NAME OF PROVIDER OR SUPPLIER ACCURA HEALTHCARE OF KNOXVILLE, LLC (VOI.) D. SUMMAY STATEMENT OF DEFICIENCIES (PROPERLY AND ACCURA HEALTHCARE OF KNOXVILLE, LLC) (VOI.) D. SUMMAY STATEMENT OF DEFICIENCIES (PROPERLY AND ACCURA HEALTHCARE OF KNOXVILLE, LLC) (VOI.) D. SUMMAY STATEMENT OF DEFICIENCIES (PROPERLY AND ACCURA HEALTHCARE OF KNOXVILLE, LA 50138 FROUGERS FLAN OF CORRECTION OF CONTROL OF THE APPROPRIATE DEFICIENCY OF LAST ACCURATE AND A	MATERIAN OF THE POPULATION OF	ENTERNISE ALTH	MEDICAID SERVICES	(X2) MULTIF A. BUILDIN	PLE CONSTRUCTION FOR MAN ON B NO Q	938-0391
ACCURA HEALTHCARE OF KNOXVILLE, LLC CAMPID PREFIX SUMMARY STATEMENT OF DEFICIENCIES FROM CONTROL ACCURATION CAMPID	OLIVILIN	TON WILDIONIL		B.WING_	C	;
ACCURA HEALTHCARE OF KNOXVILLE, LLC (PA) ID (P	NAMEOFP	ROVIDER OR SUPPLIER				
FREETY TAG REGULATORY OR ISC IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS Orientify Arended April 5, 2021. AFOCUSed Infection Control Survey, Compleints #90585,#90763,#90879,#91830,#92140, #92286, #93988, #94029, #94219, \$94645, #95285, Mandatory Complement #980510.A, and Facility Reported Incidents #90585,#90780 and #92419 were investigated February 22, 2021 to March 11, 2021. Compleints #90585-C, #90763-C, #90780-C, #90879-C, #92140-C, #92140-C, #92240-C, #92240-C, #92858-C, #94029, #94219-C, #92864-C, #96859-C, #94029, #94219-C, #92864-C, #96859-C, #94069-C, #99180-C, were not substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C. F580 Notify of Changes (Injury/Decline/Room, etc.) F580 See Code of Federal Regulations (42CFR) Part 483, Subpart B-C. F580 Notify of Changes (Injury/Decline/Room, etc.) F580 Assum Healthcare of Knoxvitile denies it violated any 64/08/20/21 Acoma Healthcare of Knoxvitile denies it violated any 64/08/20/21 Acoma Healthcare of Knoxvitile denies it violated any 64/08/20/21 Acoma Healthcare of Knoxvitile denies it violated any 64/08/20/21 Acoma Healthcare of Knoxvitile denies it violated any 64/08/20/21 Acoma Healthcare of Knoxvitile denies it violated any 64/08/20/21 Acoma Healthcare of Knoxvitile denies it violated any 64/08/20/21 Acoma Healthcare of Knoxvitile denies it violated any 64/08/20/21 Acoma Healthcare of Knoxvitile denies it violated any 64/08/20/21 Acoma Healthcare of Knoxvitile denies it violated any 64/08/20/21 Acoma Healthcare of Knoxvitile denies it violated any 64/08/20/21 Acoma Healthcare of Knoxvitile denies it violated any 64/08/20/21 Acoma Healthcare of Knoxvitile denies it violated any 64/08/20/21 Acoma Healthcare of Knoxvitile denies it violated any 64/08/20/21 Acoma Healthcare of Knoxvitile denies it violated any 64/08/20/21 Acoma Healthcare of Knoxvitile denies it violated any 64/08/20/21 Acoma Healthcare of Knoxvitile denies it violated any 64/08/20/21 Acoma Healthcare of Knoxvitile denies it violated	ACCURA	HEALTHCARE OF K	NOXVILLE, LLC		KNOXVILLE, IA 50138	
FOOD [Initial Comments] Amended April 5, 2021. AFOcused Infection Control Survey, Complaints #90585,#90763,#90879,#91830,#92140, #92286,#93958, #94029, #94219,#94645, #95253, Mandatory Comipant #950780, #991830,#92140, #92286,#93958, #94029, #94219, #94645, #95253, Mandatory Comipant #950780, and Facility Reported Incidents #90591, #93780 and #92419 were investigated February 22, 2021 to March 11, 2021. Complaints #90585-C, #90763-C, #90780-C, #90780-C, #90879-C, #92140-C, #92	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
Notify of Changes (Injury/Decline/Room, etc.) SS=D CFR(s): 483.10(g)(14) (i)-(iv)(15) S483.10(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, and/or designee will report identified concerns through the community's QA Process. F580 In continuing compliance with F 580 Notify of Changes (Injury/Decline/Room, etc.) the facility	F 000	A Focused Infection #90585,#90763,# #92286, #93958, #95253, Mandatory Facility Reported In #92419 were invest March 11, 2021. Complaints #90585 #90879-C, #92140-93958-C,#94029, #95253-C, and #95 Complaints #90591 were not substantial See Code of Federal	Control Survey, Complaints 90879,#91830,#92140, #94029, #94219, #94645, Compaint #95610.A, and cidents #90591, #90780 and cigated February 22, 2021 to 6-C, #90763-C, #90780-C, -C, #92140-C, #92419-1, #94219.C, #94645-C, 610-C were substantiated. -C, #91830-C, and #92286-C ated.	F00	of 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,	04/08/2021
	SS=D	Notify of Changes (CFR(s): 483.10(g)(14) Not (i) A facility must im consult with the resconsistent with his representative(s) w (A) An accident invesults in injury and physician interventi (B) A significant channel, or psychos deterioration in hea status in either lifeclinical complication (C) A need to alter	ification of Changes. Immediately inform the resident; Ident's physician; and notity, or her authority, the resident then there is- olving the resident which I has the potential for requiring ion; ange in the resident's physical, ocial status (that is, a Ith, mental, or psychosocial threatening conditions or ins); treatment significantly (that is,		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	
					4 .	• •

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 ollowing 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 tays 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.

PRINTED: 04/05/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED **TATEMENT OF DEFICIENCIES** (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: IND PLAN OF CORRECTION A. BUILDING C **B.WING** 165382 03/11/2021 STREET ADDRESS, CITY, STATE, ZIPCODE NAME OF PROVIDER OR SUPPLIER **806 NORTH SEVENTH STREET** ACCURA HEALTHCARE OF KNOXVILLE, LLC KNOXVILLE, IA 60138 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) [D (XS) (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) F 580 Continued From page 2 F 580 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

and faxed it.

