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 _____	08/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date 9/04/2019 The following deficiencies are a result of the facilities annual survey conducted 8/19-22/19. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	Please See Attached	
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.	F 582		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 9/13/19

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.

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F 582	Continued From page 1 (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This Requirement is not met as evidenced by: Based on record review and staff interview, the facility failed to adequately inform 2 of 3 residents reviewed, of their appeal rights following discharge from skilled services, (Residents #23 and #37). The facility reported a census of 35 residents. Findings include: 1. Facility records indicated Resident #23 received Medicare Skilled Services 2/14/19-3/1519. The resident's Skilled Nursing Facility Advance Beneficiary Notice Form CMS 10055 did not have an option selected on the sheet as to whether the resident wanted to continue or to discontinue services for Physical Therapy (PT), Occupational Therapy(OT), and Speech Therapy(ST).	F 582		

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F 582	Continued From page 2 Interview with the Director of Rehabilitation (DOR) Staff B on 8/21/19 at 11:31 a.m. regarding the notice she gave to Resident #23 with the options listed to continue or stop therapy services. The resident did not mark either choice. Staff B stated that she was not aware of the requirement to have the resident check one box or the other. Staff B stated she is new in her position and is still learning how to complete these notices and will assure that the resident's have selected one of the options going forward. 2. Facility records indicated Resident #37 received Medicare Skilled Services 7/12/19-8/9/19. The resident's Skilled Nursing Facility Advance Beneficiary Notice Form CMS 10055 did not have an option selected on the sheet as to whether the resident wanted to continue or to discontinue services. The top portion of the form appeared blank and did not indicate exactly what therapies were discontinued nor the reason why they were discontinued. The second required Advance Beneficiary Notice- the Notice of Medicare Non Coverage(NOMNC) contained the resident's signature but did not list the type of therapy services that stopped as of 8-9-19. Staff wrote Rehab services instead of the specific discontinued therapies. The second page of the NOMNC form contained no explanation to indicate why the therapy services ended. On 8/21/19 at 11:31 .m. the Director of Rehabilitation (DOR) Staff B stated she did not know of the requirement for the resident to check one box or the other nor the requirement to write the type of therapy service that ended. Staff B stated she is new in her position and is still learning how to complete the 2 required notices. Staff B stated she will assure residents select	F 582		

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F 582	Continued From page 3 one of the options on the CMS 10055 form and to fill out the sheets fully with reasons why and the type of therapies ended. She further stated she will make sure there are no blanks on the forms going forward and will train all of her staff to complete the 2 forms correctly. The facility failed to adequately inform the resident of their appeal rights to continue or stop their skilled therapy services.	F 582		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;	F 623		

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F 623	Continued From page 4 (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and	F 623		

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F 623	Continued From page 5 email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This Requirement is not met as evidenced by: Based on record review and staff interview the facility failed to notify the Long Term Care (LTC) Ombudsman of discharge/transfer of residents as required for 1 of 3 residents reviewed. (Resident # 40). The facility reported a census of 35 residents. Review of the medical record for Resident #40 on 8/21/19 at 2:51 p.m. revealed the resident discharged from the facility on 5/9/19 to the hospital. The clinical record lacked documentation of notification to the LTC Ombudsman that Resident #40 discharged to the hospital as required. During an interview with the Administrator on	F 623		

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F 623	Continued From page 6 8/21/19 at 3:30 p.m., the Administrator stated he did not complete LTC Ombudsmen office notifications for any of the facility's transfers or discharges since about January of this year. On 8/22/19 at 7:42 a.m. the business office manager stated she updated the LTC Ombudsman office of all of the facility's discharged and transferred to the hospital since January of this year.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy	F 625		

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F 625	Continued From page 7 described in paragraph (d)(1) of this section. This Requirement is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to notify a resident or his/her representative of the facility's bed hold policy, including reserve bed payment, during hospitalizations for 1 of 1 resident reviewed (Resident #40) The facility reported a census of 35 residents. Findings include: Clinical record review on 8/21/19 at 4:18 p.m. revealed Resident #40's Minimum Data Set (MDS) listed the following discharge information: -5/9/2019 Discharge Return Anticipated/End of PPS (Prospective Pay System) Part A Stay -5/13/2019 Entry (return to facility) Nursing progress notes dated 5/9/19 at 6:33 p.m. revealed the resident transferred to the emergency room and admitted to the hospital. Nursing progress notes revealed Resident #40 returned to the facility on 5/13/19 at 6:03 p.m. Review of the facility's admission agreement on 8/22/19 at 10:00 am revealed that Sections 2.1, 2.3 and 2.4 all outline the facility's policy directed staff to present bed hold to a resident or their representative upon discharge and with all transfers to the hospital or any other temporary absences from the facility. On 8/21/19 at 3:30 p.m., the Administrator stated when a resident transfers to the hospital they do not complete the bed-hold as all of the residents sign a bed-hold form at the time of admission into the facility. The Administrator further stated that the facility agreed to always hold the bed for residents and would never refuse to take a	F 625		

