STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	(X3) DATE SURVEY COMPLETED C	
		165425	B. WING		07/30/202
	ROVIDER OR SUPPLIER HEALTHCARE OF CHER	okee, ilc	921	REET ADDRESS, CITY, STATE, ZIP CODE RIVERVIEW DRIVE EROKEE, IA 51012	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHK CROSS-REFERENCED TO THE APP DEFIGIENCY)	OULD BE COMP
F 000	Correction Date: A COVID-19 Focused was conducted by the and Appeals on 7/27/ Investigation of comp was found to be in co Centers for Disease ((CDC) recommended COVID-19. The follow of the investigation of		F 000		
F 580 SS=D	CFR(s): 483.10(g)(14 §483.10(g)(14) Notifik (i) A facility must imm consult with the resid consistent with this or representative(s) whe (A) An accident involve results in injury and h physician intervention (B) A significant chan mental, or psychosoc deterioration in health status in either life-the clinical complications (C) A need to alter tree a need to discontinue	Jury/Decline/Room, etc.))(I)-(IV)(15) cation of Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident on there is- ving the resident which as the potential for requiring b; ge in the resident's physical, ial status (that is, a h, mental, or psychosocial reatening conditions or); watment significantly (that is, an existing form of erse consequences, or to m of treatment); or	F 580		
LABORATORY	resident from the faci			TTTLE_	(Xig) DA1

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

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

							APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	r				0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		165425	B. WING			C 07/30/2020	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCURA	HEALTHCARE OF C	HEROKEE LLC			921 RIVERVIEW DRIVE		
ACCONT					CHEROKEE, IA 51012		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE	
	****				DEFICIENCY)		
F 580	 Continued From page 1 §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 		F٤	580			
	that is a composite §483.5) must disclo its physical configur locations that comp part, and must spec room changes betw under §483.15(c)(9 This REQUIREMEN by: Based on record re facility failed to notif changes in resident 1 of 4 active resident The facility reported Findings include:	NT is not met as evidenced eview and staff interview, the fy the residents family of ts condition and new orders for nts reviewed, (Resident #2). I a census of 39 residents.					
	1. According to the	Minimum Data Set (MDS)					

If continuation sheet Page 2 of 5

PRINTED: 08/10/2020

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		AND HUMAN SERVICES				FORM	08/10/2020 APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES				TIP	PLE CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN OF CODRECTION		A. BUILDING			COMPLETED		
		165425	B. WING			C 07/30/2020	
NAME OF F	PROVIDER OR SUPPLIER	100420			STREET ADDRESS, CITY, STATE, ZIP CODE	077.	50/2020
ACCURA	HEALTHCARE OF C				921 RIVERVIEW DRIVE		
		-	 		CHEROKEE, IA 51012		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	diagnoses of Cance intracerebral hemore coagulation profile a care. The MDS doo 12 on the Brief Inter indicating no cognit required extensive daily living (ADL's) dressing, and toilet hygiene. The Care Plan date date of 7/28/20, ide impaired cognitive f Resident voices ner desires, as able and resident will be able as health allows thr Interventions includ a. Communicate wi resident/family/care capabilities and ner b. Ask yes/no quest residents needs as c. Encourage reside and as able to.	5/13/20, Resident #2 had er, Anemia, nontraumatic rrhage in brain stem, abnormal and encounter for palliative sumented Resident #2 scored rview for Mental Status (BIMS) ive impairment. The resident assistance with activities of including bed mobility, use, transfers and personal ed 5/16/20 with a goal target ntified Resident #2 with function/forgetfulness at times. eds, feelings, concerns as d as health allows. Goal was a to communicate basic needs ough the review date. led: th the givers regarding residents eds as needed. tion in order to determine the needed. ent to voice needs as chooses	F	580			
	expressions/comm	thought, idea, question or					
	documented the res vasovagal episode staff raised the hoy and nonresponsive to come around and	s dated 6/23/20 at 10:45 a.m., sident had a possible at the end of shower when er lift. Resident became weak to staff. When resident began d have verbalizations and out 3 minutes resident					