list of medications the other resident was taking

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

		AND HUMAN SERVICES			·	FORM.	APPROVED
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******		165382	SWING			1	11/2021
	ROVIDER OR SUPPLIER A HEALTHCARE OF K	NOXVILLE, LLC		6	STREET ADDRESS, CITY, STATE, ZIP CODE 806 NORTH SEVENTH STREET KNOXVILLE, IA 50138		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	1X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION DATE
F 580	medication cup dove patch and left the recup. Staff I returned realized she for the #2's room. Staff I of Ingested the other immediately called the error. Physician likely get sleepy any vital signs every 4 I Assistant Director of then returned to assivital signs. The Ingested Nurse and the recuprosible Party Physician A at 10:4 During an interview I (Registered Nurse a.m. to 6:00 p.m. si Resident #2's room belonging to anothe completed care for and forgot the medications. Staff I room and discover medications in error and reported the experimental processed in error and reported the error and reporte	up with her. Staff I sat the wn and administered the pain com without the medication of to the medication cup In Resident liscovered Resident #2 resident's medications and and Physician A and Informed of A advised Resident #2 would instructed Staff I to obtain hours. Staff I notified the of Nursing (ADON). Staff I sess Resident #2, and obtain notified at 3:28 p.m. and		580			

PRINTED: 04/05/2021

PRINTED: 04/05/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED À BUILDING 8. WING . 165382 03/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **606 NORTH SEVENTH STREET** ACCURA HEALTHCARE OF KNOXVILLE, LLC KNOXVILLE, IA 50138 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX DATE TAG TAG DEFICIENCY) F 580 Continued From page 4 F580 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 indested 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

and hypertension.

obstructive pulmonary disease, respiratory failure, schizophrenia, cerebrovascular accident (stroke)

According to the Progress Notes dated 11/15/20 at 3:00 p.m. (documented by Staff L Registered

PRINTED: 04/05/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938 0391 TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY ND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING B. WING 165382 03/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **606 NORTH SEVENTH STREET** ACCURA HEALTHCARE OF KNOXVILLE, LLC KNOXVILLE, IA 50138 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY** F 580 Continued From page 5 F580 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.

during waking hours.

The physician is notified via fax. Will pass on to on-coming nurse to call family and make aware

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

		AND HUMAN SERVICES &MEDICAID SERVICES			FORM.	04/05/2021 APPROVED)938-0391
ATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()(2) MULTIPL A. BUILDING	E CONSTRUCTION		SURVEY PLETED
		165382	B. WING			C 11/2021
	ROVIDER OR SUPPLIER HEALTHCARE OF KI	NOXVILLE, LLC	6	TREET ADDRESS, CITY, STATE, ZIP CODE 06 NORTH SEVENTH STREET KNOXVILLE, IA 50138		
(X4) 10 PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	N BE RIATE	(X5) COMPLETION DATE
F 584	CFR(s): 483.10(i) §483.10(i) Safe Env The resident has a comfortable and ho but not limited to re supports for daily liv The facility must pr §483.10(i)(1) A safe homelike environm use his or her perse possible. (i) This includes en receive care and se physical layout of th independence and (II) The facility shall the protection of th or theft. §483.10(i)(2) Hous services necessary and comfortable inf §483.10(i)(3) Clear in good condition; §483.10(i)(4) Privat resident room, as s	table/Homelike Environment (1)-(7) rironment. right to a safe, clean, melike environment, including ceiving treatment and ving safely. ovide- e, clean, comfortable, and ent, allowing the resident to onal belongings to the extent suring that the resident can ervices safely and that the ne facility maximizes resident does not pose a safety risk. I exercise reasonable care for e resident's property from loss ekeeping and maintenance to maintain a sanitary, orderly,	F584	In continuing compliance with F 584, Safe/Clean/Comfortable/Homelike Environn Accura Healthcare of Knoxville corrected the deficiency by educating Facility Maintenanc Directors on facility temperature requirement facility will ensure that resident #12 and like residents are provided a safe environment. To correct the deficiency and to ensure the p does not recur, maintenance staff were educe 3/15/21 by Tiffany Michaud, Administrator, facility temperature requirements and process notifying the appropriate agencies should temperatures fall outside the range. Facility maintenance staff were also educated on the portable heaters and process for obtaining performents of 02/11/2021. The Administrator and designee will audit heat temperatures twice of for four weeks and then as needed to ensure compliance. As part of Accura Healthcare of Knoxville of commitment to quality assurance, the Adminand/or designee will report identified concerthrough the community's QA Process.	roblem nted on on s for use of ermission ard nd/or weekly	04/02/2021

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1,

PRINTED: 04/05/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPUER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY ND PLAN OF CORRECTION IDENTIFICATION NUMBER: À BUILDING COMPLETED C B.WING 165382 03/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **606 NORTH SEVENTH STREET** ACCURA HEALTHCARE OF KNOXVILLE. LLC KNOXVILLE. IA 50138 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (XS) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX DATE TAG TAG DERCIENCY) F 584 Continued From page 7 F584 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 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

PRINTED: 04/05/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938--0391 **TATEMENT OF DEFICIENCIES** (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY ND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 165382 03/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **606 NORTH SEVENTH STREET** ACCURA HEALTHCARE OF KNOXVILLE, LLC **KNOXVILLE. IA 50138 SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID PREAX (X8) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) 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.

IRM CMS-2567(02-99) Previous Versions Obsolete

being cold.

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

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

Event ID:OECU11

Facility 10: IA0844

If continuation sheet Page 9 of 33

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

PRINTED: 04/05/2021 FORM APPROVED 0MB NO 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MUI A. BUIL	TIPLE	CONSTRUCTION	(X3) DATE COM	SURVEY PLETED
		165382	B. WING	₃		03/1) 11/2021
	ROVIDER OR SUPPLIER HEALTHCARE OF KI	NOXVILLE, LLC		60	REETADDRESS, CITY, STATE, ZIP CODE 16 NORTH SEVENTH STREET NOXVILLE, IA 50138		
(X4) 10 PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FUU SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PIAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE I	(XS) COMPLETION DATE
F 584	during that time. During an interview Resident #12 state and it got 40 to 50 or Resident #12 state and placed portable During random interresidents described facility as freezing at The residents Indic provided blankets, According to the fact Plan (EOP) for Extra 1) The facility is to Commander Succefurther instructions 2) Assess resident 3) Initiate actions to comfort using heat wann fluids and adappropriate. 4) Do not leave resisuarce. 5) If the internal tempotentially jeopardizes residents, consider the facility or evacuthe authority having	d residents with extra blankets of on 3/2/21 at 2:30 p.m., did they had no heat this winter degrees Fahrenheit inside. did the staff provided blankets is heaters, but it remained cold. Views with residents, two did the temperatures in the and like walking into a cooler. Eated they added heaters and but it was still cold. Silities Emergency Operation reme Cold Weather: follow the incident essor Notification Plan for	F	584			

