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	03/05/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review the facility failed to identify non-pharmacological interventions and targeted behaviors related to high risk medications for 5 of 5 sampled residents reviewed (Resident #4, #8, #25, #23, and #33). The facility reported a census of 33 residents.Findings include: 1. Review of Resident #4's Minimum Data Set (MDS) dated [DATE] revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognitive functioning. The MDS further revealed Resident #4 utilized antipsychotic, and antidepressant medication during the seven day look back period. Review of Resident #4's Electronic Healthcare Record (EHR) page titled, Clinical Physician Orders revealed an order for antianxiety medication with no antipsychotic medication listed. Further review of the Clinical Physician Orders revealed an order for Buspirone HCL oral tablet 10 MG (Antianxiety medication). Give 1 tablet by mouth in the morning. The Clinical Physician Orders further revealed an order for Venlafaxine HCl Oral Tablet 100 MG (antidepressant) Give 1 tablet by mouth twice a day. There were no antipsychotic medications listed. Review of Resident #4's Care Plan with a revision date of 1/20/26 lacked non-pharmacological interventions for antianxiety, and antidepressant medications. 2. Review of Resident #8's MDS dated [DATE] revealed Resident #8 had a BIMS score of 9 indicating moderate cognitive impairment. The MDS further revealed Resident #8 utilized antipsychotic, antianxiety, and antidepressant medications during the seven day look back period. Review of Resident #8's EHR page titled, Clinical Physician Orders revealed the following orders: a. Risperidone Oral Tablet 2 MG (antipsychotic). Give 2 MG by mouth one time a day. b. Clonazepam Tablet 0.5 MG (antianxiety). Give 1 tablet by mouth two times a day. c. Escitalopram Oxalate Tablet 10 MG. Give 1.5 tablets by mouth one time a day. Review of Resident #8's Care Plan with a revision date of 3/2/26 lacked non-pharmacological interventions for antipsychotic, antianxiety, and antidepressant medications. 3. Review of Resident #25's MDS dated [DATE] revealed Resident #25 had a BIMS score of 15 indicating intact cognitive functioning. The MDS further revealed Resident #25 utilized antianxiety, antidepressant, and hypnotic medications during the seven day look back period. (continued on next page)

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #25's EHR page titled, Clinical Physician Orders revealed the following orders: a. Lorazepam Oral Tablet 0.5 MG (antianxiety). Given 1 tablet by mouth daily. b. Paroxetine HCl Tablet 20 MG (antidepressant). Give 1 tablet by mouth daily. c. Zolpidem Tartrate Oral Tablet 5 MG (Hypnotic). Give 5 mg by mouth daily. Review of Resident #25's Care Plan with a revision date of 1/2/26 lacked non-pharmacological intervention for antianxiety, antidepressant, and hypnotic medications. 4. The Minimum Data Set (MDS) dated [DATE] for Resident #23 documented a Brief Interview for Mental Status (BIMS) of 13 indicating no cognitive impairment. The MDS documented Resident #34 had diagnoses of chronic kidney disease, urinary tract infection, atherosclerotic heart disease of native coronary artery without angina pectoris, unspecified dementia, moderate with behavioral disturbance and depression. Review of Resident #23's Electronic Health Record (EHR) titled, Care Plan indicated no individualized behaviors or non-pharmacological interventions in place for the use of antidepressants or antipsychotics. Review of Resident #23 Electronic Health Records (EHR) titled, Orders documented a physician's order with a start date of 1/14/26 for rexulti oral tablet 0.25 mg give 0.5 mg by mouth one time a day for dementia with behaviors, a physician's order with a start date of 1/22/26 for venlafaxine ER oral tablet to give 37.5 mg by mouth one time a day and a physician's order with a start date of 10/17/25 for sertraline oral capsule 150 mg to give one capsule by mouth at bed time. Review of Resident #23 Medication Administration Records - Treatment Administration Records (MAR-TAR) documented a physician's order with a start date of 1/14/26 for rexulti oral tablet 0.25 mg give 0.5 mg by mouth one time a day for dementia with behaviors, a physician's order with a start date of 1/22/26 for venlafaxine ER oral tablet to give 37.5 mg by mouth one time a day and a physician's order with a start date of 10/17/25 for sertraline oral capsule 150 mg to give one capsule by mouth at bed time. 5. The MDS dated [DATE] for Resident #33 documented a BIMS of 12 indicating moderate cognitive impairment. The MDS documented Resident #33 had diagnoses of major depressive disorder without psychotic features, malaise, weakness and failure to thrive. Review of Resident #33's EHR titled, Care Plan indicated no individualized behaviors or non-pharmacological interventions in place for the use of antidepressants. Review of Resident #33 Electronic Health Records (EHR) titled, Orders documented a physician's order with a start date of 2/6/26 for lamotrigine oral tablet 25 mg to give 1 tablet by mouth one time a day for depression, a physician's order with at start date of 2/3/26 for sertraline oral capsule 200 mg to give 1 capsule by mouth at bed time related to major depressive disorder and a physician's order with a start date