STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165535	A. BUILDING _____ B. WING _____	10/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF AURELIA, LLC	401 WEST FIFTH STREET AURELIA, IA 51005

(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	F 000		
POC OK 11/14/22 SjS	Correction date: 11/07/2022 The following deficiencies resulted from the facility's annual recertification survey and investigation of complaint #105479-C and incident #106844-I conducted on October 17, 2022 to October 25th, 2022. Complaint #105479-C was not substantiated. Incident #105479- I was substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.		Accura Healthcare of Aurelia 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.	
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 use safe transfer techniques for 2 out of 4 residents reviewed (Resident #9 and #21). The facility also failed to ensure the care plan fall intervention of a personal alarm was in place for 1 resident out of 4 residents reviewed for accidents/nursing supervision (Resident #11). The facility reported a census of 28. Findings Include:	F 689	1. In continuing compliance with F 689, Free of Accident Hazards/Supervision/Devices. The Accura Healthcare of Aurelia corrected the deficiency by educating staff B on 8/4/2022 on gait belt transfers regarding Resident #9 and all like residents, and staff D on 07/18/2022 on following care plan interventions regarding Resident #11 and all like residents. Staff E was educated on 10/24/2022 Locking brakes on wheelchair prior to transfers regarding resident #21 and all like residents. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated on resident transfers. Care plan interventions and locking brakes on wheelchair prior to all transfers by Director of Nursing on 10/26/22. The Director of Nursing and/or designee will audit resident transfers/supervision 3x a week for 4 weeks and 2x a week for 2 weeks then PRN to ensure compliance. 3. As part of Accura Healthcare of Aurelia ongoing commitment to quality assurance, the Director of Nursing and/or Designee will report identified concerns through the community's QA process.	10/26/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Execute Director | (X6) DATE: 11/10/22

Any deficiency ~~statement ending~~ with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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1. The Minimum Data Set (MDS) assessment for Resident #9 dated 6/20/22 showed a Brief Interview of Mental Status score (BIMS) of 12 which indicated intact cognition. The MDS indicated Resident #9 required an extensive assistance of 1 person for transfers. The MDS diagnoses included weakness, heart dysrhythmias and hypertension.

The Care Plan last revised on 7/1/22 documented Resident #9 required the assistance of 1 person, a gait belt and forward wheeled walker for transfers.

The Progress Note dated 8/4/2022 at 10:30 PM for Resident #9 documented nurse summoned by the aide to the residents room. Upon entering the resident was observed face down on the floor with extremities stretched outward. Scant amount of blood noted on the floor upon assessment this nurse finds bone to right arm exposed. The facility called 911 for an ambulance transfer to the emergency room (ER).

The Facility Investigation documented on 8/4/22 at approximately 10:40 PM, the Director of Nursing (DON), received a phone call from Staff A, Licensed Practical Nurse (LPN), stating Resident #9 had sustained a witnessed fall resulting in a fracture to her right arm. On 8/4/22 at approximately 10:30 PM, Staff B, Certified Nurses Assistant (CNA), was assisting Resident #9 to bed. Resident had her walker and was turning left to ambulate towards her bed when she lost her balance and fell forward. Staff A, LPN, asked Resident #9 what happened she stated, "I fell to the floor". Staff B, CNA, was not using a gait belt at the time of the fall. The facility

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investigation further documented Resident #9 sustained a comminuted, obliquely oriented fracture of the distal right humeral meta-diaphysis. The distal fracture component is displaced anterolaterally by greater than a shaft width (a severely displaced fracture located at the lower end of the arm bone).

The Emergency Room documentation dated 8/5/22 revealed the ER physician determined via X-ray Resident #9's right arm sustained a severely displaced fracture located at the lower end of the arm bone caused by the fall.

The Major Injury Determination Form dated 8/6/22 revealed the ER physician classified Resident #9's right arm fracture to be a Major Injury.