		ND HUMAN SERVICES & MEDICAID SERVICES				FORM A	04/05/2021 APPROVED <u>1938-0391</u>
TATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILI	TIPLE	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER HEALTHCARE OF KN	IOXVILLE, LLC		60	TREET ADDRESS, CITY, STATE, ZIP CODE 06 NORTH SEVENTH STREET (NOXVILLE, IA 50138		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) '	ID PREF TAG		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETION DATE
F 584 F 600 SS=D	incident if necessar activated the faciliti Free from Abuse ar	cuate, see rapid tion. ity having jurisdiction for this y to inform them that you have es' EOP. Ind Neglect			In continuing compliance with F 600, Free f Abuse, Neglect, and Exploitation. Accura H of Knoxville corrected the deficiency by sus	lealthcare	04/07/2021
	Exploitation The resident has the neglect, misappropand exploitation as includes but is not a corporal punishmer any physical or chetreat the resident's §483.12(a) The fact §483.12(a) The fact shall abuse, corporal abuse for 1 of Staff C removed Refacility failed to ensure from abuse for 1 of Staff C removed Refact threw the brief in R had a history of tour Resident #4 hugger grabbed her breast	ility must- use verbal, mental, sexual, or poral punishment, or			the staff member in question and education of staff. The facility will ensure that resident #8 residents are free from abuse, neglect, and exploitation. To correct the deficiency and to ensure the process does not recur, the staff member in question suspended on 02/23/2021; he has since been terminated. In addition, all staff were educated Tiffany Michaud, Administrator, on the facility abuse policy by 3/15/21. The Administer and designee will audit for understanding and cowith the facility abuse policy twice weekly facether weeks and then as needed to ensure compliated. As part of Accura Healthcare of Knoxville's commitment to quality assurance, the Adminand/or designee will report identified concenthrough the community's QA Process.	of all 8 and like broblem was led by lity's d/or bropliance for four unce. s ongoing nistrator	

Findings include:

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM A	04/05/2021 APPROVED
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A BUILDING	LE CONSTRUCTION	(X3) DATE	0938-0391 SURVEY PLETED
		165382	B. WING		03/1	; 11/ 2021
	PROVIDER OR SUPPLIER A HEALTHCARE OF K	NOXVILLE, LLC		STREET ADDRESS, CITY, STATE, ztp CODE 608 NORTH SEVENTH STREET KNOXVILLE, IA 50138		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	OBE	(XS) COMPLETION DATE
F 600	Continued From pa	nge 11	F600)		
	dated 1on121, Resi for Mental Status (I severely impaired required extensive transfers, ambulatio personal hygiene n	Minimum Data Set (MOS) dent#B had a Brief interview BIMS) score of "5", indicating a cognition. Resident #8 assistance of others with on, dressing, toilet use and eeds. Resident #8 had red intellectual disabilities. seizure disorder.				
	A (Certified Nurse A, Staff B (Certified Certified Nurse Aid cares for Resident #S's soiled brief an #S's face. Staff C p brief and placed it c Resident #8 did not believe it was an acceptance.	on 2/22/21 at 4:46 p.m., Staff Aide) reported on 2/6/21 Staff I Nurse Aide), and Staff C de) completed incontinence #8. Staff C removed Resident d threw the brief in Resident bicked up a piece of the tom on Resident #S's head. It respond. Staff A did not coident and reported the stant Director of Nursing.				
	B (Agency Certified worked one shift at concerns she witner (Certified Nurse Aidbeing annoyed by Staff C with Reside Staff C removed Reforcibly threw the bestaff C removed that the tab in Resident respond. Staff A (Cothe incident. Staff)	on 2/22/21 at 2:04 p.m., Staff I Nurse Aide) stated she the facility due to the essed on 2/6/21. Staff C de) complained to Staff B of Resident #8. Staff B assisted int #S's incontinence cares. esident #S's soiled brief and rief in Resident #S's face. e tab off the brief and placed #B's hair. Resident #8 did not ertified Nurse Aide) witnessed C exited the room. Staff A ned to report the incident				

2. According to the MOS assessment dated

PRINTED: 04/05/2021

		AND HUMAN SERVICES & MEDICAID SERVICES			•	FORM A	04/05/2021 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUIL	TIPLE		(X3) DATE COM	
		165382	B. WING	3	·	03/1	: 11/2021
	PROVIDER OR SUPPLIER HEALTHCARE OF KI	NOXVILLE, LLC		60	TREET ADDRESS, CITY, STATE, ZIP CODE D8 NORTH SEVENTH STREET (NOXVILLE, IA 50138		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE ·	COMPLETION DATE
F 600	11/26/20, Resident indicating no cognit required total depertransfers, dressing, hygiene. Resident ibrain injury, hemiple schizophrenia. Resident #4's Care Behavior/Altered cowhich included tour residents and staff Plan directed staff (when escorted to a leave alone with fewithin site when in (2/19/17), motion sein wheelchair (2/19/2) alert staff when residents and checks (According to Close min checks), the staff seident #4's when to 5:45 p.m. and 6: According to Program Resident #4 had a I residents inappropriand alerted the staff hand under anothe breast. The staff seident #4's dcording to the In Resident #4 observing grabbed Resident #4 observing grabb	#4 had a BIMS score of "14", ive impairments. Resident #4 indence on others with mobility, toilet use and personal #4 had diagnoses of traumatic egia, seizure disorder and a Plan revealed a Potential for oping with identified behaviors ching and grabbing female inappropriately. The Care to provide close monitoring and from room (2/19/17) to be wheelchair out of room moor at bedroom door when 17), wanderguard sensor to ident exits room (7/19/20) and 26/22/20). Observation Flow Sheet (15 aff failed to document reabouts on 7/19/20 2:15 p.m. 15 p.m. to 6:45 p.m. Less Notes dated 10/28/17 inistory of touching other riately. A resident #4 had his resident shirt touching her oparated the residents, #4 and placed an alarm on	F	600			

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

PRINTED: 04/05/2021 FORM APPROVED 0MB NO 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COM	SURVEY PLETED
		165382	SWING			03/1) 1/2021
	ROVIDER OR SUPPLIER HEALTHCARE OF M	NOXVILLE, LLC		60	REET ADDRESS, CITY, STATE, ZIP CODE 16 NORTH SEVENTH STREET NOXVILLE, IA 50138		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETION DATE
F 600	Incident reported. Incident reported. In Incident reported. In Resident #4 obser grabbed Resident staff immediately substaff E (Certified Name and the Direction of the Incident #4 at Resident #4 at Resident #4 at Resident #5's brea immediately. Resident #4 from the squeezed Staff E informed the Resident #4 from the she was the only stime and did not know the dining room. During an interview F (Agency Certified worked the 500/407/19/20. Before suffered to the incident to the residents. Resident #4 touch recall Resident #4 touch recall Resident #8 who placed Resident #8 who placed Resident is independent and since the incident.	age 13 Both residents were placed on acident Report dated 7/19/20, wed hugging Resident #8 and #S's breast at supper. The eparated the residents. If you also a stated on 7/19/20 ning Room and observed sident #S's table. Resident #4 a Resident #S's shirt, grabbing st. Staff E separated them dent #8 cried out and stated her breast hard and hurt her. He Nurse and removed the dining room. Staff E stated staff in the Dining Room at the now who brought Resident #4 and left him unsupervised. If you also a stated she of halls on the evening of sident #4 touched Resident #4 and left him unsupervised. If you also a staff F reported Nurse and separated the at #4 denied touching Resident wer, Resident #8 stated ed her breast. Staff F did not crying. Staff F did not know ent #8 in the dining room. Staff in alarm on the top of Resident shut off, because his roommate in alarm was any to alert staff when Resident was any to alert staff		600			

