STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165452	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wapello Specialty Care	601 Highway 61 South Wapello, IA 52653

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 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** 47336 Based on observations, clinical record review, facility policy review and staff interviews the facility failed to update care plans to address one residents wandering, and to address another resident taking the property of others while wandering in the building for 2 of 2 residents (Resident #39 and Resident #6) reviewed for wandering. The facility reported a census of 44 residents. Findings include: 1. The Minimum Data Set (MDS) assessment, dated 8/16/24, for Resident #39 included a Brief Interview for Mental Status (BIMS) score 00 out of 15 indicating a severe cognitive impairment. The MDS revealed the resident displayed wandering behavior daily. The MDS documented the resident used a wheelchair and dependent with chair/bed to chair transfers. The MDS listed diagnoses included: non-Alzheimer's dementia, amnesic disorder due to known physiological condition, and delirium due to known physiological condition. The Care Plan did not included a Focus area or Interventions for wandering behavior. The Progress Notes dated 9/19/24 at 7:17 AM, revealed the resident attempted to leave the front door when someone left for an appointment and had to be stopped. He had been wandering up and down halls going into other residents room this am. During an observation on 9/30/24 at 12:45 PM, the resident propelled self into another resident's room. The staff intervened and the resident self propelled himself back into the hallway. During an observation on 9/30/24 at 1:05 PM, the resident propelled self throughout the building (opposite hallway of his room), and sat at the exit door. During an observation on 10/2/24 at 1:00 PM, the resident wandered in the hall and attempted to go into another resident's room. Two staff intervened asking the resident to not go into the room. The resident moved out of the doorway to the room. During an interview on 10/2/24 at 3:04 PM, Staff D, Certified Nursing Assistant, (CNA) stated Resident #39 wandered into other resident's room. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/3/24 at 2:14 PM, Staff C, LPN (Licensed Practical Nurse) stated the resident wandered into other resident's rooms. During an interview on 10/3/24 at 2:48 PM, the Director of Nursing (DON) stated Resident #39 wandered into other resident's rooms. She stated she put out education for staff to redirect him to the front area. The DON stated the wandering needed to be care planned. 2. The MDS assessment, dated 9/6/24, for Resident #6 included a BIMS score of 4 out of 15, indicating a severe cognitive impairment. The MDS revealed the resident displayed wandering behavior daily. The MDS indicated the resident displayed behavior of significantly intrusion on the privacy or activity of others. The MDS listed diagnoses included: schizophrenia, restlessness and agitation, and obsessive-compulsive behavior. The Care Plan included a Focus area, dated 2/24/24, to address the risk for elopement related to safety awareness. Interventions included: Alert staff to my wandering behavior; I like activities that involve food and 1:1 conversation; and Provide divisional activities for me. The Care Plan included a Focus area, revised on 4/17/23, to address My wandering intrudes on other's privacy. Interventions included: Alert staff to my wandering behavior; Approach me positively and in calm, accepting manner; If I wander away from unit, instruct staff to stay with me, converse and gently persuaded me to walk back to designated area with them; Redirect me when I wander into other's rooms. The Care Plan did not address Resident #6 taking another residents property when wandering into rooms. A Behavior Note, dated 6/28/24 at 1:11 PM documented He [Resident #6] has been entering residents rooms and taking items from their rooms today. He has been re-directed multiple times and staff found he had taken a residents tablet and hid it in his shirt, Nurse is shutting doors when residents leave the rooms to keep him from coming in but he is entering the rooms in spite of doors being closed. The Behavior Note, dated 7/29/24 at 9:40 AM, documented He [Resident #6] sent into a residents room and took her phone from her room. Nurse wiped it down and gave it back to the resident since he had it inside his clothing. Nurse will let the ADON (Assistant Director of Nursing) know of his behavior. The resident told him she had an agreement and he was to stay out of her room and he stated ok. The Behavior Note, dated 8/17/24 at 10:31 AM, documented He [Resident #6] had taken two separate phones that did not belong to him and nurse had to return them. The CNA reported he yelled and became agitated with cares and hit at her during his shower. During an observation on 9/30/24 at 4:03 PM, Resident #6 self propelled himself in his wheelchair into a resident's room, under her stop sign, staff noticed and instructed him to back up and he was easily redirected and backed up from the room. During an interview on 10/2/24 at 3:07 PM, Staff D, CNA stated Resident #6 wandered into other resident's rooms and took things. Staff D stated if something came up missing they looked in his room or asked him to change his clothes to see if he hide the items on his person. Staff D stated they usually found the missing items within a couple of hours. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/3/24 at 10:00 AM, Staff E, CNA stated Resident #6 got into everything and everybody's rooms. Staff E stated the women shooed him from their hallway because they knew he would go into their rooms. Staff E stated they eventually get the items back from the resident. Staff E stated room [ROOM NUMBER] had a stop sign to prevent him from going into her room. During an interview on 10/3/24 at 10:51 AM, Staff G, CNA stated Resident #6 went into other resident's room and took things and sometimes they got them back. Staff G stated she knew the residents got quite upset and they knew he took their items. Staff G stated he went into [name redacted] room and took his billfold and flashlight, but the items were returned. During an interview on 10/3/24 at 2:11 PM, Staff C, LPN stated Resident #6 wandered and took other resident's things. Staff C stated the staff did a better job at keeping him on the men's hall and he been doing better the last few months. During an interview on 10/3/24 at 2:50 PM, the DON confirmed Resident #6 went into other resident's room and if he had something that didn't belong to him, he gave it back. The DON stated she felt his behavior improved since she returned to the facility. The DON confirmed his behavior for taking resident's property needed addressed on the care plan. The DON stated she had family in the past that were no longer here that complained about Resident #6 going into their family member's room and they put a stop sign in their door. The Facility Care Plans, Comprehensive Person-Centered Policy revised December 2016 revealed the following: a. The comprehensive, person centered care plan would: 1. Incorporate identified problem areas b. Areas of concern that were identified during the resident assessment would be evaluated before interventions were added to the care plan. c. Identified problems areas and their causes, and developed interventions that were targeted and meaningful to the resident, and were the endpoint of an interdisciplinary process.

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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. 45338 Based on observation, interview, clinical record review, and facility policy review the facility failed to ensure medication was available and administered per physician order for one of six residents reviewed for medications (Resident #18). The facility reported a census of 44 residents. Findings include: Review of the Minimum Data Set (MDS) assessment, dated 7/4/24, for Resident #18 revealed the resident scored 12 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated moderately impaired cognition. Per this assessment, the resident did not take antipsychotic medication. Review of Resident #18's Care Plan dated 8/21/24 revealed, I have a psychosocial well-being problem (actual or potential) related to lack of acceptance to current condition, lack of motivation, social isolation. The Physician Order for Resident #18 dated 7/16/24 revealed, Aripiprazole Oral Tablet 10 MG (milligram), an antipsychotic medication, with instructions to give 1 tablet by mouth at bedtime related to Borderline Personality Disorder. Review of Resident #18's Progress Notes documented the following in regards to the order for: a. 7/16/2024 at 8:49 PM: has not arrived from the pharmacy. b. 7/17/24 at 7:12 PM: Medication is not available. c. 7/21/24 at 7:44 PM: On order. d. 7/22/24 at 7:27 PM: waiting for pharmacy to send. e. 7/28/24 at 7:55 PM: ordered. f. 7/29/24 at 7:35 PM: no card found, ordered from pharmacy. Review of the resident's Medication Administration Record (MAR) dated July 2024 for 7/16/24 through 7/29/24 documented the medication administered on the following dates: a. 7/18/24 through 7/20/24 b. 7/23/24 through 7/27/24 Review of a Packing Slip dated 7/24/24 revealed 31 tablets of aripiprazole 10 MG for Resident #18 was included in the delivery. A Packing Slip dated 7/29/24 revealed 3 tablets of aripiprazole 10 MG for Resident #18 was included in the delivery. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation conducted on 10/02/24 at 10:22 AM revealed Resident #18 present in the activity room with other residents. Resident #18 had red gripper socks to their feet. On 10/3/24 at 12:28 PM, the Assistant Director of Nursing (ADON) explained pharmacy delivered every night except Sunday. Per the ADON, the pharmacy closed at noon on Saturday, so if an order did not get in before noon on Saturday would get it [medication] Monday night, and resident wouldn't have the med until Tuesday morning. Per the ADON, the pharmacy did not come in until 9:30 PM/11:00 PM, and third shift nurse would address. The ADON further explained sometimes the pharmacy did not have Abilify (brand name for aripiprazole) in stock. The ADON confirmed the facility did not have Abilify in back-up supply. On 10/3/24 at 12:42 PM when queried about the above timeline for the residents aripiprazole, the Director of Nursing (DON) explained she would call the pharmacy. Per the DON, the pharmacy came in the evening and night shift nurse received medications. The DON explained when got 31 tabs would be for the next month, for the month change over. On 10/03/24 at 1:41 PM, the