STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165382	A. BUILDING _____ B. WING _____	03/01/2018

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ACCURA HEALTHCARE OF KNOXVILLE, LLC	606 NORTH SEVENTH STREET KNOXVILLE, IA 50138

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F 000	INITIAL COMMENTS Correction Date 04/12/2018 The following deficiencies relate to the facility's annual recertification and licensure survey and the investigation of facility reported incident #73717-I, and complaint #73222-C. The facility reported incident was substantiated, the complaint was not substantiated. (See code of Federal Regulations (42 CFR), Part 483, Subpart B).	F 000	This shall serve as an allegation of compliance; all deficiencies will be corrected by the correction date. The preparation of the following corrections for these deficiencies does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or the conclusion set forth in the statement of deficiencies. The plan of correction prepared for the deficiencies was executed sole to the provisions of the state and federal law require it.	04/12/2018
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interview, the facility failed to follow physician orders for an inhaler (Resident #15) and the liters of oxygen administered by nasal cannula (Resident # 21). The sample included 14 residents. The facility reported a census of 41 residents. Findings include: 1. The 01/12/2018 Quarterly MDS (Minimum Data Set) revealed a BIMS (Brief Interview of Mental Status) score of 14, which indicated Resident # 21 experienced intact cognition. The MDS documented documented the resident had diagnoses of asthma and respiratory failure.	F 658	Resident # 21 continues with orders for continuous 3L oxygen. Resident #15 continues with inhaler, Incruse daily. Education was provided for nurses by 4/12/2018 to ensure that residents oxygen liter flow is correct and being documented appropriately and that we are following all physician orders. Facility will perform random audits to ensure residents on oxygen are receiving appropriate liter flow and documentation and compliance with physician orders. All findings or concerns will be addressed through the QA committee in a timely manner.	04/12/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pamela Lehmen	Administrator	04/11/2018

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 4/12/18 by Jmeehan, RN

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F 658	Continued From page 1 The plan of care included a diagnosis of chronic obstructive pulmonary disease. The care plan with an initiation date of 01/19/18 revealed the resident experienced self-care deficits and included an update on 02/26/18 that noted the resident used oxygen continuously. The Physician's Order Sheet dated 02/26/18 contained an order for oxygen at 3 liters continuously. The Medication Administration Record for February 2018 documented an order for 3 liters of oxygen continuously upon readmission to the facility on 02/26/18. The first nurse documented the order for 3 liters of oxygen on 02/27/18 and 02/28/18 for the 2 PM to 10 PM shift. The 6 AM to 2 PM nurse signed the administration record on the 02/28/18 only. The 10 PM to AM nurse failed to document the oxygen order at all since the resident's return. In an interview on 02/28/18 at 11:14 AM , Resident #21 verbalized being in the hospital for 4 days. Observation of Resident #21 confirmed continued difficulty clearing her airway of congestion even after coughing. The resident kept the head of the bed in a raised position. Oxygen administered to the resident by a nasal cannula originated from a concentrator set on 1 liter of oxygen. The resident stated the nurses did not check the oxygen when they came to her room. Resident # 21 did not know what the concentrator level read and denied ever touching the concentrator. An observation of the resident revealed heavy breathing after trying to cough and clear their airway.	F 658		

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F 658	Continued From page 2 During an observation on 02/28/18 at 01:49 PM, the oxygen concentrator read 3 liters. The resident stated she called the nurse to the room between 1:15 PM and 01:49 PM. and told her the concentrator read only 1 liter of oxygen and it should be 3 liters. The resident stated feeling short of breath and could not stand it, so called the nurse to the room to change it. On 02/28/18 at 4 PM, the Administrator stated there was no reason for the nursing staff not to follow the Physician's order to administer 3 liters of continuous oxygen. Based on observation, record review, staff and resident interview, the facility failed to follow physician's orders for an inhaler according to professional standards for 1 of 14 residents reviewed (Resident #15). The facility reported a census of 41 residents. Findings include: During observation of medication administration on 02/27/18 at 07:39 AM, Staff A noted the Spiriva inhaler for Resident #15 was not available for morning dosing. The order for Spiriva 2.5 MCG daily was noted by nursing staff on 2/23/18. The Medication administration sheet for the month of February documented Spiriva administered on 2/23, 2/24, 2/25, or 2/26. Staff A reported she called the physician after she discovered the medication was not available. She also called the pharmacy for emergency delivery. The medication delivered from pharmacy and administered on 2/27/18 at 12:00 PM was Incruse 62.5 mcg.	F 658		

