NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF KNOXVILLE, LLC	606 NORTH SEVENTH STREET KNOXVILLE, IA 50138

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	10 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: 4/8/21 Amended April 5, 2021. A Focused Infection Control Survey, Complaints #90585,#90763,#90879,#91830,#92140, #92286,#93958,#94029,#94219,#94645, #95253, Mandatory Complaint #95610.A, and Facility Reported Incidents #90591, #90780 and #92419 were investigated February 22, 2021 to March 11, 2021. Complaints #90585-C, #90763-C, #90780-C, #90879-C, #92140-C, #92140-C, #92419-1, 93958-C,#94029,#94219.C,#94645-C, #95253-C, and #95610-C were substantiated. Complaints #90591-C, #91830-C, and #92286-C were not substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F000	Accura Healthcare of Knoxville denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.	04/08/2021
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) **CFR(s): 483.10(g)(14)(i)-(iv)(15)** §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F580	In continuing compliance with F 580 Notify of Changes (Injury/Decline/Room, etc.) the facility corrected the deficiency by educating nursing staff on best nursing practices for family notification. The facility will ensure responsible parties are notified of changes for residents #2, #3, and like residents. To correct the deficiency and to ensure the problem does not recur all nurses were educated by 03/12/2021 on family notifications by Tara Anderson, ADON. The DON/ADON and/or designee will audit for compliance with responsible party notifications three times weekly for four weeks and then as needed to ensure compliance. As part of Accura Healthcare of Knoxville's ongoing commitment to quality assurance, the DON/ADON and/or designee will report identified concerns through the community's QA Process.	04/02/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tiffany Michaud	Administrator 4-9-2021	04/02/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165382	A. BUILDING _____ B. WING _____	C 03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF KNOXVILLE, LLC	806 NORTH SEVENTH STREET KNOXVILLE, IA 60138

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F 580	Continued From page 2 The facility reported census was 49 residents. Findings include: 1. According to the Minimum Data Set (MOS) assessment with assessment reference date of 8/25/20, Resident #2 had a brief interview for mental status (BIMS) score of 15 indicating an intact cognitive status. Resident #2 required limited assistance of others with dressing and bathing and was otherwise independent with toilet use and personal hygiene needs. Resident #2's diagnosis included diabetes mellitus, atrial fibrillation, seizure disorder, chronic obstructive pulmonary disease, respiratory failure and hypertension. During an interview on 3/1/21 at 2:20 p.m., the Assistant Director of Nursing (ADON) stated on the morning of 4/26/20 she received a call from Staff I (Registered Nurse) informing her of a medication error involving Resident #2. Staff I stated she informed the Physician. Staff I stated she left medications belonging to another resident in Resident '#2.'s room and Resident #2 ingested the medications. Staff I asked Resident #2 why she took the medications after already taking her morning medications. Resident #2 responded they were left and she thought they were hers. The ADON stated she received a call from Physician B on 4/27/20 wanting to know what medications were taken. The ADON provided a list of medications the other resident was taking and faxed it. According to an Incident Report dated 4/26/20 at 9:30 a.m., written by Staff I Registered Nurse, Staff I went into Resident #2's room to administer a pain patch and had another residents	F 580		

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F 580	Continued From page 3 medications in a cup with her. Staff I sat the medication cup down and administered the pain patch and left the room without the medication cup. Staff I returned to the medication cart and realized she for the medication cup in Resident #2's room. Staff I discovered Resident #2 ingested the other resident's medications and and immediately called Physician A and informed of the error. Physician A advised Resident #2 would likely get sleepy and instructed Staff I to obtain vital signs every 4 hours. Staff I notified the Assistant Director of Nursing (ADON). Staff I then returned to assess Resident #2. and obtain vital signs. The Incident Report documented the Responsible Party notified at 3:28 p.m. and Physician A at 10:45 a.m. During an interview on 3/2/21 at 12:42 p.m., Staff I (Registered Nurse) stated she worked from 6:00 a.m. to 6:00 p.m. shift on 4/26/20. Staff I entered Resident #2's room and had a cup of medications belonging to another resident with her. Staff I completed care for Resident #2 and and left the and forgot the medication cup. Staff I returned to the medication cart and recalled leaving the medications. Staff I returned to Resident #2's room and discovered Resident #2 ingested the medications in error. Staff I called Physician A and reported the event and what medications were ingested in error. Staff I reported Resident #2 had her routine medications earlier. Physician A ordered vital signs to be taken every four hours for twenty four hours and adamantly stated she monitored Resident #2 throughout her shift, but admitted she may not have documented everything. Staff I believed she notified Resident #2's Responsible Party but could not be certain. During an interview on 3/1/21 at 1:22 p.m.	F 580		

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F 580	Continued From page 4 Resident '#2.'s Responsible Party stated she received a call the evening of 4/26/20 from Resident#12, who is a friend of Resident'#2. Resident #12 informed the Responsible Party Resident #2 received another Resident's medications and was not doing well. The Responsible Party called the facility and learned a Nurse left another resident's medications in Resident #2's room and Resident #2 ingested them. The Nurse indicated they were in the process of sending Resident #2 to the hospital (6:15 p.m.) and hung up. According to the facilities Medication Error Incident Report Process, medication errors must be documented in the a record and directed to document family and physician notification in the Nurse's Notes. According to Progress Notes dated 4/26/20 at 10:45 a.m., the staff notified Physician A of the medication error. The Progress Notes lacked documentation to reflect the staff notified the Responsible Party. 2. According to the MOS assessment with assessment reference date of 8/28/20, Resident #3 had a BIMS score of 6 indicating a severely impaired cognitive status. Resident #3 requires total dependence on others with mobility, dressing, eating, toilet use and personal hygiene needs. Resident #3's diagnosis includes diabetes mellitus, atrial fibrillation, seizure disorder, chronic obstructive pulmonary disease, respiratory failure, schizophrenia, cerebrovascular accident (stroke) and hypertension. According to the Progress Notes dated 11/15/20 at 3:00 p.m. (documented by Staff L Registered	F580		

