STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165311	A. BUILDING _____ B. WING _____	12/16/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date 01/07/2022 The following deficiencies are the result of the facility's annual health survey and investigation of complaints #92382-C, #93019-C, #98398-C and #94712-I. Complaints #92382-C and #98398-C were not substantiated. Complaint #93019-C was substantiated. Incident #94712-I was substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	PLAN OF CORRECTION Accura Healthcare of Le Mars 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.	01/07/2022
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating	F 567	In continuing compliance with F567, Protection/Management of Personal Funds, Accura Healthcare of Le Mars corrected the deficiency through staff education by the Executive Director on 1/07/2022. The facility will ensure that all residents have access to their funds outside of normal business hours. To correct the deficiency and to ensure the problem does not recur, The BOM, Social Worker, and all staff were educated on the facility's process for ensuring residents have access to their funds outside of normal business hours by Executive Director by 1/07/2022. Residents will be informed of the process for accessing funds by the Activity Director and/or designee by 1/7/2022. The ED and/or designee will audit for staff and resident understanding of how to request and access resident funds outside of normal business hours 3 times weekly for 4 weeks, then 2x weekly and then PRN to ensure continued compliance. As part of Accura Healthcare of Le Mars ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process.	01/07/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Blake Nettleton	Administrator	1/7/2022

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F 567	Continued From page 1	F 567		

accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.
(B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff interview, and record review, the facility failed to have resident funds accessible upon requests. The facility reported a census of 35.

Findings:

In an interview on 12/14/21 at 10:07 AM, the Business Office Manager (BOM) reported Residents did not have access to personal funds during non-business hours.

In an interview on 12/14/21 at 11:19 AM, the DON reported there is no way for residents to access cash during non business hours because the BOM removed the petty cash box from the medication storage room.

In an interview on 12/14/21 at 11:24 AM, the

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F 567	Continued From page 2 Social Worker reported she did not know how residents could access their funds after hours. After checking with the BOM, the Social Worker reported the residents would have to wait until normal business hours to get money. The facility lacked documentation or a policy related to the accessibility of resident funds.	F 567		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review the facility failed to provide all residents with timely and accurate assessments and interventions for 1 of 14 residents reviewed, (Resident #17). The resident had a large area under her breast that was red and irritated. The chart lacked information on the skin condition or documentation that it was being monitored or that the doctor had been contacted. The facility reported a census of 25 residents. Findings include: According to the Minimum Data Set (MDS) dated 11/5/21, Resident #17 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15,	F 684	In continuing compliance with F684, Quality of Care, Accura Healthcare of Le Mars corrected the deficiency through staff education by the DON on (12/16/2021). The facility audited resident #17 and all like residents to ensure they are receiving timely and accurate assessments and interventions. The Nurse who charted received 1:1 education on skin assessment and physician notification by the DON on 12/15/2021. To correct the deficiency and to ensure the problem does not recur all nurses were educated on skin assessment and intervention process by the DON by 12/16/2021. The DON and/or designee will review the 24- hour report and incidents reports to ensure physician and family notification, assessment, and intervention's in place daily Monday thru Friday for 4 weeks, then 1x weekly for 4 weeks, then PRN to ensure continued compliance. As part of Accura Healthcare of Le Mars ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	12/17/2021

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F 684	Continued From page 3	F 684		

indicating intact cognitive ability. The MDS showed Resident #17 required extensive assistance with the help of two staff for toileting and extensive assistance with the help of one staff for dressing and transfers.

The Care Plan updated on 12/8/21 indicated the resident was at risk for skin breakdown related to decreased mobility and diabetes mellitus. Staff were directed to monitor the skin with cares and to alert the nurse and doctor with any redness and/or open areas.

In an observation on 12/13/21 at 12:47 PM, Resident #17 said she had a sore area under her left breast. She lifted her breast and revealed the skin on the bottom of the breast and beneath was red and irritated. The resident said that over the previous couple of evening, she asked the Nurses put some baby powder on the area.