of 4/25/25 for clonazepam oral tablet 1 mg to give 1 tablet by mouth 3 times a day related to major depressive disorder. Review of Resident #33 Medication Administration Records - Treatment Administration Records (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(MAR-TAR) documented a physician's order with a start date of 2/6/26 for lamotrigine oral tablet 25 mg to give 1 tablet by mouth one time a day for depression, a physician's order with at start date of 2/3/26 for sertraline oral capsule 200 mg to give 1 capsule by mouth at bed time related to major depressive disorder and a physician's order with a start date of 4/25/25 for clonazepam oral tablet 1 mg to give 1 tablet by mouth 3 times a day related to major depressive disorder. On 3/3/26 at 3:47 PM Staff A, MDS coordinator acknowledged Resident #4, #8, #23, #25 and #33 should have individualized behaviors and non-pharmacological interventions included in their care plans when the resident utilized medications such as anti-anxiety, antidepressants, antipsychotic, and opioids and did not. On 3/3/26 at 4:21 PM the DON explained Resident #4, #8, #23, #25 and #33 should have individualized behaviors and non-pharmacological interventions included in their care plans when the resident utilized medications such as anti-anxiety, antidepressants, antipsychotic, and opioids. The DON acknowledged Resident #4, #8, #23, #25, and #33 did not have individualized behaviors or non-pharmacological interventions in place when indicated on their care plans. Review of a policy revised 12/16 titled, Care Plans, Comprehensive Person-Centered documented A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan will incorporate risk factors associated with identified problems and reflect currently recognized standards of practice for problem areas and conditions. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and policy review the facility failed to develop a comprehensive care plan that included problems, goals, or interventions for 4 of 6 Residents (Resident #4, #25, #23, and #33) reviewed. The facility reported a census of 33. Findings include:1. Review of Resident #4's Minimum Data Set (MDS) dated [DATE] revealed an admission to the facility from a short-term general hospital stay on 1/9/26. The MDS further revealed diagnoses of anxiety disorder, and depression. Review of the Electronic Healthcare Record (EHR) page titled, Clinical Physician Orders revealed an order with a start date of 2/10/26 for Buspirone HCL oral tablet (antianxiety). Give 1 tablet by mouth in the morning. Review of Resident #4's Care Plan with a revision date of 1/20/26 revealed no documentation of antianxiety medication. 2. Review of Resident #25's MDS dated [DATE] revealed an admission to the facility from a skilled nursing facility on 10/26/23. The MDS further revealed Resident #25 utilized antianxiety, and diuretic medication during the look back period. Review of Resident #25's EHR page titled, Clinical Physician Orders revealed orders for: a. Lorazepam oral tablet 0.5mg (antianxiety). Give 1 tablet by mouth one time a day. b. Lasix oral tablet 20mg (Diuretic). Give 1.5 tablets by mouth in the morning every Tuesday, Thursday, Saturday, and Sunday. Review of Resident #25's Care Plan with a revision date of 3/2/26 revealed no documentation of antianxiety, or diuretic medications. 3. The Minimum Data Set (MDS) dated [DATE] for Resident #23 documented a Brief Interview for Mental Status (BIMS) of 13 indicating no cognitive impairment. The MDS documented Resident #34 had diagnoses of chronic kidney disease, urinary tract infection, atherosclerotic heart disease of native coronary artery without angina pectoris, unspecified dementia, moderate with behavioral disturbance and depression. Review of Resident #23's Electronic Health Record (EHR) titled, Care Plan indicated no focus, goal or interventions related to opioid use, pain or antipsychotic medication. Review of Resident #23 Electronic Health Records (EHR) titled, Orders documented a physician's order with a start date of 1/14/26 for Rexulti oral tablet 0.25 mg give 0.5 mg by mouth one time a day for dementia with behaviors and a physician's order with a start date of 12/11/25 for oxycodone-acetaminophen 7.5-325 mg give one tablet by mouth 3 times a day for pain. Review of Resident #23 Medication Administration Records - Treatment Administration Records (MAR-TAR) documented a physician's order with a start date of 1/14/26 for Rexulti oral tablet 0.25 mg give 0.5 mg by mouth one time a day for dementia with behaviors and a physician's order with a (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	start date of 12/11/25 for oxycodone-acetaminophen 7.5-325 mg give one tablet by mouth 3 times a day for pain. 4. The MDS dated [DATE] for Resident #33 documented a BIMS of 12 indicating moderate cognitive impairment. The MDS documented Resident #33 had diagnoses of malignant neoplasm of breast, malaise, weakness and failure to thrive. On 3/2/26 at 12:02 PM Resident #33 stated she had back pain that the medication was not helping Review of Resident #33's EHR titled, Care Plan indicated no focus, goal or interventions related to opioid use or pain. Review of Resident #33 Electronic Health Records (EHR) titled, Orders documented a physician's order with a start date of 12/27/25 for oxycodone oral capsule 5 mg to give 5mg by mouth 3 times a day for