STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165294	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avoca Specialty Care	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)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 37074 Based on clinical record review, facility investigative file review, staff interviews and policy review the facility failed to implement their abuse policies. The facility's staff member with concerns about the treatment of Resident #3 was not reported within two hours of the concerns. The facility also failed to complete a thorough investigation. The facility reported a census of 31 residents. Findings include: According to the quarterly Minimum Data Set (MDS) with a reference date of 2/6/2025, Resident #3 had a Brief Interview of Mental Status (BIMS) score of 12. A BIMS score of 12 indicated no cognitive impairment. The MDS documented she did not deny care during the 7-day review period. The MDS documented she did not have impairments to upper and lower extremities, but utilized a walker and wheelchair for mobility. The resident was dependent on staff for toileting hygiene and required substantial/maximal assistance for toilet transfer. The MDS documented she was frequently incontinent of urine and bowel. The following diagnoses were listed for Resident #1: atrial fibrillation, heart failure, diabetes mellitus, Alzheimer's disease, and non-Alzheimer's dementia. The Clinical Census revealed Resident #3 was discharged from the facility on 4/11/2025. The facility's investigative file contained the following statement from Staff B Licensed Practical Nurse (LPN): -On 2/22/25 (Saturday) I worked the nightshift 10:00 PM-6:00 AM. Staff E Certified Nursing Assistant (CNA) and Staff F CNA were the aides and around 10:30 PM-11:00 PM a resident had her call light on. Staff E heard the call light looked down the hall and stated oh hell no, I am not doing this tonight. When Staff B looked at her, she went down and answered the call light. Both CNAs would leave call lights go for long periods of time, while sitting at the desk talking. Staff B stated she watched and waited to see when rounds were going to be done, rounds were not done until 3-3:30 AM. The was the only time rounds were done, hospice residents were not turned, ice waters were not passed out to the residents, nor were linens. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 2/23/25 (Sunday) I again worked the night shift 10:00 PM-6:00 AM with Staff E and F. They again were reluctant to answer call lights. The call lights would stay on for more than 5 minutes, while the CNAs sat at the desk talking. A resident had started to open her door and both CNAs yelled from the desk for the resident to lay back down and go to sleep, while pointing into the resident's room, this happened at least two times. A different resident came out of his room in his wheelchair and Staff F grabbed the resident's wheelchair and stated he had to go back to bed. The resident was taken to his room and placed back in bed. Rounds were again started at 3:00 AM and that was the only time rounds were done. Staff B stated she went into Resident #3's roommate's room to do a pre-assessment on the dialysis patient. Resident #3 was sitting up on the side of the bed. She stated she was exercising and was asked if she needed to go to the bathroom. She stated yes and this nurse pulled the call light for the resident. As she was completing the assessment on Resident #3 roommate, Staff E and Staff F came into the room and asked the resident what she was doing, the resident stated she was exercising, both aides started laughing loudly in a condescending manner, and said sure you are. Staff B told the aides that the resident needed to go to the bathroom. The EZ stand (mechanical lift) was brought in to the room and both aides were rude. They stated if she had to go to the bathroom she would need to use the lift. The resident kept stating she did not need to use the lift and that she had gone to the bathroom three other times during the night, by herself. Staff B stated both aides were talking in a manner to which she would not want her loved one being talked to. Resident #3 got more upset and aggressive towards the aides and the aides were telling Resident #3 that they could not take her to the bathroom without the lift but the resident stated she was not going to use the lift. The aides lifted the resident's legs back in to bed and stated then you aren't going to go to the bathroom. The aides did ask Staff B to help them talk to her but she stated that they had already made her mad, she would not listen to her and the resident stated no she wasn't. The statement was signed by Staff B on 2/25/2025 (Tuesday). During an email correspondent with the State Agency's Complaint Intake Specialist on 5/13/2025 at 10:06 AM, she provided the facility initially reported the concern to the State Agency on 2/25/2025 at 5:01 PM. On 5/13/2025 at 2:09 PM Staff B stated the weekend in question in February, she reported her concerns to Staff H Registered Nurse (RN) that worked the day shift that weekend. She was not sure if Staff H had reported these concerns to anyone. Staff B stated she had Monday, 2/24/25 off but the next day she said something to the Director of Nursing (DON). When asked if the facility had an abuse coordinator to report abuse concerns to, she stated she was not sure. The DON was just starting in the facility. They usually have something written down to indicate who is on call, but does not recall if they had done that that weekend. She alleged the concerns took place that Sunday in to Monday morning about 4:30/5:00 AM. Staff B stated she did not know who to call at the time of her concerns, but acknowledged she should have called someone. She thought Staff H would tell Staff G previous Administrator. Staff B stated when she came to work on 2/25/2025 she provided her statement and was written up for not reporting her concerns sooner. On 5/14/2025 at 12:42 PM an attempt to contact Staff H was made; there was no answer, a voicemail was left and a text message was sent. At the conclusion of the investigation there was no return call. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/2025 at 4:23 PM the DON stated Staff B gave her written statement the same day she reported her concerns on 2/25/2025. The DON acknowledged it was not timely reporting on Staff B's part and she was educated on reporting concerns immediately. When asked who Staff B should have reported her concerns to, the DON stated she should have reported them to the Administrator and/or DON right away. She added they have their phone numbers posted at the nurse's station. The facility provided a document titled Abuse, Neglect, Exploitation, or Misappropriation-Reporting and Investigating, with a revision date of April 2021, documented all reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, federal agencies, and thoroughly investigated by facility management, findings of all investigations are documented and reported. Reporting Allegations to the Administrator and Authorities: 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to the state law. 3.Immediately is defined as within two hours of an allegation involving abuse. Review of the facility's investigative file included a page of resident questions that was filled out by various staff members. Question #6 asked Do you have any type of mistreatment to report to me now? The Social Worker documented the following information that was provided by Resident #3: I was abused, left hanging on the side of my bed. It was in the middle of the night. I was told by the aide I will not be helping you. I sat there for 2 hours. It caused me great pain. I've never been physically abused. The investigative file lacked any follow up with Resident #3 about her response to question #6. Resident #3's roommate was asked the same question but the file failed to include an interview with the roommate pertaining to the morning in question. The investigative file included interviews with the following staff members: Staff B, Staff E and Staff F. The investigative file failed to include interviews with staff members that took care of the resident on all shifts after the alleged incident occurred as well as no interview with Staff H Registered Nurse (RN) The investigative file also lacked any follow up interview(s) with Resident #3 after the alleged incident to check on her psycho-social status. On 5/13/2025 at 2:09 PM Staff B stated the weekend in question in February, she reported her concerns to Staff H that worked the day shift that weekend. She was not sure if Staff H had reported these concerns to anyone. On 5/14/2025 at 12:42 PM an attempt to contact Staff H was made; there was no answer, a voicemail was left and a text message was sent. At the conclusion of the investigation there was no return call. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/16/2025 at 10:48 AM the Social Worker acknowledged she interviewed Resident #3 using the resident questions sheet. When asked what she did with the information after her interview, she stated she gave her interview sheets to the DON. She indicated she did not ask further questions and could not remember if other residents had concerns in regards to the care they received. She would not have asked further questions with Resident #3 because she did not like upsetting her. When asked if the DON said anything when she handed her Resident #3's responses she stated she just handed her the paper and the DON said thank you. On 5/16/2025 at 11:20 AM the DON was read Resident #3's response to the questionnaire completed by the Social Worker. She was asked if she followed up with Resident #3 after the Social Worker had completed her questionnaire with her. The DON denied being aware of that statement. Those concerns should have been reported to her and another investigation should have been started. If they were reported to her, she would have found out more information. The DON indicated she followed up with Resident #3 after the alleged incident to see how she was doing, she checked on her a lot but did not document it anywhere. When she followed up with her the resident was fine, some days she was confused others she was not. When asked if the Social Worker could have followed up with Resident #3 she stated oh absolutely. When asked why the roommate was not asked questions specific to the alleged incident, she stated she should have been asked questions. She acknowledged Staff H was not interviewed. Investigating allegations: 1. All allegations are thoroughly investigated. The Administrator initiates investigations. 7. The individual conducting the investigation as a minimum: e. interviews any witnesses to the incident; f. interviews the resident; h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; i. interviews the resident's roommate l. documents the investigation completely and thoroughly. The facility provided a document titled Protection of Residents During Abuse Investigations, with a revision date of April 2021, documented the victim is evaluated for his or her feelings of safety.