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	165311	A. BUILDING _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF LE MARS	954 7TH AVENUE SE LE MARS, IA 51031

(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 12.27.19 A re-certification survey and investigation of self reported incident #85631-I completed 12/9/19 - 12/12/19 resulted in the following deficiencies. Self report #85631-I was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide adequate supervision to prevent resident to resident abuse for 2 of 14 residents reviewed, (Resident #3 and #13). The facility reported a census of 36 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 6/5/19, Resident #3 scored 3	F 600		

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

Blake M Wilson | Administrator | 12/31/2019

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 600	Continued From page 1 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. The resident required extensive assistance with activities of daily living including bed mobility, transfer and dressing. The resident's diagnoses included non-Alzheimer's dementia. A Physician Communication Form dated 9/3/19, notified the physician another resident lifted the resident's shirt and bra while she slept and exposed her breast. No injuries were noted, and the resident slept through it. 2. According to the MDS assessment dated 7/10/19, Resident #13 scored 11 on the BIMS, indicating moderately impaired cognitive status. The resident's diagnoses included non-Alzheimer's dementia. The Care Plan revised 2/26/19, (identified in place on 9/2/19) identified the resident had a psychosocial well being behavior/mood/psychotropic medication concern. The Resident reported less interest in doing things, feeling more down, trouble falling asleep and feeling tired. The interventions included if the resident expressed sexual frustration, allow resident time alone in his room, where he could address his needs privately The Progress Notes dated 3/3/19 at 3:17 p.m., documented the resident asked the nurse's aide while taking him to the bathroom if she would take off her shirt. Staff told the resident the comment was inappropriate. The Progress Notes dated 3/14/19 at 2:33 p.m.,	F 600		

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F 600	Continued From page 2	F 600		

documented the resident had inappropriate comments to a Certified Nursing Assistant (CNA) during bathing. The resident ask her if she liked undressing and bathing men. The resident informed these were inappropriate questions.

The Progress Notes dated 5/6/19 at 8:40 p.m., documented the resident pulled the light and the CNA reported when she went to answer his light, the resident grabbed her by the front of her shirt and said he wanted to see her boobs. The CNA stated she walked away and said no.

The Progress Notes dated 5/8/19 at 9:16 p.m., documented the resident demonstrated sexually inappropriate behaviors during bedtime cares. The resident grabbed the aide's breast while she helped him into bed. Staff told the resident he could not touch staff in that manner.

The Progress Notes dated 5/25/19 at 1:25 p.m., documented the resident made inappropriate sexual comments to the bath aide asking if giving old men baths made her horny, and it made him horny.

The Progress Notes dated 8/12/19 at 10:50 a.m., documented staff talked to resident about approaching staff and asking for sexual favors. Staff explained it was not appropriate to ask, and staff could not act on those requests. The staff also added it made the CNA's very uncomfortable when he made sexual comments to them. The resident responded by stating he did not see what it would hurt.

The Progress Notes dated 8/12/19 at 10:08 a.m., documented the resident said sexual notations at staff this shift while trying to get out of bed. The

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F 600	Continued From page 3 resident was reminded that he should not talk to staff in that manner and eventually calmed down. The Progress Notes dated 9/2/19 at 2:04 p.m., documented the resident lifted up a female residents shirt in the recliner next to him to try to touch her breast. He was stopped before he touched her breast but had her shirt up. A Physician Communication Form dated 9/3/19, notified the physician the resident had some concerning behaviors including being sexual in words and behaviors with young girl staff. The previous day he lifted a sleeping resident's shirt and exposed her breasts. The physician responded refer for psych evaluation. During an interview on 12/10/19 2:26 PM, Staff G, CNA stated the day of the incident they had assisted Resident #3 to the recliner by the wall and Resident #13 sat in the recliner next to it. She thought they had a 1 to 2 foot gap between the recliners. About 10 to 15 minutes later when she charted, she looked up to see Resident # 13 with his right leg hanging off the recliner reaching. She got up and walked that way. She called his name and he didn't stop. When she walked to the recliners she saw Resident #13 touching Resident #3's breasts. Resident #3's shirt was pulled up and her breasts hung from under her bra. When he saw her he sat back. She asked what he was doing but he didn't answer. She assisted Resident # 13 to sit back in the recliner, moved the chair further away and pulled Resident #3's shirt and bra down and covered her up. She said she reported to the charge nurse and and wrote a statement and gave it to the Administrator in training. She said afterwards she told the resident his actions were inappropriate and he	F 600		