pain. Review of Resident #33 Medication Administration Records - Treatment Administration Records (MAR-TAR) documented a physician's order with a start date of 12/27/25 for oxycodone oral capsule 5 mg to give 5mg by mouth 3 times a day for pain. On 3/3/26 3:47 PM Staff A, MDS coordinator stated pain and or opioid use should be identified on Resident #33's care plan because Resident #33 was on an opioid. Staff A acknowledged there was no care plan identified for use of an opioid, pain and for Resident #33 and there should have been. Staff A, MDS coordinator stated antipsychotic, pain and or opioid should be identified on Resident #23's care plan because Resident #23 was on an antipsychotic and an opioid. Staff A acknowledged there was no care plan identified for use of an antipsychotic, opioid or pain for Resident #23 and there should have been. Staff A acknowledged Resident #4 did not have a care plan that included a focus, goal or interventions for use of an antianxiety medication and Resident #4 had a physician's order for an anti-anxiety medication. Staff A explained Resident #25 did not have a care plan that included a focus, goal or interventions use of a diuretic or anxiety medication on her care plan and utilized both. On 3/3/26 at 4:21 PM the DON acknowledged an opioid and / or pain should be on Resident #33's care plan because she had a physician's order for an opioid and was not. The DON acknowledged Resident #23 utilized antipsychotic and opioid as a medication. The DON stated antipsychotic, opioid and / or pain should be documented on Resident #23's care plan and was not. The DON acknowledged Resident #4 did not have a care plan that included a focus, goal or interventions for use of an antianxiety medication and Resident #4 utilized an anti-anxiety medication. The DON stated Resident #25 did not have a care plan that included a focus, goal or interventions use of a diuretic or anxiety medication on her care plan and utilized both. Review of a policy revised 12/16 titled, Care Plans, Comprehensive Person-Centered documented A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan will incorporate risk factors associated with identified problems and reflect currently recognized standards of practice for problem areas and conditions. Identifying problem areas and their causes, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility document review, clinical record review, resident interview, family interview and staff interviews, the facility failed to provide nursing staff to assure residents safety by not responding to call lights in a timely manner and not responding to a request for toileting in a timely manner for 3 of 16 resident reviewed (Resident #10, #33, and #34). The facility reported a census of 33 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] for Resident #10 documented a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. On 3/4/26 at 2:02 PM Resident #10 stated during the resident council meeting that call lights took longer than 15 minutes to be answered. Resident #10 explained there was only 1 Certified Nurse Assistant (CNA) last night on the pm shift. Resident #10 stated it took longer than 30 minutes last night for his call light to be answered. 2. The MDS dated [DATE] for Resident #33 documented a BIMS of 12 indicating moderate cognitive impairment. The MDS documented Resident #33 had diagnoses of malignant neoplasm of breast, malaise, weakness and failure to thrive.On 3/2/26 at 11:46 AM Resident #33 stated at the lunch hour it can be longer than 15 minutes to answer her call light. Resident #33 explained this had occurred in the last week or two. Resident #33 explained it could at times take up to 30 minutes. Resident #33 explained in the last 2 weeks there was only one CNA on the floor and once there was no staff and the nurses had to get her ready. 3. The MDS dated [DATE] for Resident #34 documented a BIMS of 15 indicating no cognitive impairment. The MDS documented Resident #34 had a diagnosis of obesity. On 3/2/26 at 1:02 PM Resident #34 explained he had sat in his chair for longer than 2 or 3 hours waiting for staff to assist him to bed after turning the call light on. Resident #34 said sometimes he will have to turn the call light on multiple times, sometimes it helps, sometimes it doesn't. 4. On 3/5/26 at 1:59 PM Resident #15's husband stated he was at the facility over the last weekend and a resident that was sitting with them in the day room requested to use the toilet and it had taken an hour once for the staff to take the resident to the restroom. On 3/4/26 at 4:27 PM Staff E, Certified Medication Assistant (CMA) / CNA explained last night she had only one nurse working as a CNA on the floor with her last night. Staff E stated it can be a struggle sometimes with staffing at the facility and providing care to the residents in a timely manner. Staff E stated at times the call lights last longer than 15 minutes to be answered. Staff E acknowledged there were probably call lights that lasted longer than 15 minutes the night before. On 3/3/26 at 11:56 AM Staff F, Certified Nurse Assistant (CNA) stated she had worked a 6:00 AM - 2:00 PM shift with only one other CNA and 2 nurse or 1 nurse / 1 Certified Medication Assistant (CMA). Review of documents titled, Grievance/Concern investigation Form revealed on 1/7/26 Resident #15 sat in bed for 25 minutes with the call light