape pen, they would need to go outside with staff members to do so. When asked about Resident #7 and her vape pens, she indicated up until the other day she never went outside to smoke. The first month Resident #7 was in the facility, before the DON started, she had a doctor's appointment in the city. A couple of their CNAs assisted with getting the resident up and apparently Resident #7 took out her vape pen and took a hit off it. After Resident #7 left for her appointment they reported this to the Administrator and the resident was informed she could not vape in the building. The resident apologized and claimed she had gotten rid of the vape pen while at her appointment. The day before the survey started, the DON got a call in the middle of the night that Resident #7 had a THC vape pen and gummies in her room. Resident #7 was provided education about not being able to have those items in the facility. She handed the items over to management staff.</p> <p>The facility provided a document titled Smoking Policy-Residents with a revision date of 7/2017 and a policy statement that read the facility shall establish and maintain safe resident smoking practices.</p> <p>Policy Interpretation and Implementation</p> <ol style="list-style-type: none"> 1. Upon admission, residents shall be informed of the facility smoking policy, including designated smoking areas and the extent to which the facility can accommodate their smoking or non-smoking preferences. 2. If allowed by the facility, smoking is only permitted in designated resident smoking areas, which are located outside of the building. Electronic cigarettes are not permitted inside the facility and in designated areas only. Otherwise, smoking is not allowed inside the facility under any circumstances. 7. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker, the evaluation will include: <ol style="list-style-type: none"> a. Ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation). 8. The staff shall consult with the Attending Physician and the DON to determine if safety restrictions need to be placed on a resident's smoking privileges based on the Safe Smoking Evaluation. 12. Residents who have smoking privileges are not permitted to keep cigarettes, e-cigarettes, pipes, tobacco, and other smoking articles in their possession. Only disposable lighters are permitted. 		