		ND HUMAN SERVICES				FORM /	04/05/2021 APPROVED
TATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVICER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	938-0391 SURVEY PLETED
		165382	B.WING			03/) 11/2021
	PROVIDER OR SUPPLIER HEALTHCARE OF KI	NOXVILLE, LLC		60	REET ADDRESS, CITY, STATE, ZIP CODE 18 NORTH SEVENTH STREET NOXVILLE, IA 50138		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTNE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(XS) COMPLETION DATE
F 609	neglect exploitation must: §483.12(c)(1) Ensuinvolving abuse, no mistreatment, Inclusource and misappare reported immediate that cause the allegations bodily injurting the events that cause and do not rithe administrator officials (including adult protective serfor jurisdiction in loaccordance with Siprocedures. §483.12(c)(4) Repoinvestigations to the designated representations to the designated representations accordance with Sigury Agency, with incident, and if the appropriate correct This REQUIREME by: Based on staff interensure incidents of On 2/6/21 an aide	n the vicinity. d Violations (1)(4) onse to allegations of abuse, or mistreatment, the facility are that all alleged violations eglect, exploitation or uding injuries of unknown ropriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result in y, or not later than 24 hours if use the allegation do not involve esult in serious bodily injury, to of the facility and to other to the State Survey Agency and vices where state law provides ing-term care facilities) in tate law through established	F6		In continuing compliance with F 609, Report Alleged Violations. Accura Healthcare of K corrected the deficiency by education of all the facility's abuse policy and reporting requirements are involving resident #8 and like residents are involving resident #8 and like residents are involving resident #8 and to ensure the process of recur, all staff were educated by Ti Michaud, Administrator, on the facility's ab policy and reporting requirements by 3/15/2 Administrator and/or designee will audit for understanding and compliance with the facil policy twice weekly for four weeks and there needed to ensure compliance. As part of Accura Healthcare of Knoxville of commitment to quality assurance, the Admin and/or designee will report identified concenthrough the community's QA Process.	noxville staff on airements. ions reported. problem ffany use 1. The lity abuse 1 as	04/07/2021

PRINTED: 04/05/2021

DEPART	MENT OF HEALTH A	AND HUMAN SERVICES			Ρ		APPROVED
CENTER	S FOR MEDICARE	& MEDICAID SERVICES			0		0938-0391
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	TIP DING	LE CONSTRUCTION	(X3) DATE COM	SURVEY PLETED
		165382	SWING			03/	C 11/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCURA	HEALTHCARE OF K	NOXVILLE, LLC			806 NORTH SEVENTH STREET KNOXVILLE, IA 50138		
(X4) 10 PREFIX		ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL	ID	· N	PROVIDER'S PLAN OF CORRECTIO	N .	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREF TAC		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
F 609	Continued From pa	nge 15		309			
. 000	facility census is 49	~	"	JUE			
	-						
	Findings include:					j	
	assessment dated diagnoses of schizo Resident #8 had a Status (BIMS) scor cognitive impairme extensive assistant	inimum Data Set (MOS) 10/7/21 Resident #8 had phrenia and seizure disorder. Brief Interview for Mental re of "5" indicating severe ents. Resident #8 required the of others with transfers, and, toilet use and personal			`		
	A (Certified Nurse A and Staff C comple Resident #8 on 2/6/ #S's soiled brief an #S's face. Staff C p brief and placed it c Resident #8 did not believe it was an ac	or on 2/22121 at 4:46 p.m., Staff Aide) reported Staff A, Staff B, sted incontinence cares for /21. Staff C removed Resident of threw the brief in Resident bicked up a piece of the tom on Resident #S's head. It respond. Staff A did not occident and reported the stant Director of Nursing.			·		
	B (Agency Certifled worked one shift at concerns she witner (Certifled Nurse Aid being annoyed by I Staff C with Reside Staff C removed Reforcibly threw the bistaff C removed the tab in Resident respond. Staff A(C) the incident. Staff C	on 2/22121 at 2:04 p.m., Staff d Nurse Aide) stated she the facility due to the essed on 2/6/21. Staff C de) complained to Staff B of Resident #8. Staff B assisted nt #S's incontinence cares. esident #B's soiled brief and rief in Resident #B's face. e tab from the brief and placed: #S's hair. Resident #8 did not ertifled Nurse Aide) witnessed C exited the room. Staff A ned to report the incident.					

PRINTED: 04/05/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIOER/SUPPLIER/CLIA TATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER:** NO PLAN OF CORRECTION COMPLETED A. BUILDING C B.WING 165382 03/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **608 NORTH SEVENTH STREET** ACCURA HEALTHCARE OF KNOXVILLE, LLC KNOXVILLE. IA 50138 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY) F 609 Continued From page 16 F609 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 solled 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

RM CNS-2587(02-99) Previous Versions Obsolete

F 610

SS=D

Inspections and Appeals.

CFR(s): 483.12(c)(2)-(4)

responded on 2/22/21. On 2/23/21, the DON Interviewed Staff C who denied intentionally throwing the solled 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

Investigate/Prevent/Correct Alleged Violation

Event ID: OEDU11

Facility ID: IA0844

prevented/corrected.

In continuing compliance with F 610, Investigate/

F610 facility management on the facility's abuse policy

Prevent/Correct Alleged Violation, Accura Healthcare

and suspending the staff member in question. The

facility will ensure that alleged violations involving resident #8 and like residents are investigated/

of Knoxville corrected the deficiency by education of

If continuation sheet Page 17 of 33

04/07/2021

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

PRINTED: 04/05/2021 FORM APPROVED 0MB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		LE CONSTRUCTION	(X3) DATE	PLETED
		165382	SANG.			03/1	: 11/2021
	ROVIDER OR SUPPLIER HEALTHCARE OF H	KNOXVILLE, LLC		6	STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH SEVENTH STREET KNOXVILLE, IA 50138		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUU SC IDENTIFYING (NFORMATION)	ID PREF TAC	IX.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(XS) COMPLETION DATE
F 610	neglect, exploitation must: §483.12(c)(2) Have violations are thoro §483.12(c)(3) Preveneglect, exploitation investigation is in particular to the signated repression accordance with Survey Agency, wincident, and if the appropriate correct This REQUIREME by: Based on staff intreview the facility from the appropriate correct This REQUIREME by: Based on staff intreview the facility from	onse to allegations of abuse, in, or mistreatment, the facility e evidence that all alleged ughly investigated. The results of all the administrator or his or her entative and to other officials in that law, including to the State ethin 5 working days of the alleged violation is verified tive action must be taken. The results of all the entative and to other officials in that law, including to the State ethin 5 working days of the alleged violation is verified tive action must be taken. The results of all the entative and to other officials in extra law and ensure the safety of existence and ensure the safety of existence and ensure the facilities in accordance with state law derived (Resident #8). The facility		610	To correct the deficiency and to ensure problem does not recur, the DON and Administrator were educated by Brady Regional Vice President of Operations, 2/23/21 on the facility's process for repealleged abuse. The staff member in querwas suspended pending investigation are since been terminated. The Administrate designee will audit for understanding are compliance with the facility abuse policion weekly for four weeks and then as need ensure compliance. As part of Accura Healthcare of Knoxy ongoing commitment to quality assurant Administrator and/or designee will repeidentified concerns through the communication of the communicatio	Allen, on orting stion ad has or and/or ad ey twice ed to ille's ce, the ort	