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F 625	Continued From page 8 resident back into the facility. The Administrator verified that the facility did not complete a bed-hold for Resident #40 when the resident transferred to the hospital on 5/9/19.	F 625		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of	F 636		

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F 636	Continued From page 9 the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This Requirement is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to complete the admission Minimum Data Set (MDS) comprehensive assessment within 14 days after admission for two (#7 and #39) of sixteen residents reviewed. The facility reported a census of 35 residents. Findings include: 1. Review of Resident #7's clinical record revealed the resident admitted to the facility on 7/26/19. As of 08/20/19 at 12:21 PM, an admission MDS was in progress and not completed.	F 636		

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F 636	Continued From page 10 2. Review of Resident #39's clinical record revealed the resident was admitted to the facility 7/25/19. As of 08/21/19 at 8:12 AM, an admission MDS was in progress and not completed. During an interview 8/21/19 at 3:48 PM, the Director of Nursing (DON) confirmed that the facility did not complete Resident #7 and Resident #39's admission MDS assessments timely. The DON stated she expected staff to follow the Center for Medicare Services regulations and complete admission MDS assessments within 14 days after admission.	F 636		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This Requirement is not met as evidenced by: Based on clinical record review and staff	F 644		

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F 644	Continued From page 11 interview, the facility failed to refer a resident to the appropriate state-designated authority for a Level I Status Change Preadmission Screening and Resident Review (PASARR) evaluation and determination for a status change for one of seven residents reviewed (Resident #5). The facility reported a census of 35 residents. Findings include: Resident #5's Minimum Data Set (MDS) assessment dated 5/16/19, identified the resident with diagnoses that included: bipolar disorder, depression and mental disorder. The MDS showed a Brief Interview for Mental Status (BIMS) of 13, indicating no cognitive impairment. Admission records identified the resident admitted to the facility 2/8/19. Review of PASARR Notice of PASRR Convalescent Approval dated 2/4/19, documented approval for the resident's admission to a Medicaid certified nursing home for up to 60 calendar days. If the stay went beyond 60 calendar days, a nursing facility representative must submit a Status Change Level I to Ascend. During an interview on 8/21/19 at 12:30 PM, the Director of Nursing confirmed the facility did not refer the resident for a status change and her expectation is for staff to complete referrals as required.	F 644		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and	F 655		

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F 655	Continued From page 12 implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This Requirement is not met as evidenced by: Based on record review and interviews with	F 655		

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	165435	A. BUILDING _____ B. WING _____	08/22/2019

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ACCURA HEALTHCARE OF SIOUX CITY, LLC	3800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

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F 655	Continued From page 13 resident and facility staff, the facility failed to provide a summary of the baseline care plan to 3 of 3 newly admitted residents (Resident #7, Resident #39 and Resident #41). The facility reported a census of 35 residents. Findings included: Resident #7, Resident #39 and Resident #41's records lacked any documentation that indicated they or their representatives received copies of their baseline care plans completed within 48 hours of admission. A Brief Interview for Mental Status (BIMS) completed on 8/13/19 documented Resident #41 with intact cognitive function. During interview on 08/21/19 at 11:21 AM the resident stated she did not receive a baseline care plan. Nursing Progress Notes dated 8/13/19 identified the resident admitted to the facility on that date. During interview on 8/21/19 at 2:46 PM the Director of Nursing stated the facility did not give Resident #41 a summary of the baseline care plan. During interview on 8/21/19 at 3:18 PM the Director of Nursing stated Resident #39 and Resident #7 did not receive copies of their baseline care plans either nor did the facility give the baseline care plans the residents' representatives.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		

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F 657	Continued From page 14 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This Requirement is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to update the comprehensive care plan for two (Resident #4 and Resident #10) of sixteen residents reviewed. The facility reported a census of 35 residents. Findings include: 1. A Minimum Data Set (MDS) assessment dated 5/16/19 for Resident #4, included diagnoses of morbid (severe) obesity and diabetes mellitus. The MDS identified the resident required extensive assistance of two staff for bed mobility and dressing, total dependence and support of two staff for transfers and dressing. A Brief Interview for Mental Status (BIMS) score of 12	F 657		

