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
	165435	A. BUILDING _____ B. WING _____	C 03/15/2019

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 Correction date 3/20/2019 The following deficiencies were identified during investigation of mandatory report # 81232-M. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	This Plan of Correction is for a self report investigation # 81232-M . Preparation and/or execution of this Plan of Correction does not constitute admission agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and or executed solely because provisions of federal and state law require it.	
F 606 SS=D	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(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. §483.12(a)(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. This REQUIREMENT is not met as evidenced by: Based on personnel file reviews, facility policy review and interview, the facility failed to perform	F 606	This Plan of Correction constitutes my credible allegation of compliance and all stated deficiencies will be corrected by the dates specified. 1. Staff member K's background check was conducted on 5/3/18. 2. Prior to hire, background checks will be conducted on all staff by Business Office Manager / designee to ensure that all staff are cleared to work. 3. Administrator / designee will audit new employee files to ensure background checks have been completed. 4. Concerns will be discussed and monitored by the QAPI Committee.	

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

Administrator 4/12/19

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 4/28/19 VV

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F 606	Continued From page 1 a background check prior to hire for one of seven current employees reviewed (Staff K). The facility reported a census of 34 residents. Findings include: 1. The personnel file for Staff K, certified nursing assistant (CNA) documented a hire dated of 12/18/17. The personnel file failed to contain a criminal and abuse abuse registry checks for Staff K prior to hire. The Direct Care Worker (DCW) registry for the state of Iowa verified the facility did not do a background and abuse registry checks on Staff K until 5/3/18. During interview on 3/15/19 at 3:10 PM the Administrator stated employee file audits were done last spring and found it had not been done, so they completed it at that time. The facility's Abuse Prevention, Identification, Investigation and Reporting Policy effective 4/14/17 directed the following: Employee Screening: The facility shall screen all potential employees for a history of abuse, neglect, exploitation, misappropriation of property or mistreatment of residents. This will be accomplished through the following (including maintaining documentation of such results): 1. The facility will conducted an Iowa criminal record check and dependent adult/child abuse registry checks on all prospective employees and other individuals engaged to provide services to residents, prior to hire, in the manner prescribed under 481 Iowa Administrative Code 58.11(3).	F 606		
F 684	Quality of Care	F 684		

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F 684 SS=J	Continued From page 2 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to ensure Resident #1 received an appropriate food texture. Resident #1 had a history of choking on peanut butter sandwiches and the care plan directed staff to not provide those sandwiches. Resident #1 received the peanut butter sandwich on 2/3/19, choked and went into cardiac arrest, which resulted in an immediate jeopardy to resident health and safety. The sample consisted of four total residents. The facility identified a census of 34 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 1/16/19 documented diagnoses that included oropharyngeal dysphagia (characterized by difficulty initiating a swallow and may be accompanied by nasopharyngeal regurgitation, aspiration, and a sensation of residual food remaining in the pharynx), bipolar disorder and chronic kidney disease stage 5. The MDS also documented a Brief Interview of Mental Status (BIMS) score of 7 which indicated moderate cognitive impairment. Resident #1 required extensive assistance with transfer, ambulation,	F 684	Past noncompliance: no plan of correction required.	

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F 684	Continued From page 3	F 684		

dressing and toilet use and oversight, encouragement, cueing and set-up for eating. The assessment documented he experienced coughing or choking during meals or when swallowing medications and received a mechanically altered diet.

The care plan problem revised 5/24/17 identified the resident with a nutritional problem or potential nutritional problem related to a history of choking. The care plan instructed staff that Resident #1 could not have peanut butter sandwiches due to history of choking on one on 9/23/17. The Visual/Bedside Kardex Report, which is accessible to certified nursing assistants (CNA's), also contained the directive to not give the resident peanut butter sandwiches due to history of choking under the Safety and Eating/Nutrition sections.

A Progress Notes entry dated 9/27/17 at 11:53 PM documented the resident was given a peanut butter sandwich while in bed with the head of the bed up. The CNA across the hall heard him choking, transferred him to the wheelchair and performed the Heimlich maneuver which resulted in a piece of sandwich being cleared from his airway.

A Progress Notes entry dated 1/11/19 at 9:54 PM documented the resident appeared to be choking at 7:15 PM. Staff assisted the resident and he coughed up a piece of chicken, measuring approximately 1" x 1" (inch). Staff requested an order for a speech therapy evaluation on 1/12/19 and the physician approved the request on 1/14/19.