		AND HUMAN SERVICES				FORM /	04/05/2021 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MUI A. BUIL	LTIF DIN	PLE CONSTRUCTION NG	(X3) DATE	E SURVEY IPLETED
		165382	B. WIN	G_	Marin		C 11/2021
NAMEOFF	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·			STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCURA	HEALTHCARE OF KI	NOXVILLE, LLC			606 NORTH SEVENTH STREET KNOXVILLE, IA 50138		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	10 PREF TAG	EIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	N DBE RIATE	(X5) COMPLETION DATE
F 610	During an interview A(Certified Nurse A and Staff C comple Resident #8 on 2/6/#B's soiled brief and #S's face. Staff C p brief and placed it o Resident #8 did not believe it was an ac incident to the Assist During an interview B (Agency Certified worked one shift at concerns she witne (Certified Nurse Aid being annoyed by F Staff C with Resident Certified Nurse Aid being annoyed the tab in Resident respond. Staff A(Cethe incident Staff C the incident Staff C stated he/she plant During an interview Assistant Director of Staff Certified Nurse Aid a soiled brief next the ADON stated she re Director of Nursing During an interview Director of Nursing During an interview Director of Nursing	ge 18 and personal hygiene needs. on 2/22/21 at 4:46 p.m., Staff aide) reported Staff A, Staff B, ted incontinence cares for /21. Staff C removed Resident d threw the brief in Resident icked up a piece of the torn on Resident #S's head. It respond. Staff A did not ecident and reported the stant Director of Nursing. In Nurse Aide) stated she the facility due to the essed on 2/6/21. Staff C die) complained to Staff B of Resident #S's soiled brief and rief in Resident #S's face. It is a from the brief and placed et ab from the brief and placed #S's hair. Resident #8 did not ertified Nurse Aide) witnessed it exited the room. Staff A med to report the incident. If on 2/22/21 at 5:50 p.m., the of Nursing (ADON) stated on it a call from Staff A (Agency e) who reported Staff C placed on Resident #S's head. The eported the incident to the (DON) stated on Monday of an incident involving Staff	F	61			

DEPARTMENT OF HEALTH AND HUMAN SERVICES <u>CENTERS FOR MEDICARE & MEDICAID SERVICES</u>

PRINTED: 04/05/2021 FORM APPROVED 0MB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DATE COMI	SURVEY PLETED
		165382	B. WING			03/1	C 11/2021
	ROVIDER OR SUPPLIER HEALTHCARE OF KN	NOXVILLE, LLC		80	TREET ADDRESS, CITY, STATE, ZIP CODE 08 NORTH SEVENTH STREET NOXVILLE, IA 50138		
(X4)1D PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FUU SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(XS) COMPLETION DATE
F 677	#S's head. The DO witnessed to the evinterviewed Staff A solled brief on Residid not do or say an not want to make a left before reporting Management Team 218/21. The DON s be intentional. How falled to interview Stalked to the Region discipline recomme Resource Department the DON heard backed to the Region discipline recomme Resource Department the DON heard backed to the Region discipline recomme Resource Department the DON reported the DON reported pending investigation report the incident of the Inspections and Apple Review of Staff C's through 2/23/21 revafter the alleged in AOL Care Provided CFR(s): 483.24(a)(2) A resident for the Inspection of the Inspection of Staff C's through 2/23/21 revafter the alleged in AOL Care Provided CFR(s): 483.24(a)(2) A resident for the Inspection of the Inspection of Staff C's through 2/23/21 revafter the alleged in AOL Care Provided CFR(s): 483.24(a)(2) A resident for the Inspection of the Inspection of Staff C's through 2/23/21 revafter the alleged in AOL Care Provided CFR(s): 483.24(a)(2) A resident for the Inspection of the Inspectio	y placed a brief near Resident IN stated Staff A and Staff B yent. The DON stated she who reported Staff C placed a ident #S's face. Resident #8 nything. Staff A stated he does a scene and waited until Staff C g it. The DON stated the reviewed the incident on stated she did not believe it to wever, she confirmed she staff B and Staff C. The DON and Vice President and sent a rendation to the Human ent on 2112/21. On 2/15/21, ck from Human Resources and 1/21. On 2/23/21, the DON who denied intentionally brief on Resident #S's face. The facility suspended Staff C on and the facility did not to the Department of speals. Time Sheet from 2/1/21 yealed Staff C worked 10 shifts cident on 2/6/21. d for Dependent Residents			In continuing compliance with F 677, ADL Care Provided for Dependent Res Accura Healthcare of Knoxville corrected th deficiency by educating all nursing staff on	ie	04/02/2021
	personal and oral h This REQUIREMEI by: Based on observa	n good nutrition, grooming, and hygiene; NT is not met as evidenced ation, record review and staff lity failed to provide bathing			bathing requirements. The facility will ensur residents #4, #8, #9, #12, and like residents proper personal hygiene care.	re that	

ATEMENT OF DEFICIENCIES 10 PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA 10 PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 606 NORTH SEVENTH STREET KNOXVILLE, IA 50138 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FUU (EACH CORRECTIVE ACTION SHOULD BE (X3) DATE SURVE COMPLETED (X3) DATE SURVE COMPLETED (X3) DATE SURVE COMPLETED (X3) DATE SURVE COMPLETED (X4) ID PROVIDER OR SUPPLIER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FUU (EACH CORRECTIVE ACTION SHOULD BE COMPLETED (X3) DATE SURVE COMPLETED (X4) ID PROVIDER OR SUPPLIER (EACH CORRECTION SHOULD BE COMPLETED (X3) DATE SURVE COMPLETED (X3) DATE SURVE COMPLETED (X3) DATE SURVE COMPLETED (X4) ID PROVIDER OR SUPPLIER (X4) ID PROVIDER OR SUPPLIER (EACH CORRECTION SHOULD BE COMPLETED (X4) ID PROVIDER OR SUPPLIER (EACH CORRECTION SHOULD BE COMPLETED (X4) ID PROVIDER OR SUPPLIER (EACH CORRECTION SHOULD BE COMPLETED (X5) DATE SURVE COMPLETED (X6) DATE SURVE COMPLETED (X7) DA			E & MEDICAID SERVICES				0938-0391
IDENTIFICATION NUMBER: 165382 IAME OF PROVIDER OR SUPPLIER ACCURA HEALTHCARE OF KNOXVILLE, LLC IDENTIFICATION NUMBER: 165382 IAME OF PROVIDER OR SUPPLIER ACCURA HEALTHCARE OF KNOXVILLE, LLC IDENTIFICATION NUMBER: 165382 STREET ADDRESS, CITY, STATE, ZIP CODE 606 NORTH SEVENTH STREET KNOXVILLE, IA 50138 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUU REGULATORY OR LSC IDENTIFYING INFORMATION) 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				(X2) MULT	TIPLE CONSTRUCTION	(X3) DATI	E SURVEY
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 end for the Accordance of the residents with mobility, transfers, dressing, toilet use and personal hygiene. Resident #4 had diagnoses of			IDENTIFICATION NUMBER:	À BUILDI	NG	COM	PLETED
ACCURA HEALTHCARE OF KNOXVILLE, LLC (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FUU REGULATORY OR LSC IDENTIFYING INFORMATION) 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			165382	B. WING			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUU REGULATORY OR LSC IDENTIFYING INFORMATION) 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	AME OF P	PROVIDER OR SUPPLIER	?		STREET ADDRESS, CITY, STATE, ZIP CODE		
FREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FUU REGULATORY OR LSC IDENTIFYING INFORMATION) 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	CCURA	A HEALTHCARE OF K	KNOXVILLE, LLC				
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	PREFIX	(EACH DEFICIENCY	CY MUST BE PRECEDED BY FUU	PREFI)	((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(XS) COMPLETION DATE
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, tollet 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	F677	services to maintal residents who are undependently for 4 #8, #9, #12). The fade fade factor independently for 4 fade fade factor include: 1. According to the assessment dated Brief Interview for Market fade for indicating an investment factor fade fade fade fade fade fade fade fade	ain good personal hygiene for a unable to carry out the activity 4 of 12 sampled (Residents #4, facility reported a census of the Minimum Data Set (MOS) of 11/26/20, Resident #4 had a Mental Status (BIMS) score of a intact cognitive status. The status are detailed to the series of	F6	does not recur all nursing staff were educe 3/15/21 on the bathing requirements by Tanderson, ADON. The ADON and/or derun a shower audit three times weekly for and then as needed to ensure compliance. As part of Accura Healthcare of Knoxvil commitment to quality assurance, the AL designee will report identified concerns to	ated by 'ara signee will r four weeks le ongoing OON and/or	