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 37074 Based on record review, facility investigative file review, staff interviews and policy review the facility failed to report concerns about the treatment of Resident #3 within two hours of the alleged concerns observed. The facility reported a census of 31 residents. Findings include: According to the quarterly Minimum Data Set (MDS) with a reference date of 2/6/2025, Resident #3 had a Brief Interview of Mental Status (BIMS) score of 12. A BIMS score of 12 indicated no cognitive impairment. The MDS documented she did not deny care during the 7-day review period. The MDS documented she did not have impairments to upper and lower extremities, but utilized a walker and wheelchair for mobility. The resident was dependent on staff for toileting hygiene and required substantial/maximal assistance for toilet transfer. The MDS documented she was frequently incontinent of urine and bowel. The following diagnoses were listed for Resident #1: atrial fibrillation, heart failure, diabetes mellitus, Alzheimer's disease, and non-Alzheimer's dementia. The Clinical Census revealed Resident #3 was discharged from the facility on 4/11/2025. The facility's investigative file contained the following statement from Staff B Licensed Practical Nurse (LPN): -On 2/22/25 (Saturday) I worked the nightshift 10:00 PM-6:00 AM. Staff E Certified Nursing Assistant (CNA) and Staff F CNA were the aides and around 10:30 PM-11:00 PM a resident had her call light on. Staff E heard the call light looked down the hall and stated oh hell no, I am not doing this tonight. When Staff B looked at her, she went down and answered the call light. Both CNAs would leave call lights go for long periods of time, while sitting at the desk talking. Staff B stated she watched and waited to see when rounds were going to be done, rounds were not done until 3-3:30 AM. The was the only time rounds were done, hospice residents were not turned, ice waters were not passed out to the residents, nor were linens. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 2/23/25 (Sunday) I again worked the night shift 10:00 PM-6:00 AM with Staff E and F. They again were reluctant to answer call lights. The call lights would stay on for more than 5 minutes, while the CNAs sat at the desk talking. A resident had started to open her door and both CNAs yelled from the desk for the resident to lay back down and go to sleep, while pointing into the resident's room, this happened at least two times. A different resident came out of his room in his wheelchair and Staff F grabbed the resident's wheelchair and stated he had to go back to bed. The resident was taken to his room and placed back in bed. Rounds were again started at 3:00 AM and that was the only time rounds were done. Staff B stated she went into Resident #3's roommate's room to do a pre-assessment on the dialysis patient. Resident #3 was sitting up on the side of the bed. She stated she was exercising and was asked if she needed to go to the bathroom. She stated yes and this nurse pulled the call light for the resident. As she was completing the assessment on Resident #3 roommate, Staff E and Staff F came into the room and asked the resident what she was doing, the resident stated she was exercising, both aides started laughing loudly in a condescending manner, and said sure you are. Staff B told the aides that the resident needed to go to the bathroom. The EZ stand (mechanical lift) was brought in to the room and both aides were rude. They stated if she had to go to the bathroom she would need to use the lift. The resident kept stating she did not need to use the lift and that she had gone to the bathroom three other times during the night, by herself. Staff B stated both aides were talking in a manner to which she would not want her loved one being talked to. Resident #3 got more upset and aggressive towards the aides and the aides were telling Resident #3 that they could not take her to the bathroom without the lift but the resident stated she was not going to use the lift. The aides lifted the resident's legs back in to bed and stated then you aren't going to go to the bathroom. The aides did ask Staff B to help them talk to her but she stated that they had already made her mad, she would not listen to her and the resident stated no she wasn't. The statement was signed by Staff B on 2/25/2025 (Tuesday). During an email correspondent with the State Agency's Complaint Intake Specialist on 5/13/2025 at 10:06 AM, she provided the facility initially reported the concern to the State Agency on 2/25/2025 at 5:01 PM. On 5/13/2025 at 2:09 PM Staff B stated the weekend in question in February, she reported her concerns to Staff H Registered Nurse (RN) that worked the day shift that weekend. She was not sure if Staff H had reported these concerns to anyone. Staff B stated she had Monday, 2/24/25 off but the next day she said something to the Director of Nursing (DON). When asked if the facility had an abuse coordinator to report abuse concerns to, she stated she was not sure. The DON was just starting in the facility. They usually have something written down to indicate who is on call, but does not recall if they had done that, that weekend. She alleged the concerns took place that Sunday into Monday morning about 4:30/5:00 AM. Staff B stated she did not know who to call at the time of her concerns, but acknowledged she should have called someone. She thought Staff H would tell Staff G the previous Administrator. Staff B stated when she came to work on 2/25/2025 she provided her statement and was written up for not reporting her concerns sooner. On 5/14/2025 at 12:42 PM an attempt to contact Staff H was made; there was no answer, a voicemail was left and a text message was sent. At the conclusion of the investigation there was no return call. On 5/14/2025 at 2:54 PM Staff G indicated he reported the concerns to the State Agency he believed immediately. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/2025 at 4:23 PM the DON stated Staff B gave her written statement the same day she reported her concerns on 2/25/2025. The DON acknowledged it was not timely reporting on Staff B's part and she was educated on reporting concerns immediately. When asked who Staff B should have reported her concerns to, the DON stated she should have reported them to the Administrator and/or DON right away. She added they have their phone numbers posted at the nurse's station. The facility provided a document titled Abuse, Neglect, Exploitation, or Misappropriation-Reporting and Investigating, with a revision date of April 2021, documented all reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, federal agencies, and thoroughly investigated by facility management, findings of all investigations are documented and reported. Reporting Allegations to the Administrator and Authorities: 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to the state law. 3.Immediately is defined as within two hours of an allegation involving abuse.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 37074 Based on record review, facility investigative file review, staff interviews and policy review the facility failed to complete a thorough investigation. The facility reported a census of 31 residents. Findings include: According to the quarterly Minimum Data Set (MDS) with a reference date of 2/6/2025, Resident #3 had a Brief Interview of Mental Status (BIMS) score of 12. A BIMS score of 12 indicated no cognitive impairment. The MDS documented she did not deny care during the 7-day review period. The MDS documented she did not have impairments to upper and lower extremities, but utilized a walker and wheelchair for mobility. The resident was dependent on staff for toileting hygiene and required substantial/maximal assistance for toilet transfer. The MDS documented she was frequently incontinent of urine and bowel. The following diagnoses were listed for Resident #1: atrial fibrillation, heart failure, diabetes mellitus, Alzheimer's disease, and non-Alzheimer's dementia. Record review revealed Resident #3 was discharged from the facility on 4/11/2025. The facility's investigative file contained the following statement from Staff B Licensed Practical Nurse (LPN): -On 2/22/25 (Saturday) I worked the nightshift 10:00 PM-6:00 AM. Staff E Certified Nursing Assistant (CNA) and Staff F CNA were the aides and around 10:30 PM-11:00 PM a resident had her call light on. Staff E heard the call light looked down the hall and stated oh hell no, I am not doing this tonight. When Staff B looked at her, she went down and answered the call light. Both CNAs would leave call lights go for long periods of time, while sitting at the desk talking. Staff B stated she watched and waited to see when rounds were going to be done, rounds were not done until 3-3:30 AM. The was the only time rounds were done, hospice residents were not turned, ice waters were not passed out to the residents, nor were linens. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 2/23/25 (Sunday) I again worked the night shift 10:00 PM-6:00 AM with Staff E and F. They again were reluctant to answer call lights. The call lights would stay on for more than 5 minutes, while the CNAs sat at the desk talking. A resident had started to open her door and both CNAs yelled from the desk for the resident to lay back down and go to sleep, while pointing into the resident's room, this happened at least two times. A different resident came out of his room in his wheelchair and Staff F grabbed the resident's wheelchair and stated he had to go back to bed. The resident was taken to his room and placed back in bed. Rounds were again started at 3:00 AM and that was the only time rounds were done. Staff B stated she went into Resident #3's roommate's room to do a pre-assessment on the dialysis patient. Resident #3 was sitting up on the side of the bed. She stated she was exercising and was asked if she needed to go to the bathroom. She stated yes and this nurse pulled the call light for the resident. As she was completing the assessment on Resident #3 roommate, Staff E and Staff F came into the room and asked the resident what she was doing, the resident stated she was exercising, both aides started laughing loudly in a condescending manner, and said sure you are. Staff B told the aides that the resident needed to go to the bathroom. The EZ stand (mechanical lift) was brought in to the room and both aides were rude. They stated if she had to go to the bathroom she would need to use the lift. The resident kept stating she did not need to use the lift and that she had gone to the bathroom three other times during the night, by herself. Staff B stated both aides were talking in a manner to which she would not want her loved one being talked to. Resident #3 got more upset and aggressive towards the aides and the aides were telling Resident #3 that they could not take her to the bathroom without the lift but the resident stated she was not going to use the lift. The aides lifted the resident's legs back in to bed and stated then you aren't going to go to the bathroom. The aides did ask Staff B to help them talk to her but she stated that they had already made her mad, she would not listen to her and the resident stated no she wasn't. The statement was signed by Staff B on 2/25/2025 (Tuesday). Review of the facility's investigative file included a page of resident questions that was filled out by various staff members. Question #6 asked Do you have any type of mistreatment to report to me now? The Social Worker documented the following information that was provided by Resident #3: I was abused, left hanging on the side of my bed. It was in the middle of the night. I was told by the aide I will not be helping you. I sat there for 2 hours. It caused me great pain. I've never been physically abused. The investigative file lacked any follow up with Resident #3 about her response to question #6. Resident #3's roommate was asked the same question but the file failed to include an interview with the roommate pertaining to the morning in question. The investigative file included interviews with the following staff members: Staff B, Staff E and Staff F. The investigative file failed to include interviews with staff members that took care of the resident on all shifts after the alleged incident occurred as well as no interview with Staff H Registered Nurse (RN). The investigative file also lacked any follow up interview(s) with Resident #3 after the alleged incident to check on her psycho-social status. On 5/13/2025 at 2:09 PM Staff B stated the weekend in question in February, she reported her concerns to Staff H that worked the day shift that weekend. She was not sure if Staff H had reported these concerns to anyone. