STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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:_____ An investigation of Complaint #98540-C and Facility Reported Incidents #98661-I and #98770-I was conducted 7/13-15/21, 7/19-22/21, 7/26-29/21, 8/2-/3/21 and resulted in the following deficiencies. Complaint #98540-C substantiated Facility Reported Incident #98661-I was substantiated. Facility Reported Incident #98770-I was substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 580		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

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F 580	Continued From page 1	F 580		

(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on record review and interview with staff and family, the facility failed to notify families of unusual occurrences for 2 of 15 residents reviewed. Resident #7 and #8 exited the building unattended and the families were not notified. Resident #15 was lowered to the floor on 7/31/21, neither the family nor the physician had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 580	Continued From page 2	F 580		

contacted regarding the occurrence. The facility reported a census of 36 residents.

Findings include

1. A Minimum Data Set (MDS) dated 6/4/21 assessed Resident #8 with a Brief Interview for Mental Status (BIMS) score of 5 (severe cognitive deficit). The MDS revealed the resident required limited assistance of one staff for transfers, toileting and walking. The MDS indicated the resident used a motion sensor and an elopement alarm to help monitor her activity.

The care plan updated on 2/13/21 identified Resident #8 with dementia and the resident could transfer and ambulate independently with the use of a walker. The care plan identified the resident with self-care deficits and required staff assistance with activities of daily living.

On 7/14/21 at 11:45 AM Staff C LPN (licensed practical nurse) stated Resident #8 exited the building unattended around 6:00 PM as he began his shift. Staff C did not know the date, and the resident did not get too far before staff brought her back inside. Staff C said the door alarms sounded from hallway 2, but the elopement monitor system did not engage the magnet that should have prevented the door from opening.

On 7/19/21 at 9:54 AM the surveyor asked the Director of Nursing (DON) if Resident #8 left the facility unattended sometime in May. The Assistant Director of Nursing (ADON) and Staff V LPN were also present at the time of interview. The DON stated Resident #8 went outside but it was not an elopement and there was no incident report completed. She said because the door

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 580	Continued From page 3	F 580		

alarm sounded and Staff M, LPN walked the resident outside, just like residents are taken outside for activities, the event did not require documentation.

On 7/19/21 at 9:57 AM Staff M said that the door alarm sounded and she saw Resident #8 open the door from down the hallway. She said that the elopement monitor device magnet did not engage so Resident #8 opened the door and exited out onto the patio. When asked if she had documented the incident, Staff M said that she didn't remember.

2. A MDS dated 5/20/21 assessed Resident #7 with a BIMS score of 6 (severe cognitive deficit). The MDS revealed the resident required extensive assistance of one staff for toileting and walked and transferred independently. The MDS included diagnosis of dementia, diabetes mellitus and unspecified hearing loss. The MDS revealed the resident utilized an elopement alarm used daily.

An elopement risk assessment completed on 6/8/21, identified Resident #7 at high risk for elopement and wore a elopement monitor bracelet to help monitor his movements.

On 7/14/21 at 5:40 Staff Q LPN stated Resident #7 exited the building unattended on a Sunday night in June.. Staff Q stated the facility had trouble with the elopement monitor devices and the magnet to prevent the door from opening did not work.

On 7/19/21 at 7:09 AM Staff G LPN said that the night that Resident #7 got out unattended he/she was in the nursing station/dining area and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

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F 580	Continued From page 4	F 580		

door alarm sounded. Staff G said the DON was in the building at the time and the alarm panel indicated the East door opened. Staff G went down the 400 hallway and did not see Resident #7. Staff G then went to the North side of the building and saw the DON bringing the resident back inside. Staff G said the elopement monitor device Resident #7 used did not engage the magnet on the door as designed.

On 7/14/21 at 10:50 AM the surveyor spoke to the family of Resident #8 and asked if they had been notified of any incidences regarding exit seeking behaviors or issues related to wandering. The family member stated that they would get a text with change in medication or a fall but hadn't been contacted about exit seeking behaviors or incidences.

On 7/14/21 at 10:59 AM the surveyor spoke to a family member of Resident #7 who stated she felt they have been updated on medication changes and incidents. The family member stated they did not get any calls about wandering behavior or exit seeking.

On 7/15/21 at 9:50 AM the Director of Nursing (DON) staff would complete an incident report and contact the family in the case of an elopement. She stated they did not have any elopements at the facility because any exiting by residents had been witnessed, therefore, not considered an elopement.

3. An MDS dated 7/8/21 assessed Resident #15 with a BIMS score of 15 (no cognitive impairment). The MDS revealed the resident required extensive assistance of one for transfers, locomotion, dressing and toileting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

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F 580	Continued From page 5	F 580		

According to the census tab in the electronic chart, Resident #15 admitted to the facility on 6/11/21.

The care plan for Resident #15 dated 6/11/21 included a focus area of risk for falls due to a history of a cerebrovascular accident (CVA) with right sided weakness. The care plan identified the resident with an activities of daily living deficit due to CVA with limited range of motion of the right hand and elbow and a contracture to her right shoulder. The care plan included diagnosis of hemiplegia and hemiparesis following CVA, muscle weakness and chronic kidney disease.

An incident report dated 7/31/21 at 7:36 PM revealed at approximately 4:30 PM on that date, a CNA (certified nurse aide) reported to the registered nurse (RN) on duty that an environmental aide (EA), Staff BB attempted to transfer Resident #15 and the resident fell. The report identified the resident told the RN that the EA attempted to transfer her from the recliner to the wheelchair and the EA's feet got tangled up and the EA lowered the resident to the floor.

On 8/2/21 at 11:50 AM a nurse from the office of the primary care physician said they did not receive notification of a fall over the weekend for Resident #15. The nurse said that communication regarding a fall without injury would typically come in via fax and she was not aware of any but would check with the doctor to see if he got a call. At 11:57 AM the nurse called the surveyor and said the doctor did not receive notification of a fall for Resident #15 over the weekend.

On 8/2/21 at 1:12 PM the Director of Nursing (DON) said she received notification of the fall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 580	Continued From page 6	F 580		

over the weekend but she did not know that staff did not notify the doctor or the family. She said she contacted the family when she saw the incident report on that Monday morning.

On 8/2/21 at 12:20 Staff EE RN stated she worked for an agency but worked at the facility for about a month. Staff EE said she notified the Assistant Director of Nursing (ADON) of the fall and the ADON said that she would speak to the DON about the incident. Staff EE said she thought the DON and ADON would handle the doctor and family notification.

On 8/2/21 at 1:58 PM the surveyor asked the ADON what staff were taught about when to fill out an incident report and when to contact family and physician. She stated staff are taught upon hire to fill out an incident report for falls, unwitnessed falls, elopements, skin issues or unusual events. When asked if she could provide copy of this education, the ADON identified it as verbal education only so there was no documentation of the details of that education. She said the facility provided agency staff with the same education as permanent staff.

On 8/2/21 at 3:51 PM a family member for Resident #15 said their mother hadn't lived at the facility very long but thought that everything went okay so far. The family stated she got a message from the DON that morning informing her Resident #15 had been lowered to the floor on Saturday evening. The family member looked at her phone and said the call had come in at 12:03 PM.

An undated policy titled Falls Management revealed staff would report incidents to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 580	Continued From page 7 physician and family and any new orders given by the physician.	F 580		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and observation, the facility failed to update and follow care plans for 2 of 15 residents reviewed: Residents #10 and #11. Resident #10	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

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F 657	Continued From page 8	F 657		

experienced increased weakness at night and staff used the mechanical lift for transfers. Resident #10's care plan lacked documentation of the use of the lift. Resident #11 exhibited some confusion and weakness and often self-transferred so a motion sensor was utilized. Resident #11's care plan lacked information regarding a motion alarm. The facility reported a census of 26 residents.

Findings include:

1. A Minimum Data Set (MDS) assessment dated 6/9/21 assessed Resident #10 with a Brief Interview for Mental Status (BIMS) score of 13 (no cognitive impairment). The MDS revealed the resident required limited assistance of one staff for transferring, toileting, walking and bed mobility.