PRINTED: 04/05/2021

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM): 04/05/2021 I APPROVED . 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 3	(X3) DA	TE SURVEY MPLETED
		165382	B.WIN	G		03	C / 11/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCURA	HEALTHCARE OF K	NOXVILLE, LLC			808 NORTH SEVENTH STREET KNOXVILLE, IA 50138		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	ΉX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
F 677	Continued From pa	age 21	F	677	7		
	12/17/20, Resident Mental Status (BIM moderately impaire #9 required total de mobility, transfers, personal hygiene. I Alzheimer's, renal to Review of the POC 2/1/21 to 3/8/21 Redays on Monday and documentation of a 2/18/21, 3/4/21, and 4. According to the 11/26/20, Resident Mental Status (BIM intact cognitive statotal dependence of transfers, dressing hygiene. Resident traumatic brain injudisorder and schiz Review of the POC 2/1/21 to 3/8/21 Review of the POC 2/1/21	MOS assessment dated of t#12 had a Brief Interview for IS) score of "15", indicating an tus. Resident #12 required of others with mobility, toilet use and personal #12 had diagnoses of ary, hemiplegia, seizure cophrenia. C Legend Report sheet from esident #12 had scheduled					
	sheet lack docume on 2/10/21, 2/14/21 and 3ii/21. During an interview Resident #12 state	nesday and Sunday. The entation of a bathing opportunity, 2/21/21, 2/24/21, 2/28/21, v on 3/9/21 at 12:05 p.m., and the staff do not have time to the does not always get her					
F 689 SS≔D		azards/Supervision/Devices	F	689	9		

	AND HUMAN SERVICES			0		APPROVED
CENTERS FOR MEDICARE &				 		0938-0391
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	СОМ	SURVEY PLETED
	165382	B. WING			03/1) 11/2021
NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCURA HEALTHCARE OF KN	OXVILLE, LLC			06 NORTH SEVENTH STREET INOXVILLE, IA 50138		
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as free of accident h §483.25(d)(2)Each is supervision and assaccidents. This REQUIREMENT by: Based on record refacility failed to provide assistance devices falls and injury for 2 #11). The facility represidents. Findings include: 1. According to the assessment dated 4 Brief Interview for M "10", indicating mod Resident #7 require mobility, transfers, dependent and personal hygiene nediagnoses of cerebric diabetes mellitus and Resident #7's Care assistance with tolle alarm (initiated 3/34 assessment, assure	ts. sure that - sident environment remains nazards as is possible; and resident receives adequate sistance devices to prevent IT is not met as evidenced eview, and staff interviews, the ide adequate supervision and to mitigate a resident's risk for of 12 sampled (Residents #7, ported a census of 49 Minimum Data Set (MDS) A/21/20, Resident #7 had a flental Status (SIMS) score of lerate cognitive impairments. It minimal assistance with dressing, toilet use and eeds. Resident #7 had rovascular accident (stroke),	·	689	In continuing compliance with F 689, Free of Accident Hazards/Supervision/Devices Accident Hazards/Supervision/Devices Accident Hazards/Supervision/Devices Accidented of Knoxville corrected the deficience ducating nursing staff to check for placemer function of alarms. The facility will ensure the residents #7, #11, and like residents are provadequate supervision and assistive devices. To correct the deficiency and to ensure the places not recur nursing staff were educated by on checking function and placement of alarm Tara Anderson, ADON. The ADON and/or will audit alarm placement and function threweekly for four weeks and then as needed to compliance. As part of Accura Healthcare of Knoxville's commitment to quality assurance, the ADON designee will report identified concerns throcommunity's QA Process.	ency by ent and hat rided roblem y 3/15/21 ns by designee et times o ensure r ongoing N and/or	04/02/2021

According to an Incident Report dated 5/26/20 at

PRINTED: 04/05/2021

PRINTED: 04/05/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO 0938-0391 **STATEMENT OF DEFICIENCIES** (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ()(3) DATE SURVEY **UND PLAN OF CORRECTION** IDENTIFICATION NUMBER: COMPLETED A. BUILDING **B.WING** 165382 03/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **606 NORTH SEVENTH STREET** ACCURA HEALTHCARE OF KNOXVILLE, LLC KNOXVILLE, IA 50138 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (XS) COMPLETION **(EACH DEFICIENCY MUST BE PRECEDED BY FULL** (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX REGULATORY OR LSC (DENTIFYING INFORMATION) DATE TAG TAG **DEFICIENCY**) F 689 Continued From page 23 F689 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

time of the fall.

reflect if the personal safety alarm sounded at the

During an interview on 3/3/21 at 12:19 p.m., Staff

ZENTER:	S FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES		tordina a	01	FORM . .118 NO.	04/05/2021 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILI		E CONSTRUCTION	(X3) DATE COM	PLETED
		165382	8. WINC	} _			C 11/2021
	ROVIDER OR SUPPLIER HEALTHCARE OF KI	NOXVILLE, LLC		64	TREET ADDRESS, CITY, STATE, ZIP CODE 06 NORTH SEVENTH STREET (NOXVILLE, IA 50138		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(XS) COMPLETION DATE
F 689	K (Registered Nurs 6/30/20 she heard she found Resident Initially found no inj staff assisted Reside complained of pain bear weight. Staff Kobtained a portable showed a fractured transferred to the h Resident #7 only no Resident #7 only no Resident #7 had a unassisted to go to multiple falls. 2. According to the 4/21/20, Resident # indicating a modera impairments. Resident mairments. Resident #11 had and hypertension. Resident #11's Carfalls and directed sassessments, assuup, dycem to whee all times to alert staunassisted. According to an Inc 3:20 p.m., Residen on bathroom floor. to go to the bathroom to start to the start of the pathroom to the pathroom floor.	ge 24 se) stated the morning of Resident #7 yell for help and t #7 on the floor. Staff K uries. However, when the dent #7 to the wheelchair she in her left hip and could not k notified the physician and o x-ray order. The x-ray I left hip and Resident #7 ospital. Staff K thought eeded an alarm when in bed. history of getting up the bathroom and had MOS assessment dated of #11 had a BIMS score of "7", ate to severe cognitive lent #11 required total ers with mobility, transfers, and personal hygiene needs. diagnoses of diabetes mellitus re Plan documented a risk for taff to complete quarterly fall are appropriate footwear when elchair, and an alarm in place at aff when attempting to get up cident Report dated 10/6/20 at at#11 yelling and found laying Resident #11 stated she had om. No injuries observed. The I the alarm not functioning and	F	689			