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F 657	Continued From page 15 indicated mild cognitive impairment for decision-making. Review of Resident's (#4) Treatment Administration Record (TAR) dated 8/1/2019 - 8/31/19, documented a physician's order for oxygen 3 liters per nasal cannula continuous three times a day for history (HX) of pneumonia with start date of 8/17/2018. The TAR also documented a physician's order to apply Bipap for 4 hours for 2 weeks, then apply for 6 hours nightly two times a day for sleep apnea, apply Bipap at bedtime and leave on for 6 hours then night shift to take Bipap off with start date of 5/16/2019. Review of Resident's (#4) care plan initiated 8/17/2018 and with revisions on 2/27/19 and 7/23/19, lacked documentation of oxygen therapy and Bipap usage. 2. An Admission Record with admission date of 5/10/19 for Resident #10, included diagnoses of vascular dementia without behavioral disturbance and acquired absence of other specified parts of digestive tract. The MDS dated 5/17/19 identified the resident required supervision of one staff with bed mobility and dressing, and limited assistance of one staff for transfers and toilet use. A Brief Interview for Mental Status (BIMS) score of 14, indicated no cognitive impairment. Review of Resident's (#10) Medication Administration Record (MAR) dated 8/1/2019 - 8/31/19, documented a physician's order for olanzapine tablet 5 milligrams, give one tablet by mouth one time a day related to vascular dementia without behavioral disturbance with start date of 5/10/19.	F 657		

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F 657	Continued From page 16 Review of Resident's (#10) care plan initiated 5/10/19 and revision on 5/23/19, lacked documentation of olanzapine administration and side effects. During an interview on 8/21/19 at 4:10 PM , the Director of Nursing stated she expected staff to update careplans so they contain interventions for care.	F 657		
F 675 SS=D	Quality of Life CFR(s): 483.24 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. This Requirement is not met as evidenced by: Based on record review and staff interview, the facility failed to include problems, goals and interventions on the care plan for one of six resident receiving psychoactive medications (Resident # 15). The facility reported a census of 35 residents. Findings included: Resident #15's current physician's orders included the directive to administer the antipsychotic medication Seroquel since 6/21/18, the antidepressant medication Sertraline since 4/19/18, and the antidepressant medication Remeron since 3/21/19. The resident's care plan lacked directives to staff in relation to the use of the medications and did not list possible side	F 675		

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F 675	Continued From page 17 effects of the medications. During interview on 08/21/19 12:09 PM the Director of Nursing confirmed the care plan lacked any mention of the resident's psychoactive medications.	F 675		
F 688 SS=G	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This Requirement is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to provide restorative exercises as planned for 4 of 13 residents sampled (Resident #15, Resident #20, Resident #31, and Resident #38). The facility reported a census of 35 residents. Findings included: 1. Resident #31's 7/8/19 Minimum Data Set documented to the resident with severely impaired cognitive function. The resident required	F 688		

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F 688	Continued From page 18 extensive assistance of 2 staff for bed mobility and transfers. The resident did not ambulate. The resident's care plan included a problem which stated the resident had a deficit in activities of daily living due to a diagnosis of dementia and weakness requiring assistance of 2 for transfers and assistance with activities of daily living. The goal stated a plan for the resident to return to previous level. A 1/15/19 Therapy to Restorative Nursing Communication directed staff to place 1.5 pound weights and complete balloon tap, stand/walk (3 attempts with a front wheeled walker and assistance of 2 staff). No frequency identified. From 1/19-1/30/19 the record lacked documentation indicating staff assisted the resident with any exercises. Staff documented assistance provided with active range of motion to upper and lower extremities on 2/19/19. The record lacked documentation indicating staff assisted the resident with any exercises from 3/1/19 to 3/30/19. Staff documented assistance provided with active range of motion to the upper and lower extremities on 4/4/19, 5/1/19, 6/11/19, 6/17/19, and twice on 6/25/19. The record lacked documentation indicating staff assisted the resident with exercises in July 2019. Staff documented assistance provided with the range of motion exercises on 8/7/19. The record lacked any documentation indicating staff offered or the resident declined participation any other time from 1/15/19 to 8/21/19. During interview on 8/21/19 at 3:16 PM the DON stated the restorative plan dated 1/15/19 was not added to the electronic documentation system until February of 2019. She confirmed the restorative program not completed at all in	F 688		