The care plan revealed the resident initially admitted to the facility on 9/25/15 with diagnoses that included: congestive heart failure, iron deficiency, overactive bladder and cancer. The care plan included a focus area of risk for falls initiated on 10/8/16.

On 7/21/21 at 9:00 AM Staff W Certified Nurse Aide (CNA) stated staff used a mechanical lift to transfer Resident #10 on the overnight shift because the resident exhibited increased weakness at night. Staff W stated the last couple of times she worked at the facility, staff told him/her in shift report that the resident used the mechanical sit-to-stand at night because of increased weakness at night. Staff W said she used the stand with Resident #10 3 or 4 times before that night.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

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F 657	Continued From page 9	F 657		

On 7/20/21 at 10:30 PM Staff Q licensed practical nurse (LPN)said that the mechanical was being used recently needed the use of the mechanical lift for transfers because of increased weakness.

The care plan lacked any information regarding the use of a mechanical lift for Resident #10.

2. A MDS dated 6/9/21 assessed Resident #11 with a BIMS score of 1 (severe cognitive deficits). The MDS revealed the resident required limited assistance of one staff for bed mobility, transferring, walking, locomotion and extensive assistance with the help of one for toileting.

An admission assessment dated 7/3/21 at 2:59 PM identified a care plan focus area of risk for falls. The focus area revealed the resident became fatigued easily and would attempt to transfer without assistance. The assessment indicated an intervention would be added to the care plan to have a pull tab alarm to alert staff when the resident tried to get up without assistance. Staff were directed to ensure the alarm was on and functioning.

On 7/20/21 at 11:23 PM Resident #11 was in the bathroom on the toilet. Staff Q asked why he didn't wait for help and the resident responded he couldn't wait. There was a trail of urine on the floor from his bed to toilet. Staff Q then alerted the three CNA's in the dining room area to assist the resident. Staff Q stated Resident #11 had a bed alarm when he was first admitted but for some reason it had been discontinued.

On 7/21/21 at 6:30 AM Staff H LPN stated Resident #11 no longer used an alarm because he didn't try to transfer without help.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 657	Continued From page 10 On 7/21/21 at 1:17 PM the DON stated she did not know Resident #11 had been getting up on his own and would look into getting the bed alarm reestablished. The care plan lacked information regarding the resident ever using motion alarms.	F 657		
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 staff interview and record review the facility failed to provide accurate assessment and interventions for 3 of 15 residents reviewed; Residents #6, #8, and #3. Resident #6 suffered rib damage after a fall and the emergency room doctor recommended the use of an incentive spirometer to help prevent pneumonia. The resident's record lacked information the facility implemented the intervention and 9 days later the resident admitted to the hospital with pneumonia. Resident #8 and #3 elopement assessments did not accurately describe their level of functioning. The facility reported a census of 36 residents. Findings include:	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 684	Continued From page 11	F 684		

1. A Minimum Data Set (MDS) dated 5/15/21 assessed Resident #6 with a Brief Interview for Mental Status (BIMS) score of 9 out of 15 (moderate cognitive deficits). The MDS showed that the resident required limited assistance with the help of one for walking, transferring, dressing and toileting.

A quarterly nursing assessment dated 5/25/21 identified Resident #6 as independent with transferring and walking.

A care plan updated on 6/30/21 identified Resident #6 at risk for falls due to hypotension and frequent attempts to self-transfer without assistance. The care plan stated that due to right-sided weakness and foot drop the resident was to wear a white brace in his right shoe to aide in transferring.

The care plan included diagnoses of: hemiplegia, hemiparesis following unspecified cerebrovascular disease affecting right side, muscle weakness, acute kidney failure, acute respiratory failures, cerebral infarction and aphasia.

A nursing note dated 5/31/21 at 10:34 PM revealed staff found Resident #6 on the floor in his room with a contusion to the head and grimacing in pain. He complained of pain in right rib area and a severe headache. The resident was then sent to the emergency room.

An Emergency Department (ED) note on 5/31/21 at 10:46 PM reported the resident presented to the ED with a goose egg on the right side of his head and complained of lower rib cage pain as well as right knee pain. The ED physician stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

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F 684	Continued From page 12	F 684		

the patient was in no significant distress and could return to the nursing home. The report included details regarding displaced fractures of right lateral third, fourth and fifth ribs. The recommendations of the ED physician to the facility was to observe for onset of cough, and to use an acapella or incentive spirometer to help avoid atelectasis that could lead to pneumonia. Deep breathing exercises were highly recommended.

A nursing note dated 6/9/21 at 2:41 AM showed the resident's lung sounds wheezy and his oxygen saturation 84%. Staff applied supplemental oxygen at that time. A nursing note dated 6/9/21 at 9:31 AM indicated Resident #6 had an oxygen saturation level of 88% on 2 liters of supplemental oxygen. The lung sounds diminished with audible wheezes. Staff contacted the doctor and family and at 9:10 AM on 6/9/21 the resident transferred to the emergency room.

An ED report on 6/9/21 at 10:29 AM indicated the resident presented from the facility with an elevated temperature and respiratory symptoms. After lab work completed, the resident admitted to the hospital.

A discharge summary on 6/14/21 at 11:03 AM revealed the resident discharged back to the nursing home after treatment for acute hypoxic respiratory failure and right lower lobe pneumonia.

The electronic chart, including Treatment Administration Records (TARs) for Resident #10 lacked documentation of the use of an IS or deep breathing exercises as recommended by 5/31/21 ED notes. The chart included two nursing notes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 684	Continued From page 13	F 684		

that referenced the use of the incentive spirometer:

a) A nursing note dated 6/8/21 at 5:59 PM identified the resident's oxygen saturation level 89% on room air and staff applied supplemental oxygen per nasal cannula. The note indicated the resident used an incentive spirometer at that time and he performed the breathing exercise 10 times. The resident expressed understanding and stated he would use the spirometer. (This nursing note was entered on 6/9/21 at 10:11 AM by the Director of Nursing (DON) after the resident had been taken to the emergency room.)

b) A nursing note dated 6/8/21 at 7:25 PM revealed the resident used the incentive spirometer and performed the exercises 10 times and he was encouraged to take deep breaths. At 7:00 PM he was able to use the IS 7 times. (This nursing note was entered on 6/9/21 at 10:50 AM by the DON after the resident had been taken to the emergency room with respiratory distress.)

On 7/21/21 at 10:37 AM the primary physician for Resident #6 said that he hadn't been working in the emergency department on 5/31/21 when the resident come in after the fall. He looked at the notes entered by the ED physician and agreed with the recommendation of the use of an incentive spirometer (IS) with the injuries to the resident's ribs to help promote deep breathing and prevent pneumonia. He said the ideal order would have been to use the IS every 2 hours while awake and it was especially important to implement the intervention as soon as possible to help prevent pneumonia. The physician stated that he would have expected the nursing staff to reach out for clarification if they were unsure of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 684	Continued From page 14	F 684		

the doctor's recommendations.

On 7/26/21 at 8:45 AM Staff P RN (registered nurse) said she remembered Resident #10 had an IS in his room, because they had to call the pharmacy to get one. She did not remember using it with the resident or seeing the resident use it independently.

On 7/22/21 at 11:25 AM Staff H LPN (licensed practical nurse) remembered Resident #10 had an IS in his room after the fall on 5/31/21, but did not remember having used it with the resident or seeing him use it independently.

On 7/22/21 at 11:38 the DON acknowledged the Treatment Administration Record (TAR) did not contain the IS recommendation. She indicated she used the IS with the resident several times herself and nurses verbally passed on to the next shift to encourage the resident to practice deep breathing but there was no documentation that this happened.

2. A MDS dated 6/4/21 assessed Resident #8 with a BIMS score of 5 (severe cognitive deficit). The MDS showed the resident required limited assistance of one staff for transfers, toileting and walking. The MDS indicated the resident used a motion sensor and an elopement alarm to help monitor her activity.