Facility ID: IA0424

If continuation sheet Page 3 of 5

PRINTED: 08/10/2020

CENTERS FOR MEDICARE & MEDICALD SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCES (M) PROVIDERUPUERCIAL (R) PROVIDERUPUERCIAL (R) PROVIDERUPUERCIAL (R) PROVIDER PROVIDER (R) PROVIDER PROVINCES (R) PROVIDER PROVIN	DEPARTMENT OF HEALTH AND HUMAN SERVICES							
AND FLAN OF CORRECTION IDENTFICATION NUMBER A BUILDING COMPLETED 186425 B. WING COMPLETED ACCURA HEALTHCARE OF CHEROKEE, LLC STREET ADDRESS, CITY, STATE, ZP CODE SUBMONT STREMENT OF FERCIENCIES STREET ADDRESS, CITY, STATE, ZP CODE PREFIX REGULATORY OR IS CIDENTIFYING INFORMATION) PREFIX PREFIX REGULATORY OR IS CIDENTIFYING INFORMATION) PREFIX F 580 Continued From page 3 Information of the bed pan was not able to have bowel movement and was passing significant gas. Once on the bed pan was not able to have bowel movement and was not able to have bowel movement. Resident trate chronic irregular with attial fibrillation. Feet were purple and cold thres social from shower as well. Resident embarrassed by episode and reassurace provided. Resident stated she had never experienced that before. The Progress Notes dated 7/3/20 at 10:24 a.m., documented resident pack to back Episode passed quickly and resident dressed and assisted inho wheelchair to visit with family on phone at window. No further episodes noted prior to repositioning back to back Episode passed quickly and resident dressed and assisted into the charge to usit with family on phone at window. No further episodes noted in to wheelchair to with with family on phone at window. No further episodes noted in the answer gave out substance with a me, documented resident reposition of pain or disconfort. Resident time: The Progress Notes dated 7/5/20 at 9:14 a.m., documented resident repositions of pain or disconfort. Resident terming is show and steady. No signs or symptoms of pain or disconfort. Resident terming to say more. Resident reference functions.	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0		
166425 B. WNO 07730/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 927 ROVERVEW DRIVE CHEROKEE, I.A. 51012 STREET ADDRESS, CITY, STATE, ZIP CODE 927 ROVERVEW DRIVE CHEROKEE, I.A. 51012 COMMENT OF LASTON SPOLD BERGENOUS D PROFINE CHEROKEE, I.A. 51012 COMMENT OF LASTON SPOLD BERGENOUS COMENT OF LAS							COMPLETED	
NAME OF PROVIDER OR SUPPLER STREET ADORESS, CITY, STATE, 2P CODE ACCURA HEALTHCARE OF CHEROKEE, LLC 21 RIVERVIEW DRVE CHEROKEE, IA \$1012 (M) ID PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECULATORY ON LSC DENTIFYING INFORMATION) D PREFX RECULATORY ON LSC DENTIFYING INFORMATION) D PREFX RECULATORY ON LSC DENTIFYING INFORMATION) D PREFX TAG PROVDERS FULM OF CORRECTION (EACH OFERCINE ACTION SHORE OF MULL BEEN CORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPRIATE DETICATION (EACH OFERCINE) COMPLY TAG F 580 Continued From page 3 urgently thought needed a bowel movement and was possing significant gas. Once on the bed pan weas not able to have bowel movement. Resident blood pressure is very quiet however and heart rate chronic irregular with attail folhilation. Feet were purple and cool but was cold from shower as weall. Resident embarrassed by episode and reassurance provided. Resident stated she had never experienced that before. F 580 The Progress Notes dated 7/3/20 at 10:24 a.m., documented resident to with simily on phone at window. No further episodes noted. The Progress Notes dated 7/3/20 at 1:23 p.m., documented resident repositioned. Resident #2 opened her eyes but did not respond. Breathing is slow and statedy. No signs or symptoms of pain or discomfort. Resting in bed at this time. The Progress Notes dated 7/5/20 at 1:43 p.m., documented a verbal order for Tylenol 650 milligrams suppository rectally very of hours as needed for pain/fever ordered. The Progress Notes dated 7/5/20 at 3:50 p.m., documented hereident resident medications. It			165425	B. WING			-	
ACCURA HEALTHCARE OF CHERORZEE, LLC CHEROKEE, IA 51012 (M) ID (EACH BEFICIENCY WUST & EPRECEDED BY FULL (EACH BEFICIENCY) (PRETX (EACH BEFICIENCY) (EACH BEFICIENCY) (EACH BEFICIENCY) F 580 Continued From page 3 urgently thought needed a bowel movement and was passing significant gas. Once on the bed pan was not able to have bowel movement. Resident blood pressure is very quiet however and heart rate chronic irregular with atriat fibrillation. Feet were purple and cool but was cold from shower as well. Resident embarrassed by episode and reassurance provided. Resident stated she had never experienced that before. The Progress Notes dated 7/3/20 at 10:24 a.m., documented nesident up with assistance with hoyer for shower this a.m. vagal episode noted proferses Notes dated 7/4/20 at 2:32 p.m., documented resident respond. Breathing is slow and steady. No signs or symptoms of pain or discomfort. Resting in bed at this time. The Progress Notes dated 7/5/20 at 1:4 a.m., documented resident is lethargic this moming, able to answer yes/no questions but speech is garbide with attempts to say more. Resident refused morning scheduled medications. The Progress Notes dated 7/5/20 at 1:43 p.m., documented hereident hereideations. The Progress Notes dated 7/5/20 at 1:43 p.m., documented hereident resident is 6	NAME OF F	ROVIDER OR SUPPLIER		T	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
Prečeji rod (EACH CORRECTIVE ACTION SINULD BE Confiction Confiction TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CEACH CORRECTIVE ACTION SINULD BE Confiction F 580 Continued From page 3 F 580 F	ACCURA	HEALTHCARE OF C	HEROKEE, LLC			· · · · · · · · · · · · · · · · · · ·		
urgently thought needed a bowel movement and was passing significant gas. Once on the bed pan was not able to have bowel movement. Resident blood pressure is very quiet however and heart rate chronic irregular with atrial fibrillation. Feet were purple and cool but was cold from shower as well. Resident embarrassed by episode and reassurance provided. Resident stated she had never experienced that before. The Progress Notes dated 7/3/20 at 10:24 a.m., documented resident up with assistance with hoyer for shower this a.m. vagal episode noted prior to repositioning back to bed. Episode passed quickly and resident dressed and assisted into wheelchair to visit with family on phone at window. No further episodes noted. The Progress Notes dated 7/4/20 at 2:32 p.m., documented resident repositioned. Resident #2 opened her eyes but did not respond. Breathing is slow and steady. No signs or symptoms of pain or discomfort. Resting in bed at this time. The Progress Notes dated 7/5/20 at 9:14 a.m., documented resident is lethargic this moming, able to answer yes/no questions but speech is garbled with attempts to say more. Resident refused moming scheduled medications. The Progress Notes dated 7/5/20 at 1:43 p.m., documented a verbal order for Tylenol 650 milligrams suppository rectally every 6 hours as needed for pain/fever ordered. The Progress Notes dated 7/5/20 at 8:50 p.m., documented held resident medications this	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFID	×	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
evening because resident was not making sense with words and showed signs of not being able to	F 580	urgently thought ne was passing signific was not able to hav blood pressure is ver rate chronic irregula were purple and co as well. Resident en reassurance provid never experienced The Progress Note: documented reside hoyer for shower th prior to repositionin passed quickly and into wheelchair to v window. No further The Progress Note: documented reside opened her eyes bu slow and steady. Ne discomfort. Resting The Progress Note: documented reside able to answer yes/ garbled with attemp refused morning sc The Progress Note: documented a verb milligrams supposit needed for pain/fev The Progress Note: documented held re	eded a bowel movement and cant gas. Once on the bed pan e bowel movement. Resident ery quiet however and heart ar with atrial fibrillation. Feet ol but was cold from shower mbarrassed by episode and ed. Resident stated she had that before. s dated 7/3/20 at 10:24 a.m., nt up with assistance with is a.m. vagal episode noted g back to bed. Episode resident dressed and assisted isit with family on phone at episodes noted. s dated 7/4/20 at 2:32 p.m., nt repositioned. Resident #2 ut did not respond. Breathing is o signs or symptoms of pain or in bed at this time. s dated 7/5/20 at 9:14 a.m., nt is lethargic this morning, no questions but speech is ots to say more. Resident heduled medications. s dated 7/5/20 at 1:43 p.m., al order for Tylenol 650 ory rectally every 6 hours as er ordered. s dated 7/5/20 at 8:50 p.m., esident medications this esident was not making sense	F 5	80			