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F 600	Continued From page 4 asked why he couldn't do that. She said she knew the resident made sexual comments to staff but did not know he had done anything physical to them. She said it didn't surprise her. She said now they don't put any females near him. She said Resident #3 slept and seemingly unaware it happened. During an interview on 12/10/19 3 p.m., Staff H, Registered Nurse (RN) stated she looked up when Staff G said something and saw Resident #13 reaching. She stated they maybe had a foot between the residents. Staff G said the resident's breasts were exposed. They separated them right away. Resident #13 now not to sit by female residents. She knew the resident made sexual comments to staff and and grabbed staff boobs, but had no behaviors toward other residents prior to that. The Nursing Facility Abuse Prevention, Identification, Investigation and reporting policy, updated 10/1/19, documented residents must not be subjected to abuse by anyone including other residents.	F 600		
F 684 SS=G	Quality of Care 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	F 684		

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F 684	Continued From page 5 by: Based on record review and staff interview, the facility failed to provide adequate assessment and timely intervention for 1 of 3 residents reviewed for hospitalizations, (Resident #6). The facility reported a census of 36 residents. Findings include: According to the Minimum Data Set assessment dated 6/19/19, Resident #6 scored 6 on the Brief Interview for Mental Status, indicating no cognitive impairment. The resident's diagnoses included heart failure and atrial fibrillation. The Progress Notes dated 8/29/19 at 4:47 p.m., documented the resident complained of a hard time breathing. The resident's oxygen (O2) saturation (sat) at 63% (94-100 normal). Staff got a new concentrator and an O2 mask because the resident wouldn't deep breathe through the nasal cannula. The O2 sat rose to 90%. The resident not happy about the mask, but asked to leave it on because effective. They would continue to monitor. The clinical record lacked any documentation of an assessment of the resident other than the O2 sat or any follow up of O2 sats. The Progress Notes dated 8/30/19 at 8 a.m., documented the resident complained of shortness of breath. A check of the O2 sat revealed 71% on 2.5 liters per nasal cannula, with a heart rate of 144 (normal 60-100). O2 applied at 4 liters per mask. At 8:15 a.m. they finally got a hold of the family with the okay to send the resident to the emergency room (ER) for evaluation. At 8:30 a.m. the resident transferred	F 684		

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F 684	Continued From page 6 by ambulance. The O2 sat at 90% with a mask and heart rate 134 and irregular. Report called to the hospital. A Transfer/Discharge Report dated 8/30/19, documented the resident complained of trouble breathing, face swollen and flushed, O2 sat 82%, pulse 120, and respirations 32 (12-20 normal). The report also documented the resident complained of difficulty breathing during the night and O2 sat 62% during the night. The hospital record dated 8/31/19, documented the resident's diagnoses included acute chronic respiratory failure with hypoxia (shortage of oxygen in the blood), acute systolic congestive heart failure and atrial flutter. The resident remained critically ill. A Pulmonary Consult Note dated 8/31/19, documented the resident came to the ER from the nursing home with complaints of increased shortness of breath for 1-2 days. When the resident came to the ER her O2 sat registered in the 70's on 6 liters of O2 and the resident admitted to the intensive care unit. The resident then on 12 liters of O2, and received diuretics and antibiotics the day before. The resident had a proBNP level of 3800 (normal less than 150) a test to detect and evaluate heart failure. During an interview on 12/10/19 at 10:27 a.m., the Assistant Director of Nursing (ADON) stated she documented, on the 8/30/19 transfer sheet, the resident had difficulty breathing with O2 sats in the 60's (during the night) because that's the report she received. She said Staff H, Registered Nurse (RN) asked her if she would assist her with the resident.	F 684		