The care plan updated on 2/13/21 indicated Resident #8 had dementia and could transfer and ambulate independently with the use of a walker. The care plan revealed the resident had self-care deficits and required staff to assist with activities of daily living.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 684	Continued From page 15	F 684		

An elopement assessment dated 6/28/21 at 3:24 p.m. revealed Resident #8 as not independently mobile with or without assistive device. The assessment showed the resident not a risk for elopement as evidenced by a score of zero.

A quarterly nursing assessment dated 6/3/21 at 3:27 PM indicated the resident transferred with limited assistance of one person and could ambulate in the room with limited assist of one person. The resident used walker and bore full weight..

On 7/19/21 at 9:57 AM Staff M LPN said Resident #8 ambulated down a hallway independently and opened the door to the outside sometime in the month of May. Staff M did not know the exact date.

On 7/21/21 at 1:17 PM the surveyor alerted the DON and Staff V RN of Resident #8's elopement score of 0 on the elopement risk assessment and they both agreed that the resident is considered a high risk. The DON said the assessment was probably completed before the resident got a wheel chair and she wasn't able to move self without the chair. The surveyor reminded the DON that the resident ambulated herself to the door, opened it and went outside unattended sometime the end of May.

3. A MDS dated 6/4/21 assessed Resident #3 with a BIMS score of 8 (moderate cognitive deficit). The MDS identified the resident required limited assistance of one staff for bed mobility, ambulation and toileting.

A care plan for Resident #3 dated 6/23/21, identified the resident at risk for falls, history of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 684	Continued From page 16 left fibular fracture and heart failure and type II diabetes. A fall risk assessment dated 4/3/21 at 9:31 AM and 6/4/21 at 2:08 PM both indicated Resident #3 could not come to a standing position unassisted. A quarterly nursing assessment dated 6/3/21 at 2:16 PM identified the resident as oriented, could transfer with limited assistance of one person, walking was limited with one person assistance, and used a walker. An elopement risk assessment dated 6/3/21, signed on 6/28/21 at 2:13 PM stated the resident was not independently mobile without assistance. An incident report dated 7/11/21 at 2:20 AM revealed Resident #3 got up from bed, walked to the nearby exit door independently, pulled the fire alarm and exited the building. Staff found Resident #3 at the bottom of two steps outside on the sidewalk.	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 observation, staff interviews and record review the facility failed to provide	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 689	Continued From page 17	F 689		

adequate supervision and assistance devices to residents at risk for falls, and failed to establish reliable precautions and systems to prevent residents from exiting the building unattended for 7 out 15 residents reviewed. On 7/18/21 staff left Resident #10 (a resident known to make self transfer attempts) sitting on the side of the bed after the resident activated their motion alarm indicating movement from bed and knowing the resident needed the toilet. After staff left the resident, the resident attempted to self transfer and fell face-down, suffering from a major head injury. The resident expired 4 days later. On 7/31/21 an untrained environmental aide attempted to transfer Resident #15 and the resident fell to the floor. Residents #7 and #8 wore elopement bracelet devices and alarms failed to function when the residents exited the building unattended. In an observation on 7/20/21, Resident #11 transferred himself to the bathroom. According to staff, Resident #11 should use a bed alarm. The bed alarm was not in place at the time of observation. Residents #8, #12, and #14 wore expired elopement bracelet devices at the time of the survey. On 7/13/21 the alarm to the front door of the facility was turned off, and staff reported they have difficulty hearing the door alarms when they are in a room with a resident and the door is closed. Observation on 7/20/21 at 10:30 PM revealed two medication carts unlocked and unattended. The facility reported a census of 36 residents.

Findings include:

1. A Minimum Data Set (MDS) dated 6/9/21 assessed Resident #10 with a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognitive ability. The MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 689	Continued From page 18	F 689		

showed the resident required limited assistance of one staff for transferring, toileting, walking and bed mobility. The MDS identified the resident as not steady and only able to stabilize with staff assistance when moving from seating to standing and from surface to surface. The MDS indicated that the resident had a motion sensor alarm used daily.

The care plan revealed the resident initially admitted to the facility on 9/25/15 with diagnoses that included: congestive heart failure, iron deficiency, overactive bladder and cancer. The care plan included a focus area of risk for falls initiated on 10/8/15. The care plan revealed the resident would not use the call light to alert staff of needs and the resident would attempt to self ambulate and transfer. The Director of Nursing (DON) updated the care plan on 7/20/21 and identified the resident at risk for falls due to low hemoglobin levels and no longer wanting to treat the condition.

A care plan intervention dated 6/12/21 revealed the resident used a motion alarm in the room and directed staff to place the alarm on the floor near the dresser so the alarm didn't detect every time the resident moved around in the chair and would only activate when the resident attempted to get up without assistance. The care plan did not include the intervention for a pressure alarm in the bed until 7/18/21.

The care plan included a focus area of impaired cognitive functioning and impaired thought processes initiated on 6/12/21 that indicated the resident was experiencing gradual decline in cognitive ability. On 6/2/21 pain medication was added to the care plan and staff were instructed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 689	Continued From page 19	F 689		

to monitor for upper GI bleed. The care plan indicated that the resident had a cancerous mass on the pancreas and suffered with abdominal pain. On 6/21/21 the care plan included an intervention to monitor for side effects to antianxiety medication such as drowsiness and blurry vision.

The Medication Administration Record (MAR) for the month of July 2021, revealed on 7/17/21 at 9:00 PM the resident received two medications known to cause drowsiness; Remeron (antidepressant) 15 milligrams (mg) and Tramadol (narcotic) 50 mg.

Information on Tramadol and Remeron was retrieved on 8/3/21 at 8:03 AM from https://www.drugs.com. The web site showed that common side effects of Tramadol were dizziness, drowsiness and tiredness. Common side effects of Remeron included dizziness and drowsiness.

A fall risk assessment dated 6/8/21 showed Resident #10 could not come to a standing position on her own and required hands on assistance to move from place to place.

An incident report dated 7/18/21 at 5:15 a.m. and completed by Staff C LPN (licensed practical nurse) identified an unwitnessed fall in the resident's room. The report revealed at 5:15 a.m. the resident's alarm activated and staff observed the resident sitting on the side of the bed. The resident needed the bathroom. The resident did not use the call light. Staff left the resident seated at the bedside to get a mechanical lift located across the hall. When staff arrived back to the room with the lift, staff found the resident face down on the floor on their stomach with blood

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 689	Continued From page 20	F 689		

under her head. Staff used a bath blanket for the blood and to apply pressure. The nurse aide called 911. The resident said her head hurt and denied other pain. The ambulance arrived at 5:32 a.m. EMTs (emergency medical technicians) applied a back board and collar before placing the resident on the gurney. At that time, staff observed 2 lacerations to the right side of the resident's head and the resident's right eye turning purple. The largest of the lacerations appeared circle shaped and about the size of a nickel. Abrasions were observed to both knees. The description of the incident was: resident needed the bathroom. The resident's mental status described as: oriented to person and place and in the notes section, Staff C documented the resident attempted to ambulate independently when staff went to get the EZ stand mechanical lift. The report identified the resident's predisposing physiological factors as: gait imbalance and impaired memory. The predisposing situational factors identified as: ambulating without assistance. The report asked if this predisposing factor contributed to the fall and Staff C answered "YES". The report identified the resident as too weal to transfer and ambulate without assistance. The report did not identify when staff last saw and/or toileted the resident or if the call light was available.

An Emergency Department (ED) report dated 7/18/21 at 6:32 AM revealed the Resident #10 was found on the floor in his/her room at the facility with head face down and presented to the ED with lacerations and a small hematoma on right forehead, ecchymosis and swelling to right eye, ecchymosis and swelling on bilateral knees, and was only able to verbalize pain and mumbled incoherently. The ED staff were unsure of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 689	Continued From page 21	F 689		

resident's neurological baseline, but at the time of the exam, the resident was not oriented to self, time or place.

The ED report dated July 18 at 7:50 AM indicated that the resident suffered a major injury and ED sent the resident back to the facility with comfort care services.

