STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165414	A. BUILDING ______ B. WING ______	01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF POMEROY, LLC	303 EAST 7TH STREET POMEROY, IA 50575

(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:02-07-2021 The facility's annual recertification survey and investigation of Complaint #93145-C was conducted ending on 1Il/21 and resulted in the following deficiencies. Complaint #93145-C was not substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F000	F 580 **PLAN OF CORRECTION** Accura Healthcare of Pomeroy denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.	02/07/2021
F 580 SS=D	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 condi ons 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 (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)	F580	1. In continuing compliance with F 580, Accura Healthcare of Pomeroy corrected the deficiency immediately by the DON notifying the physician and family of resident #4 and like residents of significant weight gains. 2. To ensure the problem does not recur all staff were educated on or before 02/07/2021 on physician and responsible party timely notification of condition change by the Director of Nursing. The DON and/or designee will audit daily M-F for 2 weeks and then weekly times 4 weeks and then randomly to ensure continued compliance. 3. As part of Accura Healthcare of Pomeroy's ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF POMEROY, LLC	**303 EAST 7TH STREET POMEROY, IA 50575**

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F 580 SS=D	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 condi ons 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 (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)	F580	1. In continuing compliance with F 580, Accura Healthcare of Pomeroy corrected the deficiency immediately by the DON notifying the physician and family of resident #4 and like residents of significant weight gains. 2. To ensure the problem does not recur all staff were educated on or before 02/07/2021 on physician and responsible party timely notification of condition change by the Director of Nursing. The DON and/or designee will audit daily M-F for 2 weeks and then weekly times 4 weeks and then randomly to ensure continued compliance. 3. As part of Accura Healthcare of Pomeroy's ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF POMEROY, LLC	303 EAST 7TH STREET POMEROY, IA 50575

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F 580	Continued From page 1 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 (8) 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(9)(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 staff interview, the facility failed to notify the physician and family of a significant weight gain for 1 of 3 residents reviewed for nutrition (Resident #4). The facility reported a census of 22 residents. Findings include: A Minimum Data Set (MOS) assessment dated 10/16/20, identified Resident #4 with moderately impaired cognition. The resident required limited staff assistance for eating. The MOS documented the resident with a weight gain of 5% in the last	F 580		

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF PPMEROY, LLC	**303 EAST 7TH STREET** **POMEROY, IA 50575**

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F 580	Continued From page 2 month or gain of 10% or more in the previous 6 months. The resident's diagnoses included: Alzheimer's disease and non.:.Alzheimer's disease. The resident's care plan, with a revision date of 11/6/19, revealed the resident had an alteration in nutrition. A goal, with a target date of 11/21/20, documented no significant weight change during the time frame. Interventions included to keep the physician notified of concerns when needed (dated 11/9/18). A weight record documented the resident weighed: 4/18/2020 191.0 # 4/20/2020 191.0 # 4/25/2020 189.2 # 5/4/2020 195.3 # 5/9/2020 188.0 # 5/18/2020 188.4 # 5/23/2020 189.6 # 5/30/2020 190.2 # 6/20/2020 1906 # 7/18/2020 192.2 # 8/16/2020 198.8 # 8/22/2020 199.2 # 9/12/2020 202.8 # 9/19/2020 204.4 # 9/21/2020 208 # 9/27/2020 208.4 # 10/3/20 210.3# 10/10/20 212.8 # 10/17/20 213.2 # 11.62% weight gain since **4/18/20** The clinical record lacked documentation of notification of the physician of the significant	F580		

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F580	Continued From page 3 weight gain. During an interview 1/6/21 at 7:10 a.m. the DON (Director of Nursing) confirmed no physician and family notification of the significant weight gain had been done. An undated facility form, Condition Changes-Managing, directed staff a licenses nurse need to notify the attending physician and family or responsible party of a change in condition.	F580	**F 584** **PLAN OF CORRECTION** Accura Healthcare of Pomeroy denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1H7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of thefacility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F584	1. In continuing compliance with F 584, Accura Healthcare of Pomeroy immediately corrected the deficiency by the DON on 01/08/2021 and ensured all residents were provided clean bed linens. 2. To ensure the problem does not recur staff member C who dropped the pillow was educated on 01/06/2021 by DON. All staff were educated on or before 02/07/2021 by the Director of Nursing. The DON and/or designee will audit weekly x 4 weeks and then randomly to ensure continued compliance. 3. As part of Accura Healthcare of Pomeroy's ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	

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ACCURA HEALTHCARE OF POMEROY, LLC	303 EAST 7TH STREET POMEROY, IA 50575