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F 684	Continued From page 7 During an interview on 12/10/19 at 3:10 p.m., Staff H stated on 8/30/19 she came on and during report the night nurse, Staff I, RN reported the resident had difficulty breathing and (O2) sats were in the 60's. Staff H immediately went down and assessed the resident and then called the hospital house supervisor and the family to see about transferring to the hospital. She did not know if the night nurse took any other vital signs. She said she thought the night nurse said she turned the O2 up and put a mask on her. She did not know what she turned the O2 up to. Staff H stated the resident also had a rapid heart rate. The Progress Notes lacked any documentation regarding the resident's condition, an assessment or any intervention related to difficulty breathing on the night shift and the resident's vital signs record lacked any documentation. During an interview on 12/12/19 at 5:50 a.m., Staff I stated she did not remember the night shift prior to the resident transferring to the hospital on 8/30/19. During an interview on 12/12/19 at 7:40 a.m., the Resource Nurse concurred they had no follow up after the resident's low O2 sat (8/29/19 at 4:47 p.m.). She said they had instituted checking O2 sats routinely. During an interview on 2/12/19 at 12:42 p.m., the resident's personal physician stated if someone had a low O2 sat he would expect a nursing assessment, and if determined accurate, he expected the resident to go to the next level which would be the ER, immediately. He said if the facility had assessed the resident and sent	F 684		

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F 684	Continued From page 8 her to the ER sooner she may not have become so critically ill.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as	F 690		

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F 690	Continued From page 9 possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to assure proper care of 1 of 4 catheters reviewed, (Resident #31). The facility reported a census of 36 residents. Findings include: According to the Minimum Data Set assessment dated 6/5/19, Resident #31 demonstrated long and short term memory problems and severely impaired skills for daily decision making. The resident required extensive assistance with activities of daily living including toilet use and personal hygiene. The resident had an indwelling urinary catheter and diagnoses included obstructive uropathy. The current Care Plan, revised 10/08/19, identified the resident had a catheter due to obstructive and reflux uropathy. The interventions included; catheter care 2 times a day and as needed and monitoring for signs and symptoms of urinary tract infection (UTI): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse,increased temp, urinary frequency,foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. The Medication Administration Record (MAR) for September 2019 showed the resident received Cipro (antibiotic) 500 mg by mouth two times a day related to UTI for 2 weeks with a start date of 9/6/19, During an observation on 12/9/19 at 11:45 a.m.,	F 690		

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F 690	Continued From page 10 the resident sat at the dining room table. The resident's catheter bag hung in a dignity bag under the wheelchair but the tubing laid on the floor. During an observation on 12/10/19 at 9:40 a.m., Staff G, Certified Nursing Assistant (CNA) and Staff E, CNA provided care with the Assistant Director of Nursing (ADON) observing. The resident laid in bed with a mat beside it, with the catheter bag in a dignity bag hanging from the bed frame. Staff G wiped down the tubing with a disposable wipe, got a new wipe then wiped it again. Staff G then wiped the left groin with a wipe toward the catheter tubing, then the right groin in the same fashion, followed by wiping the front of the penis multiple times without turning the cloth toward the catheter tubing. Staff turned the resident to his left and Staff G wiped his buttock and anal area. Staff E held the catheter bag well above the level of the bladder in preparation to thread it through the pant leg. Staff G stated she would drain the bag and Staff E put it back on the bed frame. Staff G emptied the catheter bag. Staff E again held the catheter above the level of the bladder, then threaded it through the pant leg. During an interview on 12/11/19 at 12:30 p.m., the Director of Nursing (DON) stated the catheter tubing should remain off the floor and you would not want to raise the catheter bag above the level of the bladder. When doing perineal care the groin area and penis should be cleaned and the catheter tubing last to avoid re-contaminating it when wiping the other areas	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		

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F 695	Continued From page 11 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain an oxygen (O2) concentrator (used to administer O2) in a sanitary manner for 1 of 2 residents observed who required the use of an O2 concentrator, (Resident # 28). The facility reported a census of 36 residents. Findings included : According to a Diagnosis Report form dated 12/11/19, Resident #28's diagnosis included chronic obstructive pulmonary disease, asthma and dementia. An Order Summary Report form dated 12/11/19, included orders for the staff to apply O2 per a nasal cannula, every night at bedtime and remove the O2 every morning. The same order form included orders for the Resident's O2 tubing to be changed every Thursday evening. Record review on 12/10/19 of Resident #28's Treatment Administration Records (TAR's) for the months of October, November and December 2019, revealed a nurse administered the	F 695		