on to use the commode. Resident #15 indicated that it had happened between 1:00 PM - 10:00 PM several times. On 2/6/26 Resident #14 explained she had been timing call lights and waited 30 minutes.Review of Quarter 4 nurse staffing schedule documented:7/4/25 10:00 PM - 6:00 AM 1 CNA and 2 nurses7/5/25 6:00 AM - 2:00 PM 2 CNA's and 2 nurses7/6/25 6:00 AM - 2:00 PM 2 CNA's and 2 nurses7/10/25 10:00 PM - 6:00 AM 1 CNA and 2 nurses7/12/25 6:00 AM - 2:00 PM 2 CNA's and 2 nurses7/13/25 6:00 AM - 2:00 PM 2 CNA's and 2 nurses7/27/25 6:00AM - 2:00 PM 1 nurse 0 CMA and 3 CNA's7/27/25 10:00 PM - 6:00 AM 1 CNA and 2 nurses7/29/25 10:00 PM - 6:00 AM 1 CNA and 2 nurses8/2/25 6:00AM - 2:00 PM 1 nurse 0 CMA and 3 CNAs8/2/25 2:00PM - 10:00 PM 1 nurse 0 CMA and 2 CNA's8/3/25 2:00PM - 10:00 PM 1 nurse 0 CMA and 2 CNA's8/8/25 2:00PM - 10:00 PM 1 nurse 0 CMA and 2 CNA's8/16/25 2:00PM - 10:00 PM 1 nurse 0 CMA and 2 CNA's8/17/25 6:00AM - 2:00 PM 1 nurse 0 CMA and 2 CNA's9/9/25 6:00 AM - 2:00 PM 2 CNA and 2 nurses9/18/25 6:00 AM - 2:00 PM 2 CNA and 2 nurses9/26/25 2:00 PM - 10:00 PM 1 CNA and 2 nurses9/27/25 2:00 PM - 10:00 PM 1 nurse and 2 CNA's1/30/26 6:00 - 2:00 PM 2 CNA's and 2 nurses2/4/26 10:00 PM - 6:00 AM 1 CNA and 2 nurses2/8/26 6:00 - 2:00 PM 1 nurse and 3 CNA'sOn (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/3/26 at 12:21 PM the Director of Nursing (DON) said when the facility was under 30 residents for a census she tried to have 3 CNA's on day shift, 2 CNA's on PM shift and 2 CNA's on the Overnight shift 2. The DON stated if there are more than 30 residents for a census she would like 4 CNA but ran with 3 CNA in the morning. The DON explained on the pm shift 2:00 PM - 10:00 PM 1 nurse and 2 CNA's would work but the nurse would be busy and the CNA's could do it but it was not ideal. The DON stated it probably has happened since she had worked at the faculty. The DON stated the facility assessment had a Per Patient Day (PPD) was 3.54. The DON acknowledged the facility was under the PPD minimum at times. On 3/5/26 at 2:52 PM the DON stated that one or two days that were presented might not have been ideal but the residents' needs were being met. The DON explained in a facility like this, the facility census does not fluctuate that much. The DON acknowledged the national average PPD was 3.1 and the facility has more than that average. The DON explained 3.1 for the PPD would also be the minimum staffing for the facility. The DON stated she felt that 3 staff total were enough for the PM shift on 3/3/26.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and facility policy review the facility failed to verify the resident's advanced directive choice documented accurately for 1(Resident #7) of 16 residents reviewed. The facility reported a census of 33 residents. Findings include:Resident #7's Cardiopulmonary Resuscitation (CPR) and Do Not Resuscitate (DNR) Order Declaration Form, signed by the resident [DATE] and signed by the physician [DATE], documented DNR. The Clinical Resident Profile, in the electronic health record (EHR), for Resident #7, dated [DATE], revealed a code status of CPR. The Clinical Physician Orders form for Resident #7, dated [DATE], documented a physician's order, revision date of [DATE], for CPR. Interview on [DATE] at 2:12 PM, Staff C, Registered Nurse stated in the event of an emergency with a resident she would check for the resident's advanced directive choice in the resident's electronic health record. Staff C stated she was not aware if the facility had an Advanced Directives book to check the residents' code status. Interview on [DATE] at 2:50 PM, the Director of Nursing confirmed the records did not match and stated the expectation for the CPR and DNR Order Declaration Form and EHR to be accurate and match. Facility Advanced Directives policy, revised [DATE], documented upon admission the resident will be provided with written information concerning the right to refuse or accept medical treatment and to formulate an advanced directive and information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, resident interview, and staff interviews, the facility failed to provide the residents with a comfortable / clean homelike environment by not changing soiled sheets for 1 for 20 residents reviewed (Resident #3). The facility reported a census of 33 residents. Findings include:The Minimum Data Set (MDS) dated [DATE] documented Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. On 3/3/26 at 9:16 AM Resident #3 stated he had bled on his sheets after he fell on 2/28/26. Resident #3 explained the sheets on his bed had not been changed since the bleeding had occurred. On 3/3/26 at 9:15 AM an observation of three 50 cent sized circular areas of dry red colored fluid.On 3/3/26 11:56 AM Staff F, Certified Nurse Assistant (CNA) stated the CNA's change the bedding usually on the first bath day of the week for that resident. Staff F stated Resident #3 was on the list but had not had a bath yet. Staff F explained she had not got him up or changed the bedding today. Staff F stated if there was blood / urine / debris on the sheets the sheets would be changed immediately. On 3/5/26 at 11:22 AM Staff I, CNA acknowledged she stripped Resident #3's bed and had assisted with getting him out of bed on 3/3/26. Staff I stated the bed was stripped because it was dirty and needed to be changed. Staff I explained