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	10/07/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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

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	10/07/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, and policy review the facility failed to provide services meeting professional standards for 1 of 3 residents (Resident #2). The facility failed to follow physician orders for completion of labs. The facility had a census of 31. Findings include:Resident #2's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10/15 indicating moderate cognitive impairment. The document provided the resident had diagnoses of diabetes mellitus, hypertension (HTN) and Type 2 Diabetes Mellitus with unspecified complications. The MDS disclosed the resident received 7 days of insulin injections with 2 days of orders for change of insulin orders during the reporting period. The Care Plan dated 6/20/25 contained a focus area for Diabetes Mellitus initiated 4/6/24. Interventions for staff included medications as ordered by physician, monitoring for and documenting side effects and effectiveness (4/6/24), monitor for side effects (4/6/24) and provide education (4/6/24). A focus area of use of insulin/hypoglycemic medications dated 1/14/23 contained interventions of monitoring blood glucose, side effects, hypo/hyperglycemia and Accu Checks as ordered dated 1/14/23. The electronic medical record (EMR) contained the laboratory results dated [DATE] revealed the resident had an A1c 8.8 (h), estimated average glucose 200. The document provided the provider's acknowledgement with an order to check the resident's A1c in 3 months with a signature of 1/29/24 and noted by an unidentified nurse on 1/29/24. The EMR Physician Notification dated 7/24/24 disclosed an order signed by the provider on 7/25/24 to Discontinue the current A1c every 3 months.Next lab day draw CBC, BMP, A1c, TSH - due Feb/Aug every 6 months. Decrease nighttime Tresiba to 10 units.The document was noted by 1 nurse on 7/25/24 and a second nurse on 8/12/24. The facility's EMR failed to provide documentation that orders for A1c checks dated 1/29/24 and labs 7/25/24 were completed.The EMR Progress Notes revealed the following:7/29/25 Provider note to have routine Accu-Checks and routine labs including TSH.10/1/25 Care Conference held with son concerned about the resident's blood sugars being high.10/7/25 New Order for A1c.The EMR Clinical Physician Orders revealed an order for CBC, BMP, TSH, A1c, every 6 months every day shift every 6 months starting on the 7th related to Type 2 Diabetes Mellitus with unspecified complications, essential HTN and hypothyroidism with an order date of 10/7/25 and start date of 11/7/25.On 10/6/25 at 4:55 PM the Director of Nursing (DON) stated there was no documentation for labs completed after 1/24/24. On 10/7/25 at 10:15 AM the DON confirmed the labs completed on 1/24/24 contained an order for A1c to be completed in 3 months had not been completed. The DON acknowledged an order on 7/25/24 for DC of A1c every 3 months and a new order for the next lab day to draw CBC, BMP, A1c, TSH due Feb/Aug every 6 months had not been completed. The DON confirmed after the request for documents the previous day, the DON contacted the physician and requested new lab orders and entered them into the EMR. The DON stated she would be completing a blood draw shortly, and confirmed it would not be a fasting lab due to the time of day and the resident already having eaten breakfast. On 10/7/25 at 10:43 AM the DON stated she expected staff to put the order into the EMR and complete the order as required.On 10/7/25 at 11:40 AM Staff A, Licensed Practical Nurse (LPN) stated if a fax with an order for lab was received, staff would put in the order or contact the provider for clarification if it was not on document.On 10/7/25 at 11:45 AM the Administrator stated she expected staff to put orders into the EMR so they could be completed as ordered and if they had any questions regarding the orders to contact the DON.The facility's Medication and Treatment Orders: Guiding Principles, dated 9/17, provided significant medication-related concerns will be minimized. The document did not address following physician orders.