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F 695	Continued From page 12 Resident's O2, with the use of the O2 concentrator in her room, every evening at 9:00 P.M. and removed the O2 every morning at 7:00 A.M. Further review of the same TAR's revealed a nurse changed the O2 tubing on the O2 concentrator every Thursday during the months described above. Observations on 12/9/19 at 10:30 A.M., 12/10/19 at 11:59 A.M. and 12/11/19 at 8:25 A.M., revealed an O2 concentrator in the resident's room contained a moderate amount of a white substance on the outside of the concentrator and had the appearance of dust, 2 vents on each side of the concentrator contained an excess amount of a white substance in and around the perimeter of the vents and had the appearance of dust. During observation of the resident's O2 concentrator on 12/11/19 at 8:28 A.M., the facility Director of Nursing (DON), described the concentrator as dirty. During interview on 12/11/19 at 11:06 A.M., the DON stated she had spoken to the provider of the O2 concentrator/Respiratory supply company and confirmed the company comes and checks on the concentrators every 2 weeks, but does not clean the concentrators. The DON stated staff needed to clean O2 concentrators when they observe dust. She stated a task to clean O2 concentrators weekly would be added to the TAR.	F 695		
F 730 SS=E	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 of every nurse aide at least once every 12	F 730		

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(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 730	Continued From page 13	F 730		

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 employee file review and staff interview, the facility failed to ensure Certified Nurse Aides (CNA) completed 12 hours of in-service education per year for 5 of 5 employee files reviewed, (Staff B, C, D, E and F). The facility reported a census of 36 residents.

Findings included:

A facility form, People Editor Review, with a print date of 12/9/19, revealed hire dates for Staff B, C, D, E and F as follows:

Staff B - 11/12/18
Staff C - 2/28/17
Staff D - 1/26/17
Staff E- 1/3/17
Staff F- 9/26/12

A facility inservice attendance record, dated 12/10/19, revealed inservice hours provided to each CNA described above; during their anniversary year, as follows:

Staff B- 3 hours
Staff C- 3 hours
Staff D- 3 hours
Staff E- 2 hours
Staff F- no hours

During interview on 12/10/19 at 10:15 A.M., the facility Director of Nursing (DON) stated she began employment in the facility September of

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	165311	A. BUILDING _____ B. WING _____	12/12/2019

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F 730	Continued From page 14 2019 and had no record of staff education or inservices being provided to CNAs prior to her employment. During interview on 12/10/19 at 11:50 A.M., the DON, confirmed the facility expected 12 hours of annual education and/or inservice training to be provided to each CNA.	F 730		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		

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F 755	Continued From page 15 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to assure a resident did not receive outdated medication for 1 resident, (Resident #134). The facility reported a census of 36 residents. Findings include: The Medication Administration Record for November 2019 showed the resident had an order for Novolog (insulin), and received a dose on 11/6/19 in the evening. During an observation of the front medication cart on 12/12/19 at 9:16 a.m., Resident #134 had A Novolog Flexpen in use marked with an open date of 11/6/19 and directions to discard after 28 days. The Medication Administration Record for December 2019 documented the resident received Novolog the 5th, 6th, 7th, 8th, 9th, 10th, 11th, and 12th, all after the 28 days. During an interview on 12/12/19 at 9:40 a.m., the Assistant Director of Nursing (ADON) stated she called the pharmacy to see when they obtained the insulin and they said it was taken from the Cubex (automated medication dispensing system) on 11/6/19 and she confirmed the resident did receive insulin that evening. The ADON confirmed the resident had received insulin after it had expired.	F 755		

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F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, therapeutic menu review and interview, the facility failed to serve correct portion sizes to 6 of 6 residents with orders for mechanical soft (ground) meat texture. The facility reported a census of 36 residents. Findings Included: A therapeutic Diet Spreadsheet, dated 12/10/19,	F 803		

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F 803	Continued From page 17	F 803		

included a planned menu for residents on a mechanical soft diet, to receive a 3 ounce (oz) piece of ground maple pork loin during the noon meal on 12/10/19.

Observation on 12/10/19 at 11:15 A.M., revealed the following:

Staff A, Dietary Cook, confirmed 6 residents required ground meat according to the menu. Observation revealed sliced maple pork loin pieces in a pan on a steam table. Staff A stated the pieces weighed anywhere between 3- 4 oz a piece. Staff A used a tongs and moved 6 pieces of pork loin along with a small additional pork loin end piece (not comparable in size to the sliced pork loin pieces) into a robo coupe (blender). He stated he liked to add a little extra prior to a ground preparation. Staff A poured a small amount of pork loin broth into the robo coupe and ground the pork loin. The cook measured the ground meat in a graduate at 1 quart (or 4 cups) and placed the ground meat in metal plan on a steam table. He stated he needed to use a pureed diet portion sizes/scoops chart to determine the correct portion size for each residents consumption.