According to an untimed statement dated 7/18/21, Staff W assisted the roommate of Resident #10 at approximately 5:00 AM on 7/18/21 when the bed alarm sounded from Resident #10's side of the room. Staff W said the resident was in bed and Staff W turned off the alarm and told the resident that staff would be right back to help and continued to assist the roommate. Staff W said that Resident #10 sat up in bed and put his/her feet on the floor. Staff W asked the resident to stay seated while staff went across the hall to get the mechanical lift and the resident responded "okay." Staff W said that upon reentering the room, staff observed Resident #10 lying face down on the floor with blood around her head. Staff W then called for the nurse on duty. When the nurse arrived in the room, Staff W called 911 and the resident transferred to the ED shortly thereafter.

On 7/19/21 at 4:45 PM Staff C LPN identified himself as the nurse on the overnight shift 6:00 PM- 6:00 AM on 7/17/21 when Resident #10 fell. Staff C said that the aide assisted Resident #10's roommate when Resident #10 sat up on the edge of her bed. The aide told the resident to wait while she went to get the lift from across the hallway and would be right back. When the aide came back into the room, the resident was face down on the floor by her bed. Staff C said that he did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 689	Continued From page 22	F 689		

not know why the aide thought she needed the lift because the resident was known to require on staff to assist her.

Staff C revealed three staff worked on the night of 7/17/21 but one aide had to leave at 4:00 AM, leaving just two staff on at the time of the fall. Staff W Certified Nursing Assistant (CNA) went into the room alone while Staff C helped another resident. Staff W was in with the resident and that the lift located in a room across the hallway. Staff C said that they typically have two aides on overnight but they went through a stretch of time with just two staff because of someone calling in sick.

On 7/21/21 at 9:00 AM Staff W CNA stated she worked for a staffing agency and worked at the facility about 10 times before the night of the fall. Staff W said there was report given before the shift started regarding any changes in status or condition of the residents and Staff W did not know of any changes with Resident #10 on 7/17/21.

Staff W said she assisted the roommate of Resident #10 around 5:00 AM on 7/18/21 when the alarm for Resident #10 started ringing. Staff W said she turned the alarm off and told the resident to wait and the resident responded that she would wait. Staff W said the resident always listened and would wait when asked. Staff W said that it would have been good to have another aide there at that moment because it was just two staff on at that time and other call lights were ringing.

Staff W said that Resident #10 laid in bed and said she needed to use the bathroom and sat up

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 689	Continued From page 23	F 689		

on the edge of the bed. The alarm activated again and the resident sat on the bed with feet on the floor and appeared drowsy. Staff W said that the resident responded when asked to wait for the lift.

Staff W stated the last couple of times she worked at the facility, staff told her in shift report that the resident used the mechanical sit-to-stand at night because of increased weakness at night. Staff W said she had used the stand with Resident #10 3 or 4 times before that night. Staff W said she operated the EZ stand alone and did not know facility policy regarding how many staff needed to be present when using the stand. Staff W said she felt comfortable using the EZ stand alone with Resident #10 because the resident could stand up straight on the platform.

According to the following nursing notes the resident experienced some anxiety and restlessness leading up to the fall:

a) 6/29/21 at 10:06 AM trying to crawl out of bed and self-transfer
b) 6/29/21 at 9:49 PM restless and trying to leave the facility
c) 6/30/21 at 9:37 PM restless tonight
d) 7/4/21 1:16 PM restless
e) 7/11/21 at 11:23 AM attempting to stand up from the wheel chair
f) 7/11/21 at 6:28 PM increased anxiety, attempting to take off clothes
g) 7/15/21 at 4:47 PM increased anxiety and restlessness
h) 7/17/21 at 10:32 AM restless

On 7/20/21 at 10:30 PM Staff Q LPN stated Resident #10 could sit up in bed but was not strong enough to stay up on her own. Staff Q said

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 689	Continued From page 24	F 689		

that he/she would not have turned his/her back on the resident or let the resident alone sitting on the side of the bed. Staff Q said that the resident would listen when given directives, but recently needed the use of the mechanical lift for transfers because of increased weakness.

On 7/20/21 at 9:17 AM the Director of Nursing (DON) stated the facility implemented what she called a "falling star" system where they put a star on the door frame to alert staff that the resident in that room could not be left in a wheel chair unattended in their room. The DON said they did this because "obviously we have a fall problems." The surveyor asked if she thought the number of falls may be related to not having enough staff. She acknowledged that it could be and said that they have trouble getting people to work the overnight shift. She said when Resident #10 fell they had just two people here for a couple of hours because someone called in, unable to come to work. When asked why the aide went to get the lift when the care plan indicated Resident #10 was a transfer assist of one, the DON said she did not know and she asked Staff C LPN and he said maybe it was because the resident had recently become weaker.

On 7/27/21 at 10:20 AM the DON said that they do not have a policy on the use of the EZ stand but per corporation guidelines, all mechanical lifts must be an assist of 2 people.

A Major Injury Determination Form signed by the physician 7/18/21 at 7:50 a.m. informed the physician the resident self transferred an fell hitting the floor. The form identified the resident used a lift at night due to weakness and 1 to 2 staff assistance during the day. The physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 689	Continued From page 25	F 689		

documented the injury the resident sustained from the fall was a large intraparenchymal hemorrhage in the right cerebral hemisphere and identified the injury as a MAJOR injury.

The hospital report dated 7/18/21 revealed a CT performed showed a large intraparenchymal hemorrhage in the right cerebral hemisphere, predominantly in the right parietal lobe with associated local mass effect, resulting in effacement of the right lateral ventricle and approximately 1.6 centimeter (cm.) shift. The laceration to the right forehead was repaired with sutures. X-rays of the knees were done. The report identified the resident as awake but not oriented in any sphere. The resident had a hematoma to the right forehead, ecchymosis and swelling to the right eye. The physician could not examine the eye due to inability to open the eyelid because of ecchymosis and swelling. The left pupil was fixed and non reactive to light. Strength and sensation could not be assessed since resident could not follow commands.

The resident expired 7/22/21.

2. An MDS dated 7/8/21 assessed Resident #15 with a BIMS score of 15 (no cognitive impairment). The resident required extensive assistance of one staff for transfers, locomotion, dressing and toileting. According to the census tab in the electronic chart, Resident #15 admitted to the facility on 6/11/21.

The care plan for Resident #15 dated 6/11/21 included a focus area of risk for falls due to a history of a cerebrovascular accident (CVA) with right sided weakness. The care plan identified the resident with an activities of daily living deficit due

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 689	Continued From page 26	F 689		

to CVA and limited range of motion of the right hand and elbow and a contracture to right shoulder. The care plan included diagnoses of: hemiplegia and hemiparesis following CVA, muscle weakness and chronic kidney disease.

An incident report dated 7/31/21 at 7:36 PM, at approximately 4:30 PM on that date, revealed a CNA reported to the registered nurse (RN) on duty that Staff BB environmental aide (EA), attempted to transfer Resident #15 and the resident fell. The report revealed the resident told the RN that the EA attempted to transfer her from the recliner to the wheelchair and the EA's feet got tangled up and the resident was lowered to the floor.

On 8/2/21 at 11:50 AM a nurse from the office of the primary care physician said they did not receive notification of a fall over the weekend for Resident #15. The nurse said communication regarding a fall without injury would typically come in via fax and she was not aware of any, but would check with the doctor to see if he got a call. At 11:57 AM the physician's nurse called and reported the doctor did not receive notification of a fall for Resident #15 over the weekend.

On 8/2/21 at 1:12 PM the Director of Nursing (DON) said she had been informed of the fall over the weekend but she did not know that the doctor nor the family did not receive notification. She said when she saw the incident report on Monday morning she then contacted the family. The DON said that Staff BB came in on Monday morning and a received a disciplinary action report.

On 8/2/21 at 1:35 PM Staff DD (business

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 689	Continued From page 27	F 689		

manager) stated the only corrective action form completed for Staff BB completed on that day and she had no other incidences of concern.

On 8/2/21 at 2:18 PM Resident #15 was hesitant to talk to about the fall. She said it was nothing and she did not get hurt. The resident said that she activated her call light, but she did not want to give any details of the incident.