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F 580	Continued From page 5 Nurse) Resident #3 had an unwitnessed fall that resulted in a cut on his nose. Resident #3 reported he tried to get out of his wheelchair. The staff called for an ambulance and Resident #3 transferred to the Emergency Room for evaluation. The noted revealed the staff attempted to contact the Responsible Party and had to leave a message to return the call. The staff notified the Nurse Practitioner of the incident. During an interview on 3/8/21 at 4:55 p.m. Staff L (Registered Nurse) stated on 11/15/20 Resident #3 had a fall and struck his nose and sustained a cut on his nose. Resident #3 transferred to the hospital. Staff L reported she attempted to contact Resident #3's Responsible Party and had to leave a voice mail. The Responsible Party did not return the call during her shift (2:00 p.m. to 10:00 p.m.). Review of the Progress Notes from 11/15/20 to 11/16/20 revealed a lack of documentation to reflect the staff notified Resident #3's Responsible Party of the fall and transfer to the hospital. According to Progress Notes dated 11/19/20 at 9:53 p.m. written by Staff M {Licensed Practical Nurse) Resident #3 has a choking event while in the dining room. The event lasted about 5 minutes and resulted in Resident #3 vomiting. The physician is notified via fax. Will pass on to on-coming nurse to call family and make aware during waking hours. According to the Progress Notes dated 11/19/20 through 11/20/20, there is no indication of anyone following up and notifying the family of the	F580		

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F 580	Continued From page 6 incident.	F580		04/02/2021
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1,	F584	In continuing compliance with F 584, Safe/Clean/Comfortable/Homelike Environment. Accura Healthcare of Knoxville corrected the deficiency by educating Facility Maintenance Directors on facility temperature requirements. The facility will ensure that resident #12 and like residents are provided a safe environment. To correct the deficiency and to ensure the problem does not recur, maintenance staff were educated on 3/15/21 by Tiffany Michaud, Administrator, on facility temperature requirements and process for notifying the appropriate agencies should temperatures fall outside the range. Facility maintenance staff were also educated on the use of portable heaters and process for obtaining permission for use. The facility installed electric baseboard heaters on 02/11/2021. The Administrator and/or designee will audit heat temperatures twice weekly for four weeks and then as needed to ensure compliance. As part of Accura Healthcare of Knoxville ongoing commitment to quality assurance, the Administrator and/or designee will report identified concerns through the community's QA Process.	

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F 584	Continued From page 7 1990 must maintain a temperature range of71 to a1°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on facilities Emergency Preparedness Plan, staff and resident interviews, the facility failed to maintain comfortable temperature levels in the facility. A polar vortex plummeted temperatures below zero for over a week in February of 2020. The facility boiler system failed to maintain temperatures above 70 degrees Fahrenheit. The facility added an additional 8 electric base board heaters in the hallways and 6 plug in oil based heaters in the hallways, but were still unable to maintain temperatures above 70 degrees Fahrenheit. The use of portable heaters were not reported to the Department of Inspections and Appeals or approved by the State Fire Marshall. Findings include: During an interview on 2/24/21 at 3:15 p.m., Staff D (Maintenance) stated during the extreme cold in earlier February, the boiler system is unable to keep the facility at comfortable temperatures. The boiler temperature is 165 degrees Fahrenheit leaving and 155 degrees Fahrenheit returning, so it is working properly. Staff D stated every morning he would come in and check thermostats on each hall. The heat is set at 75 degrees Fahrenheit During that cold streak facility temperatures drops into the mid sixties. North hall (200) is the coldest at 64 degrees Fahrenheit. South hall (100) and the 500 halls are 65-66 degrees Fahrenheit and the 300 hall is 68	F584		

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F 584	Continued From page 8	F584		

degrees Fahrenheit. Staff D states he did not record daily temperatures. Staff D stated temperatures would increase during the day, but by the next morning would be back in the mid sixties. Staff D stated in an attempt to mitigate the cold they added two electric base board heaters in each hall and brought out five or six oil based radiant plug in heaters in the halls. Staff D states they also installed electric heater air conditioning units in two rooms. Staff D states it all helped, but it still remained in the mid sixties during the cold spell, 7-10 days.

During an interview on 2/23/21 at 3:35 p.m., the Administrator stated when it got extremely cold the boilers failed to maintain comfortable temperatures in the facility. From 2/6/21 through 2/19/21 the facility placed six oil based electric heaters in the hallways. On 2/11/21, the facility installed two electric base board heater in each hallway. Two rooms on 500 hall also had heater units installed. The Administrator stated the State Fire Marshall and Department of Inspections and Appeals were not informed of the use of plug in heating sources.

During an interview on 2/22/21 at 4:40 p.m. Staff G (Certified Nurse Aide) stated she worked some shifts during the cold spell and states it was chilly, 68 degrees. Staff G states it is coldest in the south rooms 506-510. Staff G stated The Residents in rooms 504 and 507 complained of being cold.