Review of the facility food distribution company, Pureed Diet Portion Sizes/Scoop chart, revealed 4 cups of an altered food substance for 6 residents required service with a #6 scoop or a portion size of 5 1/3 oz per resident.

During observation on 12/10/19 at 12:05 P.M., Staff A began the noon meal service. During the same observation, Staff A served the first of the ground pork loin and confirmed the scoop size used as a #12 scoop, or a portion size of 2 2/3

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F 803	Continued From page 18 oz. He stated a #12 scoop had been the incorrect size and changed the scoop size to a #8 scoop, or 4 oz portion size. During ongoing observation, Staff A served the remaining 5 residents who required ground meat, with a #8 scoop or 4 oz serving rather than a # 6 scoop or 5 1/3 oz serving. The meal service ended on 12/10/19 at 12:35 P.M.. Observation of the ground meat serving pan revealed left over ground meat. The cook estimated the amount of left over ground meat to be approximately 2 -#8 scoop sizes or approximately 8 oz. During interview on 12/10/19 at 12:40 P.M., the facility Dietary Manager (DM) stated Staff A had been certified in meal service and had been trained to follow the pureed Diet portion sizes/scoops chart to determine a serving size with a ground texture. During interview on 12/10/19 at 1:45 P.M., the DM stated during the noon meal on 12/10/19, Staff A had given the residents on mechanical soft diets (ground meat) too much meat. She stated the menu called for 3 oz and Staff A served the residents 4 oz. The DM confirmed after meat is ground, it needed to be measured and divided equally between the number of residents being served. During interview on 12/10/19 at 2:15 P.M., the DM provided a form, Process for Mechanically Grinding, scanned to the facility on 12/10/19 at 1:39 P.M. by the facility food distribution company Dietitian. The process instructed staff to measure out the desired number of servings for grinding, grind to appropriate texture and measure the total volume of the food after it is ground. Divide the total volume of the ground food by the original	F 803		

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F 803	Continued From page 19 number of servings (which would calculate as follows for the noon meal service on 12/10/19- 1 quart of ground meat or 4 cups or 32 oz, divided by 6 residents, equals 5.3 oz).	F 803		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		

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F 880	Continued From page 20 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to assure appropriate infection control practices during dressing change for 1 resident (Resident #13) and during medication pass for 8 observations. The facility	F 880		

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F 880	Continued From page 21 reported acensus of 36 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 7/10/19, Resident #13 scored 11 on the Brief Interview for Mental Status (BIMS) indicating some cognitive impairment. The resident's diagnoses included non-Alzheimer's dementia. During an observation on 12/11/19 at 6:27 a.m., Staff J, Licensed Practical Nurse (LPN) treated the resident's lower legs with the Assistant Director of Nursing (ADON) observing. Staff J washed her hands and put on gloves. She pulled down the resident's derma savers and netting and removed the old dressings. Staff J changed the right glove with no hand hygiene. Staff J cleaned both areas (large anterior left lower leg and anterolateral right lower leg) and changed gloves with no hand hygiene. She applied ointment with a cotton tipped applicator and covered the wounds with a non-adherent dressing. During an interview on 12/11/19 at 12:30 p.m., the Director of Nursing (DON) stated staff should wash hands or use hand sanitizer between glove changes. According to the Centers for Disease Control (CDC) and Prevention multiple opportunities for hand hygiene may occur during a single care episode. The clinical indications for hand hygiene included immediately after glove removal. The CDC document reads: Always clean your hands after removing gloves. Dirty gloves can soil hands.	F 880		