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F 688	Continued From page 19 January 2019, staff had assisted the resident with the program only once in February 2019, none in March 2019, staff had assisted with the program once in April and once in May 2019, four times in June 2019, not done at all in July 2019 and once in August of 2019. On 08/21/19 03:39 PM the current therapy contract physical therapist (PT) reviewed the Therapy to Restorative Nursing Communication for the resident dated 1/15/19 which did not specify frequency of the treatment. She stated daily treatment would be ideal, but 3 times weekly would be the minimum to have any effect. She stated she evaluated the resident and stated the resident's legs were very stiff. On 8/15/19 facility staff sent a facsimile to the resident's physician requesting a physical therapy and occupational therapy evaluation treatment due to a functional decline. During interview on 08/21/19 at 2:52 PM the Director of Nursing identified the resident with a decline in ability to stand and bear weight for transfers. An 8/19/19 PT Plan of Care identified the reason for referral as a decline in functional activities resulting in decreased strength , transfer, stand balance and ambulation. 2. Resident #15's 6/5/19 MDS documented the resident with severely impaired cognitive function. A 6/18/18 Therapy to Restorative Nursing Communication form directed staff to assist the resident with exercises including Motomed (exercise bicycle) for 15 minutes or walk outside around the facility or standing and tap balloon	F 688		

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F 688	Continued From page 20 back and forth as long as tolerated 3-5 times weekly. From 6/1/19 to 8/21/19 staff documented the resident declined participation once in June and once in July 2019. Staff assisted the resident with exercises twice in August 2019. The record lacked any documentation indicating staff offered to assist or the resident declined participation any other time during June, July or August 2019. 3. Resident #20's 6/13/19 MDS documented the resident with severely impaired cognitive function and the resident required extensive assistance of 2 staff for transfers and did not ambulate. A 5/2/18 Therapy to Restorative Nursing Communication form directed staff to assist the resident with exercises including Motor Med (exercise bicycle) 15 minutes 3-5 times weekly. The document noted the resident may have bad days with increased pain, shortness of breath, high anxiety when the resident occasionally refused exercises. The document stated on those days don't do restorative. The resident's care plan directed staff to assist the resident with a Restorative program 3-5 times a week with a goal to return or maintain the resident's highest practicable physical, mental and psychological functional level and well being. From June 1, 2019 to August 21/2019 staff documented they assisted the resident with the program one time in June, two times in July and one time in August. The record lacked any documentation indicating staff offered the resident exercises or that the resident declined assistance with the exercises. 4. Resident #38's 7/30/19 MDS documented the resident with intact cognitive function. The	F 688		

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F 688	Continued From page 21 resident required extensive assistance of staff for transfers and ambulation. The resident's care plan included a plan for Restorative program 3-7 times weekly with a goal to return or maintain my highest practicable physical, mental and psychological functional level and well being. A 1/25/18 Therapy to Restorative Nursing Communication directed staff to assist the resident with bilateral lower extremity exercises with a 4 pound weight and blue theraband or Motomed for 15 minutes and a walking program for 15 minutes daily, bilateral upper exercises with a 4 pound weight. The communication form directed staff to offer assistance with the exercises 6 times weekly. On 8/21/19 facility staff provided documentation they assisted the resident with ambulation program for 15 minutes on 6/13/19 and for 10 minutes on 6/26/19. Staff assisted the resident with active range of motion exercises to the upper and lower extremities for 15 minutes on 6/26/19. The record lacked any documentation indicating staff offered or the resident declined participation any other time from 6/1/19 to 8/21/19. During interview on 8/22/19 at 7:29 AM when asked if staff assisted him with exercises, the resident stated, "not very often". When told documentation showed no exercises completed since June he confirmed that was probably correct.	F 688		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 881		

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F 881	Continued From page 22 a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This Requirement is not met as evidenced by: Based on staff interview, the facility failed to establish an infection prevention and control program that included an antibiotic stewardship program with antibiotic use protocols and a system to monitor antibiotic use. The facility reported a census of 35 residents. Findings include: During interview on 8/21/19 at 4:25 p.m. the Director of Nursing (DON) stated she needed training on meeting the Antibiotic Stewardship Program requirement. She stated the facility did not have an antibiotic stweardship program in place and she worked as DON for the facility for approximately 1 year. During interview with the Administrator on 8/22/19 at 10:10 a.m., he confirmed that the DON did not understand what the Antibiotic Stewardship Program was and that facility did not have an active program.	F 881		

Accura Healthcare of Sioux City
3800 Indian Hills Drive
Sioux City, IA 51104
Provider number: 165435

F000
This is a plan of correction for the recertification survey that was conducted August 19-22, 2019. Preparation and/or execution of this plan of correction does not constitute admission or 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/or state law require it.