DON explained she reached out to the nurses, and they did not remember. The DON explained she was still waiting on the pharmacy to send their delivery slips, and staff were not aware of additional information. Review of the facility policy titled Administering Medications, dated 2001 and revised 4/2019, revealed the following: Medications are administered in a safe and timely manner, and as prescribed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47336 Based on clinical record review, facility policy review and staff interviews the facility failed to follow Care Plan fall risk interventions, leading to a fall for one of four residents (Resident #36) reviewed for falls. The facility reported a census of 44 residents. Findings include: The Minimum Data Set (MDS) assessment, dated 5/14/24, revealed Resident #36 scored a 15 out 15 on the Brief Interview for Mental Status (BIMS) exam, indicating intact cognition. The MDS listed an impairment on both lower extremities. The MDS assessed the resident needed maximal/substantial assistance with upper and lower body dressing, and dependent on staff for sit to stand transfers, and chair/bed to bed transfers. The MDS listed diagnoses included: heart failure, lack of coordination, and reduced mobility. The MDS assessment did not indicate the residents fall history prior to or since admission on 3/5/24. The Care Plan Focus area, dated 3/5/24, addressed Activities of Daily Living (ADLs). Interventions included, in part: Transfer-I require 1 assist using bariatric walker and gait belt; Upper Body Dressing - I require 1 assist; Lower Body Dressing - I require one assist. The Care Plan Focus area, dated 7/23/24, addressed I am at risk for falls. Interventions included, in part: Staff will assist me with dressing and undressing while sitting down. A Nurses Note, dated 7/22/24 at 10:00 PM, documented CNA (Certified Nurse Aide) was dressing resident for bed and resident lost balance and fell backward into closet hitting his ear on the door frame. Acquired 2 skin tears to right wrist, a skin tear between left thumb, and first finger, and a skin tear to his left ear. Also has abrasion to middle of his back. Wife notified and ADON (Assistant Director of Nursing) notified and Dr. faxed. I just lost my balance and went backwards. Assist of 3 to get up to walker and into bed. The Incident report #1351 revealed a witnessed fall dated 7/22/24 at 10:00 PM with the following information: a. Nursing description: CNA was dressing the resident for bed and resident lost his balance and fell backward into closet hitting his ear on the door frame. acquired 2 skin tears to right wrist, a skin tear to left thumb, a skin tear between left thumb and first finger, and a skin tear to his left ear. Also had abrasion to middle of his back. Wife notified and ADON notified and doctor faxed. b. Resident description: I just lost my balance and went backwards. c. Immediate Action Taken: Assist of 3 to get up to walker and into bed. e. Injuries: abrasion to the right scapula; skin tear to right hand, left ear, left finger(s), and right wrist. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. Mobility: ambulatory with assistance g: No predisposing environmental or physiological factors h: Predisposing situation factors: ambulating with assist I: Statements: Staff D stated the resident held onto the walker and while she put his gown on for bed, the resident went backwards and fell into the closet hitting his ear on the doorframe. DJ: Notes: dated 7/23/24: staff assisted resident with dressing and undressing while sitting down. During an interview on 9/30/24 at 12:11 PM, Resident #36 stated he fell twice since being at the facility and the first time was the staff's fault. He stated the staff member got him up to go to bed and when she let go of him, he fell into the closet and onto the floor. He stated he didn't get hurt, but was bruised and scratched up. Resident #36 stated the staff member didn't use a gait belt. Resident #36 stated the staff member took off his shirt when he stood up and they normally did it when he sat in the chair or on the bed, and when she took off his shirt he lost his balance and fell . Resident #36 stated he didn't recall what the staff member's name was. During an interview on 10/2/24 at 2:54 PM, Staff D, CAN (Certified Nurse Aide) stated she recalled the incident with she helped Resident #36 and he fell backwards. She stated he fell into the closet and she tried to catch him and he bumped his ear. She stated she was transferring him to change him. She stated she had a gait belt on the resident and she wasn't going to change him until she got him to bed. Staff D stated the resident a one assist with a gait belt and would lose his balance out of nowhere. She stated she was moving to the other side of him and she let go of the gait belt to get to the other side and within a second he lost his balance. Staff D stated now, she holds on to the gait belt with a death grip because she doesn't want that to happened again. During an interview on 10/3/24 at 10:20 AM, Staff E, CAN queried if she changed Resident #36 while standing and she stated no and the only time would be if he sat on the toilet and when he stood up, she would pull his pants up. Staff E stated she would never change a resident's shirt while standing up because they were unsteady and didn't have the balance and she didn't feel