Resident #3's sheets looked like there was dried blood on them. Staff I stated Resident #3 did not get up the morning before so she did not know or remember if there was blood on the sheet the day before. On 3/3/26 at 12:09 PM Staff C, Registered Nurse (RN)/Nurse Practitioner (NP) explained Resident #3 had a skin tear to the left posterior of his forearm from a fall back on 2/28/26. Staff C stated she had applied the dressing Resident #3 had on his arm on 2/28/26. Staff C acknowledged the CNA's changed the residents' bedding on their bath days. Staff C stated there was a chance that the blood on Resident #3's sheets had been there since last 2/28/26 because the dressing is still the same that she applied. On 3/3/26 at 12:21 PM the DON stated the sheets are supposed to be changed either on the resident's bath days or at least once a week. The DON stated she expected if the residents' sheets were soiled they would be changed and fresh ones would be applied.

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Avoca Specialty Care	610 East York Street Avoca, IA 51521

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review the facility failed to represent an accurate picture of the resident's status during the observation period of the Minimum Data Set (MDS) for 3 of 5 residents (Resident #25, #5, #33) reviewed. The facility reported a census of 33 residents. Findings include: 1. Review of Resident #25's Minimum Data Set (MDS) dated [DATE] revealed Resident #25 utilized antipsychotic medication during the look back period. Review of the Electronic Healthcare Record (EHR) page titled, Clinical Physician's Orders revealed no orders for antipsychotic medications. 2. The MDS dated [DATE] for Resident #5 documented a Brief Interview for Mental Status (BIMS) of 9 indicating moderate cognitive impairment. The MDS further documented placement of an indwelling catheter. On 3/3/26 at 8:31 AM Resident #5 stated he had never had a catheter. On 3/3/26 at 1:34 PM Resident #5's son stated his dad was at the hospital for a severe bladder infection. Resident #5 stated his dad never had a catheter that he remembered. Review of Resident #5's Electronic Health Record (EHR) titled, Care Plan documented no focus, goal, or interventions since admission related to placement of a catheter. Review of Resident #5's EHR titled, Progress Note dated 1/6/26 at 12:27 PM entered by the DON documented no catheter at time of admission. Review of Resident #5 Electronic Health Records (EHR) titled, Orders documented no physician's order for catheter placement. Review of Resident #5 Medication Administration Records - Treatment Administration Records (MAR-TAR) documented no physician's order for catheter placement. On 3/4/26 at 8:41 AM Staff A, MDS Coordinator acknowledged she had incorrectly documented Resident #5 had an indwelling catheter on the MDS dated [DATE]. On 3/4/26 at 8:35 AM the DON explained Resident #5 had never had a catheter since admission to the facility on 1/5/26. The DON acknowledged Resident #5's MDS dated [DATE] incorrectly documented that Resident #5 had an indwelling catheter. 3. The MDS dated [DATE] for Resident #33 documented a BIMS of 12 indicating moderate cognitive impairment. The MDS documented Resident #33 utilized an antipsychotic medication. Review of Resident #33's EHR titled, Care Plan documented no focus, goal, or interventions since admission related to use of an antipsychotic medication. Review of Resident #33 Electronic Health Records (EHR) titled, Orders documented no physician's order for an antipsychotic medication. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #33 Medication Administration Records - Treatment Administration Records (MAR-TAR) documented no physician's order for an antipsychotic medication. On 3/3/26 at 3:47 PM Staff A, MDS Coordinator stated Resident #33 was not on any antipsychotic. Staff A explained she must have mistakenly coded the MDS incorrectly when looking at the Lamotrigine for Resident #33. On 3/3/26 at 4:21 PM the DON acknowledged Resident #33 was not on an antipsychotic. The DON acknowledged possible coding issues on the MDS. Review of a policy revised 11/19 titled, Certifying Accuracy of the Resident Assessment documented any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment. Any person who completes any portion of the MDS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of that assessment. The information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment. Different items on the MDS may have different observation periods. Any individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement in a resident assessment is subject to disciplinary action.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on clinical record review, staff interview, and policy review the facility failed to Incorporate the recommendations from the Preadmission Screening and Resident Review (PASRR) level II determination and the PASRR evaluation report into a resident's care plan for 1 (Resident #13) of 3 resident reviewed. The facility reported a census of 33 residents. Findings include: The Minimum Data Set assessment for Resident #13, dated 2/6/26, included diagnoses of schizophrenia, anxiety disorder, and depression. Resident #13's Notice of PASRR Level II Outcome, dated 1/21/26, revealed the resident required specialized services for ongoing psychiatric medication management by a psychiatrist and rehabilitative services of supportive counseling. Resident #13's Care Plan, with a target date of 5/7/26, lacked documentation of PASRR specialized services. Interview on 3/4/26 at 4:00 PM, the Director of Nursing stated the expectation for specialized services to be included in the resident's care plan. Facility Comprehensive Person-Centered Care Plans Policy, revised December 2016, revealed the comprehensive person-centered care plan will describe any specialized services to be provided as a result of PASRR recommendations.