Accept this plan as the facility's credible allegation of compliance, all stated deficiencies, except F688, will be corrected on or before September 16, 2019. F688 was corrected on Sept 4, 2019.

F582 Medicaid/Medicare Coverage/Liability Notice

1. Advance Beneficiary Notice for resident(s) #23 and #37 were corrected and reissued 9/5/2019.
2. Resident #23 and #37 and all like residents Advance Beneficiny Notices have been delivered correctly to residents/responsible party per ABN notice guidelines. Education was conducted for staff who complete ABN
3. Random audits will be conducted by Administrator or designee to ensure continued compliance.
4. Any concerns will be addressed timely through the quality assurance process.

F623 Notice Requirements Before Transfer/Discharge

1. Ombudsman was notified by Business Office Manger on 8/21/19 of all discharges/transfers from Accura Healthcare of Sioux City.
2. Resident #40 and all like residents who have been transferred/discharged since survey have had ombudsman notified by BOM on 9/4/19. BOM or designee was assigned and educated on 9/4/19.
3. Administrator or designee will audit monthly for three months to ensure continued compliance.
4. Any concerns will be addressed timely through the quality assurance process.

F625 Notice of Bed Hold Policy Before/Upon Transfer
1. Resident #40 discharged from facility to home on 8/29/2019.
2. Facility Nursing staff was received education that the "Bed Hold" must accompany a resident to the hospital or be singed prior to leaving the facility. Education was conducted by DON/ADON on 8/27/19.
3. DON or Designee will randomly audit to ensure bed holds are signed and returned.
4. Any concerns will be addressed timely through the quality assurance process.

F636 Comprehensive Assessment and Timing

1. Admission MDS were completed for Residents #7 and #39.
2. Resident #7 and #39 and all like resident's admission assessment have been submitted and completed timely. MDSs Coordinator has been educated on timely submission on 9/4/19.
3. DON or designee will conduct weekly audits until substantial compliance is achieved.
4. Any concerns will be addressed timely through the quality assurance process.

F644 Coordination of PASRR and Assessments

1. Accura Healthcare of Sioux City will ensure that PASRR's will be completed timely and when necessary for residents including resident #5.
2. An audit was complete for all residents to ensure compliance. DON and designees were provided education on 9/4/19 regarding status change levels of PASRR to Ascend.
3. DON and/or designee will perform random audits of PASARR to ensure timely completion.
4. Any concerns will be addressed timely through the quality assurance process.

F655 Baseline Care Plan

1. Baseline Care plans were given to resident(s) #7, #39 and #41.
2. Resident #7, #39, #41 and all like resident's baseline care have be issued to resident's since survey within 48 hours.
3. DON or Designee will conduct random audit to ensure continued compliance.
4. Any concerns will be addressed timely through the quality assurance process.

F657 Care Plan Timing and Revision

1. Accura Healthcare of Sioux City updated resident #4 and #10 care plan on 9/4/19.
2. All resident care plans have been audited to ensure a comprehensive person-centered plan of care for each resident. MDS Coordinator educated on 9/4/19 on timely update of care plans with physician order changes and/or changes in nursing interventions.
3. DON and/or designee will perform audits of assessments/care plans to ensure timely completion for three months to ensure compliance.
4. Any concerns will be addressed timely through the quality assurance process.

F675 Quality of Life

1. Resident #15's care plan was updated on 9/4/19 with annotation of use of antipsychotic medications.
2. Resident #15 and all like resident's care plans were updated by DON and Designee to ensure that any directives to staff in the relation to the use of medications were corrected.
3. DON or designee will random checks of care plans for 3 months to ensure continued compliance.
4. Any concerns will be addressed timely through the quality assurance process.

F688– Date of correction 09/04/2019

1. All residents were assessed by a licensed nurse in collaboration with therapy as needed for current restorative needs.
2. Individual plan(s) and goal(s) developed for all residents meeting restorative needs. CNA/RA will document time spent on plan(s) in electronic health record for aids.
3. A licensed nurse will monitor documentation weekly. Restorative plan(s) will be reviewed monthly by a licensed nurse, plan(s) will be adjusted as needed based on resident's needs.
4. Therapy will screen residents on a quarterly basis.

F881

1. Accura Healthcare of Sioux City has an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.
2. Nurse Administration trained and educated on antibiotic stewardship and program implantation.
3. DON or Designee will conduct random audits to review to ensure continue compliance.
4. Any concerns will be addressed timely through the quality assurance process.