The Investigation Questionnaire dated 8/4/22 Staff B, CNA, asked what occurred at the time of the incident. Staff B replied, the resident walked to her bed. Gait belt not in use due to lack of judgment.

In an interview on 10/19/22 at 2:53 PM, Staff B, CNA, reported on 8/4/22 she assisted Resident #9 transfer from the recliner using a walker. As Resident #9 stood, she started to fall forward. Staff B attempted to catch the resident but instead kicked the resident's walker causing the resident to fall to the ground. Staff B stated she normally used a gait belt when transferring Resident #9 but for some reason just didn't use a gait belt on this occasion. Staff B confirmed the facility followed up with her regarding gait belt education after the incident.

In an interview on 10/20/22 at 7:30 AM, Staff A,

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LPN, stated she arrived to Resident #9's room immediately after the fall where she observed Resident #9 on the ground not wearing a gait belt. Staff A reported that she would have expected staff to use a gait belt when transferring Resident #9.

The facility reported they lacked a policy regarding gait belts or transfers.

In an interview on 10/20/22 at 2:36 PM, the DON stated that she would have expected staff to use a gait belt and walker when transferring Resident #9.

2. The MDS assessment for Resident #11 dated 6/6/22 for showed a BIMS of 4 which indicated severe cognitive impairment. The MDS indicated Resident #11 required an extensive assistance of 2 persons for transfers, dressing and personal hygiene. The MDS diagnoses included dementia, anxiety disorder and psychotic disorder.

The Care Plan dated 6/6/22 instructed staff to use a TAB alarm on Resident #11 to alert staff when the resident attempted self-transfer.

The Progress Note dated 7/18/2022 at 1:30 PM documented Resident #11 found by staff on the floor next to her wheelchair. The resident reported to staff that she fell forward when vomiting from the wheelchair. As a result Resident #11 sustained a hematoma to the left forehead. The Progress Note further documented the CNA stated she forgot to place the TAB alarm back on the resident and CNA educated about the importance of having the TAB alarm on the resident at all times.

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In an interview on 10/20/22 at 10:11 AM, Staff C, Registered Nurse (RN), reported she responded to Resident #11 's room when Staff D, CNA, reported the resident fell out of her wheelchair. Staff C stated she found Resident #11 on the ground next to the wheelchair with vomit beside her on the floor. Staff C noted a hematoma to the resident's forehead, however did not call for an ambulance at the request of the family. Staff C, RN, reported Staff D, CNA, failed to place the TAB alarm on the resident before the fall. Staff C said the CNAs used the TAB alarm on a consistent basis but this time Staff D forgot to place the alarm after moving the resident back to her room.

In an interview on 10/24/22 at 7:25 AM, Staff D, CNA, stated she forgot to place the alarm on Resident #11 because while in the room the resident's neighbor called out for help. Staff D stated she got sidetracked and felt horrible for not placing the alarm on the resident.

The facility reported they lacked a policy regarding personal or TAB alarms.

In an interview on 10/19/22 at 9:37 AM, the DON explained the TAB alarm works by a pull-string that attached magnetically to the alarm with a garment attachment that clipped to the resident. When a resident leaned too far forward or attempted to stand, the string would be pulled, engage the alarm and alert staff to the resident's movement. When asked if Resident #11 should have a TAB alarm placed when she is not in bed, the DON responded, yes. The DON acknowledged the alarm could have prevented the fall.

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3. The MDS assessment for Resident #21 dated 9/26/22 showed a BIMS of 3 which indicated severe cognitive impairment. The MDS indicated Resident #21 was totally dependent on staff for transfers, dressing, toilet use and personal hygiene. The MDS diagnoses included morbid obesity, Alzheimer's Disease, renal insufficiency and cancer.

The Care Plan dated 10/10/22 showed transfers are to be done with assistance of 2 persons using a Hoyer (mechanical) lift.