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F 658	Continued From page 3 The physician's order dated 2/23/18 documented Respimat 2.5 mcg daily. The Director of Nursing (DON) verified on 2/27/18 at 1:30 the nurse had never sent the order to pharmacy. The physician's office called the pharmacy and ordered Incruse; although staff ultimately administered the correct medication, it was given without a current physician's order in hand. The DON completed Medication Error Reports for the discrepancies.	F 658		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide adequate supervision and consistently develop interventions to prevent an injury for 1 of 3 residents reviewed with falls (Resident #43). The facility reported a census of 41 residents. Findings: 1. According to the MDS (Minimum Data Set) assessment tool dated 11/4/17, Resident #43 had	F 689	Resident #43 returned from hospital on 1/19/2018, low bed was put into place as intervention along with a fall mat. Education to staff to monitor placement of pressure alarm box until wireless alarm is delivered. Wireless, tamper resistant, pressure alarm was put into place as intervention on 1/30/2018. Staff was provided education on use of alarms as interventions and effectiveness on 1/15/2018. Specific education was given on 1/19/2018 for Resident # 43 for alarm placement and interventions. Facility will perform random audits of care plan interventions for appropriate use and effectiveness. All findings or concerns will be addressed though the QA committee in a timely manner.	04/06/2018

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F 689	Continued From page 4 diagnoses that included weakness, symptoms and signs with cognitive functions and awareness, and personal history of transient ischemic attacks (mini-strokes). The MDS documented the resident required extensive assistance of 1 staff for bed mobility, transfers, walking, dressing, toilet use, personal hygiene, and bathing, and listed the resident as not steady and only able to stabilize with staff assistance when moving from a seated to standing position, walking, turning around, moving on and off the toilet, and transferring between the bed and chair or wheelchair. The MDS stated the resident had 2 falls without injury since the prior assessment and listed the resident's BIMS (Brief Interview for Mental Status) score as 10 of 15, which indicated a moderately impaired cognitive status. During an observation on 2/27/18 at 7:09 a.m., the resident lay in bed with a pressure pad under him connected wirelessly to an alarm in the hallway. The resident's bed was in a low position and a floor mat lay beside the bed. The resident's 11/26/17 Morse Fall Scale listed the resident's score as 80 with a score of 45 or higher indicating a high risk for falls. Facility Quality Assurance Monitoring Tools (incident reports) for the resident during the survey year revealed the following: a. On 1/13/17, the resident went to the bathroom by himself, fell at the foot of the bed, landed on his back, and sustained an abrasion to the back. b. On 1/18/17, a CNA (Certified Nursing Assistant) found the resident on the floor in front of the recliner. The resident stated he stood up to get into his chair.	F 689		

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F 689	Continued From page 5 c. On 4/21/17, staff found the resident onthe floor in the closet. d. On 8/3/17, the resident slid out of his recliner and sat on the floor. e. On 10/10/17, the resident transferred himself from bed to toilet and on the way back from the toilet went down on one knee. f. On 10/17/17, staff found the resident sitting in front of the recliner. g. On 12/28/17, the resident transferred himself and fell. h. On 1/15/18, a CNA found the resident lying on the floor. The resident had turned off the personal alarm. The facility sent the resident to the hospital due to hip pain. A 12/29/17 9:50 a.m. nursing note documented the resident continued to attempt self transfers after many reminders to wait for staff assistance . A 12/30/17 1:28 p.m. nursing note documented the resident continued to attempt self transfers after many attempts to educate; the personal alarm in place and functioning. A 1/5/18 6:30 p.m. nursing note documented the resident attempted to transfer himself prior to supper. A 1/6/18 11:15 a.m. nursing note documented the resident was noncompliant with assistance with walking and transfers and shut off the alarm and/or placed it in crevice of chair to muffle the sound so staff couldn't hear it. A 1/7/18 10:21 a.m. nursing note documented the resident continued to attempt self-transfers and shut off or hid the alarm.	F 689		

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

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F 689	Continued From page 6 A 1/8/18 3:59 p.m. nursing note documented the resident continued to self-transfer and hid or turned off the alarm. A 1/10/18 3:20 p.m. nursing note documented the resident continued to self transfer and hid or shut off the alarm. A 1/15/18 hospital report documented the resident sustained a right hip fracture after a fall. A 1/19/18 10:50 a.m. nursing note documented the resident admitted to the hospital on 1/15/18 with a left hip fracture and had surgery on 1/16/18. A 1/19/18 12:20 p.m. nursing note documented the resident readmitted to the facility to a room closer to the nurse's station. The resident's care plan included the following entries/interventions: a. 10/28/16 Encourage the resident to wear gripper socks at night. b. 11/16/16 Keep call light in reach and remind to use. c. 10/10/17 Physical therapy/Occupational therapy evaluation/treatment. d. 1/4/18 Place alarm box out of reach. The facility lacked documentation of an additional intervention initiated completed between the dates of 1/4/18 and the resident's fall with fracture on 1/15/18. Nursing notes during this period revealed staff documented the resident continued to turn his/her alarm off. A care plan entry dated 1/19/18 (the resident's	F 689		