safe to do it. Staff E queried if you could ever take your hand off the gait belt when transferring and she stated no. During an interview on 10/3/24 at 2:04 PM, Staff HO, LP (Licensed Practical Nurse) stated she recalled the incident with Resident #36 falling into the closet and she stated the resident fell backwards because the CAN stood in front of him. Staff HO stated the CAN did use a gait belt and the CAN told her, she was changing his bottoms and he fell backwards when he lifted his feet. Staff HO stated she wouldn't change a resident's clothing standing up because they were unsteady as it was and she would sit him down and change him. During an interview on 10/3/24 at 3:00 PM, the DON (Director of Nursing) stated she didn't recall the incident and needed to go back and look. The DON queried if a resident should have his pants and shirt changed while standing up and the DON stated socks and a shirt could be put on before the resident stood up and no, they shouldn't change him while standing. The facility policy, revised March 2018, titled Assessing Falls and Their Causes, Preparation section directed staff to: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review the resident's care plan to assess for any special needs of the resident.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 45338 Based on clinical record review, staff interview, and facility policy review the facility failed to ensure prompt treatment for a urinary tract infection (UTI) for one of two residents reviewed for UTI (Resident #30). The facility reported a census of 44 residents. Findings include: Review of Resident #30's Minimum Data Set (MDS) assessment revealed the resident scored 5 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated the resident was severely cognitively impaired. Review of the Care Plan dated 9/27/23 revealed, Activities of Daily Living (ADL's). The Intervention most recently revised 12/11/23 revealed, Toileting - I require no assist. The Physician Order dated 6/3/24 revealed, UA (urinalysis), reflex to culture one time only for urgency and burning until 06/03/2024 23:59 (11:59 PM). Review of Progress Notes for Resident #30 dated 6/3/24 and 6/4/24 revealed the following: a. 6/3/24 at 11:31 AM: Resident has been complaining of urgency with urination, can hardly make it to the bathroom. And burning with urination, note to physician, coming today to see her. b. 6/3/24 at 12:58 PM: New order for UA (urinalysis) with culture, son aware of new order. c. 6/4/24 at 9:24 AM: Nurse will have her to give a fresh clean catch urine sample. d. 6/4/24 at 11:02 AM: She had reported discomfort with voiding the other day and her urine sample was collected and it will be sent to the lab to check for UTI (urinary tract infection). Review of Urinalysis Results for Resident #30 dated 6/4/24 revealed the resident had turbid urine with abnormal leuk esterase (screen for white blood cells and other signs of infection in urine), abnormal urine WBC (white blood cell), and abnormal urine RBC (red blood cell). Continued review of Resident #30's Progress Notes dated 6/5/24 to 6/6/24 revealed the following: e. 6/5/2024 at 8:34 AM: Awaiting results from UA. Resident states she is still having some discomfort upon urination. f. 6/5/24 at 8:25 PM: Waiting on UA results. Continues to urinate often with very little output. g. 6/6/24 at 9:46 AM: This nurse called [Hospital Name Redacted] for UA results lab states results are preliminary at this time. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	h. 6/6/24 at 10:53 AM: [Name Redacted] noted UA results with ABN awaiting C&S (culture and sensitivity) to guide Tx (treatment). Review of the Bacteriology Report with Verified Date and Time 6/7/24 at 7:11 AM revealed greater than 100, 000 cfu/ml (colony forming unit per milliliter) Psuedomonas aeruginosa. The fax was dated 6/7/24. Continued review of Resident #30's Progress Notes dated 6/8/24 to 6/11/24 revealed the following: i. 6/8/24 at 2:59 PM: Awaiting provider to review UA results, no new orders at this time. Resident appears at baseline & able to make needs known to this nurse. VS (vital signs) WNL (within normal limits) with no S/S (signs/symptoms) of UTI at this time. j. 6/10/24 at 10:11 AM: Physician in today to look over ua results, resident has been out to meals without any symptoms of UTI at this time. k. 6/10/24 at 11:43 AM: New order for Cipro 500 mg (milligram), daily for 3 days for UTI. l. 6/11/24 at 10:24 AM: Resident started ATB (antibiotic) today 6/11 for a UTI. Resident tolerating first dose this morning well. Denies any pain or discomfort at this time. In room doing nebulizer treatment. Vitals stable, plan of care ongoing. The Physician Order dated 6/11/24 to 6/14/24 revealed, Cipro Oral Tablet 500 MG (milligram)(Ciprofloxacin HCl), an antibiotic medication, with instructions to give 500 mg (milligram) by mouth one time a day for UTI for 3 Days. Review of the resident's Medication Administration Record dated June 2024 revealed the resident received Cipro on 6/11/24, 6/12/24, and 6/13/24. On 10/3/24 at 1:42 PM, the Director of Nursing (DON) queried about UA and C&S results, and explained they would be faxed to the facility. When queried how results sent to the provider, the DON explained by fax. The DON explained the following about C&S: would get a response that day or would call. When queried if would wait for the