Observation on 10/19/22 at 11:14 AM showed Staff E, CNA and Staff F, CNA, prepared to move Resident #21 from the bed to the wheelchair using a EZ Way Smart Lift. The CNAs connected the sling to the machinal lifted and raised Resident #21 from the bed. As Staff F lowered the resident into the wheelchair, Staff E then readjusted the wheelchair without engaging the wheelchair breaks. As the lift shifted and moved forward Staff E struggled to hold the wheelchair in place while pulling and guiding the resident down into the wheelchair.

EZ Way Smart Lift Manufacturers Instructions last updated on 8/10/18 instructed when moving the resident from the bed to the wheelchair or toilet on Step 6, #1 Position the wheelchair under the patient and lock the wheels of the wheelchair.

In an interview with the DON on 10/20/22 at 3:01 PM, the DON reported that she wasn't sure if the wheelchair locks needed to be engaged when transferring a resident from the bed to a wheelchair using the EZ Way Lift. The DON stated, I don't know. I know I don't lock the breaks.

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F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880	Accura Healthcare of Aurelia 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. 1. In continuing compliance with F 880, Infection Prevention and Control. The Accura Healthcare of Aurelia corrected the deficiency on 10/19/2022 on Staff G and 10/24/2022 on Staff E by providing education on proper peri care, hand hygiene, dining room meal assistance regarding resident #127 and resident #21 and all like residents by Director of Nursing. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated on 10/26/2022 on proper hand hygiene, dining room meal service, assisting residents with meals, peri care, and proper glove use by Director of Nursing. The DON and/or designee will audit hand hygiene, peri care, and glove use 3x a week for 4 weeks, 2x a week for 2 weeks then PRN to ensure compliance. 3. As part of Accura Healthcare of Aurelia ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	11/07/2022

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(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility staff failed to practiced appropriate infection control measures and provide proper hand hygiene and glove usage during perineal cares and during resident meals for 2 out of 2 residents reviewed (Resident #21 and Resident #127). The facility reported a census of 28.

Finding included:

Observation on 10/19/22 at 11:01 AM revealed

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Staff E, Certified Nursing Assistant (CNA) and Staff G, CNA, provided perineal cares to Resident #21. Staff E cleansed the front perineal area, removed gloves, wiped hands on scrubs then entered the bathroom and rinsed her hands for less than 5 seconds. Staff E then applied gloves, assisted to roll the resident onto her side to clean and remove bowel movement then with soiled gloves Staff E assisted the resident to roll to the other side, changed the bed pad, changed the brief and opened the drawer of the bedside table to obtain another package of wipes. Staff E still with soiled gloves finished wiping the resident, assisted the resident to get comfortable, put away supplies then removed the soiled gloves, wiped hands on scrubs then entered the bathroom to wash her hands.

Observations on 10/19/22 at 11:14 AM during Resident #21's perineal care Staff E's waist length hair brushed against several surfaces touching a dirty bed pad, the resident's leg, a garbage bag and garbage receptacle. Staff E's hair also rested against Resident #21's perineal area after Staff E assisted the resident to roll on to her side.

Observation on 10/19/22 at 12:07 PM showed Staff E, CNA's, waist length hair brushed against the table top, wheelchair and Resident #127's leg as Staff E reached under the table to adjust the resident's left wheelchair pedal during lunch. Staff E failed to perform hand hygiene then returned to the kitchen door to assist with passing lunch trays.

Observations on 10/19/22 at 12:08 PM showed Staff E, CNA, did not perform hand hygiene at any time while passing trays or while assisting

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F 880	Continued From page 9 residents at lunch. Staff E, CNA, observed to grasp cups by the top rim as she sat the cups on the tables. The Hand Hygiene policy dated 6/16/22 instructed hand hygiene should be performed after contact with blood, body fluids or contaminated surfaces and before moving from a soiled body site to a clean body site on the same resident. In an interview on 10/20/22 at 3:10 PM, the Director of Nursing (DON), stated that she expected staff to perform proper hand hygiene between glove changes and after coming in contact with soiled surfaces. The DON also expected staff to hold cups by the handles and that hair be tied back in a manner that prevented cross contamination issues.	F 880		