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/2025 at 12:42 PM an attempt to contact Staff H was made; there was no answer, a voicemail was left and a text message was sent. At the conclusion of the investigation there was no return call. On 5/16/2025 at 10:48 AM the Social Worker acknowledged she interviewed Resident #3 using the resident questions sheet. When asked what she did with the information after her interview, she stated she gave her interview sheets to the DON. She indicated she did not ask further questions and could not remember if other residents had concerns in regards to the care they received. She would not have asked further questions with Resident #3 because she did not like upsetting her. When asked if the DON said anything when she handed her Resident #3's responses she stated she just handed her the paper and the DON said thank you. On 5/16/2025 at 11:20 AM the DON was read Resident #3's response to the questionnaire completed by the Social Worker. She was asked if she followed up with Resident #3 after the Social Worker had completed her questionnaire with her. The DON denied being aware of that statement. Those concerns should have been reported to her and another investigation should have been started. If they were reported to her, she would have found out more information. The DON indicated she followed up with Resident #3 after the alleged incident to see how she was doing, she checked on her a lot but did not document it anywhere. When she followed up with her the resident was fine, some days she was confused others she was not. When asked if the Social Worker could have followed up with Resident #3 she stated oh absolutely. When asked why the roommate was not asked questions specific to the alleged incident, she stated she should have been asked questions. She acknowledged Staff H was not interviewed. The facility provided a document titled Abuse, Neglect, Exploitation, or Misappropriation-Reporting and Investigating, with a revision date of April 2021, documented investigating allegations: 1. All allegations are thoroughly investigated. The Administrator initiates investigations. 7. The individual conducting the investigation as a minimum: e. interviews any witnesses to the incident; f. interviews the resident; h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; i. interviews the resident's roommate l. documents the investigation completely and thoroughly.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 37074 Based on clinical record review, staff interviews and policy review the facility failed to ensure 1 of 9 resident's care plans (Resident #3) was revised once her transfer assistance requirement was changed to the use of a mechanical lift. The facility reported a census of 31 residents. Findings include: According to the quarterly Minimum Data Set (MDS) with a reference date of 2/6/2025, Resident #3 had a Brief Interview of Mental Status (BIMS) score of 12. A BIMS score of 12 indicated no cognitive impairment. The MDS documented she did not deny care during the 7-day review period. The MDS documented she did not have impairments to upper and lower extremities, but utilized a walker and wheelchair for mobility. The resident was dependent on staff for toileting hygiene and required substantial/maximal assistance for toilet transfer. The MDS documented she was frequently incontinent of urine and bowel. The following diagnoses were listed for Resident #1: atrial fibrillation, heart failure, diabetes mellitus, Alzheimer's disease, and non-Alzheimer's dementia. The Care Plan Focus Area titled Activities of Daily Living (ADLs) with an initiated date of 11/25/2024 documented Resident #3 required substantial assistance of two staff for transfers, ambulation, mobility and toileting. The Care Plan lacked documentation for the use of an EZ stand for transfers. Review of Resident #3's visual/bedside Kardex Report documented she required substantial assistance of two staff for toileting, transfers, mobility and ambulation. On 5/13/2025 at 2:09 PM Staff B Licensed Practical Nurse (LPN) stated in February 2025 Staff E Certified Nursing Assistant (CNA) and Staff F CNA had attempted to assist Resident #3 to the restroom. When they advised her, they needed to get the EZ-Stand (mechanical lift to assist a resident to a sitting position) the resident refused to allow this. On 5/14/2025 at 3:55 PM Staff F stated Resident #3 had put her call light on, when her and Staff E went in her room she was attempting to get up and walk. They reminded her they needed to use the EZ stand to assist her to the bathroom. Staff F stated Resident #3 used to be assisted with two staff, a gaitbelt and walker but she got weak. When asked if she used the care plans when assisting residents, she stated they are never updated so they would have to talk with physical therapy for guidance. On 5/14/2025 at 2:10 PM Staff E stated in February Resident #3 was being combative and hanging off the side of her bed. She was not able to get up on her own, she required the use of an EZ stand for transfers. The previous shift indicated she was using the lift without issues. She tried to explain to the resident that it was their policy that if they required a lift for transfers, they could not, not use it. Staff E stated they had been using the mechanical lift with Resident #3 for about a week or two. She added at times they would use a Hoyer left then were able to downgrade to an EZ stand but the resident did not like the way the straps were positioned. When asked how they were made aware to use the lift, she indicated the staff on the evening shift let them know. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165294	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avoca Specialty Care	610 East York Street Avoca, IA 51521

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/2025 at 4:23 PM the Director of Nursing (DON) stated Resident #3 required the use of an EZ stand for transfers or she may have been an assistance of two staff. She knew the resident did not like to use the EZ stand. During a follow-up interview on 5/16/2025 at 11:20 AM she stated the MDS Coordinator completes the main portion of the care plans. If she is not working, anyone can update them as needed. When asked what staff use when caring for the residents, she stated they can use the Kardex, can be pulled up in the resident's Electronic Health Record (EHR), and updated as necessary. Care plans should be updated as needed (PRN), checked quarterly and annually with care conferences. When she was informed that Resident #3's care plan did not reflect the use of an EZ stand for transfers, she stated oh. The facility provided a document titled Care Plans, Comprehensive Person-Centered, with a revision date of December 2016, indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychological and functional needs is developed and implemented for each resident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37074 Based on observations, clinical record review, resident council notes, grievances, staff and resident interviews, and facility policy review, the facility failed to ensure residents received baths twice a week or per their requested amount a week for 6 of 6 residents reviewed (Resident #2, #4, #5, #6, #7, and #8). The facility also failed to offer toileting assistance for 2 of 4 resident reviewed (Resident #5 and #8). The facility reported a census of 31 residents. Findings include: 1. According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of 3/21/2025, documented Resident #2 had severely impaired cognitive skills for daily decision making. The MDS documented she required partial/moderate assistance for toileting hygiene, lower body dressing, personal hygiene and toilet transferring. In the bathing section not applicable was documented. The following diagnoses were documented for Resident #2: dementia, hyperlipidemia, dementia, malnutrition, and depression. The Care Plan Focus Area Activities of Daily Living (ADLs), with an initiation date of 10/5/2023 documented she required moderate assistance of one staff for bathing. At times she does refuse. Review of Resident #2's shower/bath documentation from 2/1/2025 until 5/15/2025 revealed she was to receive a shower or bath on Mondays and Thursdays during the day shift. The documentation revealed the following: 2/3/2025-resident refused 2/10/2025-not applicable 2/13/2025-not applicable 2/16/2025-she received a bath 2/17/2025-she received a bath 2/24/2025-not applicable 2/27/2025-she received a bath The February bathing record revealed a bath was not documented as being offered from 2/3/2025 to 2/10/2025 and 2/17/2025 to 2/24/2025. The record also revealed she was not offered a bath after she refused or after not applicable was documented. 3/13/2025-resident refused 3/17/2025- she received a bath (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165294	A. Building B. Wing	05/16/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/24/2025-not applicable 3/25/2025 resident received a bath 3/27/2025-resident refused 3/31/2025-resident refused The March bathing record revealed a bath was not documented as being offered from 2/27/2025 to 3/13/2025, 3/17/2025 to 3/24/2025. The record also revealed she was not offered a bath after she refused or after not applicable was documented. 4/7/2025-not applicable 4/10/2025-she received a bath 4/14/2025-not applicable 4/17/2025-not applicable 4/24/2025- she received a bath 4/28/2025-resident refused 4/29/2025-she received a bath The April bathing record revealed a bath was not documented as being offered between 4/17/2025 to 4/24/2025. The record also revealed she was not offered a bath after she refused or after not applicable was documented, with the exception of when she received a bath on 4/29/2025. 5/1/2025-not applicable 5/8/2025-not applicable 5/10/2025-she received a bath 5/14/2025-she received a bath 5/15/2025-not applicable The May bathing record revealed a bath was not documented as being offered between 5/1/2025 to 5/8/2025. (continued on next page)