During an interview on 2/22/21 at 4:45 p.m. Staff H (Certified Nurse Aide) stated it was cold in the facility during the cold spell, 68 degrees. Staff H stated the facility added two electric baseboard heaters in the south halls, which helped. Staff H

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F 584	Continued From page 9 stated she provided residents with extra blankets during that time. During an interview on 3/2/21 at 2:30 p.m., Resident #12 stated they had no heat this winter and it got 40 to 50 degrees Fahrenheit inside. Resident #12 stated the staff provided blankets and placed portable heaters, but it remained cold. During random interviews with residents, two residents described the temperatures in the facility as freezing and like walking into a cooler. The residents indicated they added heaters and provided blankets, but it was still cold. According to the facilities Emergency Operation Plan (EOP) for Extreme Cold Weather: 1) The facility is to follow the Incident Commander Successor Notification Plan for further instructions. 2) **Assess** residents for signs of distress. 3) Initiate actions to safely increase resident comfort using heating pads, electric blankets, warm fluids and additional heating units if appropriate. 4) Do not leave residents unattended by a heat source. 5) If the internal temperatures remain low and potentially jeopardizes the safety and health of residents, consider relocation to warmer areas in the facility or evacuate to another facility. Notify the authority having jurisdiction for this incident if necessary to inform them that you activated the facilities' EOP.	F 584		

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F 584	Continued From page 10 6) If decision to evacuate, see rapid response-evacuation. 7) Notify the authority having jurisdiction for this incident if necessary to inform them that you have activated the facilities' EOP.	F584		
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 interviews, the facility failed to ensure residents remained free from abuse for 1 of 12 sampled (Resident #8). Staff C removed Resident #S's soiled brief and threw the brief in Resident #S's face. Resident #4 had a history of touching other residents. Resident #4 hugged Resident #8 and then grabbed her breast. Resident #4 cried out and reported it hurt The reported facility census is 49. Findings include:	F600	In continuing compliance with F 600, Free from Abuse, Neglect, and Exploitation. Accura Healthcare of Knoxville corrected the deficiency by suspending the staff member in question and education of all staff. The facility will ensure that resident #8 and like residents are free from abuse, neglect, and exploitation. To correct the deficiency and to ensure the problem does not recur, the staff member in question was suspended on 02/23/2021; he has since been terminated. In addition, all staff were educated by Tiffany Michaud, Administrator, on the facility's abuse policy by 3/15/21. The Administer and/or designee will audit for understanding and compliance with the facility abuse policy twice weekly for four weeks and then as needed to ensure compliance. As part of Accura Healthcare of Knoxville's ongoing commitment to quality assurance, the Administrator and/or designee will report identified concerns through the community's QA Process.	04/07/2021

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F 600	Continued From page 11 1. According to the Minimum Data Set (MOS) dated 1on121, Resident#B had a Brief Interview for Mental Status (BIMS) score of "5", indicating a severely impaired cognition. Resident #8 required extensive assistance of others with transfers, ambulation, dressing, toilet use and personal hygiene needs. Resident #8 had diagnoses of impaired intellectual disabilities. schizophrenia and seizure disorder. During an interview on 2/22/21 at 4:46 p.m., Staff A (Certified Nurse Aide) reported on 2/6/21 Staff A, Staff B (Certified Nurse Aide), and Staff C (Certified Nurse Aide) completed incontinence cares for Resident #8. Staff C removed Resident #S's soiled brief and threw the brief in Resident #S's face. Staff C picked up a piece of the tom brief and placed it on Resident #S's head. Resident #8 did not respond. Staff A did not believe it was an accident and reported the incident to the Assistant Director of Nursing. During an interview on 2/22/21 at 2:04 p.m., Staff B (Agency Certified Nurse Aide) stated she worked one shift at the facility due to the concerns she witnessed on 2/6/21. Staff C (Certified Nurse Aide) complained to Staff B of being annoyed by Resident #8. Staff B assisted Staff C with Resident #S's incontinence cares. Staff C removed Resident #S's soiled brief and forcibly threw the brief in Resident #S's face. Staff C removed the tab off the brief and placed the tab in Resident #B's hair. Resident #8 did not respond. Staff A (Certified Nurse Aide) witnessed the incident. Staff C exited the room. Staff A stated he/she planned to report the incident 2. According to the MOS assessment dated	F600		

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F 600	Continued From page 12 11/26/20, Resident #4 had a **BIMS** score of "14", indicating no cognitive impairments. Resident #4 required total dependence on others with mobility, transfers, dressing, toilet use and personal hygiene. Resident #4 had diagnoses of traumatic brain injury, hemiplegia, seizure disorder and schizophrenia. Resident #4 's Care Plan revealed a Potential for Behavior/Altered coping with identified behaviors which included touching and grabbing female residents and staff inappropriately. The Care Plan directed staff to provide close monitoring when escorted to and from room (2/19/17)t do not leave alone with female residents (2/19/17), to be within site when in wheelchair out of room (2/19/17), motion sensor at bedroom door when in wheelchair (2/19/17), wanderguard sensor to alert staff when resident exits room (7/19/20) and 15 minute checks 96/22/20). According to Close Observation Flow Sheet (15 min checks), the staff failed to document Resident#4's whereabouts on 7/19/20 2:15 p.m. to 5:45 p.m. and 6:15 p.m. to 6:45 p.m. According to Progress Notes dated 10/28/17 Resident #4 had a history of touching other residents inappropriately. A resident yelled out and alerted the staff that Resident #4 had his hand under another Resident shirt touching her breast. The staff separated the residents, educated Resident #4 and placed an alarm on Resident #4's door. According to the Incident Report dated 6/22/20, Resident #4 observed hugging Resident #8 and grabbed Resident #S's breast during supper. The residents were immediately separated and the	F600		

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	165382	A. BUILDING _____ WING _____	C 03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF KNOXVILLE, LLC	606 NORTH SEVENTH STREET KNOXVILLE, IA 50138