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F 880	Continued From page 22 2. During an observation on 12/10/19 at 7:28 a.m., Staff H, Registered Nurse (RN) took Resident #25's Incruse Elipta inhaler and Refresh eye drops to the resident's room. She placed the plastic bag with the eye drops on the counter by sink with no barrier. When finished she put the bag with the eye drops back in the med cart. 3. During an observation on 12/10/19 at 11:32 a.m.,Staff K, RN took Systane eye drops to Resident #27's room. Staff K sat the box containing the eye drops on the resident's stand with no barrier. After she administered the drops Staff K returned the box with the eye drops to the med cart. 4. During an observation on 12/10/10 at 11:39 a.m., Staff K took Refresh eye drops, insulin and a pill to Resident #12's room. Staff K had a blood glucose monitor and the insulin pen on a barrier, but sat the eye drop bottle on a table with no barrier. After the administration she returned the bottle to the med cart. 5. During an observation on 12/10/19 at 12:15 p.m., Staff H took a Novolog Flexpen to resident #6's room. Staff H laid the flexpen on the counter by the sink and washed her hands reaching over the flexpen to get paper towels. After administering the insulin Staff H returned the flexpen to the med cart. 6. During an observation on 12/11/19 at 7 a.m., Staff J took Refresh eye drops to Resident #25's room. Staff J laid the bag containing the eye drops on the counter by the sink. After administering the eye drops Staff J returned the	F 880		

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F 880	Continued From page 23 eye drops in the bag to the med cart. 7. During an observation on 12/11/19 at 7:07 a.m., Staff J took a Novolog insulin pen to Resident #4's room. Staff J laid the bag with the insulin pen on the counter by the sink, then got paper towels and put under it. Staff J washed her hands and applied gloves, then handled the bag that had laid on the counter with no barrier. After administering the insulin Staff J returned the insulin in the bag to the med cart. 8. During observation on 12/11/19 at 11:17 a.m., Staff J took a Novolog pen to Resident # 134's room. Staff J laid the bag containing the insulin pen on the counter by the sink with no barrier. When Staff J prepped the pen, she laid the cap on the counter. Staff J returned the isulin pen in the bag to the med cart. 9. During observation on 12/11/19 at 11:27 a.m., Staff J took a Novolog pen to Resident #6's room. Staff J laid the insulin pen bag on the resident's bedside table with no barrier. After she administered the insulin, Staff J returned the pen/bag to the med cart. During an interview on 12/11/19 at 12:30 p.m., the Director of Nursing (DON) stated any supplies taken to a resident's room that would go back in the med cart should be placed on a barrier, not directly on the resident's table, counter by the sink, etc...	F 880		
F 943 SS=E	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect,	F 943		

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F 943	Continued From page 24 and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on in-service review and interviews, the facility failed to provide all staff the required abuse, neglect, and exploitation training. The facility reported a census of 36 residents. Findings include: The facility provided an in-service Sign out/in Sheet for 1/29/19 that included elder abuse. The sheet contained only 7 names, none of which were on the current Nurse Aide Roster dated 11/13/19. The roster contained names of 10 CNA's hired prior to the past year. During an interview on 12/11/19 at 3:01 p.m., the acting Administrator stated when he started at the facility, in-services were not getting done correctly and staff would not show up. So the sheet provided from 1/29/19 on Elder Abuse with only 7 people documented as attending would be all they had. The Nursing Facility Abuse Prevention,	F 943		

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F 943	Continued From page 25 Identification, Investigation and Reporting Policy, updated 10/1/19, documented all nurse's aides should receive initial and annual resident abuse prevention training which would educate staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property, procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of the resident's property, and dementia management and resident abuse prevention. All employees should receive annual training relating to the reporting requirements of the Elder Justice Act, and each employees obligation to comply with the reporting requirements of the Act.	F 943		

Accura Healthcare of Le Mars
954 7th Avenue SE
Le Mars, IA 51031
Provider #165311

F000

This Plan of Correction is submitted as required under Federal and State regulation and statues applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied. All deficiencies were corrected by 12/27/19 with the exception of F684 which was corrected on 12/23/19

F600

In continuing compliance with F600, Freedom from Abuse, Neglect, and Exploitation, Accura HealthCare of LeMars corrected the deficiency by providing adequate supervision to prevent resident to resident abuse for resident #3, #13 and all like residents. Resident #13's care plan was reviewed and updated with appropriate interventions. To ensure the problem does not recur staff was re-educated on 12/20/19 on abuse policy and providing supervision to prevent resident to resident abuse by Executive Director and DON. The DON and /or designee will randomly audit Care Plans for appropriate interventions and appropriate supervision to ensure compliance. As part of Accura Healthcare of LeMars ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA process.