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F 584	Continued From page 4 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90(e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to a1°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to ensure the resident utilized clean bed linens for 1 of 6 residents observed (Resident #13). The facility reported a census of 22 residents. Findings include: 1. The Minimum Data Set Assessment (MOS) dated 11/25/20, documented Resident #13 with intact cognition, required extensive staff assistance with bed mobility, transfers, toileting, and personal hygiene, had upper and lower range of motion impairment on one side, and always incontinent of urine. The MOS revealed the resident's diagnoses included diabetes, history of a cerebral vascular accident (stroke), anxiety, and depression. The resident's care plan, with a revision date of 2/22/19 and target date of 3/23/21, revealed the	F584		

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F 584	Continued From page 5 resident had bladder incontinence, worebriefs, and dependent on staff for incontinence care. Observation on 1/6/21 at 1:18 p.m. showed Staff C and Staff D, CNAs (Certified Nursing Assistants), (with the DON (Director of Nursing) observing), provide incontinence care for the resident while in bed. The CNAs turned the resident during cares and a pillow fell from the bed to the floor. The staff positioned the resident on her left side after cares, placed a pillow behind the resident's back, and Staff C picked the pillow on the floor up and placed the pillow under the resident's legs. During an interview immediately after completion of cares, the DON verified the staff need to put a clean pillow case on the pillow before using and instructed the staff to change the pillow case.	F584	**F 657** **PLAN OF CORRECTION** Accura Healthcare of Pomeroy denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F657, Accura Healthcare of Pomeroy immediately corrected the deficiency by the DON educating the MDS coordinator on 01/11/2021 on updating care plans for resident #4 and like residents, with significant weight gains.	
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. (8) 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	F657	2. To ensure the problem does not recur the MDS coordinator was educated on or before 02/07/2021 on updating care plans with condition changes by the Director of Nursing. The DON and/or designee will audit care plans daily M-F times 2 weeks, then weekly times 4 weeks and then randomly to ensure continued compliance. 3. As part of Accura Healthcare of Pomeroy's ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	

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F 657	Continued From page 6 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 and staff interview, the facility failed to revise a resident's care plan after a significant weight change for 1 of 3 residents reviewed for nutrition (Resident #4). The facility reported a census of 22 residents. Findings include: A Minimum Data Set (MOS) dated 10/16/20, identified Resident #4 with moderately impaired cognition. The resident required limited staff assistance for eating. The MOS documented the resident with a weight gain of 5% in the last month or gain of 10% or more in the previous 6 months. The resident's diagnoses included: Alzheimer's disease and non-Alzheimer's disease. The resident's care plan, with a revision date of 11/6/19, revealed the resident had an alteration in nutrition. A goal, with a target date of 11/21/20, documented no significant weight change during the time frame. Interventions included to keep the physician notified of concerns when needed (dated 11/9/18), the resident may eat meals and snacks in room (dated 5/14/19) and the resident	F657		

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F 657	Continued From page 7	F657		

received a Magic Cup mixed with 4 ounces of whole milk daily (dated 2/19/20).

A Consultant Dietitian progress note, dated 11/3/20, revealed the resident had a significant weight gain of 11.6% over the past 6 months and the resident had non pitting edema. The Dietitian planned to discuss the resident's weight gain with the DON (Director of Nursing), and may consider decreasing the resident's supplement as the resident preferred snacks and sweets.

A weight record documented the resident weighed:

4/18/2020 191.0 #
4/20/2020 191.0 #
4/25/2020 189.2 #
5/4/2020 195.3 #
5/9/2020 188.0 #
5/18/2020 188.4 #
5/23/2020 189.6 #
5/30/2020 190.2 #
6/20/2020 1906 #
7/18/2020 192.2 #
8/16/2020 198.8 #
8/22/2020 199.2 #
9/12/2020 202.8 #
9/19/2020 204.4 #
9/21/2020 208 #
9/27/2020 208.4 #
10/3/20 210.3#
10/10/20 **212.8** #
10/17/20 213.2# 11.62%weightgain since **4/18/20**

The clinical record and care plan lacked documentation of the significant weight gain and any new interventions.

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F 657	Continued From page 8 During an interview 111/21 at 8:30 a.m. the DON (Director of Nursing) stated she had not noticed the significant weight gain and no new interventions had been implemented.	F657	**F 690** **PLAN OF CORRECTION** Accura Healthcare of Pomeroy denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that re ident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure·that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must	F690	1. In continuing compliance with F 690, Accura Healthcare of Pomeroy immediately corrected the deficiency by educating staff member #C and D by the DON on complete and appropriate incontinence care for resident #13 and like residents. 2. To ensure the problem does not recur all nursing staff were educated on or before 02/07/2021 on complete and appropriate incontinence care by the Director of Nursing. The DON and/or designee will audit incontinence care daily M-F for 2 weeks, then weekly times 4 weeks and then randomly to ensure continued compliance. 3. As part of Accura Healthcare of Pomeroy's ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	

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F 690	Continued From page 9	F690		

ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on record review, observation, staff interview, and a pericare audit form, the facility failed to provide complete and appropriate incontinence care in a manner to prevent urinary infections for 1 of 2 residents observed (Resident #13). The facility reported a census of 22 residents.