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	165294	A. Building B. Wing	05/16/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. According to the significant change MDS assessment tool with a reference date of 3/6/20205 Resident #4 had a BIMS score of 11. A BIMS score of 11 suggested moderate cognitive impairment. The MDS documented she was dependent on staff for toileting hygiene and personal hygiene. In the bathing section not applicable was documented. The following diagnoses were documented for Resident #4: debility, Chronic Obstructive Pulmonary Disease (COPD), atrial fibrillation, Alzheimer's, dementia, anxiety, and depression. The Care Plan Focus Area ADLs with initiation date of 10/9/2023 documented she required the assistance of 1 staff for bathing. The Care Plan documented she will refuse her baths multiple times in a row. She has been educated multiple times regarding the importance of good hygiene. She will state I don't care, just leave me alone. Record review revealed the resident was discharged from the facility on 3/16/2025. Review of Resident #4's bath/shower documentation from 2/1/2025 through her discharge date of [DATE] revealed she was to receive a bath/shower on Wednesdays and Saturdays day shift. The documentation revealed the following: 2/1/2025-resident refused 2/8/2025-resident refused 2/12/2025-resident refused 2/15/2025-resident refused 2/19/2025-resident refused 2/22/2025-resident refused The February bathing record revealed a bath was not documented as being offered between 2/1/2025 to 2/8/2025 and 2/22/2025 to 2/28/2025. The record also revealed she was not offered a bath after she refused a bath. The resident did not receive a bath in February. 3/1/2025-resident refused 3/8/2025-resident refused 3/12/2025-resident refused The March bathing record revealed a bath was not documented as being offered between 3/1/2025 to 3/8/2025 and 3/12/2025 to her discharge date of [DATE]. The record also revealed she was not offered a bath after she refused a bath. The resident did not receive a bath in March. (continued on next page)

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	165294	A. Building B. Wing	05/16/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. According to the quarterly MDS assessment tool with a reference date of 5/9/2025 documented Resident #5 had a Brief Interview of BIMS score of 15. A BIMS score of 15 suggested no cognitive impairment. The MDS documented Resident #5 did not refuse evaluations or care during the 7-day review period. The MDS documented Resident #5 had no lower or upper extremity impairments and utilized a wheelchair. Resident #7 was dependent on staff to shower or bathe and upper body dressing. The MDS documented the following diagnoses: cerebrovascular disease, anemia, neurogenic bladder, obstructive uropathy, diabetes mellitus, aphasia, anxiety, depression, schizophrenia, morbid obesity, and stroke. The Care Plan Focus Area with an initiation date of 10/9/2023 documented he was dependent on one staff for bathing, upper body dressing and required substantial assistance of two staff for lower body dressing. Review of Resident #5 bath/shower documentation from 2/1/2025 through 5/15/2025 revealed he was to receive a bath/shower on Tuesdays and Fridays day shift. The documentation revealed the following: 2/14/2025-resident refused 2/16/2025-he received a bath 2/18/2025-he received a bath 2/21/2025-resident refused 2/25/2025-he received a bath The February bathing record revealed a bath was not documented as being offered from 2/1/2025 to 2/14/2025 and on 2/28/2025 his bath day. The record also revealed he was not offered a bath after he refused. 3/18/2025-resident refused 3/21/2025-not applicable 3/28/2025-he received a bath The March bathing record revealed a bath was not documented as being offered from 3/1/2025 to 3/18/2025, 3/21/2025 to 3/28/2025. The record also revealed he was not offered a bath after he refused a bath or after not applicable was documented. 4/8/2025-he received a bath 4/11/2025-not applicable 4/15/2025-he received a bath 4/29/2025-not applicable (continued on next page)

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	165294	A. Building B. Wing	05/16/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The April bathing record reviewed a bath was not documented as being offered between 4/1/2025 to 4/8/2025, 4/15/2025 to 4/29/2025. The record also revealed he was not offered a bath after he refused a bath or after not applicable was documented. 5/2/2025-not applicable 5/7/2025-he received a bath The May bathing record reviewed a bath was not documented as being offered between on 5/6/2025 and from 5/7/2025 to 5/15/2025. The record also revealed he was not offered a bath after not applicable was documented. On 5/15/2025 at 10:37 AM Resident #5 was lying in bed. His finger nails were long, his nails were passed his fingertips. Some of his finger nails were dirty with brown/black debris in his nail beds. When asked how often he received a bath he indicated once a month. He added his last bath was this previous Friday. This was not his choice as he preferred to receive a bath once a week. Resident #5 stated he would like his bath more often. When asked if the facility trims his fingernails he indicated they are supposed to trim them but the podiatrist will trim his toe nails every 3 months. Resident #5 added he will tell staff when his nails need to be trimmed. He stated when they are short staffed he will not get his bath. He added that if they don't have both of the slings they use for his bath cleaned they will not bathe him. When they bathe him they leave one lift under him. After his bath is done, they will put a clean and dry sling under him to get him dressed and ready. If that second sling is not available then he will not get a bath. He added when they are short staffed call lights can take 10 minutes to 1 hour, but not certain how often has happened. At night it seems to be bad. He uses a bedpan to have a bowel movement and when a he has to wait up to an hour for them to answer his call light, he will have an accident. When this happens, Resident #5 stated this makes him feel uncomfortable. Once staff come to his room and notice he had an accident they will ask why he didn't say something. He would tell them he had his call light on for help. Response time all depends on who is working. At 11:09 AM Staff I Certified Nursing Assistant, Staff J non-Certified Nursing Assistant (NA), and Staff B Licensed Practical Nurse (LPN) assisted Resident #5 with getting dressed and transferred to this wheelchair. When Staff I and Staff J removed his sheets and provided cares a strong odor was present. 4. According to the quarterly MDS assessment tool with a reference date of 3/7/2025, Resident #6 had a BIMS score of 15. A BIMS score of 15 suggested no cognitive impairment. In the bathing section not applicable was documented. The following diagnoses were documented for Resident #6: heart failure, aphasia, stroke, seizure disorder, depression, schizophrenia, and atrial fibrillation. The Care Plan Focus Area titled ADL's with an initiation date of 5/17/2024, documented Resident #6 was dependent on one staff member for bathing. Review of Resident #6 bath/shower documentation from 2/1/2025 through 5/15/2025 revealed he was to receive a bath/shower on Wednesdays and Saturdays. The documentation revealed the following: 2/8/2025-he received a bath 2/12/2025-he received a bath (continued on next page)

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	165294	A. Building B. Wing	05/16/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/15/2025-he received a bath 2/22/2025-he received a bath 2/27/2025-he received a bath The February bathing record revealed a bath was not documented as being offered from 2/1/2025-2/8/2025 and 2/15/2025 to 2/22/2025. 3/1/2025-resident refused 3/8/2025-resident refused 3/12/2025-he received a bath 3/19/2025-he received a bath 3/27/2025-he received a bath The March bathing record revealed a bath was not documented as being offered from 3/1/2025 to 3/8/2025, 3/12/2025 to 3/19/2025, and 3/19/2025 to 3/27/2025. The record also revealed he was not offered a bath after he refused a bath. 4/2/2025-he received a bath 4/9/2025-he received a bath 4/24/2025-he received a bath 4/26/2025-he received a bath The April bathing record reviewed a bath was not documented as being offered between 4/2/2025 to 4/9/2025, 4/9/2025 to 4/26/2025 and 4/26/2025 to 4/30/25. 5/1/2025-he received a bath 5/7/2025-not applicable 5/10/2025-he received a bath 5/14/2025-he received a bath The May bathing record reviewed a bath was not documented as being offered between on 5/1/2025 and from 5/7/2025 to 5/15/2025. The record also revealed he was not offered a bath after not applicable was documented. (continued on next page)

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	165294	A. Building B. Wing	05/16/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. According to the quarterly MDS assessment tool with a reference date of 3/14/2025 documented Resident #7 had a BIMS score of 15. A BIMS score of 15 suggested no cognitive impairment. The MDS documented not applicable in the shower/bathe self-portion of the assessment. The resident was dependent on staff for upper and lower body dressing. The following diagnoses were listed for Resident #7: right ankle contracture, malnutrition, and depression. The Care Plan Focus Area with an initiation date of 10/11/2023 documented Resident #7 required moderate assistance of one staff for bathing. Review of Resident #7 bath/shower documentation from 2/1/2025 through 5/15/2025 revealed she was to receive a bath/shower on Wednesdays and Saturdays day shift. The documentation revealed the following: 2/9/2025-resident received a bath 2/12/2025-resident received a bath 2/19/2025-resident received a bath 2/22/2025-resident received a bath 2/26/2025-resident received a bath The February bathing record revealed a bath was not documented as being offered from 2/1/2025 to 2/9/2025 and 2/12/2025 to 2/19/2025. 3/1/2025-resident refused 3/8/2025-resident refused 3/19/2025-resident received a bath 3/22/2025-resident received a bath 3/26/2025-resident received a bath 3/29/2025-resident received a bath The March bathing record revealed a bath was not documented as being offered from 3/1/2025 to 3/8/2025, 3/8/2025 to 3/19/2025. The record also revealed he was not offered a bath after she refused a bath. 4/9/2025-resident received a bath 4/12/2025-not applicable 4/25/2025-resident refused (continued on next page)

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	165294	A. Building B. Wing	05/16/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The April bathing record reviewed a bath was not documented as being offered between 4/1/2025 to 4/9/2025, 4/12/2025 to 4/25/2025, and 4/25/2025 to 4/30/2025. The record also revealed she was not offered a bath after he refused a bath or after not applicable was documented. 5/1/2025-resident refused 5/7/2025-not applicable 5/8/2025-resident received a bath 5/10/2025-resident refused 5/14/2025-resident refused The May bathing record reviewed a bath was not documented as being offered between on 5/1/2025 to 5/7/2025. The record also revealed she was not offered a bath after not applicable was documented. On 5/14/2025 at 11:04 AM observed the resident lying in bed, resting. Resident #7 indicated she is supposed to get a bath on Wednesdays and Saturdays but lately she has been getting a bath once a week. She has not received a bath yet today. She would preferred to be offered a bath between 10:00 AM and 6:00 PM; she does not like to have a bath earlier than 10:00 AM. She stated there was one month where she did not receive a bath for 3 weeks and she shared that was disappointing to her. She denied being offered wash clothes to freshen up when this happened. She would like to have more baths. 6. According to the quarterly MDS assessment tool with a reference date of 4/11/2025, Resident #8 had a BIMS score of 15. A BIMS of 15 suggested no cognitive impairment. The MDS documented he had an impairment on one side of his lower extremity and utilized a wheelchair. Resident #8 required partial/moderate assistance with upper body dressing, was dependent of staff for lower body dressing and required substantial/maximal assistance with personal hygiene. The MDS documented a toilet transfer was not attempted due to his medical condition. Resident #8 was occasionally incontinent of urine and frequently incontinent of bowel. The MDS documented the following diagnoses for the resident: diabetes mellitus, anemia, depression, weakness, insomnia, and left below the knee amputation. The Care Plan Focus Area with an initiation date of 1/8/2025 documented he required substantial assistance of one staff for bathing and moderate assistance of one staff for upper and lower body dressing. Review of Resident #8 bath/shower documentation from 2/1/2025 through 5/15/2025 revealed he was to receive a bath/shower on Mondays and Thursdays. The documentation revealed the following: 2/3/2025-received a bath 2/10/2025-not applicable 2/13/2025-not applicable 2/17/2025-received a bath (continued on next page)