On 8/2/21 at 12:20 Staff EE RN stated she worked for an agency but worked at the facility for about a month. Staff EE stated she passed medications on Saturday afternoon, 7/31/21 when around 4:30, a CNA came to the nurses station and asked for the vitals equipment. She asked why the CNA needed it she said an EA staff transferred a resident and the EA got her feet tangled up and the resident fell. Staff EE said she went along and completed an assessment on the resident and found no injuries and vitals within normal limits. Staff EE remembered the resident expressed concern the EA would get in trouble.

Staff EE said she notified the Assistant Director of Nursing (ADON) and was told that since the EA lowered the resident to the floor, she would not count it as a fall. Staff EE said that the ADON's directions were to just put in a nursing note that the resident had been lowered to the floor. Staff EE said that she was concerned that an incident report risk management form should have completed so she consulted with Staff C who arrived for the 6:00 PM shift. Staff EE said that Staff C recommended she go ahead and complete an incident report so Staff EE decided to complete one. Staff EE said the ADON would talk to the DON about the incident and Staff EE thought they would then decide about doctor and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 689	Continued From page 28	F 689		

family contact.

On 8/3/21 at 9:17 AM Staff C LPN stated he arrived for the evening shift on 7/31/21 and Staff EE informed him of the directive she received to just enter a progress note regarding the fall. Staff C advised Staff EE to complete a risk management form and assisted with that task. Staff C said that he advised that if it were him, an incident report would be filled out.

On 8/2/21 at 3:00 PM Staff GG CNA said he charted in the nurses station when Staff E Certified Medication Aide (CMA) asked him to go help Staff BB EA with Resident #15's transfer. Staff GG stated Staff BB helped around the facility throughout the shift and he thought Staff BB was a CNA. When Staff GG got to the resident's hallway, he saw Staff BB in the hallway crying, saying she didn't know what to do. Staff GG went into the resident's room and observed the resident on the floor by her recliner. The resident's bottom was on the floor and she leaned up against the wheel chair. Staff GG said he/she went to get the vitals equipment and when he/she got back Staff BB was gone and the resident was alone in the room. The resident told him that she had been lowered to the floor and was not hurt.

Staff GG said he received report at the beginning of the shift that the resident required assistance of one or two staff with pivoting but the resident had some increased weakness recently. Staff GG said he didn't know why the EA would have gone to the resident and tried to help since there were two other CNA's present. He didn't have any knowledge of any other resident transfers completed by Staff BB.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 689	Continued From page 29	F 689		

On 8/2/21 at 12:30 PM Staff FF CNA said she worked on 7/31 when Resident #15 fell but assisted other residents at the time and did not know anything about the details of the fall. Staff FF said she worked in the hallway where Resident #15's room was and did not know why the EA would have needed to assist or if the resident's call light had been on at the time of the fall.

On 8/2/21 at 1:58 PM, the ADON said that she received a phone call on Saturday night 7/31/21 that Resident #15 had been lowered to the floor and the nurse asked what kind of a note she should complete. The ADON said she told the RN to do a detailed progress notes and follow protocol. The ADON identified protocol for this type of incident as call the doctor and the family and complete a follow up skin assessment. The ADON said that she was not sure about time of day it was when she got the call and she talked to the DON later sometime on Saturday night. The surveyor asked if she usually get calls from nurses asking what to do in case of a fall, the ADON said sometimes they want guidance especially when it's an agency nurse. The ADON said she asked Staff EE if it was a standard fall or just a lowering to the floor. The surveyor what the difference was in the documenting of a fall verses lowering to the floor and the ADON said that both would require a detailed progress note, incident report and notification of family and the doctor. The ADON said Staff EE RN worked at the facility for about 2-3 weeks and she would have expected that an RN would have an understanding of the follow up assessments to complete and the incident report risk management process.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 689	Continued From page 30	F 689		

The ADON stated staff are taught upon hire to fill out an incident report for falls, unwitnessed falls, elopements, skin issues or unusual events. When asked if she could provide copy of this education, the ADON said that it is verbal education only so there was no documentation of the details of that education. She said that agency staff are provided the same education as permanent staff.

The ADON said that she did not have any knowledge of the EA transferring any other residents.

On 8/2/21 at 3:51 PM a family member for Resident #15 said the resident didn't reside at the facility very long but the family member thought everything was okay so far. The family member identified receiving a message from the DON that morning that staff lowered Resident #15 to the floor on Saturday evening. The family member looked at their phone and said the call came in at 12:03 PM.

On 8/2/21 at 4:05 PM Staff BB EA stated she discussed the incident with the DON that morning around 11:30 AM. Staff BB said she entered the resident's room around 4:30 on 7/31/21 and offered to help the resident transfer from the recliner to the wheel chair. Staff BB said she moved the wheel chair close to the recliner and the resident stood up and started moving herself around to the wheel chair with her back to the night stand next to the chair. Staff BB grabbed the resident's upper arm, and while trying to get closer to the resident, the EA tripped over her own feet and fell off balance and leaned into the resident, causing the resident to lose her balance and fall. Staff BB said she then grabbed the residents back and lowered her down to the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 689	Continued From page 31	F 689		

The resident did not have a gait belt on. Staff BB was not sure if the call light activated prior to the incident. Staff BB sent a text to Staff E and asked for some help, that's when Staff GG came down the hallway to see what she needed. Staff BB said she stayed with the resident while Staff GG got the vitals' equipment. Staff BB said she received training on EA and had no training on resident care.

On 8/3/21 at 10:38 AM Staff E stated was not in the room when Resident #15 fell because she helped with a different resident. Staff E said she did not have any interaction with the resident earlier in the shift and did not know if the resident activated her call light. Staff E said she got a text message from Staff BB to come help in the room of Resident #15. She said that she was busy so then went to Staff GG and asked him to go assist. Staff E maintained that she had not knowledge to Staff BB transferring other residents.

3. A Minimum Data Set (MDS) dated 6/4/21 assessed Resident #8 with a Brief Interview for Mental Status (BIMS) score of 5 (severe cognitive deficit). The MDS showed the resident required limited assistance one staff for transfers, toileting and walking. The MDS indicated the resident used a motion sensor and an elopement alarm to help monitor her activity.

The care plan updated on 2/13/21 revealed Resident #8 had dementia and could transfer and ambulate independently with the use of a walker. The care plan identified the resident with self-care deficits and required staff to assist with activities of daily living.

On 7/14/21 at 11:45 AM Staff C LPN revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 689	Continued From page 32	F 689		

Resident #8 exited the building unattended around 6:00 PM at the beginning of Staff C's shift. Staff C said the resident got to the corner of the building. Staff C revealed door alarms sounded from hallway 2, but the elopement system did not engage the magnet to prevent the door from opening.

The elopement system should activate an alarm and engage the door magnet to prevent a dementia patient from leaving the facility without staff knowledge.

On 7/19/21 at 9:54 AM the surveyor asked the DON if Resident #8 left the building without staff knowledge in May. The ADON and Staff V RN were also present. The DON stated the resident went outside but it was not an elopement and there was no incident report completed because the door alarm sounded and Staff M, LPN walked the resident outside, just like residents are taken outside for activities.

On 7/19/21 at 9:57 AM Staff M LPN said the door alarm activated and she saw Resident #8 open the door from down the hallway. She said that the door magnet did not engage as it should have so Resident #8 got the door open, she got out onto the patio. When asked if she documented the incident, Staff M said she didn't remember. When asked if this type of incident would normally require an incident report and documentation in the nursing note, she said that it should since the door magnet did not function properly.

On 7/20/21 at 7:50 AM the surveyor asked Staff M found the date or documentation of the incident with Resident #8 and she said that she had not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 689	Continued From page 33	F 689		

A MDS dated 5/20/21 assessed Resident #7 with a BIMS score of 6 (severe cognitive deficit). The MDS revealed the resident required extensive staff assistance for toileting and was independent with walking and transferring. The MDS included diagnoses of: dementia, diabetes mellitus and unspecified hearing loss and identified the resident used an elopement alarm daily.

An elopement risk assessment completed on 6/8/21, identified Resident #7 at high risk for elopement and used an elopement system bracelet to help monitor the resident's movements.

