

**Iowa Department of Inspections and Appeals
Health Facilities Division
Citation**

Citation Number: #10568		Date: September 4, 2024		
Facility Name: Accura of Spirit Lake		Survey Dates: August 19, 2024 – August 22, 2024		
Facility Address/City/State/Zip 1912 Zenith Avenue Spirit Lake, IA 51360		DC		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

58.43(2)	<p>481—58.43(135C) Resident abuse prohibited. Each resident shall receive kind and considerate care at all times and shall be free from mental, physical, sexual, and verbal abuse, exploitation, neglect, and physical injury. Each resident shall be free from chemical and physical restraints except as follows: when authorized in writing by a physician for a specified period of time; when necessary in an emergency to protect the resident from injury to the resident or to others, in which case restraints may be authorized by designated professional personnel who promptly report the action taken to the physician; and in the case of an intellectually disabled individual when ordered in writing by a physician and authorized by a designated qualified intellectual disabilities professional for use during behavior modification sessions. Mechanical supports used in normative situations to achieve proper body position and balance shall not be considered to be a restraint. (II)</p> <p>58.43(2) Physical abuse includes, but is not limited to, corporal punishment and the use of restraints as punishment. (II)</p> <p>Description: Based on clinical record review, facility record review, staff interviews and facility policy the facility failed to appropriately implement interventions to protect 1 out of 3 residents reviewed from physical abuse, (Resident #71). The facility reported a census of 67 residents.</p>	II	\$500 (Held in Suspension)	Upon Receipt
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Facility Administrator

Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty-five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

