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	06/16/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and policy review the facility failed to provide bathing assistance for 2 of 4 residents reviewed for bathing (Residents #1 and #2). The facility reported a census of 35 residents. Findings include: 1. Resident #1's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS identified bathing activity for Resident #1 was not applicable/not attempted. Resident #1's MDS included diagnoses of cancer, anemia, atrial fibrillation (irregular heart beat), hypertension (high blood pressure), heart failure (heart does not pump blood well), and end stage renal disease (kidney). The Clinical Census documented Resident #1 was admitted to the facility on [DATE] and discharged from the facility on 6/4/25. The Care Plan with a target date of 6/12/25 identified Resident #1 required assistance of 1 staff member to provide bathing. Review of Point of Care (POC) Tasks in the electronic medical record revealed Resident #1 was scheduled for a sponge bath or shower on Monday and Thursday. The bathing records lacked documentation Resident #1 received a bath during her stay at the facility from 5/28 to 6/4/25. The Clinical Record lacked documentation of any other attempts to offer or encourage Resident #1 to shower or bathe. 2. Resident #2's Minimum Data Set (MDS) dated [DATE] assessment identified a BIMS score of 11, indicating moderately impaired cognition. The MDS identified Resident #2 required substantial/maximal assistance with shower/bathing. Resident #2's MDS included diagnoses of hypertension (high blood pressure), peripheral vascular disease, diabetes mellitus, and cerebrovascular accident (CVA) (stroke) affecting the right side. The Care Plan with a target date of 7/1/25 identified Resident #2 required substantial assistance of 1 staff member to provide bathing (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of POC Tasks in the electronic medical record revealed Resident #2 was scheduled for a bath or shower on Wednesday and Saturday. The facility electronic form title Shower/Bath for the last 30 days documented Resident #2 received a bath on 5/17, 5/28 and 6/8. The form documented a shower/bath was refused on 6/4 and not applicable on 6/7. A facility paper form titled Baths for the week of 5/26 to 6/1 documented Resident #2 received a bath or shower on 5/28 and 5/31. The bathing form directed the staff to write down their initials next to each bath/shower that was given. The form documented that any shower/bath not given needed to be reviewed with the charge nurse and communicated to leadership, as each resident was to be offered bathing two times per week. The form indicated if a resident refused their shower, the staff was to try and offer again the next day. A facility paper form titled Baths for the week of 6/2 to 6/8 documented Resident #2 refused a bath on 6/4 and received a bath on 6/7. Review of the Clinical Record and bathing forms revealed Resident #2 did not have a bath or shower from 5/31 to 6/7. The Clinical Record lacked documentation of any other attempts to offer or encourage Resident #2 to shower or bathe. On 6/10/25 at 4 PM, Resident #2 reported he got a bath about once per week and would prefer to have three baths per week. On 6/11/25 at 10:10 AM, Staff A, Certified Nursing Assistant (CNA) reported she was normally scheduled to do baths/showers. Staff A reported the bathing documentation was completed in the resident's electronic medical record. In addition, she said there was a paper list in the shower house that she highlighted when the baths were completed along with documenting her initials next to the resident name. She said she gave the paper list to the DON when she was done. When asked about Resident #2 baths, she reported he refused to take a bath last Wednesday (6/4). She reported when a resident refused to take a bath the staff were to tell the nurse, then ask the resident one more time, then after that the resident had the right to refuse the bath. When asked when not applicable would be charted for bathing, she said it would be charted when the staff did not get the bath done that day as scheduled instead of charting refused. On 6/11/25 at 11:09 AM, the Director of Nursing (DON) reported she had reviewed the paper documentation for bathing for Resident #2 and acknowledged the documentation in POC did not match the paper documentation. The DON reported she was auditing the bathing documentation on paper and it was a work in progress for the staff to document in POC accurately and consistently all the time. She reported if a resident did not get a bath, she expected the resident to be the first one completed the next day and the staff needed to chart the bath was offered. On 6/11/25 at 3:10 PM, the DON verified Resident #1 did not have a bath during her stay from 5/28 to 6/4/25. In addition, the DON acknowledged Resident #2 refused his bath on 6/4/25. The DON verified Resident #2 did not have a documented bath between 5/31 and 6/7. The DON reported she expected staff to re-approach, offer a bath the following day, and document the attempt. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy title Activities of Daily Living (ADLs), Supporting revised March 2018 documented the facility would provide appropriate care and services for the residents who are unable to carry out ADLs independently with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene that include (bathing, dressing, grooming and oral care).