A review of the skin assessments found that she had a bruise on her back that they were watching weekly but the chart lacked any information about the intertrigo (rash in skin folds).

According to the Skin Shower Sheets dated 12/10/21, Resident #17 was found to have redness under both breasts. The sheet was signed by the Nurse but the chart lacked documentation that the doctor had been contacted or Skin Monitoring Tool had been initiated.

In an observation on 12/14/21 at 1:45 PM the Assistant Director of Nursing (ADON) was present in the room of Resident #17 while two unidentified Certified Nursing Assistants (CNA's) provided toileting assistance. The ADON stated

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F 684	Continued From page 4 she was responsible for skin assessments and wound cares and she said she did the weekly assessments. The resident lifted her left breast for the ADON to look at and the ADON acknowledged that this was something the doctor should have been informed about.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices 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, interviews and observation the facility failed to provide adequate nursing supervision resulting in a fractured hip due to a fall for 1 out of 3 residents reviewed, (Resident #125). The facility reported a census of 25 residents. Findings Include: The Minimum Data (MDS) with an Assessment Reference Date of (ARD) of 11/11/20 for Resident #125 showed a Brief Interview of Mental Status Score (BIMS) of 08 which indicated moderately impaired cognitive skills. The MDS showed the resident had diagnoses of dementia, disorientation, weakness, chronic kidney disease, and anxiety. The resident required limited assistance with one staff for transfers, dressing and ambulation.	F 689	In continuing compliance with F689, Free of Accident Hazards/Supervision/Devices, Accura Healthcare of Le Mars corrected the deficiency through staff education by the DON on 12/16/2021. The facility audited resident #125 and all like residents care plan interventions to ensure all interventions were in place on 12/16/2021. On 12/17/2021 the DON completed an audit of all falls in the last 30 days to ensure appropriate interventions were in place. To correct the deficiency and to ensure the problem does not recur, all nurses were educated on timely intervention following incidents and updating care plan, and following care plan interventions by DON on 12/16/2021. The DON and/or designee will audit fall interventions to ensure all are in place 3x weekly for 4 weeks, then 1x weekly for 4 weeks, then PRN to ensure continued compliance. As part of Accura Healthcare of Le Mars ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process	12/17/2021

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F 689	Continued From page 5	F 689		

Review of Progress Note dated 9/6/2020 at 10:26 PM stated Resident #125 was found sitting in the hallway in front of room 45 sitting on buttocks holding on to side rail in hallway. The Resident stated, I just wanted to get out of bed. I wasn't tired yet. Intervention at time of fall was to educate staff on alarm use.

Review of the Incident Report dated 9/6/20 stated the immediate action taken was staff to ambulate resident with walker and gait belt, lay resident back down in bed, alarm activated. Certified Nurse's Aides (CNA) educated on making sure alarm box is turned on.

Review of the Progress Note dated 11/29/20 at 3:45 PM noted the resident was resting in a recliner in the lounge area of the commons room. The Nurse had seen the resident about 30 minutes prior to the incident. The two CNA's were down a hall helping another resident when they heard a thump from the commons room and found the resident lying on the floor on her right side. The Progress Note stated it appeared the resident got up on her own and started waking to the piano in the dining room. There was a chair alarm placed in the recliner but it was not turned on. The resident was complaining of pain in her right leg and was sent to the emergency room for evaluation.

On 12/14/21 at 10:22 AM observation made of the area with Director of Nursing (DON). The DON showed the resident was sitting in the commons area with the recliners and TV and was found on the floor by a piano which was located about 50 feet from where she was seated.

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F 689	Continued From page 6	F 689		

Review of the Incident Report dated 11/29/20 prepared by Staff C, Registered Nurse (RN) stated the resident was sitting in a recliner in the front lounge area, got up unassisted and fell on her right side. Alarm was in place but was not turned on.