The SLP (Speech/Language Pathologist)

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F 684	Continued From page 4	F 684		

Evaluation & Plan of Treatment dated 1/16/19 documented a Clinical Bedside Assessment of Swallowing: Neuromuscular/Anatomic Disorders which assessed the resident to be within functional limits for oral prep phase and oral phase and mild impairment in the pharyngeal phase and no signs or symptoms of esophageal dysphagia present.

The Objective Tests/Measured & Additional Analysis of SLP assessment documented the resident exhibited reduced attention to task and inattention to bolus (the rounded mass of chewed food right before swallowing). The SLP discharged the resident from care on 1/25/19 and directed resident continue on a mechanical soft diet with regular liquids as previously ordered with occasional supervision and to cue the resident to complete his meals.

A Progress Notes entry dated 2/3/19 at 9:34 PM completed by Staff A, licensed practical nurse (LPN) documented she was at the nursing desk at 7:30 PM at which time Resident #1 was propelling himself in his wheelchair and stating "I'm choking, I'm choking." Staff A yelled for help and performed the Heimlich maneuver without success. Staff C, LPN responded and also performed the Heimlich without success. Staff called 911 and transferred the resident to the floor to start CPR (cardiopulmonary resuscitation). The fire department responded, took over CPR performance as Resident #1 remained non-responsive and then transferred him to the hospital.

The hospital History and Physical dated 2/3/19 documented the resident brought to the emergency room because it was reported the

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F 684	Continued From page 5	F 684		

resident was given a peanut butter sandwich, which he was not supposed to have, and it appeared he choked and aspirated. EMS services reported the resident had no heart rhythm enroute to the hospital and advanced cardiac life support (ACLS) protocol was initiated and the patient regained spontaneous circulation. Resident #1 admitted to the intensive care unit (ICU) due to his cardiac arrest.

A computerized axial tomography (CT) report dated 2/3/19 documented the following:
1. Complete collapse to the left lung with significant right-to-left shift of the mediastinal structures. Suspect food impacted within the proximal left mainstem bronchus based on provided clinical history.
2. Malpositioned enteric tube terminating within the upper esophagus
3. Displaced fractures of the right 3rd through 6th and left 3rd through 7th ribs.
4. Scattered ground-glass and dense consolidation throughout the right lung, aspiration pneumonitis versus possible developing infection.
A bronchoscopy was performed and pieces of sandwich were removed from the resident's bronchus. The resident expired in the hospital on 2/8/19.

During interview on 2/7/19 at 3:29 PM Staff A stated she is usually assigned to the hall where the resident resided and was aware he could not have peanut butter sandwiches because it was on his care plan as he had experienced choking spells on them in the past. Resident #1's wife had told her in the past she did not think he should have peanut butter. After supper on 2/3/19 Resident #1 and two other residents sat in the lounge next to the nursing desk watching TV .

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F 684	Continued From page 6 Staff B, CNA, passed snacks to all residents and she knew she was in the lounge area. Staff B left the area and started down the 200 hallway when Resident #1 wheeled himself around the fireplace in the lounge and said "I'm choking, I'm choking". She said the resident's lips were blue in color and she yelled for help. The resident went nonresponsive. She attempted the Heimlich maneuver without success. Staff C responded to her call for help, called 911 also attempted the Heimlich maneuver without success. Staff D, CNA, also attempted the Heimlich maneuver without success so he and Staff E, CNA, lifted Resident #1 from the wheelchair to the floor and began chest compressions and she used the Ambu bag to support respirations. The emergency management system (EMS) personnel arrived and cleared the resident's airway when they intubated him and took over CPR. Staff B, CNA, also responded to her call for help and told her she had given the resident 1/2 peanut butter and jelly sandwich. Staff A stated the resident had a tendency to put too much food in his mouth and sometimes staff had to remind him not to take big bites. During interview on 2/7/19 at 2:20 PM Staff B stated she passed snacks to the residents after supper on 2/3/19. The snack cart contained a bowl of Jello for Resident #1. She offered it to him two different times and encouraged him to eat it, but he wanted a peanut butter and jelly sandwich. There are peanut butter and jelly sandwiches on the snack cart and she gave him ½ of one. She sat in the lounge area and assisted another resident to eat a snack and Resident #1 was eating his sandwich just fine. After the other residents in the lounge were done with their snacks, she left the area to go down a	F 684		

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F 684	Continued From page 7	F 684		

hallway. She had just gone around the nursing desk and she heard the nurse yell for help and she responded. Staff tried to do the Heimlich maneuver but it did not work. She told the nurse she gave him a peanut butter and jelly sandwich. Staff B stated she had given the resident peanut butter sandwiches two times before and he never had any problems with them. She was not sure, but she thought she did not know the resident was not to have them.

