DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING Accura HSC B. WING	C 06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF SIOUX CITY, LLC	3800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

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F 000	INITIAL COMMENTS The following deficiencies are the result of a complaint investigation conducted 6/15/17-6/22/17. Complaint 68726-C was not substantiated. 68767-C was substantiated. See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C.	F 000	Accura Healthcare of Sioux City does ensure that alleged violations involving mistreatment, neglect, or abuse are reported immediately to the Administrator or the facility and to other officials in accordance with state law through established procedures.	
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 225	1. Resident #1 remains in the facility and has been free of abuse. Staff meeting was conducted on 6/13/17 in which abuse reporting was addressed. 2. Counseling was conducted immediately to all 3 employees involved on proper reporting time and reporting all allegations of abuse, immediately to charge nurse per facility policy. 3. Abuse reporting procedure will continue to be part orientation of all staff upon hire. 4.Quality assurance team will monitor al allegations of abuse and timely reporting. Date of Correction 6/23/17	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Admin Asst | (X6) DATE: 06/29/2017

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.

POC accepted 7/10/17 VNunnink

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F 225	Continued From page 1 (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and review of facility policy and procedures, the facility failed to report allegations of possible abuse to the Iowa Department of Inspections and Appeals (DIA) within 24 hours (Resident #1). The sample	F 225		

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F 225	Continued From page 2 consisted of 4 residents and the facility reported a census of 41 residents. Findings include: Resident #1 had a MDS (Minimum Data Set) assessment with a reference date of 6/14/17. Resident #1 scored 3 on the Brief Interview for Mental Status (BIMS). A score of 3 identified the resident had a severe cognitive impairment. The MDS indicated the resident's diagnoses included Alzheimer's disease, underweight, and an anxiety disorder. The resident required extensive of two staff members for bed mobility, transfers, dressing, and toilet use. Resident #1 required extensive assistance of one staff member with personal hygiene and bathing. The MDS identified Resident used a wheelchair for mobility. A late entry Progress Note by Staff D, licensed practical nurse (LPN) for 6/11/17 identified the resident exhibited increased agitation at 1:45 PM, headed for the front door and stated he/she was going to blow the place up. The staff redirected the resident to the nursing station while the resident grabbed the handrails in the hall and standing and yelling the same thing. The staff gave the resident a scheduled Lorazepam (anti-anxiety medication) at 3:10 PM. The progress note further documented the agitation continued to increase with the resident swinging his/her fist, kicking and yelling at the nurse's station. The aides took the resident to his/her room. The Hall 100 nurse assisted Staff D to give a Haldol (anti-psychotic medication) injection. On 6/15/17 at 11:35 AM, the Administrator was interviewed and stated on 6/11/17, Staff A (LPN)	F 225		

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F 225	Continued From page 3 notified him that a certified nursing assistant (CNA) struck a resident approximately 2 or 2.5 hours ago. The Administrator stated the shift ended at 6:00 p.m. for the nursing assistant involved in the incident. The incident happened about 4:45 p.m. The Administrator stated he came to the facility and contacted the police. The police officer informed the Administrator that there was no abuse. The Administrator said he did not report the incident to the Iowa Department of Inspection and Appeals since the details were so gray. The Administrator stated the resident did not have injuries and the facility suspended the nursing assistant involved. The Administrator stated he conducted an in-service to the staff on 6/13/17 about resident rights and abuse. On 6/19/17 at 1:40 PM, Staff A was interviewed and stated she called the Administrator at approximately 8:00 PM after Staff B, CNA and Staff C, CNA reported the incident to her. The Administrator stated the staff weren't quite sure if the incident was self-defense on the CNA's part because the resident had been very combative and hitting the CNA. On 6/19/17 at 1:50 p.m., Staff B (CNA) was interviewed and stated Resident #1 punched at the aides and had been hit many times by this resident. Staff B stated she pulled the resident backwards in the wheelchair from the nurse's station to the resident's room. Staff B stated she did this because his/her feet were down. Staff C came into the room and stood the resident from the wheelchair (this can cause further agitation to a resident). The resident raised his/her right hand up to Staff E's face but did not see contact with Staff E. Staff E raised an open hand and made contact with the resident's left cheek and	F 225		

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F 225	Continued From page 4 with her right hand. Staff B stated she heard a pop and she did not know if Staff E blocked a hit. Staff B stated she would back off if the resident seemed agitated. Staff B stated she waited to report this but didn't want to believe this had happened. Staff B stated the resident had no marks on his/her face but should have reported this incident right away. Staff B stated she reported this to Staff A around 7:20 p.m. and the incident occurred at 4:45 p.m. On 6/19/17 at 11:11 a.m. Staff C (CNA) was interviewed and stated the door of the resident's room opened and she turned to see what was happening. The resident seemed calm then. The resident was incontinent and she saw Staff E's hand come down and heard a skin to skin sound but did not see a slap. Staff E wanted to change the resident's brief and the resident said "no you are not". Staff C instructed Staff E to leave the resident alone until he/she is calm. Staff E stayed with the resident until he/she calmed down and then she changed his/her brief. On 6/20/17 at 2:29 p.m., Staff E (CNA) was interviewed and stated Resident #1 will become very combative and non-compliant. Staff E stated she worked on 6/11/17 from 6:00 a.m. until 6:00 p.m. Staff E stated the resident became agitated about 3:00 p.m. and wanted to go home. The resident got close to the nurse's station to pull himself/herself up from the wheelchair. Staff E locked the wheelchair wheels and held the chair on one side. The resident began to hell and cussed for 40 minutes. Staff B stated she and Staff B took the resident to his/her room. Staff E stated she stayed in front of the resident and pushed the chair down the hall with feet dragging. The resident's gray sweat pants were	F 225		

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F 225	Continued From page 5 soiled with urine. The urine leaked through the brief and pants. Staff E stated when she went to open the room door, the resident punched Staff E in the chin. The resident grabbed her under the left eye and Staff E put hand up to pull his/her hand off of her face. Staff E stated the other hand came up to block spitting in her face. Staff E stated her hand brushed the resident's left side of face. Staff E stated she waited 40 minutes at the foot of the resident's bed for him/her to settle down. Staff E stated she could never change the resident's brief. Staff E stated after the resident settled, she took the resident to the dining room. Review of the facility policy and procedure titled Abuse Prevention, Identification, Investigation and Reporting, effective 4/14/17, documented all allegations of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin, and misappropriation should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Administrator or designated representative. All allegations of resident abuse shall be reported to the Iowa Department of Inspections and Appeals (DIA) not later than two (2) hours after the allegation is made. All allegations of resident neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation shall be reported to the Iowa Department of Inspections and Appeals, not later than two (2) hours after the allegation is made, if the events that cause the allegation result in serious bodily injury or not later than twenty-four (24) hours if the events that cause the allegation involve neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation, but do not result in bodily injury.	F 225		

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F 225	Continued From page 6 Review of the Iowa Department of Inspections and Appeals form titled Intake Information, identified the facility reported the allegation on 6/14/17 at 9:00 a.m. and at 10:43 a.m.	F 225		