According to an Incident Report dated 10/29/20 at

PRINTED: 04/05/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIOER/SUPPLIER/CLIA (X3) DATE SURVEY TATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED ND PLANOF CORRECTION IDENTIFICATION NUMBER: A BUILDING B. WING 165382 03/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **606 NORTH SEVENTH STREET** ACCURA HEALTHCARE OF KNOXVILLE, LLC **KNOXVILLE, IA 50138** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTNE ACTION SHOULD BE CROSS-REFERENCEDTO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE **DEFICIENCY**) F 689 Continued From page 25 F689 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. F 760 Residents are Free of Significant Med Errors F760 In continuing compliance with F 760, Residents are 04/02/2021 CFR(s): 483.45(f)(2) SS=D Free of Significant Med Errors, Accura Healthcare of Knoxville corrected the deficiency by educating The facility must ensure that itsnursing staff on nursing standards for medication §483.45(f)(2) Residents are free of any significant administration and compliance with physician orders. The facility will ensure resident #2 and like residents medication errors. are free of significant med errors. This REQUIREMENT is not met as evidenced To correct the deficiency and to ensure the problem Based on record review and staff interviews, the does not recur, all nursing staff were educated by facility failed to ensure residents are free of 03/12/2021 on nursing standards for medication significant medication errors for 1 of 12 sampled administration and compliance with physician orders (Resident #2). The facility failed to complete by Tara Anderson, ADON. The ADON and/or assessments as ordered by the physician after a designee will audit eMARs and TARs three times significant medication error. The facility reported weekly for four weeks and as needed for compliance a census of 49 residents. with orders. The ADON and/or designee will also audit medication passes three times weekly for four Findings include: weeks and as needed for compliance with medication

RM CMS-2567(02-99) Previous Versions Obsclete

According to the Minimum Data Set (MOS)

assessment dated 8/25/20, Resident #2 had a

Resident #2 required limited assistance with

dressing and bathing. Resident #2 had

Brief Interview for Mental Status (BIMS) score of indicating an intact cognitive status.

diagnoses of diabetes mellitus, atrial fibrillation, seizure disorder, chronic obstructive pulmonary disease, respiratory failure and hypertension.

Event ID:0E0U11

Facility ID: IA0844

administration standards to ensure compliance.

community's QA Process.

As part of Accura Healthcare of Knoxville ongoing

commitment to quality assurance, the ADON and/or

designee will report identified concerns through the

if continuation sheet Page 26 of 33

PRINTED: 04/05/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 TATEMENT OF DEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED B. WING 165382 03/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **606 NORTH SEVENTH STREET ACCURA HEALTHCARE OF KNOXVILLE, LLC KNOXVILLE, IA 50138** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLANOF CORRECTION (X4) ID PREFIX (XS) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **PREFIX** TAG **TAG DEFICIENCY**) Continued From page 26 F760 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.

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

PRINTED: 04/05/2021 FORM APPROVED 0MB NO 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATIONNUMBER:			LE CONSTRUCTION	(X3) DATE COM	SURVEY PLETED
		165382	B. WING	·			C 11/2021
	ROVIDER OR SUPPLIER HEALTHCARE OF K	NOXVILLE, LLC		6	STREET ADDRESS, CITY, STATE, ZIP CODE 106 NORTH SEVENTH STREET KNOXVILLE, IA 50138		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BB PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BB	(XS) COMPLETION DATE
F 760	g. Gabapentin 600 h. Hydrocodone 10 i. Lorazepam 0.5 m j. Omeprazole 20 m k. Potassium 20 mi l. Seroquel 300 mg m. Senna. The Progress Note revealed the staff or reported a medicati #2. Physician A ord for the next 24 hour Resident#2 would I The Progress Notes Staff I documented able to sit up with a alert and oriented to #2 able to drink pop stated she feels find documented vitals sign entry documented vitals sign entry documented vitals sign entry documented rub with no increas pupils pin point and transferred to the h lacked vital signs entry documented vitals signs entry documented rub with no increas pupils pin point and transferred to the h lacked vital signs entry entry documented rub with no increas pupils pin point and transferred to the h lacked vital signs entry documented rub with no increas pupils pin point and transferred to the h lacked vital signs entry documented rub with rub pin point and transferred to the h lacked vital signs entry documented rub with rub pin point and transferred to the h lacked vital signs entry documented rub with rub pin point and transferred to the h lacked vital signs entry documented rub with rub pin point and transferred to the h lacked vital signs entry documented rub with rub pin point and transferred to the h lacked vital signs entry documented rub with rub pin point and transferred rub pin	mg. /325 mg. .g. ng. liquilevents.	F	760			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEPICIENCES (AT) DEPOVIDED RI IEDICIENCES

PRINTED: 04/05/2021 FORM APPROVED 0MB NO 0938-0391

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPUER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DATE COM	SURVEY PLETED
		165382	SWNG.			03/1	C 1 1/2021
	ROVIDER OR SUPPLIER HEALTHCARE OF K	NOXVILLE, LLC		6	TREET ADDRESS, CITY, STATE, ZIP CODE 06 NORTH SEVENTH STREET (NOXVILLE, IA 50138	I	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTY)	BE	(XS) COMPLETION DATE
	revealed on 4/26/20 had a blood pressure 111 beats per minure Resident #2 had a larespiratory rate of 1 temperature of 97.5 sheet lacked vital sordered by the Physical Registered Nurse a.m. to 6:00 p.m. si Resident #2's room belonging to anothe completed care for and forgot the medications. Staff I room and discovered medications. Staff I room and discovered medications in error and reported the every medications in error and reported the every medications. A ordered vital sign for twenty four hour monitored Resident admitted she may reverything. Staff I be #2's Responsible Prood Procurement, CFR(s): 483.60(i) Food saff The facility must - \$483.60(i)(1) - Proof.	of at 11:32 a.m. Resident #2 re of 110/50 and a pulse of the on 4/26/20 at 10:46 p.m., blood pressure of 98/48, a 19 breaths per minute and a 5 degrees Fahrenheit The ligns every four hours as sician. on 3/2/21 at 12:42 p.m., Staff is stated she worked from 6:00 hift on 4/26/20. Staff I entered and had a cup of medications ar resident with her. Staff I Resident #2 and teft the room cation cup. Staff I returned to and recalled leaving the returned to Resident #2.'s ad Resident #2 ingested the returned to Resident #2 ingested the restand what medications for. Staff I reported Resident medications earlier. Physician as to be taken every four hours and adamantly stated she with the theorem of the resident and what medications earlier. Staff I reported Resident medications earlier. Physician as to be taken every four hours and adamantly stated she with the theorem of the resident and what medications earlier. Staff I reported Resident as to be taken every four hours and adamantly stated she with the tot have documented elleved she notified Resident arty but could not be certain. Store/Prepare/Serve-Sanitary 1)(2) ety requirements.		760		ency by ture ant #12	04/02/2021