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	165294	A. Building B. Wing	05/16/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/24/2025-not applicable 2/27/2025--resident refused The February bathing record revealed a bath was not documented as being offered from 2/3/2025 to 2/10/2025 and 2/17/2025 to 2/24/2025. The record also revealed he was not offered a bath after he refused and not offered a bath after not applicable was documented. 3/13/2025-resident refused 3/24/2025-not applicable 3/27/2025--resident refused 3/31/2025-not applicable The March bathing record revealed a bath was not documented as being offered from 3/1/2025 to 3/13/2025 and 3/13/2025 to 3/24/2025. The record also revealed he was not offered a bath after he refused a bath or after not applicable was documented. Resident #8 did not receive a bath in March. 4/7/2025-not applicable 4/10/2025-resident refused 4/14/2025-received a bath 4/17/2025-not applicable 4/28/2025-received a bath The April bathing record reviewed a bath was not documented as being offered between 4/1/2025 to 4/7/2025, 4/17/2025 to 4/28/2025. The record also revealed he was not offered a bath after he refused a bath or after not applicable was documented. 5/1/2025-resident refused 5/8/2025-not applicable The May bathing record reviewed a bath was not documented as being offered between on 5/1/2025 to 5/8/2025 and from 5/8/2025 to 5/15/2025. The record also revealed he was not offered a bath after not applicable was documented. The resident had not received a bath in the first 15 days of May. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/14/2025 at 11:28 AM observed Resident #8 sitting in his wheelchair in his room, playing a game on his phone. He stated he is supposed to get a bath two times a week but at times he will only get one a week for a month. He required a mechanical lift to a chair, then uses a slide board to get in the shower chair. Once staff realize the process they will run off and he will not hear back from them on why he did not receive a bath. He indicated there are two staff members that will give him his bath. If they don't have enough staff members they will skip over his bath. Resident #8 stated he has not had a shower in two weeks. Resident #8 stated the wait time for help depends on how many staff members are working. He has had to wait 45 minutes during the day shift when the have two CNAs on the floor. Resident #8 stated he has issues with his bowels and at times he can't hold it while waiting for help on the bed pan. He has had a lot of accidents, more than it should happen. Some of his accidents happen because no CNAs come in to help. This happened at night; he would push his call light, but would fall asleep waiting for someone to come. When he wakes up, he already had an accident and his call light was off. They would come in and shut if off because he was sleeping. Review of the Resident Council Notes revealed the following: -During a meeting dated 2/6/2025 staff documented concerns on showers. -During a meeting dated 2/19/2025 staff documented concerns on showers. -During a meeting dated 4/2/2025 staff documented trim nails. Review of Grievances filed revealed the following: -Resident #11 filled out the form dated 2/13/25 stating she needs more baths. Family member questioned why are they not getting done, residents need care first. -Resident #12 filed out the form dated 2/13/25 stating she does not get a bath when she is supposed to. On 5/13/2025 at 1:19 PM Staff I Certified Nursing Assistant (CNA) stated they need more staff here, staffing can be difficult at times. When asked if baths are getting done, she stated if they have enough people they will get done. They do have an extra staff member that will come in to give baths but when she comes in varies. If they have three CNAs they can do baths but if it's less than that on the morning shift, they do not get done. She indicated having three CNAs on the morning shift happens maybe once a week. Staff I stated when she comes in for her 6:00 AM -2:00 PM shift after Staff N has finished her overnight shift, she finds residents soaked in bed. She has noticed this happens more when there is only one CNA and one nurse on the overnight shift. On 5/13/2025 at 3:40 PM Staff K Licensed Practical Nurse (LPN) laughed when asked how staffing was at the facility. She added when they hire people they do not last long. When asked when they are short staff are baths getting done, she stated that is iffy. On 5/14/2025 at 9:54 AM the Housekeeping Supervisor and Staff M Laundry Aide stated they have noticed residents mainly on the 200 hall to be soaked in bed in the mornings after the night shift has left. They stated it happens a lot with Resident #2 and at times Resident #6. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165294	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avoca Specialty Care	610 East York Street Avoca, IA 51521

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/14/2025 at 12:53 PM Staff L Certified Medication Aide (CMA) stated staffing is good for the most part. When asked if there was enough staff to get their tasks done every day, she stated it depended on the day. She added baths are hard to do but will pick it up on the next shift but sometimes they get missed. She has come into work a few times to residents soaked in bed. She worked the 2:00 PM-10:00 PM shift. On 5/16/2025 at 9:02 AM Staff D CNA stated they are provided weekly bath sheet that is kept under a clipboard in the tub room. Once they are completed and documented on the sheet, they go to the Director of Nursing. CNAs that completed the bath/shower will document in the residents' Electronic Health Record (EHR). When asked why staff would document non-applicable (NA) on a resident's bath day, she stated she would assume the bath was not done. She added they have been told to document NA when they don't have staff to complete the baths or if they were not done, then they would do them on the next shift. They have been told not to leave the bath day blank, something has to be documented. When a bath is given on a non-bath day, they can add an as needed (PRN) bath so it's documented that one was completed. If a resident refuses a bath Staff D stated the CNA attempting the bath is to go back after the bath three separate times. If they are still unsuccessful, they have to tell the nurse so they can offer the bath for the resident and then document their attempts and refusals. Staff D stated baths getting done is dependent on the number of staff working. If they have two staff on the morning shift, they will look to see who is working the next shift and if it's more than two staff members, they will pass the baths onto the next shift. They have a staff member that has come in to complete baths. Staff D stated she has spoken to the DON about coming in after the overnight shift to residents being soaked in bed. She added recently, it has gotten better. Staff D indicated it happened a lot when Staff N was working. On 5/16/2025 at 10:42 AM Staff B LPN stated the CNAs will ask the resident if they want a bath. If they refuse after being offered a bath a couple of times, they will come to her, then she will try to talk with them about taking a bath. If the resident continues to refuse, she will chart it. She will chart a progress note in the resident's Electronic Health Record (EHR). They will relay the information to the next shift to see if the resident will allow the bath to be completed. If not, they will attempt the following day. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/16/2025 at 11:20 AM the Director of Nursing (DON) stated the CNAs will have a bathing schedule that she puts in a book on Monday mornings. The staff will highlight the resident's name if the bath was completed. If the name is not highlighted the bath was either refused or not completed. If the bath was refused, she would like staff to notify the nurse so they can intervene, see if they would like it completed later. If the bath is still not completed, it needs to be charted why it was not completed. They can leave the list in the bath house, so the staff coming in the next day can see which baths were not done from the previous shift. They will start with completing those baths first before moving to the baths scheduled that day. When asked what happens when a resident refuses a bath she indicated staff are to notify the nurse, the nurse can attempt to assist with getting the bath done. If the bath continues to be refused they are to notify management or see if another CNA can assist. If the resident refuses three times, the nurse will need to document why and reason they do not want to take a bath, in a progress note. The DON stated staff would document NA in the bathing task if the resident is not in the building, did not have the bath done in the morning shift. Will chart NA on the bath day then ask the evening shift to complete the bath. If they are successful they can chart the bath in an as needed (PRN) section of their chart. These PRN baths would be on the documents provided to the surveyor. Staff could also chart NA if they did not have a bath aide that day. When asked how the staffing was in her facility, she stated it could be better, they need more staff but some days they have a good amount of staff on duty. When they don't have adequate staff, baths do get pushed back a day or two. When asked what staff are to do if a resident falls back asleep after they activate their call light, she stated they should go in the resident's room, ask if they need anything, wake them up to find out. The facility provided a document titled Bath, Shower/Tub with a revision date of February 2018 documented the purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Documentation: 5. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken. Reporting: 1. Notify the supervisor if the resident refuses the shower/tub bath.