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	<p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated 3/24/24 for Resident #71 documented diagnoses of Bipolar disorder, hypertension and diabetes mellitus. The MDS showed the Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment.</p> <p>Review of the facility self report revealed the facility was made aware on 5/3/24 at 3:00 p.m., by Staff A, Restorative Aide and Staff B, Social worker Resident #71 reported Staff C, CNA was rough during a transfer.</p> <p>Interview on 8/21/24 at 12:05 p.m., with Staff D, Certified Nursing Assistant (CNA) revealed Resident #71 ' s husband had been pushing her down the hallway that morning and she was waving at her to come to her. Staff D could see Resident #71 had been crying and asked her what was wrong. Resident #71 stated don ' t let her come back and take care of me and said the aide that got her up was rough with her. Staff D revealed Resident #71 ' s husband said the aide threw the gait belt across the room. Staff D further revealed she reported the incident to Staff E, Licensed Practical Nurse (LPN).</p> <p>Interview on 8/21/24 at 2:03 p.m., with Staff E, LPN revealed it was around breakfast time when Staff D told her Resident #71 ' s husband was upset and Resident #71 was crying. Staff E explained to her Resident #71 told her the morning aide had been</p>			
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	<p>rough with her and she had been throwing things around in Resident #71 's room. Staff E explained Resident #71 had been tearful that morning when she saw her. Staff E stated she had told Staff F, Registered Nurse (RN), Assistant Director of Nursing (ADON) what was going on when she came in approximately between 8:00 a.m. and 9:00 a.m.</p> <p>Interview on 8/21/24 at 8:52 a.m., with Staff B, Social Worker revealed Staff A, Restorative Aide said Resident #71 was visibly upset and could see she had been crying and was still crying. Resident #71 explained the morning aide had hit her leg on the wheelchair when she was assisting her. Resident #71 kept saying she didn't want anyone to get into trouble but it wasn't right on how she had been treated. Resident #71 cried throughout the interview. After talking with Resident #71 Staff A and Staff B reported it to the Administrator.</p> <p>Interview on 8/21/24 at 10:57 a.m., with Staff A revealed she had seen Resident #71 at the breakfast table and could see she was crying at the table. Staff A revealed Resident #71 was talking to other people so she didn't want to interrupt at that time. Staff A revealed later in the day she heard staff members talking Resident #71 did not have a good day and had an altercation with an aide. Staff A asked Staff B to go and talk with Resident #71. Staff A explained Resident #71 was hesitant at first but explained to her there was an aide that came in her room in the morning and ripped her pajamas off of her and told her it was time to get up. Resident #71 further explained to her that</p>			
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	<p>she threw me into my wheelchair for breakfast and when we came back the aide stood her up and her foot got caught on her walker but she pushed her into her recliner. Resident #71 stated she didn't know what she did to make her mad but she didn't deserve to be treated like this. Staff A revealed she assured Resident #71 she was safe and reported it to the Administrator.</p> <p>Interview on 8/21/24 at 11:57 a.m., with Staff F revealed after she learned about the situation from the Administrator she went and talked to Resident #71. Resident #71 explained she felt the aide was rough and when she was transferring her into her wheelchair she felt like the aide had her over the wheelchair and just dropped her and was rough when she changed her sweatshirt. Staff F revealed she did an assessment and didn't find anything but didn't chart the assessment in the resident's chart.</p> <p>Interview on 8/21/24 at 8:40 a.m., with the Administrator revealed he had been in the building and late that afternoon Staff A and Staff B came to him and stated Resident #71 was upset and after they talked to her it seemed like an allegation of abuse. The Administrator went and talked to Resident #71 and her husband. The Administrator further revealed Resident #71 revealed an aide pushed her walker away from her and she did a rough transfer. The Administrator further revealed he had the ADON talk with Staff C regarding what happened. The facility sent Staff C home pending an investigation.</p>			
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	<p>Review of Resident #71 ' s Progress Notes lacked documentation of the incident from the incident occurring on 5/3/24.</p> <p>Review of the facility provided policy titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy update on 10/19/22 revealed residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.</p> <p>Interview on 8/21/24 at 3:41 p.m., with the Administrator revealed the facility separated and reported the allegation of abuse as soon as they were aware of it.</p> <p>Facility Response:</p>				
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58.43(9)	<p>481—58.43(135C) Resident abuse prohibited. Each resident shall receive kind and considerate care at all times and shall be free from mental, physical, sexual, and verbal abuse, exploitation, neglect, and physical injury. Each resident shall be free from chemical and physical restraints except as follows: when authorized in writing by a physician for a specified period of time; when necessary in an emergency to protect the resident from injury to the resident or to others, in which case restraints may be authorized by designated professional personnel who promptly report the action taken to the physician; and in the case of an intellectually disabled individual when ordered in writing by a physician and authorized by a designated qualified intellectual disabilities professional for use during behavior modification sessions. Mechanical supports used in normative situations to achieve proper body position and balance shall not be considered to be a restraint. (II)</p> <p>58.43(9) Allegations of dependent adult abuse. Allegations of dependent adult abuse shall be reported and investigated pursuant to Iowa Code chapter 235E and 481—Chapter 52. (I, II, III)</p> <p>Description: Based on clinical record review, facility record review, staff interviews and facility policy review the facility failed to report an allegation of abuse to the Iowa Department of Inspections & Appeals and Licensing</p>	II	\$500 (Held in Suspension)	Upon Receipt
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	<p>(DIAL) within 2 hours of an allegation of abuse for 1 of 1 resident reviewed for abuse (Resident #71). The facility reported a census of 67 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated 3/24/24 for Resident #71 documented diagnoses of Bipolar disorder, hypertension and diabetes mellitus. The MDS showed the Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment.</p> <p>Interview on 8/21/24 at 12:05 p.m., with Staff D, Certified Nursing Assistant (CNA) revealed Resident #71 ' s husband had been pushing her down the hallway that morning and she was waving at her to come to her. Staff D could see Resident #71 had been crying and asked her what was wrong. Resident #71 stated don ' t let her come back and take care of me and said the aide that got her up was rough with her. Staff D revealed Resident #71 ' s husband said the aide threw the gait belt across the room. Staff D further revealed she reported the incident to Staff E, Licensed Practical Nurse (LPN).</p> <p>Interview on 8/21/24 at 2:03 p.m., with Staff E, LPN revealed it was around breakfast time when Staff D told her Resident #71 ' s husband was upset and Resident #71 was crying. Staff E said Staff D explained to her Resident #71 told her the morning aide had been rough with her and she had been throwing things around in Resident #71 ' s room. Staff</p>			