Review of the facilities investigation stated at approximately 3:15 PM Staff C RN conducted vitals on the resident while in the recliner and then went on to obtain other residents vital signs. At approximately 3:30 PM Staff D CNA noticed the resident laying on the floor from a distance after hearing a noise. Staff D CNA noted the pad alarm was not sounding. Staff C RN then called the emergency room and Emergency Medical Team arrived on site at 3:40 PM. Plan of action taken was to reeducate all nursing staff to ensure proper alarm utilization by the end of day 12/2/20.

Review of the Progress Note dated 11/29/20 at 5:27 PM showed the facility was notified by the hospital Resident #125 sustained a dislocated trochanter and a fractured hip.

Review of the Progress Note dated 12/1/20 at 1:51 PM stated the facility was informed by the hospital Resident #125 had surgery on 11/30/20.

Review of the Respiratory Surveillance Form showed Resident #125 tested positive for Covid-19 on 11/29/20 at the hospital.

Review of the Progress Note 12/2/20 at 12:54 PM showed the resident returned to the facility

Review of Progress Note dated 12/11/20 at 5:18 PM Resident #125 was admitted to hospice with diagnosis of Covid-19 and comorbidities of right

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F 689	Continued From page 7 hip fracture repair. The Progress Note dated 12/12/20 at 6:00 PM noted the resident had passed away. Review of the Care Plan stated a personal alarm was to be on at all time with an initiation date of 6/10/20. Review of the Fall Risk Assessment dated 11/13/20 stated resident was a high risk for falls with a high fall risk score of 18. Interview on 12/14/21 at 1:50 PM the DON stated the facility does not have personal alarms any more, it has been about a year since they have used alarms, she stated she does not like to use alarms and expects staff to observe residents.	F 689	In continuing compliance with F758, Free from Unnec Psychotropic Meds/PRN Use, Accura Healthcare of Le Mars corrected the deficiency through a review of all current PRN psychotropic use and staff education by the DON. The DON audited resident #4 and all like residents receiving PRN psychotropic medications for compliance with the 14 day stop date on 12/16/2021.	12/17/2021
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that— §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a	F 758	To correct the deficiency and to ensure the problem does not recur, the DON and ADON were educated by the nurse specialist on 12/16/2021 on requirements for PRN psychotropic medications. All nurses were educated on PRN psychotropic requirements by the DON on 12/15/2021. The DON and/or designee will audit the psychotropic medication orders daily Monday thru Friday for 4 weeks, then 2x weekly for 4 weeks, then PRN to ensure continued compliance. As part of Accura Healthcare of Le Mars ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process	

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F 758	Continued From page 8 specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview the facility failed to limit the timeframe for PRN (as needed) psychotropic medication to 14 days or obtain appropriate documentation from the provider for 1 of 4 residents reviewed, (Resident # 4). The facility reported a census of 25 Residents.	F 758		

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F 758	Continued From page 9 Findings Include: The Minimum Data (MDS) with an Assessment Reference Date of (ARD) of 9/10/21 for Resident #4 showed a Brief Interview of Mental Status Score (BIMS) of 03 which indicated severe cognition impact. The MDS showed the resident had diagnoses of dementia, glaucoma, insomnia, falls, and anxiety. The resident was total dependent on 2 staff for transfers and locomotion and extensive assistance with 2 staff for toileting. Review of the Orders tab in the Electronic Health Record (EHR) showed an order for Haloperidol 5mg/ml to give 5mg as needed for severe agitation with an order date of 9/8/21. Review of the Pharmacies Medication Regimen Review dated 10/1/21 to 10/12/21 showed on 10/12/21 the Pharmacist noted the resident was receiving hospice services with a protocol anxiolytics orders for as needed Ativan and haloperidol, also noted Center of Medicare Services (CMS) requires a specified stop date regardless of hospice services and please consider adding a stop date and re-evaluate. The recommendation was reviewed by the Physician who noted to discontinue the medication in 180 days from 10/15/21. Interview on 12/16/21 at 8:24 AM with the Director of Nursing (DON) stated the expectation is for any as needed anti-psychotropic medication to be reviewed with the provider for an end date.	F 758		