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F 600	Continued From page 13 incident reported. Both residents were placed on 15 minute checks. According to the Incident Report dated 7/19/20, Resident #4 observed hugging Resident #8 and grabbed Resident #S's breast at supper. The staff immediately separated the residents. During an interview on 2/25/21 at 11:54 a.m., Staff E (Certified Nurse Aide) stated on 7/19/20 she entered the Dining Room and observed Resident #4 at Resident #S's table. Resident #4 had his hand down Resident #S's shirt, grabbing Resident #S's breast. Staff E separated them immediately. Resident #8 cried out and stated that he squeezed her breast hard and hurt her. Staff E informed the Nurse and removed Resident #4 from the dining room. Staff E stated she was the only staff in the Dining Room at the time and did not know who brought Resident #4 to the dining room and left him unsupervised. During an interview on 2/25/21 at 12:56 p.m. Staff F (Agency Certified Nurse Aide) stated she worked the 500/400 halls on the evening of 7/19/20. Before supper Staff E approached Staff F and reported Resident #4 touched Resident #S's breast in the dining room. Staff F reported the incident to the Nurse and separated the residents. Resident #4 denied touching Resident #S's breast. However, Resident #8 stated Resident #4 touched her breast. Staff F did not recall Resident #8 crying. Staff F did not know who placed Resident #8 in the dining room. Staff F stated the motion alarm on the top of Resident #S's door is often shut off, because his roommate is independent and activates it. Staff F stated since the incident a wanderguard type alarm was placed in the hallway to alert staff when Resident	F600		

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F 600	Continued From page 14 #8's wheelchair is in the vicinity.	F600		
F 609 SS=D	Reporting of Alleged Violations **CFR(s): 483.12(c)(1)(4)** §483.12(c) In response to allegations of abuse, neglect exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, Including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interviews, the facility failed to ensure incidents of abuse are properly reported. On 2/6/21 an aide threw a soiled brief into the face of a resident (Resident #8) The reported	F609	In continuing compliance with F 609, Reporting of Alleged Violations. Accura Healthcare of Knoxville corrected the deficiency by education of all staff on the facility's abuse policy and reporting requirements. The facility will ensure future alleged violations involving resident #8 and like residents are reported. To correct the deficiency and to ensure the problem does not recur, all staff were educated by Tiffany Michaud, Administrator, on the facility's abuse policy and reporting requirements by 3/15/21. The Administrator and/or designee will audit for understanding and compliance with the facility abuse policy twice weekly for four weeks and then as needed to ensure compliance. As part of Accura Healthcare of Knoxville ongoing commitment to quality assurance, the Administrator and/or designee will report identified concerns through the community's QA Process.	04/07/2021

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F 609	Continued From page 15 facility census is 49. Findings include: According to the Minimum Data Set (MOS) assessment dated 10/7/21 Resident #8 had diagnoses of schizophrenia and seizure disorder. Resident #8 had a Brief Interview for Mental Status (BIMS) score of "5" indicating severe cognitive impairments. Resident #8 required extensive assistance of others with transfers, ambulation, dressing, toilet use and personal hygiene needs. During an interview on 2/22121 at 4:46 p.m., Staff A (Certified Nurse Aide) reported Staff A, Staff B, and Staff C completed incontinence cares for Resident #8 on 2/6/21. Staff C removed Resident #S's soiled brief and threw the brief in Resident #S's face. Staff C picked up a piece of the tom brief and placed it on Resident #S's head. Resident #8 did not respond. Staff A did not believe it was an accident and reported the incident to the Assistant Director of Nursing. During an interview on 2/22121 at 2:04 p.m., Staff B (Agency Certified Nurse Aide) stated she worked one shift at the facility due to the concerns she witnessed on 2/6/21. Staff C (Certified Nurse Aide) complained to Staff B of being annoyed by Resident #8. Staff B assisted Staff C with Resident #S's incontinence cares. Staff C removed Resident #B's soiled brief and forcibly threw the brief in Resident #B's face. Staff C removed the tab from the brief and placed the tab in Resident #S's hair. Resident #8 did not respond. Staff A (Certified Nurse Aide) witnessed the incident. Staff C exited the room. Staff A stated he/she planned to report the incident.	F609		

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F 609	Continued From page 16 During an interview on 2122/21 at 5:50 p.m., the Assistant Director of Nursing (ADON) stated on 2/6/21 she received a call from Staff A (Agency Certified Nurse Aide) who reported Staff C placed a soiled brief next to Resident #S's head. The ADON stated she reported the incident to the Director of Nursing (DON and Administrator. During an interview on 2/23/21 at 9:30 a.m., the Director of Nursing (DON) stated on Monday 2/8/21 she learned of an incident involving Staff C. Staff C allegedly placed a brief near Resident #S's head. The DON stated Staff A and Staff B witnessed to the event. The DON stated she interviewed Staff A who reported Staff C placed a soiled brief on Resident #S's face. Resident #8 did not do or say anything. Staff A stated he does not want to make a scene and waited until Staff C left before reporting it. The DON stated the Management Team reviewed the incident on 2/8/21. The DON stated she did not believe it to be intentional. However, she confirmed she failed to interview Staff B and Staff C. The DON talked to the Regional Vice President and sent a discipline recommendation to the Human Resource Department on 2/12/21. On 2/15/21, the DON heard back from Human Resources and responded on 2/22/21. On 2/23/21, the DON interviewed Staff C who denied intentionally throwing the soiled brief on Resident #S's face. The DON reported the facility suspended Staff C pending investigation and the facility did not report the incident to the Department of Inspections and Appeals.	F609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F610	In continuing compliance with F 610, Investigate/ Prevent/Correct Alleged Violation, Accura Healthcare of Knoxville corrected the deficiency by education of facility management on the facility's abuse policy and suspending the staff member in question. The facility will ensure that alleged violations involving resident #8 and like residents are investigated/ prevented/corrected.	04/07/2021