During interview on 2/7/19 at 3:07 PM Staff C stated she was not aware the resident could not have peanut butter sandwiches and the resident's recent SLP evaluation did not address if he could or could not have peanut butter.

During interview on 2/8/19 at 11:45 AM, Staff F, CNA, stated she had not been aware of the fact the resident could not have peanut butter sandwiches. She stated the resident had never asked her for one but if he had she would check with the charge nurse first to get approval.

During interview on 2/7/19 at 1:36 PM the Director of Nursing (DON) stated Staff B routinely cared for the resident and all CNA's have access to the Point of Care (Kardex) plan on the tablets accessible to staff at any time. She stated the resident's care plan stated that he could not have a peanut butter sandwich due to his history of choking. She expects CNA's to know the information contained on the point of care plan for each resident but the facility has no policy that directs staff to routinely review the resident care pan directives because any changes to them are addressed in the daily huddle meetings.

The facility abated the immediate jeopardy

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F 684	Continued From page 8 situation on 2/4/19 through the following actions: a. Staff education on all resident diet orders, allergies and food restrictions. b. Staff response when residents request food items they are restricted from eating. c. Nursing education for residents who wish to receive restricted foods. d. Posting residents' current diet orders, restrictions and allergies on the snack cart.	F 684		
F 729 SS=D	Nurse Aide Registry Verification, Retraining CFR(s): 483.35(d)(4)-(6) §483.35(d)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. §483.35(d)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual. §483.35(d)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program,	F 729	1. A Direct Care Worker Registry check was completed on 05/03/18 f or staff member K. 2. Business Office Manager / designee will perform a Direct Care Worker Registry check, prior to hire, for all certified nursing assistants. 3. Administrator / designee will audit new employee files to ensure a Direct Care Worker Registry check has been completed. 4. Concerns will be discussed and monitored by the QAPI Committee.	5/3/18

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F 729	Continued From page 9 there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on personnel file reviews, facility policy review and interview, the facility failed to perform a Direct Care Worker Registry check prior to hire for one of five current certified nursing assistants (CNAs) reviewed (Staff K). The facility reported a census of 34 residents. Findings include: 1. The personnel file for Staff K, certified nursing assistant (CNA) documented a hire dated of 12/18/17. The personnel file failed to contain an Iowa Direct Care Worker (DCW) registry check of Staff K's eligibility to be employed as a CNA prior to hire. The DCW registry for the state of Iowa verified the facility did not check Staff K's eligibility to be employed as a CNA until 5/3/18. During interview on 3/15/19 at 3:10 PM the Administrator stated employee file audits were done last spring and found it had not been done so staff completed it at that time.	F 729		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review	F 730		

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F 730	Continued From page 10 of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on personnel file reviews and staff interview, the facility failed to completed an annual performance review for two of four certified nursing assistants (CNA's) sampled employed one year or more (Staff H and K). The facility reported a census of 34 residents. Findings include: 1. The personnel file for Staff H, CNA, documented a hire date of 3/6/17. The personnel file failed to contain annual performance evaluations. 2. The personnel file for Staff K, CNA documented a hire date of 12/18/17. The personnel file contained an undated annual performance evaluation. During interview on 3/15/19 at 2:50 PM the Administrator stated the facility had been previously cited for failure to do employee annual evaluations and thought they had brought all employees up to date.	F 730	1. Staff members H and K's annual performance evaluations were completed on 3/18/19. 2. Employee files were audited for date of last completed performance eval. 3. A performance review date database will be maintained by Business Office Manager / designee to ensure annual performance reviews are completed as required for each nurse aide. 4. Concerns will be discussed and m onitored by the QAPI Committee.	3/18/19

