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

PRINTED: 06/29/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI	TIPLE NG	CONSTRUCTION ASC	(X3) DATE COMP	SURVEY PLETED		
		165436	B. WING			l .	C		
_		199430	D. WING			U5!	06/22/2017		
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE				
ACCURA	HEALTHCARE OF SIOUX	CITY, LLC			800 INDIAN HILLS DRIVE				
Adopter thank the district of the state of t				S	BIOUX CITY, IA 51104				
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		3D		PROVIDER'S PLAN OF CORRECTION	=	(X5) COMPLETION		
PREFIX	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL AG REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		DATE		
IAG			,,,,,		DEFICIENCY)				
	<u></u>		<del>                                     </del>				-		
F 000	INITIAL COMMENTS		l F	000					
, 000	((4) 11 12 00 IMIN 21 11 0		•		Accura Healthcare of Sioux City d	റക്ക			
					ensure that alleged violations invo				
		ncies are the result of a	1		mistreatment, neglect, or abuse a				
	complaint investigatio				reported immediately to the	<del>.</del>			
		nplaint 68726-C was not				other	] .		
	•	-C was substantiated. See ulations (42 CFR) Part 483,			Administrator or the facility and to officials in accordance with state				
	Subpart.B-C.	illations (42 OFR) Fait 405,				avv			
E 225	•	(4) INVESTIGATE/REPORT	F-	225	through established procedures.		[		
1 220 CC-D	ALLEGATIONS/INDIV	Intial s	'	220		.:1:4			
33-0	ALLEO, MONOMINE	110011110			1. Resident #1 remains in the fac				
	483.12(a) The facility	must-			and has been free of abuse. Staf				
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				meeting was conducted on 6/13/				
	(3) Not employ or other	erwise engage individuals			in which abuse reporting was add				
	who-		]		2. Counseling was conducted im		iy j		
					to all 3 employees involved on pr				
	(i) Have been found g	uilty of abuse, neglect,	İ		reporting time and reporting all al		\ <sup>18</sup>		
		priation of property, or			of abuse, immediately to charge	luise			
	mistreatment by a cou	ɪrt of law;			per facility policy.	ļ			
					3. Abuse reporting procedure will				
		entered into the State			continue to be part orientation of	ali Staff			
		nceming abuse, neglect,			upon hire. 4.Quality assurance team will mo	nitar al			
	exploitation, mistreatn misappropriation of th				allegations of abuse and timely re	nortine	L I		
	meappropriation or th	eli property, oi			Date of Correction 6/23/17	sporung	<b>!</b> ·		
	(iii) Have a disciplinan	y action in effect against his			Date of Correction 0/23/17	ı			
		ense by a state licensure							
		inding of abuse, neglect,							
	exploitation, mistreatn								
	misappropriation of re								
		nurse aide registry or				ļ			
-		ny knowledge it has of							
		aw against an employee,					. 1		
		Infitness for service as a	[	Ì					
	nurse aide or other fac	cility staff.				ļ			
1	(a) in sonnanna in -II-	gatiana of shuga madast	[						
***************************************	evolutation or mistra	gations of abuse, neglect, atment, the facility must:					Ì		
	_					]			
ABORATORY D	IREO OR'S OR PROVIDERS	UPPOER REPRESENTATIVE'S SIGNATURE	I		A TITLE		(X6) DATE		
=	K _ //	// _			Ad in the		NR/20/2017		