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	<p>E explained Resident #71 had been tearful that morning when she saw her. Staff E stated she had told Staff F, Registered Nurse (RN), Assistant Director of Nursing (ADON) what was going on when she came in approximately between 8:00 a.m. and 9:00 a.m.</p> <p>Interview on 8/21/24 at 2:28 p.m., with Staff F revealed she did not know about the situation prior to the Administrator notifying her of what was going on around 3:00 p.m.</p> <p>Review of the facility self report revealed the facility was made aware on 5/3/24 at 3:00 p.m., by Staff A, Restorative Aide and Staff B, Social that Resident #71 reported Staff C, Certified CNA was rough during a transfer.</p> <p>Review of facility intake information the facility submitted a self report on 5/3/24 at 5:04 p.m.</p> <p>Review of the facility provided policy titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy update on 10/19/22 revealed the following information:</p> <p>a. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.</p> <p>b. All allegations of Resident abuse shall be reported to the Iowa Department of Inspections and Appeals not later than two (2) hours after the allegation is made.</p>			
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	<p>Interview on 8/21/24 at 3:41 p.m., with the Administrator revealed the facility reported the allegation as soon as they were aware of it.</p> <p>Facility Response:</p> <p>Description: Based on clinical record review, staff interviews, and facility investigation record review, the facility failed to protect residents from further potential abuse after receiving an allegation of abuse alleging a CNA treated Resident #71 roughly and threw her into her wheelchair. Staff reported Resident #71 had feared the staff member would answer her call light on 5/3/24. The resident reported the concern to a staff member who reported it to the charge nurse who reported it to the Assistant Director of Nursing (ADON). The ADON denied being aware of the situation. The situation occurred before breakfast and the facility didn't start to investigate until after 3:00 PM. The facility identified a census of 67 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated 3/24/24 for Resident #71 documented diagnoses of Bipolar disorder, hypertension and diabetes mellitus.</p>			
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	<p>The MDS showed the Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment.</p> <p>Review of Resident #71 ' s Progress Notes lacked documentation of the incident from the incident occurring on 4/3/24.</p> <p>Interview on 8/21/24 at 12:05 p.m., with Staff D, Certified Nursing Assistant (CNA) revealed Resident #71 ' s husband had been pushing her down the hallway that morning and she was waving at her to come to her. Staff D could see Resident #71 had been crying and asked her what was wrong. Resident #71 stated don ' t let her come back and take care of me and said the aide that got her up was rough with her. Staff D revealed Resident #71 ' s husband said the aide threw the gait belt across the room. Staff D further revealed she reported the incident to Staff E, Licensed Practical Nurse (LPN).</p> <p>Interview on 8/21/24 at 2:03 p.m., with Staff E, LPN revealed it was around breakfast time when Staff D told her Resident #71 ' s husband was upset and Resident #71 was crying. Staff E Staff explained to her Resident #71 told her the morning aide had been rough with her and she had been throwing things around in Resident #71 ' s room. Staff E explained Resident #71 had been tearful that morning when she saw her. Staff E stated she told Staff F, Registered Nurse (RN), Assistant Director of Nursing (ADON) what was going on when she came in approximately between 8:00 a.m. and 9:00 a.m.</p>			
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	<p>Interview on 8/21/24 at 8:52 a.m., with Staff B, Social Worker revealed Staff A, Restorative Aide said Resident #71 was visibly upset and could see she had been crying and was still crying. Resident #71 explained the morning aide had hit her leg on the wheelchair when she was assisting her. Resident #71 kept saying she didn't want anyone to get into trouble but it wasn't right on how she had been treated. Resident #71 cried throughout the interview. After talking with Resident #71 Staff A and Staff B reported it to the Administrator.</p> <p>Interview on 8/21/24 at 10:57 a.m., with Staff A revealed she had seen Resident #71 at the breakfast table and could see she was crying at the table. Staff A revealed Resident #71 was talking to other people so she didn't want to interrupt at that time. Staff A revealed later in the day she heard staff members talking Resident #71 did not have a good day and had an altercation with an aide. Staff A asked Staff B to go and talk with Resident #71. Staff A explained Resident #71 was hesitant at first but explained to her there was an aide that came in her room in the morning and ripped her pajamas off of her and told her it was time to get up. Resident #71 further explained to her that she threw me into my wheelchair for breakfast and when we came back the aide stood her up and her foot got caught on her walker but she pushed her into her recliner. Resident #71 stated she didn't know what she did to make her mad but she didn't deserve to be treated like this. Staff A revealed she assured Resident #71 she was safe and reported it to the</p>			
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	<p>Administrator.</p> <p>Interview on 8/21/24 at 11:57 a.m., with Staff F revealed after she learned about the situation from the Administrator she went and talked to Resident #71. Resident #71 explained she felt the aide was rough and when she was transferring her into her wheelchair she felt like the aide had her over the wheelchair and just dropped her and was rough when she changed her sweatshirt. Staff F revealed she did an assessment and didn't find anything but didn't chart the assessment in the residents chart.</p> <p>Interview on 8/21/24 at 8:40 a.m., with the Administrator revealed he had been in the building and late that afternoon Staff A and Staff B came to him and stated Resident #71 was upset and after they talked to her it seemed like an allegation of abuse. The Administrator went and talked to Resident #71 and her husband. The Administrator further revealed Resident #71 revealed an aide pushed her walker away from her and she did a rough transfer. The Administrator further revealed he had the ADON talk with Staff C regarding what happened. The facility sent Staff C home pending an investigation.</p> <p>Review of the facility provided policy titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy update on 10/19/22 revealed the following information:</p> <p>a. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other</p>				
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	<p>agencies serving the resident, family members or legal guardians, friends, or other individuals.</p> <p>b. All allegations of Resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative.</p> <p>c. Upon receiving a report of an allegation of resident abuse, neglect, exploitation or mistreatment, the facility shall immediately implement measures to prevent further potential abuse of residents from occurring while the facility investigation is in process. If this involves an allegation of abuse by an employee, this will be accomplished by separating the employee accused of abuse from all residents through the following or a combination of the following, if practicable: (1) suspending the employee; (2) segregating the employee by moving the employee to an area of the facility where there will be no contact with any residents of the facility; and in rare instances (3) separating the employee accused of abuse from the resident alleged to have been abused, but allowing the employee to care for and have contact with other residents, only if there is a second employee who remains with and accompanies the employee accused of abuse at all times to supervise all contacts and interactions with the residents.</p> <p>Interview on 8/21/24 at 3:41 p.m., with the Administrator revealed the facility separated Staff C from all residents and sent her home and reported the allegation as soon as they were aware of it.</p>			
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