DEPARTMENT OF INSPECTIONS AND APPEALS

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L 190	58.10(3)a General policies 481-58.10(135C) General policies. 58.10(3) There shall be written personnel policies for each facility. Personnel policies shall include the following requirements: a. Employees shall have a physical examination and tuberculin test before employment; (I, II,III) This Statute is not met as evidenced by: Based on personnel file reviews and interview, the facility failed to assure all staff had a physical examination prior to hire for five of five current staff sampled (Staff G, H, J, K and L). The facility reported a census of 34 residents. Findings include: 1. The personnel file for Staff G, certified nursing assistant (CNA) documented a hire date of 4/14/17. The personnel file failed to contain documentation of a physical examination prior to hire. 2. The personnel file for Staff H, CNA documented a hire date of 3/6/17. The personnel file failed to contain documentation of a physical examination prior to hire. 3. The personnel file for Staff J, CNA documented a hire date of 5/14/18. The personnel file failed to contain documentation of a physical examination prior to hire. 4. The personnel file for Staff K, CNA documented a hire date of 12/18/17. The personnel file failed to contain documentation of a physical examination prior to hire. 5. The personnel file for Staff L, Environmental	L 190	This Plan of Correction is for a self report investigation # 81232-M . Preparation and/or execution of this Plan of Correction does not constitute admission agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and or executed solely because provisions of federal and state law require it. This Plan of Correction constitutes my credible allegation of compliance and all stated deficiencies will be corrected by the dates specified. 1. Physicals were completed for staff G, H, J, K, L and all like staff. 2. Employee files were audited for current physical examination. All staff will have a physical examination and tuberculin test prior to hire. 3. Administrator / designee will audit new employee files to ensure a physical examination has been completed. 4. Concerns will be discussed and monitored by the QAPI Committee.	3/20/19

POC accepted 4/22/19 VS

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L 190	Continued From page 1 Aide, documented a hire date of 3/2/19. The personnel file failed to contain documentation of a physical examination prior to hire. During interview on 3/15/19 at 3:00 PM the Administrator stated physical examinations for new employees had not been completed as directed and he was not sure why the facility stopped obtaining them.	L 190		
L 191	58.10(3)b General policies 481-58.10(135C) General policies. 58.10(3) There shall be written personnel policies for each facility. Personnel policies shall include the following requirements: b. Employees shall have a physical examination at least every four years. This Statute is not met as evidenced by: Based on personnel file reviews and interview, the facility failed to assure employee receive a physical every 4 years for two of two employees sampled employed four years or more (Staff C and I). the facility reported a census of 34 residents. Findings include: 1. The personnel file for Staff C, licensed practical nurse (LPN) documented a hire date of 7/19/10. The filed failed to contain documentation of a physical examination since the one done 7/19/10. 2. The personnel file for Staff I, registered nurse (RN) documented a hire date of 12/12/11. The	L 191	1. Physicals were completed for staff C, I, and all like staff 3/20/19. 2. Employee files were audited for date of last completed physical, all staff will have a physical completed every four years. 3. A physical examination database will be maintained by Business Office Manager / designee to ensure physical examinations are completed at least every four years for all staff. 4. Concerns will be discussed and monitored by the QAPI Committee.	3/20/19

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0444	A. BUILDING: _____ B. WING _____	C 03/15/2019

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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L 191	Continued From page 2 filed failed to contain documentation of a physical examination since the one done 12/9/11. During interview on 3/15/19 at 3:00 PM the Administrator stated physicals for employees had not been completed as directed and he was not sure why the facility stopped obtaining them.	L 191		

F606-

1. Staff member K's background check was conducted on 3/15/19 .
2. Prior to hire, background checks will be conducted on all staff by Business Office Manager / designee to ensure that all staff are cleared to work.
3. Administrator / designee will audit new employee files to ensure background checks have been completed.
4. Concerns will be discussed and monitored by the QAPI Committee.

F684-

1. Past noncompliance: no plan of correction required.

F729-

1. A Direct Care Worker Registry check was completed on 3/15/19 for staff member K.
2. Business Office Manager / designee will perform a Direct Care Worker Registry check, prior to hire, for all certified nursing assistants.
3. Administrator / designee will audit new employee files to ensure a Direct Care Worker Registry check has been completed.
4. Concerns will be discussed and monitored by the QAPI Committee.

F730-

1. Staff members H and K's annual performance evaluations were completed on 3/18/19.
2. Employee files were audited for date of last completed performance eval.
3. A performance review date database will be maintained by Business Office Manager / designee to ensure annual performance reviews are completed as required for each nurse aide.
4. Concerns will be discussed and monitored by the QAPI Committee.

L190-

1. Physicals were completed for staff G, H, J, K, L and all like staff.
2. Employee files were audited for current physical examination. All staff will have a physical examination and tuberculin test prior to hire.
3. Administrator / designee will audit new employee files to ensure a physical examination has been completed.
4. Concerns will be discussed and monitored by the QAPI Committee.

L191-

1. Physicals were completed for staff C, I, and all like staff 3/20/19.
2. Employee files were audited for date of last completed physical, all staff will have a physical completed every four years.
3. A physical examination database will be maintained by Business Office Manager / designee to ensure physical examinations are completed at least every four years for all staff.
4. Concerns will be discussed and monitored by the QAPI Committee.