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KJ9T11

Facility ID: IA044

If continuation sheet Page 1 of 7

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/29/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 165435 B. WING 06/22/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3800 INDIAN HILLS DRIVE ACCURA HEALTHCARE OF SIOUX CITY, LLC SIOUX CITY, IA: 51104 PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 225 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 of 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE ŞURVEY COMPLETED		
		165435	B. WNG_		C 06/22/2017		
NAME OF PROVIDER OR SUPPLIER  ACCURA HEALTHCARE OF SIOUX CITY, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 3800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	QULD BE	(X5) COMPLETION DATE	
	Findings include:  Resident #1 had a Mi assessment with a re Resident #1 scored 3 Mental Status (BIMS) resident had a severe MDS indicated the resident for bed disorder. The resident staff members for bed dressing, and toilet us extensive assistance personal hygiene and identified Resident us  A late entry Progress practical nurse (LPN) resident exhibited incrheaded for the front digoing to blow the place the resident grabbed the istanding and yelling the gave the resident a sc (anti-anxiety medication progress note further econtinued to increase his/her fist, kicking and station. The aides too room. The Hall 100 mi give a Haldol (anti-psy injection.	DS (Minimum Data Set) ference date of 6/14/17. on the Brief Interview for . A score of 3 identified the e cognitive impairment. The sident's diagnoses included underweight, and an anxiety it required extensive of two if mobility, transfers, se. Resident #1 required of one staff member with bathing. The MDS ed a wheelchair for mobility.  Note by Staff D, licensed for 6/11/17 identified the reased agitation at 1:45 PM, oor and stated he/she was be up. The staff redirected ring station while the mandrails in the hall and the same thing. The staff cheduled Lorazepam on) at 3:10 PM. The documented the agitation with the resident swinging d yelling at the nurse's k the resident to his/her turse assisted Staff D to rehotic medication)	. F 2				
		M, the Administrator was Гол 6/11/17, Staff A (LPN)					

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		166435	B. WING		C 06/22/2017			
		100439	12.110	_	STREET ADDRESS, CITY, STATE, ZIP CODE	j Ubi	22/2017	
NAME OF P	ROVIDER OR SUPPLIER							
ACCURA	HEALTHCARE OF SIOL	IX CITY, LLC			800 INDIAN HILLS DRIVE			
71000101	,,_,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,		S	SIOUX CITY, IA 51104			
(X4) ID PREFIX TAG				x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 225	Continued From pag	ge 3	F	225				
	notified him that a ce	ertified nursing assistant					ļ	
	(CNA) struck a resid	ent approximately 2 or 2.5						
	hours ago. The Adm	inistrator stated the shift						
	ended at 6:00 p.m. f	or the nursing assistant						
	involved in the incide	ent. The incident happened						
	about 4:45 p.m. The	Administrator stated he					1	
	came to the facility a	and contacted the police. The					<b></b>	
		ed the Administrator that						
		The Administrator said he						
	did not report the incident to the Iowa Department							
	of Inspection and Appeals since the details were							
		istrator stated the resident did						
		the facility suspended the						
	~	olved. The Administrator	i					
		an In-service to the staff on						
	6/13/17 about reside	ent rights and abuse.						
	On 6/19/17 at 1:40 F	M, Staff A was interviewed						
		d the Administrator at						
		PM after Staff B, CNA and		ļ				
		d the incident to her. The		ĺ				
		the staff weren't quite sure if		ŀ				
		defense on the CNA's part		1	·			
		t had been very combative	İ					
	and hitting the CNA.					1		
,	On 6/19/17 at 1:50 p	.m., Staff B (CNA) was						
+	interviewed and state	ed Resident #1 punched at						
	the aides and had be	en hit many times by this						
]	resident. Staff B staf	ted she pulled the resident		ļ				
		eelchair from the nurse's						
		it's room. Staff B stated she						
		her feet were down. Staff C						
		and stood the resident from						
	•	can cause further agitation to					ľ	
1		dent raised his/her right	1					
1		ace but did not see contact				1		
1		raised an open hand and						
1	made contact with the	e resident's left cheek and	1			ŀ		