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 37074 Based on observations, review of resident council notes, review of grievances and resident and staff interviews the facility failed to ensure they had adequate staff members to answer resident's call lights, provide baths, and assist with toileting needs. The facility reported a census of 31 residents. Findings Include: 1. According to the quarterly MDS assessment tool with a reference date of 4/11/2025, Resident #8 had a BIMS score of 15. A BIMS of 15 suggested no cognitive impairment. The MDS documented he had an impairment on one side of his lower extremity and utilized a wheelchair. Resident #8 required partial/moderate assistance with upper body dressing, was dependent of staff for lower body dressing and required substantial/maximal assistance with personal hygiene. The MDS documented a toilet transfer was not attempted due to his medical condition. Resident #8 was occasionally incontinent of urine and frequently incontinent of bowel. The MDS documented the following diagnoses for the resident: diabetes mellitus, anemia, depression, weakness, insomnia, and left below the knee amputation. The Care Plan Focus Area with an initiation date of 1/8/2025 documented he required substantial assistance of one staff for bathing and moderate assistance of one staff for upper and lower body dressing. On 5/14/2025 at 11:28 AM Resident #8 was sitting in his wheelchair in his room, playing a game on his phone. He stated he is supposed to get a bath two times a weeks but at this time he is only getting one a week for a month. He required a mechanical lift to a chair, then uses a slide board to get in the shower chair. Once staff realize the process they will run off and will not hear back from them on why he did not receive a bath. He indicated there are two staff members that will give him his bath. If they don't have enough staff members they will skip over his bath. Resident #8 stated he has not had a shower in two weeks. Resident #8 stated the wait time for help depends on how many staff members are working. He has had to wait 45 minutes during the day shift when they have two CNAs on the floor. Resident #8 stated he has issues with his bowels and at times he can't hold it while waiting for help on the bed pan. He has had a lot of accidents, more that it should happen. Some of his accidents happen because no CNAs come in to help. This happened at night; he would push his call light, but would fall asleep waiting for someone to come. When he wakes up, he already had an accident and his call light was off. They would come in and shut if off because he was sleeping. 2. According to the quarterly MDS assessment tool with a reference date of 5/9/2025 documented Resident #5 had a Brief Interview of BIMS score of 15. A BIMS score of 15 suggested no cognitive impairment. The MDS documented Resident #5 did not refuse evaluations or care during the 7-day review period. The MDS documented Resident #5 had no lower or upper extremity impairments and utilized a wheelchair. Resident #7 was dependent on staff to shower or bathe and upper body dressing. The MDS documented the following diagnoses: cerebrovascular disease, anemia, neurogenic bladder, obstructive uropathy, diabetes mellitus, aphasia, anxiety, depression, schizophrenia, morbid obesity, and stroke. (continued on next page)

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	165294	A. Building B. Wing	05/16/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Care Plan Focus Area with an initiation date of 10/9/2023 documented he was dependent on one staff for bathing, upper body dressing and required substantial assistance of two staff for lower body dressing. On 5/15/2025 at 10:37 AM Resident #5 was lying in bed. His finger nails were long, the nails were passed his fingertips. Some of his finger nails were dirty with brown/black debris in his nail beds. When asked how often he received a bath he indicated once a month. He added his last bath was this previous Friday. This was not his choice as he preferred to receive a bath once a week. Resident #5 stated he would like his bath more often. When asked if the facility trims his fingernails he indicated they are supposed to trim them but the podiatrist will trim his toe nails every 3 months. Resident #5 added he will tell staff when his nails need to be trimmed. He stated when they are short staffed he will not get his bath. He added that if they don't have both of the slings they use for his bath cleaned they will not bath him. When they bathe him they leave one lift under him. After his bath is done, they will put a clean and dry sling under him to get him dressed and ready. If that second sling is not available then he will not get a bath. He added when they are short staffed call lights can take 10 minutes to 1 hour, but not certain how often has happened. At night it seems to be bad. He uses a bedpan to have a bowel movement and when a he has to wait up to an hour for them to answer his call light, he will have an accident. When this happens, Resident #5 stated this makes him feel uncomfortable. Once staff come to his room and notice he had an accident they will ask why he didn't say something. He would tell them he had his call light on for help. Response time all depends on who is working. At 11:09 AM observed Staff I Certified Nursing Assistant, Staff J non-Certified Nursing Assistant (NA), and Staff B Licensed Practical Nurse (LPN) assist Resident #5 with getting dressed and transferred to his wheelchair. When Staff I and Staff J removed his sheets and provided cares a strong odor was present. 3. Record review revealed the following Progress Note for Resident #5: -On 2/10/2025 at 1:30 PM activities staff member went in to the resident's room and begged him to come to an activity; he would not get up and come down. I let him know that we have the accurate number of staff to get him up; he still declined. Review of the Resident Council Notes revealed the following: -During a meeting dated 2/6/2025 staff documented concerns on showers. -During a meeting dated 2/19/2025 staff documented concerns on showers. -During a meeting dated 3/5/2025 staff documented concerns about needed more Certified Nursing Assistants (CNA). -During a meeting dated 4/2/2025 staff documented trim nails. Review of Grievances filed revealed the following: -Resident Council on 2/6/2026-call light times, it takes them too long to get to us. -Resident #11 filled out the form stating she needs more baths. Family member questioned why are they not getting done, residents need care first. Filled out on 2/13/2025. (continued on next page)

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	165294	A. Building B. Wing	05/16/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #12 filed out the form stating she does not get a bath when she is supposed to. Filled out on 2/13/2025. On 5/13/2025 at 1:19 PM Staff I Certified Nursing Assistant (CNA) stated they need more staff here, staffing can be difficult at times. When asked if baths are getting done, she stated if they have enough people they will get done. They do have an extra staff member that will come in to give baths but when she comes in it varies. If they have three CNAs they can do baths but if it's less than that on the morning shift, they do not get done. She indicated having three CNAs on the morning shift happens maybe once a week. Staff I stated when she comes in for her 6:00 AM -2:00 PM shift after Staff N has finished her overnight shift, she finds residents soaked in bed. She has noticed this happens more when there is only one CNA and one nurse on the overnight shift. On 5/13/2025 at 3:40 PM Staff K Licensed Practical Nurse (LPN) laughed when asked how staffing was at the facility. She added when they hire people they do not last long. When asked when they are short staff are baths getting done, she stated that is iffy. On 5/14/2025 at 9:54 AM the Housekeeping Supervisor and Staff M Laundry Aide stated they have noticed residents mainly on the 200 hall to be soaked in bed in the mornings after the night shift has left. They stated it happens a lot with Resident #2 and at times Resident #6. On 5/14/2025 at 12:53 PM Staff L Certified Medication Aide (CMA) stated staffing is good for the most part. When asked if there was enough staff to get their tasks done every day, she stated it depended on the day. She added baths are hard to do but will pick it up on the next stuff but sometimes they get missed. She has come into work a few times to residents soaked in bed. She worked the 2:00 PM-10:00 PM shift. On 5/16/2025 at 9:02 AM Staff D CNA stated they are provided weekly bath sheet that is kept under a clipboard in the tub room. Once they are completed and documented on the sheet, they go to the Director of Nursing. CNAs that completed the bath/shower will document in the residents' Electronic Health Record (EHR). When asked why staff would document non-applicable (NA) on a resident's bath day, she stated she would assume the bath was not done. She added they have been told to document NA when they don't have staff to complete the baths or if they were not done, then they would do them on the next shift. They have been told not to leave the bath day blank, something has to be documented. When a bath is given on a non-bath day, they can add an as needed (PRN) bath so it's documented that one was completed. If a resident refuses a bath Staff D stated the CNA attempting the bath is to go back and after the bath three separate times. If they are still unsuccessful, they have to tell the nurse so they can offer the bath for the resident and then document their attempts and refusals. Staff D stated baths getting done is dependent on the number of staff working. If they have two staff on the morning shift, they will look to see who is working the next shift and if it's more than two staff members, they will pass the baths on to the next shift. They have a staff member that has come in to complete baths. Staff D stated she has spoken to the DON about coming in after the overnight shift to residents being soaked in bed. She added recently, it has gotten better. Staff D indicated it happened a lot when Staff N was working. (continued on next page)

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	165294	A. Building B. Wing	05/16/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/16/2025 at 10:42 AM Staff B LPN stated the CNAs will ask the resident if they want a bath. If they refuse after being offered a bath a couple of times, they will come to her, then she will try to talk with them about taking a bath. If the resident continues to refuse, she will chart it. She will chart a progress note in the resident's Electronic Health Record (EHR). They will rely the information to the next shift to see if the resident will allow the bath to be completed. If not, they will attempt the following day. On 5/16/2025 at 11:20 AM the Director of Nursing (DON) stated the CNAs will have a bathing schedule that she puts in a book on Monday mornings. The staff will highlight the resident's name if the bath was completed. If the name is not highlighted the bath was either refused or not completed. If the bath was refused, would like staff to notify the nurse so they can intervene, see if they would like it completed later. If the bath is still not completed, it needs to be charted why it was not completed. They can leave the list in the bath house, so the staff coming in the next day can see which baths were not done from the previous shift. They will start with completing those baths first before moving to the baths scheduled that day. When asked what happens when a resident refuses a bath she indicated staff are to notify the nurse, the nurse can attempt to assist with getting the bath done. If the bath continues to be refused notify management or see if another CNA can assist. If the resident refuses three times, the nurse will need to document why and reason they do not want to take a bath, in a progress note. The DON stated staff would document NA in the bathing task if the resident is not in the building, did not have the bath done in the morning shift. Will chart NA on the bath day then ask the evening shift to complete the bath. If they are successful they can chart the bath in an as needed (PRN) section of their chart. These PRN baths would be on the documents provided to the surveyor. Staff could also chart NA if they did not have a bath aide that day. When asked how the staffing was in her facility, she stated it could be better, they need more staff but some days they have a good amount of staff on duty. When they don't have adequate staff, baths do get pushed to back a day or two. When asked what staff are to do if a resident falls back asleep after they activate their call light, she stated they should go in the resident's room, ask if they need anything, wake them up to find out.