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

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F 610	Continued From page 17 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interviews and personnel file review the facility failed to thoroughly investigate an allegation of abuse, failed to take action to prevent further abuse and ensure the safety of residents by permitting the alleged perpetrator to continue to work and failed to report the facilities investigation results in accordance with state law for 1 of 12 sampled (Resident #8). The facility reported a census of 49. Findings include: he Minimum Data Set (MOS) assessment dated of 1on121 revealed Resident #8 had diagnoses of schizophrenia and seizure disorder. Resident #8 had a Brief Interview for Mental Status (BIMS) score of "5", indicating severe cognitive impairments. Resident #8 required extensive assistance of others with transfers, ambulation,	F610	To correct the deficiency and to ensure the problem does not recur, the DON and Administrator were educated by Brady Allen, Regional Vice President of Operations, on 2/23/21 on the facility's process for reporting alleged abuse. The staff member in question was suspended pending investigation and has since been terminated. The Administrator and/or designee will audit for understanding and compliance with the facility abuse policy twice weekly for four weeks and then as needed to ensure compliance. As part of Accura Healthcare of Knoxville's ongoing commitment to quality assurance, the Administrator and/or designee will report identified concerns through the community's QA Process.	

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 610	Continued From page 18 dressing, toilet use and personal hygiene needs. During an interview on 2/22/21 at 4:46 p.m., Staff A(Certified Nurse Aide) reported Staff A, Staff B, and Staff C completed incontinence cares for Resident #8 on 2/6/21. Staff C removed Resident #B's soiled brief and threw the brief in Resident #S's face. Staff C picked up a piece of the torn brief and placed it on Resident #S's head. Resident #8 did not respond. Staff A did not believe it was an accident and reported the incident to the Assistant Director of Nursing. During an interview on 2/22/21 at 2:04 p.m., Staff B (Agency Certified Nurse Aide) stated she worked one shift at the facility due to the concerns she witnessed on 2/6/21. Staff C (Certified Nurse Aide) complained to Staff B of being annoyed by Resident #8. Staff B assisted Staff C with Resident #S's incontinence cares. Staff C removed Resident #S's soiled brief and forcibly threw the brief in Resident #S's face. Staff C removed the tab from the brief and placed the tab in Resident #S's hair. Resident #8 did not respond. Staff A(Certified Nurse Aide) witnessed the incident Staff C exited the room. Staff A stated he/she planned to report the incident. During an interview on 2/22/21 at 5:50 p.m., the Assistant Director of Nursing (ADON) stated on 2/6/21 she received a call from Staff A (Agency Certified Nurse Aide) who reported Staff C placed a soiled brief next to Resident #S's head. The ADON stated she reported the incident to the Director of Nursing (DON and Administrator. During an interview on 2/23/21 at 9:30 a.m., the Director of Nursing (DON) stated on Monday 2/8/21 she learned of an incident involving Staff	F610		

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F 610	Continued From page 19 C. Staff C allegedly placed a brief near Resident #S's head. The DON stated Staff A and Staff B witnessed to the event. The DON stated she interviewed Staff A who reported Staff C placed a soiled brief on Resident #S's face. Resident #8 did not do or say anything. Staff A stated he does not want to make a scene and waited until Staff C left before reporting it. The DON stated the Management Team reviewed the incident on 218/21. The DON stated she did not believe it to be intentional. However, she confirmed she failed to interview Staff B and Staff C. The DON talked to the Regional Vice President and sent a discipline recommendation to the Human Resource Department on 2112/21. On 2/15/21, the DON heard back from Human Resources and responded on 2/22/21. On 2/23/21, the DON interviewed Staff C who denied intentionally throwing the soiled brief on Resident #S's face. The DON reported the facility suspended Staff C pending investigation and the facility did not report the incident to the Department of Inspections and Appeals. Review of Staff C's Time Sheet from 2/1/21 through 2/23/21 revealed Staff C worked 10 shifts after the alleged incident on 2/6/21.	F610		
F 677 SS=E	AOL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide bathing	F677	In continuing compliance with F 677, ADL Care Provided for Dependent Residents. Accura Healthcare of Knoxville corrected the deficiency by educating all nursing staff on the bathing requirements. The facility will ensure that residents #4, #8, #9, #12, and like residents receive proper personal hygiene care.	04/02/2021

TATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 677	Continued From page 20 services to maintain good personal hygiene for residents who are unable to carry out the activity independently for 4 of 12 sampled (Residents #4, #8, #9, #12). The facility reported a census of 49. Findings include: 1. According to the Minimum Data Set (MOS) assessment dated 11/26/20, Resident #4 had a Brief Interview for Mental Status (BIMS) score of "14" indicating an intact cognitive status. Resident #4 required total dependence of others with mobility, transfers, dressing, toilet use and personal hygiene. Resident #4 had diagnoses of traumatic brain injury, hemiplegia, seizure disorder and schizophrenia. Review of the POC Legend Report sheet from 2/1/21 to 3/8/21 Resident #4 had scheduled bath days on Monday and Thursday. The sheet lack documentation of a bathing opportunity on 2/22/21, 2/25/21 and 3/4/21. 2. According to the MOS assessment dated 1011/21, Resident #8 had a Brief Interview for Mental Status (SIMS) score of "5", indicating a severely impaired cognitive status. Resident #8 required extensive assistance of others with transfers, ambulation, dressing, toilet use and personal hygiene needs. Resident #8 had diagnoses of impaired intellectual disabilities, schizophrenia and seizure disorder. Review of the POC Legend Report sheet from 2/1/21 to 3/8/21 Resident #8 had scheduled bath days on Tuesday and Friday. The sheet lack documentation of a bathing opportunity on 2/2/21 and 2/26/21.	F677	To correct the deficiency and to ensure the problem does not recur all nursing staff were educated by 3/15/21 on the bathing requirements by Tara Anderson, ADON. The ADON and/or designee will run a shower audit three times weekly for four weeks and then as needed to ensure compliance. As part of Accura Healthcare of Knoxville ongoing commitment to quality assurance, the ADON and/or designee will report identified concerns through the community's QA Process.	