F684

In continuing compliance with F684, Quality of Care, Accura HealthCare of LeMars corrected the deficiency by educating nurses on proper resident assessment and timely physician notification for resident #6 and all like residents. To correct the deficiency and to ensure the problem does not recur nursing staff was educated on 12/23/19 on providing accurate assessments with timely interventions with changes of condition and timely physician notification by the DON. The DON and/or designee will randomly audit nurse assessments weekly to ensure compliance. As part of Accura Healthcare of LeMars ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA process.

F690

In continuing compliance with F600, Bowel/Bladder Incontinence, Catheter, UTI, Accura HealthCare of LeMars corrected the deficiency by ensuring staff provide appropriate care of catheters. Resident #31 and all like residents tubing will not touch the floor and will receive appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. To correct the deficiency and to ensure the problem does not recur all nursing staff was re-educated 12/23/19 on the appropriate catheter care and the proper storage of catheters. The DON and/or designee will perform random weekly audits of catheters to ensure compliance. As part of Accura Healthcare of LeMars ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA process.

F695

In continuing compliance with F695, Respiratory/Tracheostomy Care and Suctioning, Accura HealthCare of LeMars corrected the deficiency by cleaning Residents #28's concentrator upon discovery. All concentrators were inspected to ensure they are being maintained in a sanitary manner. To correct the deficiency and to ensure the problem does not recur nursing staff were re-educated on 12/20/19 on proper sanitation of oxygen concentrators by the DON. O_2 concentrator sanitation was placed on the TAR for residents with concentrators. The DON and/or designee will perform random audits of oxygen concentrators to ensure compliance. As part of Accura Healthcare of LeMars ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA process.

F730

In continuing compliance with F730, Nurse Aide Perform Review-12 hr/yr In-Service, Accura HealthCare of LeMars corrected the deficiency by reviewing Nurse Aide employee files to ensure they have received 12 hours of in-service education. To ensure the problem does not recur Accura HealthCare of LeMars will utilize an online/computer-based education partner, Health Care Academy, for required in-servicing and tracking. The Executive Director and/or designee will randomly audit employee files to ensure compliance. As part of Accura Healthcare of LeMars ongoing commitment to quality assurance, the Administrator and/or designee will report identified concerns through the community's QA process.

F755

In continuing compliance with F755, Pharmacy Services/Procedures/Pharmacist/Records, Accura HealthCare of LeMars corrected the deficiency by procuring new insulin that was not expired for resident #134 and like residents. To ensure the problem does not recur all medication was audited by DON to verify none had past the date of expiration. Nursing staff was re-educated on 12/20/19 on verification that insulin has an open date and to check date prior to dispensing the med. DON and/or designee will conduct random weekly audits of medication expiration dates to ensure compliance. As part of Accura Healthcare of LeMars ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA process.

F803

In continuing compliance with F803, Menus and nutritional adequacy, all residents are being served correct portion sizes in accordance with their physician's orders and in consideration of the resident's choices and preferences. To correct the deficiency and to ensure the problem does not recur dietary staff was educated on 12/17/2019 on preparation of therapeutic diets including ground meat diets and portion sizes. The Dietary Manager and/or designee will conduct random audit to ensure compliance. As part of Accura Healthcare of LeMars ongoing commitment to quality assurance, the Dietary Manager and/or designee will report identified concerns through the community's QA process.

F880

In continuing compliance with F880, Infection Prevention & Control, Accura HealthCare of LeMars corrected the deficiency by providing appropriate infection control practices for resident #13 and all like residents. To correct the deficiency and to ensure the problem does not recur all staff were educated on 12/23/2019 regarding proper hand washing techniques and infection prevention, and nursing staff was educated on appropriate use of a barrier to prevent the development and transmission of communicable diseases and infection. The DON and/or designee will perform random hand washing audits along with medication pass audits to ensure compliance. As part of Accura Healthcare of LeMars ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA process.

F943

In continuing compliance with F943, Abuse, Neglect, and Exploitation Training, Accura Healthcare of LeMars corrected the deficiency by all employees have received annual training relating to the reporting requirements of the Elder Justice Act, and each employee's obligation to comply with the reporting requirements of the Act. To correct the deficiency and to ensure the problem does not recur all staff have been educated on 12/20/2019 on requirement for all employees to receive training relating to the reporting requirements of the Elder Justice Act upon hire and annually thereafter. Employee files were audited to verify completion on required in-service training. As part of Accura Healthcare of LeMars ongoing commitment to quality assurance, the Administrator and/or designee will report identified concerns through the community's QA process.