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 37074 Based on clinical record review, staff interviews, and facility policy review the facility failed to implement additional individualized interventions for 1 of 3 residents (Resident #3) related to behaviors to assist residents with dementia in the completion of a task. Resident #3 refused staff to assist her to the bathroom and refused staff to check her for incontinence and change her when she was incontinent. The facility reported a census of 31 residents. Findings include: According to the quarterly Minimum Data Set (MDS) with a reference date of 2/6/2025, Resident #3 had a Brief Interview of Mental Status (BIMS) score of 12. A BIMS score of 12 indicated she had moderate cognitive impairment. The MDS documented she did not deny care during the 7-day review period. The MDS documented she did not have impairments to upper and lower extremities, but utilized a walker and wheelchair for mobility. The resident was dependent on staff for toileting hygiene and required substantial/maximal assistance for toilet transfer. The MDS documented she was frequently incontinent of urine and bowel. The following diagnoses were listed for Resident #1: atrial fibrillation, heart failure, diabetes mellitus, Alzheimer's disease, and non-Alzheimer's dementia. The Care Plan Focus Area titled Activities of Daily Living (ADLs) with an initiated date of 11/25/2024 documented #3 required substantial assistance of two staff for transfers, ambulation, mobility and toileting. The Care Plan Focus Area indicated she had a behavior problem related to her dementia, with an initiated date of 3/27/2025. The Care Plan directed staff to assist Resident #3 in the selection of appropriate coping mechanism, not to argue with the resident and to talk with the resident in a calm voice when her behavior is disruptive. The resident's Clinical Census documented she was discharged from the facility on 4/11/2025. On 5/13/2025 at 2:09 PM Staff B Licensed Practical Nurse (LPN) stated she was in with Resident #3's roommate when Staff E Certified Nursing Assistant (CNA) and Staff F attempted to assist her. The resident was sitting on the edge of the bed when the CNAs came in to the room. She let them know she wanted to go to the bathroom. When they informed her, they needed to get the mechanical lift, the resident refused to use it. The resident became upset when they would not transfer her without the mechanical lift. The CNAs asked Staff B if she was going to help them. She told them no because she was already upset. When the CNAs asked for help she knew Resident #3 was not going allow her to help her because she was already upset. She indicated Resident #3 can be naughty a times, will cuss and hit the staff members. When helping her it's all about the approach you take with her. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/2025 at 3:55 PM Staff F stated when her and Staff E reminded Resident #3 they needed to use the mechanical lift to transfer her to the bathroom she started to tell them they did not know what they were doing and was dumb founded at the request. The resident began to call them incompetent and used curse words. When they told Staff B about Resident #3 refusing to use the mechanical lift, she went in and told the resident they needed to use the mechanical lift as it's their job, then she walked out. For the rest of the night Staff E and Staff F would go in and check on Resident #3 but she refused to be checked and changed even when she was soiled. Resident #3 was adamant about walking and not waiting to use the mechanical lift, then would not let them change her. Staff B knew everything that was going on with Resident #3 but she did not go in to see if Resident #3 would allow her to assist her. On 5/14/2025 at 2:10 PM Staff E stated Resident #3 was being combative and refused to allow her and Staff F to help her to the bathroom. When her and Staff F went in to the resident's room, she was hanging off the bed. When asked what she was doing and where she was going, she wanted to go to the bathroom. She was not able to get up on her own and required an EZ stand, which she had used that day just fine according to the staffing report. When they informed her they needed to use the mechanical lift, she did not want to use it. Staff E left the resident know per the facility's policy they were not allow to no use the mechanical lift for the transfer. The nurse, Staff B, was in the room with the resident's roommate at the time. Staff B told Staff E and F they have done what they could do. Staff E said she was like what are we supposed to do if she needs to go to the bathroom and Staff B said you done what you can. Staff B added if she is refusing to do anything, we can't do anything but document it. Staff E added the nurse had a whatever type of attitude that night. She felt the nurse should have been able to do more especially since the CNAs worked directly under the nurse. Staff E and F offered to change Resident #3's brief but she would not allow them to complete their check and changes, in fact she barely allowed them to get her back in bed. Staff E stated this was not the first time the resident has had behaviors like this but they were usually able to deescalate the situation. On 5/16/2025 at 11:20 AM the Director of Nursing (DON) was asked what interventions the CNAs should have attempted with Resident #3 when she refused assistance to the bathroom. She indicated she felt approach was a big deal. They could have come back and approached the situation, or the nurse could have helped. If she allowed it, they could have assisted with cares in bed. If she refused that, the nurse should have been notified. They could have called her family as sometimes family can offer some assistance. The DON was asked what the nurse could have done to help the CNAs with their unsuccessful attempts to assist the resident. She stated the nurse could have helped the resident or asked the CNAs to leave the room. She could have asked the CNAs to leave for a bit and come back to approach the task differently. The resident was mad at the CNAs so she may not have been upset with the nurse. She could have gone in there to see if Resident #3 would have allowed her to help. The facility provided a document titled Problematic Behavior Management with a revision date of September 2017 documented problematic behavior and psychiatric symptoms will be identified and managed appropriately. The staff will seek to identify pertinent non-pharmacological interventions to try to address behavior and psychiatric symptoms.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074 Based on observations, staff interviews, and policy review the facility failed to ensure medications and supplies stored in the medication room and medication carts were stored and held within their expiration dates. The facility reported a census of 31 residents. Findings include: On [DATE] at 10:40 AM during a medication room check with Staff B Licensed Practical Nurse (LPN) present observed 12 unopened bottles of Aspirin 81 milligrams (mg), all with an expiration date of ,d+[DATE]. Staff B indicated she was under the impression the Director of Nursing (DON) overlooked the items in the medication room. The Regional Nurse Consultant was made aware of the expired Aspirin bottles. On [DATE] at 10:53 AM completed a check of the two medication carts with Staff C Certified Medication Aide (CMA) present. Noted one 3 milliliter (mL) empty syringe with an expiration date of [DATE] and one opened bottle of Aspirin 81 mg with an expiration date of ,d+[DATE]. The bottle was filled with tablets to the rim. Staff C was notified of the expired items before leaving the medication cart. On [DATE] at 3:40 PM Staff K Licensed Practical Nurse (LPN) denied having issues with expired items. If she does it's usually treatment stuff that they rarely use but she will toss it. On [DATE] at 4:23 PM the DON stated she tries to go through the medication room. She added the pharmacy goes through the medication room monthly and staff look at the medications and supplies as they are put away. Moving forward she will be the one looking at the expiration dates on the items. The facility provided a document titled Storage of Medications with a revision date of [DATE] indicated the facility stores all drugs and biologicals in a safe, secure and orderly manner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165294	A. Building B. Wing	05/16/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074 Based on clinical record review, resident and staff interviews and facility policy review the facility failed to maintain complete and accurate records for 7 of 7 residents reviewed (Resident #2, #3, #4, #5, #6, #7, #8). The facility reported a census of 31 residents. Findings include: 1. Review of Resident #2's shower/bath documentation from 2/1/2025 until 5/15/2025 revealed she was to receive a shower or bath on Mondays and Thursdays during the day shift. The documentation revealed the following: 2/3/2025-resident refused 2/10/2025-not applicable 2/13/2025-not applicable 2/24/2025-not applicable 3/13/2025-resident refused 3/24/2025-not applicable 3/27/2025-resident refused 3/31/2025-resident refused 4/7/2025-not applicable 4/14/2025-not applicable 4/17/2025-not applicable 4/28/2025-resident refused 5/1/2025-not applicable 5/8/2025-not applicable 5/15/2025-not applicable Record review revealed there were only two notes documented about her bathing refusals on 4/8/2025 and 4/29/2025. The progress notes lacked documentation about other bathing refusal and the reason for not applicable being documented. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #4's bath/shower documentation from 2/1/2025 through her discharge date of [DATE] revealed she was to receive a bath/shower on Wednesdays and Saturdays day shift. The documentation revealed the following: 2/1/2025-resident refused 2/8/2025-resident refused 2/12/2025-resident refused 2/15/2025-resident refused 2/19/2025-resident refused 2/22/2025-resident refused 3/1/2025-resident refused 3/8/2025-resident refused 3/12/2025-resident refused Record review revealed there was only one not documenting her bath refusals on 2/9/2025. The progress notes lacked documentation about other bathing refusals. Review of Resident #5 bath/shower documentation from 2/1/2025 through 5/15/2025 revealed he was to receive a bath/shower on Tuesdays and Fridays day shift. The documentation revealed the following: 2/14/2025-resident refused 2/16/2025-he received a bath 2/18/2025-he received a bath 2/21/2025-resident refused 2/25/2025-he received a bath 3/18/2025-resident refused 3/21/2025-not applicable 4/11/2025-not applicable 4/29/2025-not applicable 5/2/2025-not applicable (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's Progress Notes from 2/1/2025 through 5/15/2025 revealed it lacked documentation of bath refusals and reason for not applicable documentation. Review of Resident #6 bath/shower documentation from 2/1/2025 through 5/15/2025 revealed he was to receive a bath/shower on Wednesdays and Saturdays. The documentation revealed the following: 3/1/2025-resident refused 3/8/2025-resident refused 5/7/2025-not applicable Record review of Resident #6's Progress Notes from 2/1/2025 through 5/15/2025 revealed there were no notes about his bath refusals and why not applicable was documented. Review of