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review the facility failed to revise and implement care plans for 1 of 4 residents (Resident #4) reviewed. The facility reported a census of 33 residents. Findings include: Review of Resident #4's Minimum Data Set (MDS) dated [DATE] revealed Resident #4 utilized antipsychotic medications during the seven day look back period. Review of Resident #4's Electronic Healthcare Record (EHR) page titled, Clinical Physician Orders revealed order for antianxiety medication with no antipsychotic medication listed. Further review of the Clinical Physician Orders revealed an order for Buspirone HCL oral tablet 10 MG (Antianxiety medication). Give 1 tablet by mouth in the morning. There was no antipsychotic medication listed. Review of Resident #4's Care Plan with a revision date of 1/20/26 revealed #4 was utilizing antipsychotic medications. The Care Plan further revealed that antianxiety medications were not listed. Interview on 3/3/26 at 3:47 PM with the MDS coordinator confirmed Resident #4 was not taking antipsychotic medication, and actually taking antianxiety medication. The MDS coordinator further revealed that the care plan should have been updated as this would be her expectation. Interview on 3/3/26 at 4:22 PM with the Director of Nursing (DON) confirmed that Resident #4 was on anti-anxiety medication, and this was not on the care plan. The DON further revealed that Resident #4's antipsychotic medication should not be on the care plan, and that care plans should be updated and revised in an appropriate time frame. The DON revealed her expectation would be for care plans to be revised and developed accordingly. Review of a facility provided policy titled, Care Plans, Comprehensive Person-Centered with a revision date of December 2016 revealed:a. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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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. Based on observation, prescription package insert review, clinical record review, staff interviews, and policy review the facility failed to meet professional standards of care when administering insulin to one (Resident #24) of one residents reviewed. The facility reported a census of 33 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #24, dated 12/12/25 included a diagnosis of Diabetes Mellitus and documented the resident received insulin. Observation on 3/4/26 at 11:25 AM, Staff A, MDS Coordinator drew up 4 units of Novolog Aspart insulin, from a multi-use vial (bottle) of insulin, into a syringe and administered the insulin by injection to Resident #24. The vial was labeled with an open date of 1/19/26. Interview on 3/4/26, the MDS Coordinator stated she thought the insulin was good for 30 days, maybe 90 days. Package Insert/Prescribing Information for Insulin Aspart Injection, updated 3/10/25, revealed multi-dose vial storage date of 28 days after opened. Facility Insulin Administration Policy, revised September 2014, revealed in steps in the procedure for insulin injections via syringe to check expiration date, if drawing from a multi-dose vial, and if opening a new vial, record expiration date and time on the vial (follow manufacturer recommendations for expiration after opening). Interview on 3/4/26 at 4:00 PM, the Director of Nursing stated the vial of insulin was only good for 28 days after opened and the expectation that the insulin needs to be disposed of 28 days after the open date.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy review the facility failed to ensure residents received showers to maintain good personal hygiene for 2 (Residents #7 and #34) of 3 residents reviewed. The facility reported a census of 33 residents. Findings include:1. The Minimum Data Set (MDS) assessment for Resident #7, dated 12/26/25, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 12, indicating mild cognitive impairment. Interview on 3/2/26 at 12:57 PM, Resident #7 revealed that she does not get baths twice a week. Resident #7 further stated she would like to have her baths twice a week, but there is only one bath aide at the facility and she can't get to every bath during her shift. Review of Resident #7's clinical record task form for showers, dated 3/3/26, for a 30 day period from 2/4/26 - 3/3/25, showers were documented as completed for 5 days: 2/5, 2/7, 2/11, 2/18, and 2/25. The task form documented the resident was to receive a shower on Wednesdays and Saturdays. 