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F 689	Continued From page 7 readmission date) listed the following interventions: a floor mat, low bed, and cordless pressure alarm. The facility's undated policy "Falls Management" directed staff for residents at risk for falls , the nurse would review the resident's condition, put an appropriate intervention into place, and update the care plan. The policy also directed staff to monitor the care plan, monitor for effectiveness of interventions, and make changes as deemed necessary or when reviewed and updated. During an interview on 2/27/18 at 12:44 p.m., Staff C CNA stated on the night the resident fell, he tried to get up and down and the alarm sounded multiple times prior to the incident. When she completed rounds she saw the resident lying on the floor with his feet pointing toward the bathroom. The resident's alarm had been turned off and the resident told Staff C he shut it off. Staff C stated she thought he had already been to the bathroom because of the way he was positioned, and reported it didn't matter where one placed the alarm, the resident could get to it. She stated the resident currently had an alarm which was wireless and couldn't be disabled. During an interview on 2/27/18 at 1:27 p.m., Staff D CNA stated the resident currently used a wireless alarm and confirmed the resident knew how to turn off the old alarm. During an interview on 2/27/18 at 2:28 p.m., the DON (Director of Nursing) stated staff should have made sure the alarm was under the bed. She reported the resident went to the bathroom and fell on the way back to bed; the facility added	F 689		

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F 689	Continued From page 8 a low bed and a fall mat after the resident sustained a fracture. During an interview on 2/27/18 at 2:39 p.m., Staff A LPN (Licensed Practical Nurse) reported on the night of the fall, one of the CNAs alerted her the resident was on the floor. When she entered the room, the resident lay on his left side. She stated the alarm was within reach on the bedside table and Resident #43 could have easily reached it, and reported if it was placed under the bed, he could not have reached it. She reported the resident told her he turned off the alarm and reported she had seen him do this in the past. She stated after the fall, she called an ambulance for the resident. During an interview on 2/28/18 at 1:06 p.m., the ADON (Assistant Director of Nursing) reported if a care plan intervention was ineffective they would attempt something else. She stated the resident was able to turn off his alarm and added staff should have made sure it was out of his reach. During an interview on 2/28/18 at 1:42 p.m., the MDS Coordinator stated if an intervention didn't work, they would try to come up with something else. She verified she did not see another intervention added to the care plan after the intervention of placing the alarm out of the resident's reach.	F 689		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812	Floor tiles around dish washer were replaced on 3/2/2018. Floor around the dishwasher was cleaned on 3/2/2108. Cabinet drawers along with the refrigerator doors were cleaned on 3/2/2018. The task of cleaning the outside of the refrigerator has been added to the cleaning schedule.	04/12/18

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F 812	Continued From page 9 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to maintain the facility kitchen and dining room in a clean manner in accordance with professional standards for food service safety. The facility reported a census of 41. Findings include: During tour of the kitchen on 02/26/18 at 09:40 AM, observations revealed: 1. Floors with chipped tiles and built up food and dirt on the floor around the dishwashing area. 2. The cabinet drawers and refrigerator doors were soiled on the outside. 3. The dining area behind ice machine had dirt with layers of dust and food residue, and cracked/missing tiles. 4. The inside top of microwave contained brown food residue.	F 812	Behind the ice machine was cleaned on 3/2/2018. The cracked and missing tile was fixed and repaired 4/9/2018. Microwave was cleaned on 3/2/2018. The cleaning of the microwave was added to the cleaning schedule. Wood door to the kitchen was cleaned and repaired on 3/2/2018.Education was provided to the dietary manager and staff regarding importance of following the cleaning schedule by 04/12/2018. Facility will perform random checks of cleanliness and documentation to ensure compliance. All findings or concerns will be addressed though the QA committee in a timely manner.	

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F 812	Continued From page 10 5. The wooden door to kitchen had black sticky residue and chips in the wood along and by the door handle The Weekly Cleaning List lacked directions for routine cleaning of the microwave. The Monthly Cleaning Schedule for February included washing the kitchen door, mopping the floor, cleaning the outside of cupboard. The Monthly cleaning list lacked specific directions to clean the outside of refrigerators. The Dietary Manager stated during tour that they were not able to clean behind the ice machine because it was a small space. The Manager then directed Staff B (cook) to clean behind the ice machine that day.	F 812		