Facility ID: IA0424

If continuation sheet Page 4 of 5

PRINTED: 08/10/2020

		AND HUMAN SERVICES				FORM	: 08/10/2020 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		165425	B. WING	i		C 07/30/2020	
NAME OF I	PROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCURA	HEALTHCARE OF C	HEROKEE, LLC			21 RIVERVIEW DRIVE HEROKEE, IA 51012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 580	documented reside breathing, her oxyg Resident still unabl wants to say and g The Progress Note documented receiv acetaminophen 1,0 day oral (2 tablets of pain, resident is aw The Progress Note regarding the family mentioned new ord During an interview Director of Nursing clinical record lack family was notified in the residents cor	s dated 7/6/20 at 1:51 a.m., ent was having a hard time jen level was 86% on room air. e to make words that she ets frustrated when unable. s dated 7/21/20 at 2:57 p.m., red new orders for 00 milligrams three times a of 500 milligram) for continued vare. s lacked any documentation y notification of any of the lers or changes in condition. r on 7/29/20 at 4:10 p.m. the confirmed and verified the ed any documentation that the of the new orders or changes ndition and it was the nurses to notify the family of	F	580			

Facility ID: IA0424

If continuation sheet Page 5 of 5

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Accura Healthcare of Cherokee 921 Riverview Drive Cherokee, IA 51012 Provider number: 165425

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This Plan of Correction for the Complaint #92308 & Focused Infection Control Survey conducted 07/27-07/30/20 and is submitted as required under Federal and State regulation and statues applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied.

Accept this plan as the facility's credible allegation of compliance, all stated deficiencies will be corrected on or before 08/17/20.

F 580-Notify of Changes (Injury/Decline/Room, etc.)

- 1. Accura Healthcare will ensure all residents' family in our facility, including resident # 2's family will be notified of changes in resident condition and new orders.
- 2. Education provided to nursing staff on 8/3/20.
- 3. Audits conducted by DON or designee twice a week for 6 weeks to ensure this problem does not recur and all family members are notified of changes in condition and new orders.
- 4. This plan of correction is integrated into the Quality Assurance Performance Improvement Program (QAPI).

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