A nursing note entered on 5/24/21 at 12:49 PM for Resident #7 revealed the elopement system bracelet checker not functioning due to need for new battery, battery replaced and device then functioned.

On 7/14/21 at 5:40 LPN Staff Q revealed Resident #7 exited the building unattended on a Sunday night in June. The facility experienced trouble with the elopement monitoring system and the magnet that prevented the door from opening did not work.

On 7/19/21 at 7:09 AM Staff G LPN reported the night that Resident #7 got out unattended, Staff G worked in the nursing station/dining area and the door alarm sounded. Staff G identified the DON as in the building at the time and the alarm panel indicated that the East door opened. Staff G went down the 400 hallway and did not see Resident #7. Staff G then went to the North side of the building and saw the DON with the resident as she brought the resident back inside. Staff G said

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 689	Continued From page 34	F 689		

the elopement device on Resident #7 did not engage the magnet on the door as designed.

On 7/15/21 at 8:52 AM the maintenance manager (MM) showed the surveyor where the location of the magnets at the top of the door and how they engage when the elopement device got close. The MM said the magnets got rusty in the past so he sanded them off to make a connection. The MM said he's only sanded them one time and he's worked in the facility since October 2020. MM couldn't say exactly when he sanded them and he did not keep a log of when he fixes things.

On 7/15/21 at 11:30 AM DON said that she called Feld Security about the door magnets and asked about the safety feature that when the door is pushed over and over again it opens. She said Feld Security stated that what may be happening is that when it's pushed over and over, the magnets become misaligned and that is why it may come open but this would be a malfunction, not a safety feature.

On 7/13/21 at 8:40 AM the DON got an elopement monitoring bracelet device from her office. She first tested the bracelet to a meter that staff used to test on the residents while they wore the bracelets. The meter indicated that the bracelet was in working order. The DON then took the device to the door at the end of hallway one and as she got closer to the alarm on the wall the light did not change on the panel and the magnets did not engage. The DON said it wasn't working so she was going to go back to her office and get a different bracelet.

At that point, Staff B CNA came out of a resident's room with Resident #4 who wore an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 689	Continued From page 35	F 689		

elopement bracelet. The surveyor asked Staff B to walk the resident closer to the door. As she got close to the panel on the wall, a light changed to red, but since the latch on the door did not latch properly, the magnets did not engage and the door could be pushed open. The DON, ADON and Administrator were present and all said they did not know of the door not latching properly.

On 7/15/21 at 7:05 AM the DON denied ever having any other elopement device bracelet give a false reading on the monitor. When asked if the staff still used this device to determine the function of the bracelets residents wore, she said yes it was still in use.

On 7/15/21 at 10:14 AM DON said that they continued to use the same device on the residents' elopement bracelets and the staff were not moving the resident toward the door to verify that it is working.

On 7/22/21 at 11:00 AM the surveyor asked the DON about staff documenting "DONE" when there was a discrepancy between what the tester saying it functioned and then going to the door and finding that it didn't work. She said the service said that can happen due to placement on the resident, like under a sock, vibration to system, weather related, dryer vibrations. The Don stated she felt confident with the system and stated nothing was 100% fool proof. She said that they do not have the nurses walk the residents to the door to double check function.

4. A review of charts revealed that the elopement monitoring bracelets continued to be used on three resident past the expiration dates.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 689	Continued From page 36	F 689		

a. A MDS dated 5/13/21 assessed Resident #12 with a BIMS score of 4 (severe cognitive impairment). The resident required extensive assistance of one staff for transfers, walking, and toileting and locomotion.

A care plan revised on 2/14/21 showed Resident #12 would wander throughout the facility by peddling in the wheelchair. Staff were directed to check for functioning and placement of elopement bracelet.

A risk assessment elopement dated 5/10/21 at 11:47 PM identified the resident at high risk for elopement, According to the orders tab in the electronic chart, the bracelet was changed for Resident #12 on 7/13/21 at 11:00 PM.

On 7/22/21 the DON provided a copy of a hand-written sheet dated 11/11/20 with a list of residents with bracelets and the expiration dates. The list included: Resident #12 with expiration date May of 2021

b. A MDS dated 5/13/21 assessed Resident #14 with a BIMS score of 3 (severe cognitive deficit). The resident required extensive assistance with the help of one for transferring, walking and toileting.

A risk assessment for elopement dated 5/12/21 at 3:49 PM, identified Resident #14 at risk and able to self-propel in the wheel chair and exhibited exit seeking behavior.

The care plan for Resident #14 revealed the resident wandered through the facility by peddling in the wheelchair. The care plan directed staff to find structured activities for the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 689	Continued From page 37	F 689		

On 7/22/21 the DON provided a copy of a hand-written sheet dated 11/11/20 with a list of residents with bracelets and the expiration dates. The list included: Resident #14 with expiration date of May of 2021

c. Resident #8's MDS dated 6/4/21 assessed the resident with a BIMS score of 5 (severe cognitive deficit). The resident required limited assistance with the help of one staff for transfers, walking, toileting and bed mobility.

A risk assessment for elopement dated 6/28/21 at 3:24 PM, revealed the resident not at risk for elopement with a score of 0. The assessment indicated the resident was not independently mobile with or without assistive device. A quarterly nursing assessment dated 6/3/21 at 3:25 PM indicated the resident transferred with limited assistance and could ambulate in her room with the use of a walker and full weight bearing status.

A nursing note dated 7/14/21 at 7:54 AM stated the elopement device for Resident #8 expired and staff placed a new device on the left wrist.

On 7/22/21 the DON provided a copy of a hand-written sheet dated 11/11/20 with a list of residents with bracelets and the expiration dates. The list included: Resident #8 with expiration date of June of 2021.

On 7/20/21 at 9:17 AM the surveyor asked the DON if she could get the surveyor a list of elopement bracelet devices changed and the expiration dates of the removed bracelets. The DON said they did not change out any elopement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 689	Continued From page 38	F 689		

bracelets the past week, they just changed the location of the bracelet on residents because after talking to the security company they said a change in location may help with the device detection. The surveyor asked her if she talked to the security company about the tester giving a false reading the previous week. She said she did not talk to him about that concern.

On 7/21/21 at 1:17 PM in an interview with the DON and LPN Staff V present, the surveyor directed the DON to a nursing note that indicated that the elopement bracelet for Resident #7 expired so it was being changed. The surveyor reminded her that a list of expired bracelets had been requested and she indicated that the bracelets had not expired but locations changed. She then said that some actually expired but she did not know where the list of expired bracelets was at that time.

5. When the surveyor entered the facility on 7/13/21 at 7:45 AM Staff X from housekeeping was vacuuming in the front sitting area. Staff X opened the door for this worker and went to get a nurse to do the screening. Staff M LPN completed the screening and then this worker asked her to push open the door with an alarm on it. She identified the alarm panel in the nurses station/dining area, and acknowledged an alarm could not be heard when the door opened. The surveyor went with Staff M to the alarm panel in the dining room area and she flipped a switch that had been turned off. Staff X said they would do this sometimes when the housekeeper is vacuuming in the front entrance, but she could not say how long it may have been turned off.

On 7/13/21 at 8:10 AM Staff X said that she did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 689	Continued From page 39	F 689		

not turn the alarm off herself.

On 7/13/21 at 2:57 Staff M went with this worker to check a door alarm and asked if it was ever difficult to hear the alarm when staff are in rooms with residents. Staff M acknowledged that it is difficult to hear the alarm panel from inside the residents rooms at the end of hallways.

On 7/13/21 at 3:00 PM Staff B Certified Nursing Assistant (CNA) said that she cannot hear the panel door alarm when she is in a room at the end of the hallway with a resident.

On 7/14/21 at 6:15 AM the panel of door alarm switches had a locked case installed. On 7/13/21 at 8:31 AM Staff D, ADON said that it had been installed and just the charge nurse had a key and can turn the alarms off. If someone is coming in and out and they want to temporarily turn it off, there was a black button to hold down during that time.