2. The Minimum Data Set (MDS) dated [DATE] for Resident #34 documented a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. The MDS documented it was very important to choose between a tub bath, shower, bed bath, or spine bath Resident #34. The MDS also documented the ability for Resident #34 to shower or bathe self was not attempted due to medical condition or safety concerns. On 3/2/26 at 12:55 PM Resident #34 stated he had only received a bed bath since he had been admitted to the facility. Resident #34 explained that he did not always get 2 baths a week as he was supposed to either. Review of Resident #34's Care Plan dated 1/21/26 documented an intervention for bathing that Resident #34 was dependent on 2 staff for assistance. Review of Resident #34's EHR titled, ADL Self Care - Shower/Bathe self Tuesday and Friday documented Resident #34 was dependent and the helper did all the effort and the bath was completed on 2/3, 2/20, and 2/24 between the dates of 2/3/26 - 3/3/26. Review of document dated 3/5/26 titled, Follow Up Question Report ADL Self Care Shower/Bathe Self Tuesday and Friday provided by the DON documented bathing was completed 2/20, 2/24 and 3/3 between the dates of 2/5/26 - 3/5/26. On 3/3/26 at 11:56 AM Staff F, Certified Nurse Assistant (CNA) stated residents are supposed to get baths at least twice a week. Staff F stated there was not a bath aide at the facility but she wanted to be the bath aide and completed most of the baths on the am shift. Staff F acknowledged residents at the facility missed baths sometimes and they were not made up. Staff F explained some residents only want one bath a week. Staff F stated she would document the resident refusal and there is a form that they put the refusal on. Staff F explained the nurse was given the form and then would ask the resident over the next couple days. Staff F explained if there was only one CNA and her then the baths would not get completed and the pm shift would have to complete them. Staff F stated she had never given Resident #34 a shower. Staff F explained she had only given Resident #34 a bed bath. Staff F thought maybe some staff had one time given Resident #34 an actual shower. Staff F stated the facility had ordered Resident #34 more slings so he can get in the shower. Staff F said there were (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	only 2 slings at the facility that were the correct size for Resident #34. Staff F explained there were 2 residents at the facility that required a sling of that size. Staff F stated Resident #34 did not get showers because the facility does not have enough slings to give him a shower. Staff F acknowledged there were 2 residents that required that size slings. On 3/3/26 at 12:21 PM the DON stated she had worked at the facility since the last week of February. The DON stated if baths are missed then staff would attempt the next shift and then the next day. The DON stated unfortunately baths are missed at times and not made up. The DON explained the residents are scheduled to have a bath at least twice a week. The DON stated the bath sheet was supposed to be put under her door or Staff A, MDS Coordinator's door daily. The DON stated the baths that were missed were highlighted and moved it over on the graph to the next day. The DON acknowledged baths are missed and not made up. The DON stated the refusal should be documented on a piece of paper or in POC in the resident's EHR. On 3/5/26 at 2:35 PM the Administrator stated she had just been made aware that Resident #34 had not been given showers but only bed baths at the facility. The Administrator stated she would expect that showers would have been available to get in the last month. The Administrator explained residents at the facility should get at least 2 showers a week unless they refused the shower and that should be recorded / documented. Review of a policy revised 2/18 titled, Bath, Shower/Tub documented the purpose of the procedure was to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Documentation should include the date and time the shower / tub bath was performed. The name and title of the individual(s) who assisted the resident with the shower/tub bath. All assessment data of the resident's skin obtained during the shower/tub bath. How the resident tolerated the shower/tub bath. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken. The signature and title of the person recording the data. The staff are to notify the supervisor if the resident refuses the shower/tub bath and report any other information in accordance with facility policy and professional standards of practice.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, resident interview, staff interviews and policy review the facility failed to provide respiratory services in accordance with professional standards of practice for 1 of 2 residents reviewed (Resident #34) who required the use of a Continuous Positive Airway Pressure (CPAP) machine. The facility failed to have an order for the CPAP and failed to clean the CPAP. The facility reported a census of 33 residents.Findings include:The Minimum Data Set (MDS) dated [DATE] for Resident #34 documented a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. The MDS documented Resident #34 had a diagnosis of obstructive sleep apnea.On 3/2/26 at 3:38 PM Resident #34 stated he had not had his CPAP machine or mask cleaned by the staff since admission to the facility. Review of Resident #34's Electronic Health Record (EHR) documented no physician's order for use of a CPAP machine or any orders to clean Resident #34's CPAP machine / mask.On 3/4/26 at 4:21 PM Staff D, Certified Nurse Assistant (CNA) stated she had seen a CPAP machine in Resident #34. Staff D