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F 677	Continued From page 21 3. According to the MOS assessment dated 12/17/20, Resident #9 had a Brief Interview for Mental Status (BIMS) score of "9", indicating a moderately impaired cognitive status. Resident #9 required total dependence of others with mobility, transfers, dressing, toilet use and personal hygiene. Resident #9 had diagnoses of Alzheimer's, renal failure and diabetes mellitus. Review of the POC Legend Report sheet from 2/1/21 to 3/8/21 Resident #9 had scheduled bath days on Monday and Thursday. The sheet lack documentation of a bathing opportunity on 2/4/21, 2/18/21, 3/4/21, and 3/8/21. 4. According to the MOS assessment dated of 11/26/20, Resident #12 had a Brief Interview for Mental Status (BIMS) score of "15", indicating an intact cognitive status. Resident #12 required total dependence of others with mobility, transfers, dressing, toilet use and personal hygiene. Resident #12 had diagnoses of traumatic brain injury, hemiplegia, seizure disorder and schizophrenia. Review of the POC Legend Report sheet from 2/1/21 to 3/8/21 Resident #12 had scheduled bath days on Wednesday and Sunday. The sheet lack documentation of a bathing opportunity on 2/10/21, 2/14/21, 2/21/21, 2/24/21, 2/28/21, and 3ll/21. During an interview on 3/9/21 at 12:05 p.m., Resident #12 stated the staff do not have time to get to baths and she does not always get her scheduled baths.	F677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices	F689		

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F 689	Continued From page 22 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to provide adequate supervision and assistance devices to mitigate a resident's risk for falls and injury for 2 of 12 sampled (Residents #7, #11). The facility reported a census of 49 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 4/21/20, Resident #7 had a Brief Interview for Mental Status (SIMS) score of "10", indicating moderate cognitive impairments. Resident #7 required minimal assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #7 had diagnoses of cerebrovascular accident (stroke), diabetes mellitus and hypertension. Resident #7's Care Plan directed staff to provide assistance with toilet use, utilize a personal safety alarm (initiated 3/34/20), complete a quarterly fall assessment, assure appropriate footwear when up, sensor alarm (initiated 10/31/19), and scoop mattress. According to an Incident Report dated 5/26/20 at	F689	In continuing compliance with F 689, Free of Accident Hazards/Supervision/Devices Accura Healthcare of Knoxville corrected the deficiency by educating nursing staff to check for placement and function of alarms. The facility will ensure that residents #7, #11, and like residents are provided adequate supervision and assistive devices. To correct the deficiency and to ensure the problem does not recur nursing staff were educated by 3/15/21 on checking function and placement of alarms by Tara Anderson, ADON. The ADON and/or designee will audit alarm placement and function three times weekly for four weeks and then as needed to ensure compliance. As part of Accura Healthcare of Knoxville's ongoing commitment to quality assurance, the ADON and/or designee will report identified concerns through the community's QA Process.	04/02/2021

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F 689	Continued From page 23 4:10 p.m., Staff J documented Resident#7 found sitting on the floor next to the toilet and reported bowel incontinence. No injuries identified. The report failed to indicate if the the personal safety alarm functioned. During an interview on 3/2/21 at 3:52 p.m., Staff J (Registered Nurse) stated she does not remember the specifics of Resident #7's fall on 5/26/20. Staff J reported Resident #7 frequently gets up independently and had history of falls. Staff J stated if the incident report stated there is no alarm sounding, then there was no alarm sounding. During an interview on 3/2/21 at 3:50 p.m., the Assistant Director of Nursing (ADON) stated the facility discusses falls at the Quality Assurance held every morning and the team comes up with interventions. The ADON stated Resident #7 was very active and used alarms to alert staff. The ADON reported for the fall on 5/26/20 she did not see any notes or interventions. According to an Incident Report on 6/30/20 at 6:40 a.m., Staff K (Licensed Practical Nurse) documented hearing Resident #7 yell from the lounge that she fell. Staff K observed Resident #7 on her right side on the floor. Resident #7 complained of left hip pain, unable to bear weight and reported no feeling in her left leg. The staff notified the Physician and ordered an x-ray. The x-ray showed a left hip fracture and Resident #7 transferred to the hospital for further evaluation. The Incident Report lacked documentation to reflect if the personal safety alarm sounded at the time of the fall. During an interview on 3/3/21 at 12:19 p.m., Staff	F689		

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	165382	A. BUILDING _____ B. WING _____	C 03/11/2021

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F 689	Continued From page 24 K (Registered Nurse) stated the morning of 6/30/20 she heard Resident #7 yell for help and she found Resident #7 on the floor. Staff K initially found no injuries. However, when the staff assisted Resident #7 to the wheelchair she complained of pain in her left hip and could not bear weight. Staff K notified the physician and obtained a portable x-ray order. The x-ray showed a fractured left hip and Resident #7 transferred to the hospital. Staff K thought Resident #7 only needed an alarm when in bed. Resident #7 had a history of getting up unassisted to go to the bathroom and had multiple falls. 2. According to the MOS assessment dated of 4/21/20, Resident #11 had a **BIMS** score of "7", indicating a moderate to severe cognitive impairments. Resident #11 required total dependence on others with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #11 had diagnoses of diabetes mellitus and hypertension. Resident #11's Care Plan documented a risk for falls and directed staff to complete quarterly fall assessments, assure appropriate footwear when up, dycem to wheelchair, and an alarm in place at all times to alert staff when attempting to get up unassisted. According to an Incident Report dated 10/6/20 at 3:20 p.m., Resident#11 yelling and found laying on bathroom floor. Resident #11 stated she had to go to the bathroom. No injuries observed. The report documented the alarm not functioning and replaced. According to an Incident Report dated 10/29/20 at	**F689**		