On 7/26/21 at 8:50 Staff V, LPN went with the surveyor to two resident rooms at the end of hallway 3 and closed the doors and had Staff M set off the door alarms. The alarms could be very faintly heard. From room #48, with the television on the alarm could be very faintly heard. From room #17 with the air conditioner fan running and door closed, the alarm could not be heard.

6. On 7/13/21 at 8:40 AM the surveyor went to the exit door at the end of hallway one with the Administrator, DON and ADON. At that time, observation showed the latch on the fire door was stuck open and that the latch did not latch properly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 689	Continued From page 40	F 689		

On 7/14/21 at 1:25 PM Staff S Registered Nurse (RN) said that the door at the end of hallway one had not been latching properly for over 6 months and she told the DON it did not latch and that the elopement bracelets did not work properly.

On 7/14/21 at 3:03 PM Staff J, LPN said she told the DON, ADON and a representative from the corporate office 5 months previously that the door did not latch correctly.

On 7/15/21 at 8:52 MM said that he sprayed the latch with WD-40 and it was working. Staff V RN present for this conversation

7. On 7/20/21 at 10:20 PM this worker was able to enter from the front door of the facility and push the green button to enter without the alarm sounding. Upon entrance, Staff Y CNA, Staff Z CNA and Staff AA CNA sat in the dining room at a table chatting. There were no residents in the dining room at the time. The surveyor asked for someone to complete screening and they said that the nurse on duty was doing rounds. The surveyor then went to the two medication carts in the dining room and found them both unlocked.

Staff Q LPN then came up the hallway and continued rounds. At 10:30 PM the surveyor alerted the LPN to the fact that the medication carts were not locked. He said that they had just done the medication check with the offgoing nurse so he hadn't gotten back to lock it again.

8. A MDS dated 6/9/21 assessed Resident #11 with a BIMS score of 1 (severe cognitive deficit)s. The MDS showed that the resident required limited assistance with the help of one staff for bed mobility, transferring, walking, locomotion

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 689	Continued From page 41 and extensive assistance with the help of one for toileting. On 7/20/21 at 11:23 PM Resident #11 was in the bathroom on the toilet. Staff Q asked why he didn't wait for help and the resident responded that he couldn't wait. There was a trail of urine on the floor from his bed to toilet. Staff Q then alerted the three CNA's in the dining room area to assist the resident. Staff Q said that Resident #11 had a bed alarm when he was first admitted but for some reason it had been discontinued. An admission assessment dated 7/3/21 at 2:59 PM contained a care plan focus area of risk for falls addendum. The focus area revealed the resident became fatigued easily and would attempt to transfer without assistance. The assessment indicated the intervention of a pull tab alarm would be added to the care plan to alert staff that he was trying to get up without assistance. Staff were directed to ensure the alarm was on and functioning. On 7/21/21 at 6:30 AM LPN Staff H said that Resident #11 no longer used an alarm because he hadn't been trying to transfer without help. On 7/21/21 at 1:17 PM the DON said that the expectation is that the medication cart is kept locked if the nurse is not within eyesight of the cart. She said that she was not aware the Resident #11 had been getting up on his own and would look into getting the bed alarm reestablished.	F 689		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 755	Continued From page 42	F 755		

§483.45 Pharmacy Services
The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff and pharmacy interviews, the facility failed to establish an accounting system for medications not used. Resident #9 received Coumadin, a high risk medication that required close monitoring of side effects. The resident suffered an episode of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 755	Continued From page 43	F 755		

internal bleeding and when investigated, there was a discrepancy between the total number of milligrams of Coumadin the resident used based on pharmacy charges versus and what was ordered. Six milligrams of Coumadin were billed for and unaccounted for according to the April 2021 medication administration record (MAR). Due to inaccurate accounting of the medication it was unable to be determined if the resident received the Coumadin or what happened with the 6 mg. unaccounted for. The facility reported a census of 36 residents.

Findings include:

A Minimum Data Set Dated 6/10/21 assessed Resident #9 with a Brief Interview for Mental Status (BIMS) score of 15 (no cognitive impairment). The MDS identified the resident as totally dependent and required two staff for toileting and transfers. The MDS revealed diagnoses that included: chronic obstructive pulmonary disease (COPD), muscle weakness, obesity, dependence on supplemental oxygen, Alzheimer's disease and anxiety disorder.

The care plan for Resident #9, initiated on 11/29/20, included risk for falls related to a seizure disorder. The care plan directed staff to monitor for medication side effects and environmental hazards to prevent falls. Entries on the care plan on 5/22/21 included references to the facility's attempts to transfer the resident to other facilities that declined due to behaviors. The care plan updated on 11/29/20 included interventions to monitor for side effects of Coumadin therapy such as easy bruising, bleeding, nausea, vomiting, stomach pain, red or brown urine, joint pain and back/bloody stools.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 755	Continued From page 44	F 755		

A fall risk assessment dated 4/1/21 and entered on 4/24/21 revealed the resident at high risk for falls due to use of diuretics, antiseizures, antihypertensive and psychotropic medications. The assessment showed the resident as continent with complete control, loss of balance while standing, strays off the straight path of walking, uses an assistive device and decreased muscle coordination.

A physician note dated 4/21/21 (no time documented) revealed Resident #9 seen by a nurse practitioner (NP) at the nursing home due to hip pain and a hematoma that appeared to increase in size. The NP evaluated the resident in bed and found the resident exhibited pain with palpation of bruised areas and left hip bruising that extended along the leg and to the knee. The NP also found the resident with bruising from the labia area around to the buttocks. The NP then decided to send the resident to the emergency room (ER) for further examination.

According to information from the United States National Library of Medicine and downloaded on 8/2/21 at 7:47 AM from; https://medlineplus.gov/lab-tests/prothrombin-time-test-and-inr-ptinr/, the prothrombin time (PT) laboratory test evaluates for blood clotting and the PT time is expressed as an International normalized ratio (INR).

The Laboratory reports from Manning Regional Healthcare Center (MRHC) showed a therapeutic range for an INR test as 2.0-3.0 and a high risk level as 2.5-3.5.

The MRHC lab reports on:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 755	Continued From page 45	F 755		

a) 4/9/21 at 9:37 AM INR 3.9
b) 4/14/21 at 7:11 AM INR 3.6
c) 4/21/21 at 7:21 PM INR >4.0

A lab report from Mercy One on 4/21/21 at 7:20 PM revealed an INR of 11.6 (critical high).

A hospital discharge summary dated 4/26/21 at 10:14 AM showed Resident #9 admitted on 4/21/21 after a fall with head injury. The report identified the resident with a large left lower extremity hematoma, subdural hematoma, severe anemia requiring 2 units of packed red blood cells and supratherapeutic INR. The physician treated the critical INR on admission with vitamin K (for clotting) and a head CT (computerized tomography) obtained on 4/23/21 showed a small subdural hematoma.

According to the Medication Administration Record (MAR) for April 2021, Resident #9 received Coumadin 3.5 milligrams (mg) daily from April 1 through April 8th for a total of 28 mg.

On April 9th the INR measured 3.9 and the physician ordered a change to Coumadin 3 mg on Tuesday, Thursday and Saturdays, and 3.5 mg on Monday, Wednesday, Friday, and Saturdays, and to hold the dose on the 9th.

According to the April Medication Administration Record (MAR), the resident refused the Coumadin medication on April 6th (3.5 mg).

On the 10th received 3 mg 11th 3.5 mg., 12th 3.5 mg, 13th 3 mg, 14th 3.5 mg, 15th 3 mg, 16th 3.5, 17th 3 mg, 18th 3.5, 19th 3.5 mg and 20th 3 mg. for a total of 36 mg from the 4/11/21 through

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 755	Continued From page 46	F 755		

4/21/21 when the resident went to the hospital and did not get the medication.
According to the MAR, the resident received 64 mg of Coumadin in the month of April.

According to the Manning Pharmacy documentation of Coumadin charged for the following during the month of April 2021:
8-2.5 mg tabs
14- 1 mg tabs
12- 3 mg tabs
For a total of 70 mg sent
This left a discrepancy of 6 mg unaccounted for.