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

NAME OF PROVIDER OR SUPPLIER  ACCURA MEALTHGARE OF SIOUX CITY, LLC  STREET ADDRESS, CITY, STATE, ZIP CODE SIROUX CITY, IA 51104  SIOUX CITY, IA 51104  SIOUX CITY, IA 51104  SIOUX CITY, IA 51104  FREGULATORY OR LSO DENTIFYTHING INFORMATION)  FREGULATORY OR LSO DENTIFYTHING INFORMATION  FREGU	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
INME OF PROVIDER OR SUPPLIER  ACCURA HEALTHCARE OF SIOUX CITY, LLC  SIOUX CITY, IA ST104  SHAMARY STATEMENT OF DEFICIENCIES SHAMARY STATEMENT OF DEFICIENCIES SHAMARY STATEMENT OF DEFICIENCIES SHAMARY STATEMENT OF DEFICIENCIES SHAMARY STATEMENT OF DEFICIENCIES TAG  FREFIX TAG  FREGULATORY OR LISC IDENTIFYING INFORMATION)  FREGULATORY OR LISC IDENTIFYING INFORMATION 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 of if the resident seemed agitadd. Staff B stated she waited to report this but didn't want to believe this had happened. Staff B stated she waited to report this but didn't want to believe this had happened agitadd. Staff B stated she waited to reported this rollent right away. Staff B stated she resident had no marks on his/her face but should have reported this incident right away. Staff B stated she resident seemed calim 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 staff in sound but did not see a slap. Staff E wanted to change the resident until he/she is celm. Staff E stayed with the resident will he/she is celm. Staff E stayed with the resident will he/she is celm. Staff E stayed with the resident will be some very combetive and non-compliant. Staff E stated she worked on 6/11/17 from 5:00 a.m. until 6:00 p.m. Staff E stated the resident become agitated about 3:00 p.m. and wanted to go homo. The resident pot close to the nurse's state into pull himself/herself up from the whoelchair. Staff E locked the wheelchair wheels and held the chair on one side. The resident to his/her room. Staff E stated she stayed in front of the resident and pushed the chair down the hall with feel to the contract of the own the state of the staff on the room.			166435	B. WNG				_	
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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

CENTERS FOR MEDICARE & MEDICALD SERV		MEDICAID SEKAICES	<del></del>			<u> </u>	, 000 <u>0 000 ;</u>			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		E CONSTRUCTION	(X3) DATE COME	eted }			
							C			
165435			B. WING			06/22/2017				
NAME OF P	ROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE					
	A SALINA DINA DINA DINA DINA DINA DINA DINA D			3	800 INDIAN HILLS DRIVE		•			
ACCURA	HEALTHCARE OF SIOU	( CITY, LLC		Ş	SIOUX CITY, IA 51104					
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ĺΩ		PROVIDER'S PLAN OF CORRECTION		(X5)			
PREFIX TAG	(EACH DEFICIENC) REGULATORY OR I	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE				
F 225	Continued From page	. 5	F	225						
1 220			1	223						
		urine leaked through the	1							
		E stated when she went to					}			
		the resident punched Staff E								
		ent grabbed her under the								
		ut hand up to pull his/her					·			
		Staff E stated the other			1					
		k spitting in her face. Staff								
		shed the resident's left side								
		d she waited 40 minutes at					ļ .			
		nt's bed for him/her to settle	1							
		she could never change the								
		E stated after the resident	1				ļ l			
	settled, she took the r	esident to the dining room.								
	Review of the facility	policy and procedure titled	Ī		İ					
		entification, investigation								
1		ve 4/14/17, documented all	Ţ							
	allegations of residen									
	_	nent, injuries of unknown								
		riation should be reported	1							
		arge nurse. The charge								
		or immediately reporting the			'					
	allegations of abuse to						·			
	designated representa									
	ees.grade repressing	20.13.								
	All allegations of resid	lent abuse shall be reported								
	to the Iowa Departme									
		er than two (2) hours after								
		. All allegations of resident								
		nistreatment, injuries of					l			
		isappropriation shall be								
	<b>-</b>	Department of Inspections								
		than two (2) hours after the								
		the events that cause the								
		ious bodily injury or not later								
		hours if the events that				İ				
			1				l			
		nvolve neglect, exploitation,	1				ĺ			
		of unknown origin and					l			
1	misappropriation, but	do not result in bodity injury.	1	ı						

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			UWI	B MO' 0839-0381	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG;	(X3) DATE SURVEY COMPLETED		
		165435	B, WNG_			C: 06/22/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	•	
ACCURA HEALTHCARE OF SIQUX CITY, LLC				3800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104			
			ID		narana.		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CO  (EACH CORRECTIVE ACTION  CROSS-REFERENCED TO THE  DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE:	
F 225	Continued From page 6  Review of the lowa 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.			225		***	
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