provider to come in and look at C&S results, the DON responded no. When queried if nurses would chart if fax the doctor with results, DON responded, yeah. On 10/3/24 at approximately 2:25 PM, the Assistant Director of Nursing (ADON) queried about the provider (who was noted to sign the culture result for the resident), and explained it was a provider who had covered in a gap between other Providers. On 10/3/24 at 2:30 PM during an interview with Staff C, Licensed Practical Nurse (LPN), Staff C queried about how they got results from a urine culture from the lab. Staff C explained she would call the lab for culture results, then would call the doctor. Per Staff C, would call and have the results faxed to them so they had the paper. (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/3/24 at 2:39 PM the ADON/Infection Preventionist queried if staff got urine culture back,what do they do? The ADON explained the following for providers noted to be current providers at the facility (not the provider who signed Resident #30's culture report): For one provider, would call and read results to them, and other provider would get them immediately. The ADON explained for provider who could see results, facility would call and explain that the results were in. Per the ADON, at time when providers were covering, there was an on-call phone that nurses could call. When queried if staff should have called, the ADON acknowledged should have called the on call phone, and if did call acknowledged staff needed to note it. On 10/3/24 at 3:05 PM, the DON explained once got the ua sent to lab, the DON always called the next day, and would call every single morning to see if the results back. Per the DON, if C&S indicated, took a few more days, and the DON would call and check until results received. The DON further explained the provider would be notified that day. Per the DON, sometimes the C&S took 2 to 3 days, and as soon as back like to get started on antibiotics as indicated. Review of the Facility Policy titled Antibiotic Stewardship dated 2001, revised 12/16, revealed the following: 11. When a culture and sensitivity (C&S) is ordered lab results and current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165452	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Wapello Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 601 Highway 61 South Wapello, IA 52653	

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45338 Based on observations, staff interviews, Food Code review, and facility policy review the facility failed to ensure foods were appropriately labeled and dated and failed to ensure meal service conducted in a sanitary manner for all residents who received food from the kitchen. The facility reported a census of 44 residents. Findings include: On 9/30/24 at approximately 10:20 AM during an initial tour of the kitchen, the following was observed: a. One package of cheddar cheese open and undated. b. Open smoked ham dated 9/22. c. One 5 pound container homestyle chicken salad dated 9/22. d. One bag of chicken fried steak in the reach in freezer with no date visible on the bag. Observation of the lunch meal service conducted on 10/1/24 revealed the following: a. On 10/1/24 at 11:28 AM Staff B, [NAME] picked up a key from the floor and then went back to preparing drinks. b. On 10/1/24 at 11:43 AM Staff B picked up an ice scoop that was present on top of the milk cooler and used it to fill drinks with ice. c. During the lunch meal service, the handwashing sink observed to be used to fill drinks. d. On 10/1/24 at 11:40 AM, Staff B observed wiping hands on shirt then touching drink. e. On 10/1/24 at 11:56 AM Staff B picked something up from the floor. Another staff member utilizing the hand sink at the time. Staff B then observed working with drinks in the kitchen. f. On 10/1/24 at 12:10 PM, Staff B brushed off a tray that Staff B held over the hand washing sink. On 10/3/24 at 1:55 PM during an interview with Staff A, [NAME] who was covering during the Manager's absence, Staff A explained the following about label/dating: No matter what comes on the truck is first date, with freezer has pull date, and for other items has open date. Staff A explained everything should have two dates, delivery and opened or sticky pull date (date when pulled out of freezer). When queried about using the hand sink to fill water pitchers, Staff A acknowledged was 50/50 if used the hand sink. Staff A acknowledged if staff dropped item on ground should wash hands, and also explained tried to keep the ice scoop with the ice. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165452	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Wapello Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 601 Highway 61 South Wapello, IA 52653	

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 2022 Food Code revealed, 5-205 Operation and Maintenance 5-205.11 Using a Handwashing Sink. (A) A HANDWASHING SINK shall be maintained so that it is accessible at all times for EMPLOYEE use. Pf (B) A HANDWASHING SINK may not be used for purposes other than handwashing. On 10/3/24 at approximately 3:20 PM, the Administrator explained the other sink in the kitchen was the handwashing sink. Review of the Facility Policy titled Sanitation, dated 2001 and revised 10/2008, revealed the following: The food service area shall be maintained in a clean and sanitary manner.