A nursing progress note entry dated 4/16/21 at 5:30 p.m. revealed an order for Coumadin entered. Coumadin tablet 1 mg--give 0.5 tablet by mouth one time a day every Monday, Wednesday, Friday and Sunday in addition to 3 mg. for a total of 3.5 mg.

A nursing note dated 4/16/21 at 6:28 PM and documented by Staff K revealed she changed the order for the Coumadin in the computer to match the cassette of medicine that arrived from the pharmacy. The extra dose of Coumadin was in the xxx window in the bottom.

On 7/22/21 at 2:20 PM LPN Staff K LPN (licensed practical nurse) identified her 6:28 PM entry on 4/16/21 as regarding a dose of Coumadin came in the cassette unsplit and it didn't match the order in the computer for what the resident should received so she changed the order and split one tab of Coumadin for that days dose, but she couldn't remember what the dose was or any other information. Failure to document what the dose was or other information, failed to ensure accurate acquiring, receiving, dispensing, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 755	Continued From page 47	F 755		

administering of the Coumadin.

On 7/26/21 at 1:05 the pharmacy technician (PT) said that she would credit for returned medications in the following month, except for Coumadin because orders change so frequently so she will adjust the number billed at the end of each month. She stated she only billed for doses the resident used.

On 7/27/21 at 10:00 AM the pharmacy technician (PT) provided medication labels that showed how the 3.5 mg of Coumadin was delivered in April. The label directed staff to give a 3 mg tab with 0.5 mg. She said she must have split the 1mg tabs for the doses needed from 4/9-4/21. She remembered Staff K LPN called and informed her of a wrong dose sent over and she would have to split a tab to get to the 3.5 mg needed for that day. She said that she would have sent over the corrected dose the next day but couldn't remember for sure because it had been a while ago. Failure to accurately document exactly what she sent did not ensure accurate acquiring, receiving, dispensing, and administering of the drug.

After the change in order on 4/9/2, staff entered the order on the MAR as: Coumadin 3 mg on Tuesday, Thursday and Saturday. Coumadin 3 mg give 3.5 mg one time a day on Monday, Wednesday, Friday and Sunday, give 2.5 mg tab with a 1 mg tablet to equal 3.5 mg. Staff K changed this order to read give 3.5 mg every Monday, Wednesday, Friday and Sunday give 3.0 mg tab with a 0.5 mg tablet to equal 3.5 mg.

On 7/27/21 at 10:00 AM the PT said that she did not have documentation of the extra Coumadin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 755	Continued From page 48 not used in the month of April for Resident #9. Failure to have this information showed failure of accounting of Coumadin doses. On 7/22/21 at 12:59 PM Staff H LPN said staff placed unused medications in a basket in the medication room and the pharmacy technician picks up those medications when she brings in the new cassettes for the week. She said there was not a documentation process for unused medications returned to the pharmacy. On 7/26/21 at 11:35 AM the Director of Nursing (DON) said that she thought they only accounted for narcotics delivered from and returned to pharmacy.	F 755		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 842	Continued From page 49	F 842		

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 842	Continued From page 50	F 842		

and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews with staff and family, the facility failed to provide adequate documentation of unusual incidents for 2 of 15 residents reviewed. Residents #7 and #8 exited the facility unattended and there was no record of these events. The facility reported a census of 36 residents.

Findings include:

1. A Minimum Data Set (MDS) dated 6/4/21 assessed Resident #8 with a Brief Interview for Mental Status (BIMS) score of 5(severe cognitive deficit). The MDS showed the resident required limited assistance with the help of one staff for transfers, toileting and walking. The MDS indicated the resident used a motion sensor and an elopement device/alarm to monitor her activity.

The care plan updated on 2/13/21 indicated Resident #8 had dementia and able to transfer and ambulate independently with the use of a walker. The care plan identified the resident with self-care deficits and required staff to assist with activities of daily living.

2. A MDS dated 5/20/21 assessed Resident #7 with a BIMS score of 6 (severe cognitive deficit). The MDS showed the resident required extensive assistance of one staff for toileting and was independent with walking and transferring. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 842	Continued From page 51	F 842		

MDS included diagnoses of: dementia, diabetes mellitus and unspecified hearing loss and stated that the resident used an elopement alarm daily.

An elopement risk assessment completed on 6/8/21 identified Resident #7 at high risk for elopement and the facility used a elopement monitor bracelet to help monitor his movements.

On 7/13/21 at 7:05 AM Staff G Licensed Practical Nurse (LPN) said she knew of two residents left the building unattended and they were: Resident #7 and Resident #8. Resident #7 left the weekend of the 20th of June. She worked that evening and Resident #7 got out of the East door and was found on the North side of the building. Staff G said that the incident with Resident #8 occurred around end of May.

On 7/14/21 at 3:03 PM Staff J LPN stated she heard Resident #7 got outside unattended but didn't get too far. She said the Director of Nursing (DON) knew of the incident because, after the incident, she put up a Stop sign on the exit door to help detour the resident.

On 7/13/21 at 7:43 PM Staff L Certified Nursing Assistant (CNA) said that Resident #7 would get up early in the mornings and check doors and try to get them open. Staff J said that there had been times that the resident got out of the facility because the elopement monitor system was not always working. Staff J said that Resident #7 went down hall 4 and exited and Resident #8 exited unattended on the night shift in the previous couple of months.

On 7/14/21 at 11:45 AM LPN Staff C said Resident #8 exited the building unattended

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165627	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MANNING LLC	402 MAIN STREET MANNING, IA 51455

(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 842	Continued From page 52	F 842		

around 6:00 PM as he began the shift. Staff C said the resident got to the corner of the building and the alarms went off hall two but the elopement device system did not engage the magnet which would have prevented the door from being opened. Staff C thought is may have been end of May.

On 7/14/21 at 5:40 Staff Q LPN said that it had been a Sunday night in June when Resident #7 exited the building unattended. He said that they had been having trouble with the elopement monitor system and the magnet to prevent the door from opening did not work.

7/19/21 at 7:09 AM Staff G LPN said the night Resident #7 got out unattended he was in the nursing station/dining area and the door alarm went off. The DON was in the building at the time and the alarm panel indicated the East door opened. Staff G went with staff down the 400 hallway and did not see Resident #7. Staff G then went to the North side of the building and saw the DON with the resident as she brought him back inside.

On 7/19/21 at 9:54 AM Assistant Director of Nursing (ADON) was in with the DON and Staff V RN also present. The surveyor asked the DON to explain the incident in May when Resident #8 exited the building unattended. She said Staff M LPN had been with the resident and there was no incident report or nursing documentation because Staff M walked her out the door.

On 7/19/21 at 9:57 AM Staff M said that the door alarm sounded when Resident #8 exited but the elopement monitoring system did not engage the door so the resident got the door open and onto

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F 842	Continued From page 53	F 842		

the patio. When asked if she wrote a nursing note on the incident, Staff M said that she didn't remember.

On 7/15/21 at 9:50 AM in an interview with the DON and the ADON, the DON stated that if/when a resident exits the building unwitnessed then it's an elopement but, that had "never happened here." She said that if a resident is determined to be high risk for elopement she would expect the staff to bring the resident back inside and then call her. She added that anytime a resident had gotten out it's been witnessed. The surveyor asked if she expected a nurses note or incident report and she said that if the elopement monitoring system did not work as it designed, then yes, she would expect an incident report.

The surveyor asked the DON 6/20/21 the evening Resident #7 exited the East door. She said she remembered that evening and she had been at the facility, standing at the end of the hallway and saw him push the door several times until it unlatched. She said "I saw it so it wasn't an elopement"

The DON said she didn't know if staff documented Resident #7's incident and it would be the responsibility of the nurse on duty. When asked if she had a conversation with either one of the nurses about documenting or filling out an incident report, or family notification, she said she did not have a conversation with nursing and expected the nurse in charge of the resident to fill out a report. She acknowledged incident reports come to her and she did not receive a report about this incident and did not follow up when a report hadn't been submitted.

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F 842	Continued From page 54 According to a facility policy titled Accidents/incidents investigation and reporting, regardless of how minor an accident or incident may be, including injuries of unknown origin it must be documented and an incident report form must be complete on the shift that it occurred.	F 842		