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

PRINTED: 04/05/2021 FORM APPROVED OMB NO 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMI	PLETED
		165382	B. WING		03/1	; 11/2021
	PROVIDER OR SUPPLIER HEALTHCARE OF KI	NOXVILLE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 606 NORTH SEVENTH STREET KNOXVILLB, IA 50138		
(X4) 10 PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	D BE	COMPLETION DATE
F 812	(i) This may include from local producer and local laws or regulation (ii) This provision of facilities from using gardens, subject to safe growing and for (iii) This provision of from consuming for (iii) This provision of from consuming for serve food in accordanderds for food: \$483.60(i)(2) - Store, serve food in accordanderds for food: This REQUIREMED by: Based on observation in accordant for food service for facility reported a consuming include: During an observation for food service for facility reported a consuming include: During an observation for food from the store a cart. The staff delivered the staff	e food items obtained directly rs, subject to applicable State gulations. Des not prohibit or prevent produce grown in facility compliance with applicable od-handling practices. Des not preclude residents ods not procured by the facility. Prepare, distribute and dance with professional service safety. NT is not met as evidenced tion, record review and staff y failed to ensure foods were ce with professional standards 1 of 1 meal observed. The	F 812	To correct the deficiency and to ensure the does not recur, all cooking staff were educa 03/12/2021 on food temperature requirement temperature documentation by Tiffany Mic Administrator. The Administrator and/or dewill audit food temperatures and temperature with weekly for four weeks and as needed compliance. As part of Accura Healthcare of Knoxville commitment to quality assurance, the Admiand/or designee will report identified concentrough the community's QA Process.	nts and haud, ssignee re logs to ensure ongoing inistrator	

PRINTED: 04/05/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 TATEMENT OF DEFICIENCIES (X1) PROVICER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING SWING 165382 03/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **606 NORTH SEVENTH STREET** ACCURA HEALTHCARE OF KNOXVILLE, LLC KNOXVILLE, IA 50138 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTNE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE **TAG** TAG **DEFICIENCY** F812 Continued From page 30 F 812 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. Safe/Functional/Sanitary/Comfortable Environ F 921 F 921 CFR(s): 483.90(i) SS=E 04/08/2021 In continuing compliance with F 921, §483.90(i) Other Environmental Conditions Safe/Functional/Sanitary/Comfortable Environment. The facility must provide a safe, functional, Accura Healthcare of Knoxville corrected the sanitary, and comfortable environment for deficiency by correcting identified concerns and residents, staff and the public. implementing weekly rounds. This REQUIREMENT is not met as evidenced by: To correct the deficiency and to ensure the problem Based on observation and staff interview, the does not recur, maintenance staff were educated by 3/15/21 by Tiffany Michaud, Administrator, on facility failed to provide a safe functional, sanitary

49.

and comfortable environment for the residents.

staff and public. The facility reported a census of

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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM /	04/05/2021 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA	(X2) MUI A BUILI	LTIPL DING	E CONSTRUCTION	(X3) DATE	
		165382	B. WING			03/1	; 1/2021
	ROVIDER OR SUPPLIER HEALTHCARE OF K	NOXVILLE, LLC		61	TREET ADDRESS, CITY, STATE, ZIP CODE 06 NORTH SEVENTH STREET (NOXVILLE, IA 50138		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	TX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY))BE	COMPLETION DATE
F 921	West Shower Room floor allowing water The Northeast Shower Room tile along the come utilized baseboard coverings had disrethroughout the facil lacked a cover. A report of the facil lacked and floor tiles. In the facil lacked in the facil lacked and the floor of Room 203 of the floor of Room 2	tion on 3/4/21 at 10:05 a.m. the in had a split in the linoleum to permeate under the floor. wer Room had broken ceramic of the walls. The facility radiant heat. Multiple radiator opair and not secured ity. The radiator in room 207 adiator covering in the a bent area that stuck out. scrapes and gouges in the 206 had significant wall 8 (4) and Room 104 (1) had Room 310 had a loose tile entrance. The floor in Room ked a transitional piece. The contained water stains along atton on 3/8/21 at 10:00 a.m., noted concerns as above. You on 3/8/21 at 11:45 a.m., Staff that de completed a weekly to do which included alarms, imperatures, air filters, fryer is. Staff D reported the 500 der remodel of new air and new flooring. Staff D ve sticky notes with work sone app. Staff D stated the good, but it is all he can do to any to day expectations. Staff D that there is a lot of repairs and a when he can get to it.	F		On 04/01/21, new radiator coverings were obeing replacing those in disrepair. On 03/31 repairs were completed and new floor was in room 206. On 03/30/21, the floor tiles in roc and 310 were repaired. On 04/08/2021, a netransition strip was ordered for room 310. On 04/07/21, the water stains in room 203 were addressed through cleaning. The Administrand/or designee will do weekly rounds with maintenance staff to identify any environment concerns and to prioritize repairs needing of the commitment to quality assurance, the Administrand/or designee will report identified concerthrough the community's QA Process.	/21, wall installed in om 208 w in facility ental ompleted.	

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

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NAME OF PROVIDER OR SUPPLIER ACCURA HEALTHCARE OF KNOXVILLE, LLC SUMMAY STATEMENT OF DEFICIENCES KNOXVILLE, AS 0138 1949 ID. SUMMAY STATEMENT OF DEFICIENCES KNOXVILLE, AS 0138 1949 ID. SUMMAY STATEMENT OF DEFICIENCES KNOXVILLE, AS 0138 1949 ID. SUMMAY STATEMENT OF DEFICIENCES BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FRESTIX TAG 1940 ID. PROVIDERS NAME OF CORRECTION (RACHOORSECTIVE ACTION SHOULD BE CROSS-REPERENCETO THE APPROPRIATE DEFICIENCY) PRETIX TAG PROVIDERS NAME OF CORRECTION (RACHOORSECTIVE ACTION SHOULD BE CROSS-REPERENCETO THE APPROPRIATE DEFICIENCY) 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 oblier maintenance. The Administrator stated repairs and painting are done on a priority basis.	ND PLAN O	OF DEFICIENCIES F CORRECTION	()(1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMI	SURVEY PLETED
ACCURA HEALTHCARE OF KNOXVILLE, LLC (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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			165382	SWING				
FRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOR 1 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			NOXVILLE, LLC		60	06 NORTH SEVENTH STREET		
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	F 921	During an interview Administrator state Maintenance to kee maintenance of the temperatures, and Administrator state	on 3/8/21 at 10:45 a.m., the d an expectation of ep up with the day to day facility, checking water boiler maintenance. The d repairs and painting are	P	921			