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F 689	Continued From page 25 2:42 p.m., Resident #11 found on bedroom floor with legs twisted underneath her. Resident #11 stated she slid off the bed and complained of right hip and knee pain. The report documented the alarm not functioning and replaced. During an interview on 3/10/21 at 4:50 p.m., the Assistant Director of Nursing stated the facility currently does not have a system for ensuring personal safety alarms function properly.	F689		
F 760 SS=D	Residents are Free of Significant Med Errors **CFR(s): 483.45(f)(2)** The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure residents are free of significant medication errors for 1 of 12 sampled (Resident #2). The facility failed to complete assessments as ordered by the physician after a significant medication error. The facility reported a census of 49 residents. Findings include: According to the Minimum Data Set (MOS) assessment dated 8/25/20, Resident #2 had a Brief Interview for Mental Status (BIMS) score of "15", indicating an intact cognitive status. Resident #2 required limited assistance with dressing and bathing. Resident #2 had diagnoses of diabetes mellitus, atrial fibrillation, seizure disorder, chronic obstructive pulmonary disease, respiratory failure and hypertension.	F760	In continuing compliance with F 760, Residents are Free of Significant Med Errors, Accura Healthcare of Knoxville corrected the deficiency by educating nursing staff on nursing standards for medication administration and compliance with physician orders. The facility will ensure resident #2 and like residents are free of significant med errors. To correct the deficiency and to ensure the problem does not recur, all nursing staff were educated by 03/12/2021 on nursing standards for medication administration and compliance with physician orders by Tara Anderson, ADON. The ADON and/or designee will audit eMARs and TARs three times weekly for four weeks and as needed for compliance with orders. The ADON and/or designee will also audit medication passes three times weekly for four weeks and as needed for compliance with medication administration standards to ensure compliance. As part of Accura Healthcare of Knoxville ongoing commitment to quality assurance, the ADON and/or designee will report identified concerns through the community's QA Process.	04/02/2021

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F 760	Continued From page 26 According to an Incident Report dated 4/26/20 at 9:30 a.m., Staff I (Registered Nurse) documented she entered Resident #2.'s room to administer a pain patch and had another residents medications in a cup with her. Staff I sat the medication cup down and administered the pain patch and left the room without the medication cup. Staff I returned to the medication cart and realized she for the medication cup in Resident #2.'s room. Staff I discovered Resident #2 ingested the other resident's medications and and immediately called Physician A and informed of the error. Physician A advised Resident #2 would likely get sleepy and instructed Staff I to obtain vital signs every 4 hours. Staff I notified the Assistant Director of Nursing (ADON). Staff I then returned to assess Resident #2 and obtain vital signs. Resident #2 drowsy, had slurred speech and reported she was tired and wanted sleep. The Incident Report documented the Responsible Party notified at 3:28 p.m. and Physician A at 10:45 a.m. The Intake Information sheet printed 2/22/21 revealed Resident #2 ingested the following medications belonging to Resident #13: a. Tylenol 650 milligrams (mg). b. Asprin 81 mg c. Baclofen 10 mg. d. Benztropine 1 mg. e. Clopidogel 75 mg. f. Famatidine 20 mg.	F760		

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F 760	Continued From page 27 g. Gabapentin 600 mg. h. Hydrocodone 10/325 mg. i. Lorazepam 0.5 mg. j. Omeprazole 20 mg. k. Potassium 20 milliquilevents. l. Seroquel 300 mg. m. Senna. The Progress Notes dated 4/26/20 at 10:45 a.m., revealed the staff contacted Physician A and reported a medication error involving Resident #2. Physician A ordered vital signs every 4 hours for the next 24 hours. Physician A reported Resident#2 would likely just be sleepy. The Progress Notes dated 4/26/20 at 11:30 a.m., Staff I documented Resident #2 sleepy in bed, able to sit up with assistance, speech slurred, but alert and oriented to name and place. Resident #2 able to drink pop with assistance. Resident #2 stated she feels fine, just really sleepy. The entry documented vitals in vital tab. Then next vital sign entry documented at 6:15 p.m., Staff J documented Resident #2 extremely groggy and unable to arouse, no responses to verbal stimuli, vital signs obtained and recorded in note, sternal rub with no increase in response, 911 called, pupils pin point and not reactive, and Resident #2 transferred to the hospital. The Progress Notes lacked vital signs every four hours as ordered by the Physician. The Weights and Vitals Exceptions sheet	F 760		

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F 760	Continued From page 28 revealed on 4/26/20 at 11:32 a.m. Resident #2 had a blood pressure of 110/50 and a pulse of 111 beats per minute. On 4/26/20 at 10:46 p.m., Resident #2 had a blood pressure of 98/48, a respiratory rate of 19 breaths per minute and a temperature of 97.5 degrees Fahrenheit The sheet lacked vital signs every four hours as ordered by the Physician. During an interview on 3/2/21 at 12:42 p.m., Staff I (Registered Nurse) stated she worked from 6:00 a.m. to 6:00 p.m. shift on 4/26/20. Staff I entered Resident #2's room and had a cup of medications belonging to another resident with her. Staff I completed care for Resident #2 and left the room and forgot the medication cup. Staff I returned to the medication cart and recalled leaving the medications. Staff I returned to Resident "#2.'s room and discovered Resident #2 ingested the medications in error. Staff I called Physician A and reported the event and what medications were ingested in error. Staff I reported Resident "#2. had her routine medications earlier. Physician A ordered vital signs to be taken every four hours for twenty four hours and adamantly stated she monitored Resident #2 throughout her shift, but admitted she may not have documented everything. Staff I believed she notified Resident #2's Responsible Party but could not be certain.	F760		
F 812 SS=E	Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812	In continuing compliance with F 812 Food Procurement, Store/Prepare/Serve-Sanitary Accura Healthcare of Knoxville corrected the deficiency by educating Dining Staff Cooks food temperature requirements. The facility will ensure resident #12 and like residents receive food in accordance with temperature requirements.	04/02/2021