Resident #7 bath/shower documentation from 2/1/2025 through 5/15/2025 revealed she was to receive a bath/shower on Wednesdays and Saturdays day shift. The documentation revealed the following: 3/1/2025-resident refused 3/8/2025-resident refused 4/12/2025-not applicable 4/25/2025-resident refused 5/1/2025-resident refused 5/7/2025-not applicable 5/10/2025-resident refused 5/14/2025-resident refused Record review revealed there were no notes about his bath refusals and why not applicable was documented. Review of Resident #8 bath/shower documentation from 2/1/2025 through 5/15/2025 revealed he was to receive a bath/shower on Mondays and Thursdays. The documentation revealed the following: 2/10/2025-not applicable 2/13/2025-not applicable 2/24/2025-not applicable 2/27/2025--resident refused (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/13/2025-resident refused 3/24/2025-not applicable 3/27/2025--resident refused 3/31/2025-not applicable 4/7/2025-not applicable 4/10/2025-resident refused 4/17/2025-not applicable 5/1/2025-resident refused 5/8/2025-not applicable Record review revealed there was only one note documenting her bath refusals on 4/15/2025. The progress notes lacked documentation about other bathing refusals. The facility provided a document titled Bath, Shower/Tub with a revision date of February 2018 documented the purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Documentation: -If the resident refused the shower/tub bath, the reason(s) why and the intervention taken. Reporting: -Notify the supervisor if the resident refuses the shower/tub bath. 2. According to the quarterly Minimum Data Set (MDS) with a reference date of 2/6/2025, Resident #3 had a Brief Interview of Mental Status (BIMS) score of 12. A BIMS score of 12 indicated no cognitive impairment. The MDS documented she did not deny care during the 7-day review period. The MDS documented she did not have impairments to upper and lower extremities, but utilized a walker and wheelchair for mobility. The resident was dependent on staff for toileting hygiene and required substantial/maximal assistance for toilet transfer. The MDS documented she was frequently incontinent of urine and bowel. The following diagnoses were listed for Resident #1: atrial fibrillation, heart failure, diabetes mellitus, Alzheimer's disease, and non-Alzheimer's dementia. The Care Plan Focus Area titled Activities of Daily Living (ADLs) with an initiated date of 11/25/2024 documented #3 required substantial assistance of two staff for transfers, ambulation, mobility and toileting. Review of Resident #3's visual/bedside Kardex Report documented she required substantial assistance of two staff for toileting, transfers, mobility and ambulation. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Clinical Census revealed Resident #3 was discharged on [DATE]. Record review 2/1/2025 thru 2/26/2025 revealed it lacked Progress Notes related to her behaviors that were experienced on 2/23/2025 and 2/24/2025. On 5/13/2025 at 2:09 PM Staff B Licensed Practical Nurse (LPN) stated in February 2025 Staff E Certified Nursing Assistant (CNA) and Staff F CNA had attempted to assist Resident #3 to the restroom. When they advised her, they needed to get the EZ-Stand (mechanical lift to assist a resident to a sitting position) the resident refused to allow this. On 5/14/2025 at 3:55 PM Staff F stated Resident #3 had put her call light on, when her and Staff E went in her room she was attempting to get up and walk. They reminded her they needed to use the EZ stand to assist her to the bathroom. On 5/14/2025 at 2:10 PM Staff E stated in February Resident #3 was being combative and hanging off the side of her bed. She was not able to get up on her own, she required the use of an EZ stand for transfers. The previous shift indicated she was using the lift without issues. She tried to explain to the resident that it was their policy that if they required a lift for transfers, they could not, not use it. On 5/14/2025 at 4:23 PM the Director of Nursing (DON) stated Resident #3 required the use of an EZ stand for transfers or she may have been an assistance of two staff. She knew the resident did not like to use the EZ stand. During a follow-up interview on 5/16/2025 at 11:20 AM she stated the MDS Coordinator completes the main portion of the care plans. If she is not working, anyone can update them as needed. When asked what staff use when caring for the residents, she stated they can use the Kardex, can be pulled up in the resident's Electronic Health Record (EHR), and updated as necessary. Care plans should be updated as needed (PRN), checked quarterly and annually with care conferences. When she was informed that Resident #3's care plan did not reflect the use of an EZ stand for transfers, she stated oh. The DON stated it was not acceptable to update a care plan three months after the resident was noted to be using an EZ stand. On 5/16/2025 at 9:15 AM the DON was asked if they had any documentation about Resident #3 using an EZ Stand for transfers. She said she would look. On 5/16/2025 at 9:23 PM in an email correspondence with Staff A Administrator from a sister facility, sent an email that contain Resident #3's care plan. The care plan attached documented Resident #3 required substantial assistance of two staff and used the EZ stand as needed (PRN). Staff A was asked when the care plan had been updated and she stated it was added on 5/16/2025. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/13/2025 at 2:09 PM Staff B Licensed Practical Nurse (LPN) stated she was in with Resident #3's roommate when Staff E Certified Nursing Assistant (CNA) and Staff F attempted to assist her. The resident was sitting on the edge of the bed when the CNAs came in to the room. She let them know she wanted to go to the bathroom. When they informed her, they needed to get the mechanical lift, the resident refused to use it. The resident became upset when they would not transfer her without the mechanical lift. The CNAs asked Staff B if she was going to help them. She told them no because she was already upset. When the CNAs asked for help she knew Resident #3 was not going allow her to help her because she was already upset. She indicated Resident #3 can be naughty a times, will cuss and hit the staff members. When helping her it's all about the approach you take with her. During a follow up interview on 5/16/2025 at 10:42 AM Staff B stated when a resident has behaviors and she is aware of them, she is to chart them in a behavior note and intervene. When asked if she documented on the weekend in February when Resident #3 was refusing cares, she indicated she could not remember if she charted that weekend on her behaviors. She added, she does not believe she charted because she thought her behaviors were justified on her behalf. On 5/14/2025 at 3:55 PM Staff F stated when her and Staff E reminded Resident #3 they needed to use the mechanical lift to transfer her to the bathroom she started to tell them they did not know what they were doing and was dumb founded at the request. The resident began to call them incompetent and used curse words. When they told Staff B about Resident #3 refusing to use the mechanical lift, she went in and told the resident they needed to use the mechanical lift as it's their job, then she walked out. For the rest of the night Staff E and Staff F would go in and check on Resident #3 but she refused to be checked and changed even when she was soiled. Resident #3 was adamant about walking and not waiting to use the mechanical lift, then would not let them change her. Staff B knew everything that was going on with Resident #3 but she did not go in to see if Resident #3 would allow her to assist her. When asked where staff are to document these kinds of behaviors, she stated there is a behavior task that the CNAs can chart on. On 5/14/2025 at 2:10 PM Staff E stated Resident #3 was being combative and refused to allow her and Staff F to help her to the bathroom. When her and Staff F went in to the resident's room, she was hanging off the bed. When asked what she was doing and where she was going, she wanted to go to the bathroom. She was not able to get up on her own and required an EZ stand, which she had used that day just fine according to the staffing report. When they informed her they needed to use the mechanical lift, she did not want to use it. Staff E left the resident know per the facility's policy they were not allow to no use the mechanical lift for the transfer. The nurse, Staff B, was in the room with the resident's roommate at the time. Staff B told Staff E and F they have done what they could do. Staff E said she was like what are we supposed to do if she needs to go to the bathroom and Staff B said you done what you can. Staff B added if she is refusing to do anything, we can't do anything but document it. The rest of the night Resident #3 was very agitated and continue to not let them do anything such as checking and changing her, she was hanging on her wheelchair, not wanting to be in bed. Every time they would try to check and change her she would scratch and hit at staff. Staff E added the nurse had a whatever type of attitude that night. She felt the nurse should have been able to do more especially since the CNAs worked directly under the nurse. Staff E and F offered to change Resident #3's brief but she would not allow them to complete their check and changes, in fact she barely allowed them to get her back in bed. Staff E stated this was not the first time the resident has had behaviors like this but they were usually able to deescalate the situation. The CNAs can document in the tasks tab but they also told the nurse about more of her behaviors and assumed she would have done it too. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/16/2025 at 11:20 PM the DON indicated there is a supplemental tab for behaviors that nurses will use to document behaviors and in the progress notes. The CNAs can chart as well. She acknowledged the behaviors that Resident #3 had experienced on the weekend of 2/22/2025 should have been documented by the nurse and CNAs. When asked what should have been documented she stated what was offered, refusals, should have showed the refusal of any interventions that were attempted and what ever they did to assist the resident. The facility provided a document titled Problematic Behavior Management with a revision date of September 2017 documented problematic behavior and psychiatric symptoms will be identified and managed appropriately. The staff will seek to identify pertinent non-pharmacological interventions to try to address behavior and psychiatric symptoms. 3. Record review revealed Resident #5's Progress Notes lacked documentation of failed attempts to set up Telehealth appointments with his endocrinologist. On 5/15/2025 at 10:37 AM Resident #5 stated he was supposed to be seen by the Endocrinologist but have since tried to get him to be seen via Telehealth. He has since been on a Telehealth call with an Endocrinologist. The facility has told him they got a letter that the Endocrinologist has discontinued his services because he has not been to the clinic. The facility has also told him the clinic is refusing to assist with setting up the Telehealth appointments. On 5/16/2025 at 9:00 AM management was asked if they had any documentation for Resident #5's Telehealth meetings with his Endocrinologist. The MDS Coordinator stated she dropped the ball on the documentation part. She has been in contact with the clinic and given them various options to set up Telehealth meetings but they are not being receptive.