stated Resident #34 was usually awake when she left at 10:00 PM so she had never assisted him in the application of the mask. On 3/4/26 at 4:27 PM Staff E, Certified Medication Assistant (CMA) / CNA stated she had worked with Resident #34 several times. Staff E stated she had seen the CPAP machine in Resident #34's room but had never seen him use the CPAP machine. On 3/4/26 at 4:31 PM Staff A, MDS Coordinator stated Resident #34 does wear a CPAP mask at night. Staff A explained that usually there was an order on the Treatment Administration Record (TAR) for cleaning the CPAP machine. Staff A acknowledged Resident #34 did not have an order for use of a CPAP machine or cleaning of a CPAP machine or mask on his TAR. Staff A stated she was not sure who was supposed to clean Resident #34's CPAP. Staff A acknowledged she had never cleaned Resident #34's CPAP machine or mask. On 3/4/26 at 5:01 PM the DON stated Resident #34 should have a physician's order for the use of a CPAP machine and an order for the CPAP machine / mask to be cleaned. The DON explained the CPAP was usually cleaned on the am shift to allow time for the equipment to dry. The DON acknowledged Resident #34 had no physician's order for the use of the CPAP machine and no order for cleaning the CPAP machine / mask on the TAR. Review of a policy revised 3/15 titled, CPAP/BiPAP Support documented the purpose of the policy was to provide the spontaneously breathing resident with continuous positive airway pressure with or without supplemental oxygen. In preparation, review the physician's order to determine the oxygen concentration and flow, and the PEEP pressure for the CPAP machine. General guidelines for cleaning include obtaining from the manufacturer / supplier of the CPAP device specific cleaning instructions. When cleaning the CPAP machine wipe the machine with warm, soapy water and rise at least once a week and as needed. Masks would be cleaned daily by placing them in warm, soapy water and soaking for 5 minutes. Mild dish detergent is recommended. Rinse with warm water and allow it to air dry between uses. Documentation for use of CPAP in the resident's medical record would include a general assessment prior to procedure, time CPAP was started with duration of therapy, mode and settings for CPAP, how the resident tolerated the procedure.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interview and policy review the facility failed to provide appropriate infection prevention practices when providing care to a resident with a catheter for 1 of 3 reviewed (Resident #10). The facility reported a census of 33 residents.Findings include:The Minimum Data Set (MDS) dated [DATE] for Resident #10 documented a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. The MDS also documented utilization of an indwelling catheter. Review of Resident #10's Treatment Administration Record (TAR) documented a physician's order to cleanse suprapubic catheter sites with soap, rinse/dry thoroughly. Apply 4x4 or drain sponge every shift. On 3/4/26 at 10:19 AM an observation of catheter cares and transfer of Resident #10 revealed Staff H, Certified Nurse Assistant (CNA) and Staff G, CNA / Certified Medication Assistant (CMA) completed hand hygiene. Staff G applied gloves, cleansed abdomen with peri wipe, cleansed catheter tubing down about 6-8 inches, completed hand hygiene, applied gloves, applied 4x4 split sponge to catheter tubing. Both staff removed gloves, completed hand hygiene, applied gloves. Staff H applied straps to left side lift straps to the full body mechanical lift, Staff G applied right side lift straps to the full body mechanical lift. Staff H utilized full body lift controls, Staff G assisted Resident #10 and directed the resident in the full body mechanical lift cloth to the wheelchair. Staff H removed lift cloth from the lift, applied blanket to Resident 10, Staff G removed gown and gloves, opened room door, did not complete hand hygiene. Staff G backed Resident #10 from the room, placed Resident #10's feet on the foot pedals, pushed Resident #10 down the hall past the next room on the right room [ROOM NUMBER], obtained hand sanitizer from the wall dispenser, completed hand hygiene. Staff H removed gown, removed gloves, completed hand hygiene, Staff H took lift towards the door, applied gloves, cleansed lift with sanitizing wipes, and placed lift in room across the hallway. On 3/4/26 at 11:27 AM Staff G, stated there was a missed opportunity for hand hygiene when she removed her gown and gloves in the bathroom prior to taking the resident down the hall. Staff G explained she thought when she was walking down the hall that she should have completed hand hygiene in the bathroom when she removed the gloves and gown.On 3/4/26 at 12:23 PM the DON acknowledged concerns when observation was shared with her about hand hygiene not being completed appropriately when Staff G left the room with Resident #10 and did not complete hand hygiene in the room after doffing gloves and gown. The DON stated she expected hand hygiene would be completed whenever gloves were removed.Review of a policy revised 8/19 titled, Handwashing / Hand Hygiene documented the facility considered hand hygiene the primary means to prevent the spread of infections. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water before and after direct contact with residents and after removing gloves.