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

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F 812	Continued From page 29 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to ensure foods were served in accordance with professional standards for food service for 1 of 1 meal observed. The facility reported a census of 49. Findings include: During an observation on 3/9/21 at 11:45 a.m., revealed six meals trays with insulated covers placed outside of the kitchen door. At 11:55 a.m., the staff delivered the trays to residents in the dining room. The Dietary staff continued to serve food from the stove and placed the food trays on a cart. The staff delivered the trays to individual resident rooms. At 12:20 p.m., the Dietary Staff obtained food temperatures. The Mannicoti had a temperature of 155 degrees Fahrenheit (F), Mannicoti sauce had a temperature of 175 degrees F, and mixed vegetables 137 degrees F. Surveyor requested a tray and notes the Mannicoti with sauces was very flavorable. The mixed vegetables were bland, but palatable and the garlic bread was soft and flavorable.	F 812	To correct the deficiency and to ensure the problem does not recur, all cooking staff were educated by 03/12/2021 on food temperature requirements and temperature documentation by Tiffany Michaud, Administrator. The Administrator and/or designee will audit food temperatures and temperature logs twice weekly for four weeks and as needed to ensure compliance. As part of Accura Healthcare of Knoxville ongoing commitment to quality assurance, the Administrator and/or designee will report identified concerns through the community's QA Process.	

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F 812	Continued From page 30 During an interview on 3/9/21 at 12:05 p.m., Staff N (Cook) stated the facility does not utilize a steam table. Staff N reported she obtained temperatures of the food but failed to record them in the log. During an interview on 3/9/21 at 12:30 p.m., Staff 0 (Dietary Supervisor) provided the temperature logs for March 2021 and stated they have issues with the staff documenting the food temperatures. Review of the Temperature Logs from 3/1/21 to 3/9/21 revealed the staff failed to document food temperatures checks for breakfast on 3/3/21, 3/5/21, 3/6/21, 3/7/21 and 3/9/21. The staff failed to document food temperatures for lunch on 3/6/21, 3/7/21, and 3/9/21. The staff failed to document food temperatures for supper on 3/8/21. During an interview on 3/9/21 at 12:05 p.m., Resident #12 stated today's lunch was pretty good, but often it is not and the food is often cold.	F 812		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a safe functional, sanitary and comfortable environment for the residents, staff and public. The facility reported a census of 49.	F 921	In continuing compliance with F 921, Safe/Functional/Sanitary/Comfortable Environment. Accura Healthcare of Knoxville corrected the deficiency by correcting identified concerns and implementing weekly rounds. To correct the deficiency and to ensure the problem does not recur, maintenance staff were educated by 3/15/21 by Tiffany Michaud, Administrator, on identification of environmental concerns and prioritization for completion of tasks. On 04/08/21, the linoleum in the West Shower Room was caulked to prevent leaking. On 04/08/21, the ceramic tile in the Northeast Shower Room was repaired.	04/08/2021

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F 921	Continued From page 31 Findings include: During an observation on 3/4/21 at 10:05 a.m. the West Shower Room had a split in the linoleum floor allowing water to permeate under the floor. The Northeast Shower Room had broken ceramic tile along the comer of the walls. The facility utilized baseboard radiant heat. Multiple radiator coverings had disrepair and not secured throughout the facility. The radiator in room 207 lacked a cover. A radiator covering in the Northeast Hall had a bent area that stuck out. Multiple rooms had scrapes and gouges in the sheet rock. Room 206 had significant wall damage. Room 208 (4) and Room 104 (1) had missing floor tiles. Room 310 had a loose tile near the bathroom entrance. The floor In Room 308 into the hall lacked a transitional piece. The floor of Room 203 contained water stains along the north wall. During an observation on 3/8/21 at 10:00 a.m., revealed the same noted concerns as above. During an interview on 3/8/21 at 11:45 a.m., Staff D (Maintenance) stated completed a weekly checklist of things to do which included alarms, key pads, water temperatures, air filters, fryer vents and hand rails. Staff D reported the 500 Hall is currently under remodel of new air conditioning units and new flooring. Staff D stated the staff leave sticky notes with work orders and on a phone app. Staff D stated the communication is good, but it is all he can do to keep up with the day to day expectations. Staff D states he realizes that there is a lot of repairs and painting to be done when he can get to it.	F921	On 04/01/21, new radiator coverings were ordered to being replacing those in disrepair. On 03/31/21, wall repairs were completed and new floor was installed in room 206. On 03/30/21, the floor tiles in room 208 and 310 were repaired. On 04/08/2021, a new transition strip was ordered for room 310. On 04/07/21, the water stains in room 203 were addressed through cleaning. The Administrator and/or designee will do weekly rounds with facility maintenance staff to identify any environmental concerns and to prioritize repairs needing completed. As part of Accura Healthcare of Knoxville's ongoing commitment to quality assurance, the Administrator and/or designee will report identified concerns through the community's QA Process.	

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F 921	Continued From page 32 During an interview on 3/8/21 at 10:45 a.m., the Administrator stated an expectation of Maintenance to keep up with the day to day maintenance of the facility, checking water temperatures, and boiler maintenance. The Administrator stated repairs and painting are done on a priority basis.	F 921		