Findings include:

1. The Minimum Data Set Assessment (MOS) dated 11/25/20, documented Resident #13 with intact cognition, required extensive staff assistance with bed mobility, transfers, toileting, and personal hygiene, had upper and lower range of motion impairment on one side, and always incontinent of urine. The MOS revealed the resident's diagnoses included: diabetes, history of a cerebral vascular accident (stroke), anxiety, and depression.

The resident's care plan, with a revision date of 2/22/19 and target date of 3/23/21, revealed the resident had bladder incontinence, wore briefs and dependent on staff for incontinence care.

Observation 1/6/21 at 1:18 p.m., showed Staff C and Staff D, CNAs (Certified Nursing Assistants), (with the DON (Director of Nursing) observing), provide incontinence care for the resident Staff C used a new disposable wipe each time and washed the resident's groins and between the labia in an appropriate manner. Staff C and Staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165414	A. BUILDING ______ B. WING ______	01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF POMEROY, LLC	303 EAST 7TH STREET POMEROY, IA 50575

(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 690	Continued From page 10 D turned the resident to her left side. Staff C used one disposable cloth and used a circular motion to clean the resident's left and right buttocks without turning the cloth. Staff C used the same cloth and without using a clean cloth surface, cleaned the resident's perineal area from front to back 2 times without turning the cloth. During an interview immediately after completion of cares, the DON verified Staff C failed to use a clean cloth surface to clean the resident's buttocks and perineal area. The DON stated the staff needed education. An undated Pericare Audit form directed staff to clean all skin areas contaminated with urine and to wipe residents from front to back and place the contaminated cloth in a designated bag.	F690	**F 812** **PLAN OF CORRECTION** Accura Healthcare of Pomeroy denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F 812, Accura Healthcare of Pomeroy corrected the deficiency immediately by the Maintenance Director cleaning the stove hood on 01/08/2021. 2. To ensure the deficiency does not recur, the Maintenance Director and Dietary Service Manager was educated by 02/07/2021 by the Administrator on professional standards food safety. The Administrator and/or designee will audit the food service areas daily M-F x 2week, then weekly x 4 weeks and then randomly to ensure continued compliance. 3. As part of Accura Healthcare of Pomeroy's ongoing commitment to quality assurance, the Administrator and/or designee will report identified concerns through the community's QA Process.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165414	A. BUILDING ______ B. WING ______	01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF POMEROY, LLC	303 EAST 7TH STREET POMEROY, IA 50575

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F 812	Continued From page 11 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a clean stove hood and failed to serve food under sanitary conditions. The facility reported a census of 22 residents. Findings include: 1. Initial tour of the kitchen on 1/4/21 at 10:15 a.m., revealed the stove hood filters contained a gray material that appeared to be dust directly above 6 stove burners. Staff A (cook) verified the material looked like dust and the filters needed washed. Staff A stated a commercial company cleaned the hood once a year and came in March of 2020. Staff A did not know how often the facility cleaned the filters. On 1/4/21 at 11:00 a.m., the Maintenance Supervisor verified the stove hood required cleaning now, scheduled for monthly cleaning, and he last cleaned it in November of 2020. 2. During an observation 1/5/21 at 10:57 a.m., Staff B (cook) began serving the noon meal. Observation at 11:19 a.m. revealed Staff B's mask slipped down under her nose. Staff B used her hand and pushed the mask up above her nose. Staff B continued to serve food without washing or sanitizing her hands. On 1n121 at 8:30 a.m., the DON (Director of Nursing) stated she expected a cook to wash her hands after any type of contamination during food service.	F 812		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0133	A. BUILDING: ______ B. WING ______	01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF POMEROY, LLC	303 EAST 7TH STREET POMEROY, IA 50575

(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) COMPLETE DATE
L1093	58.12(1)IAdmission, transfer, and discharge 58.12(135C) Admission, transfer, and discharge. 58.12(1) General admission policies. l. For all residents residing in a health care facility receiving reimbursement through the medical assistance program under Iowa Code chapter 249A on July 1, 2003, and all others subsequently admitted, the facility shall collect and report information regarding the resident's eligibility or potential eligibility for benefits through the Federal Department of Veterans Affairs as requested by the Iowa commission on Veterans Affairs. The facility shall collect and report the information on forms and by the procedures prescribed by the Iowa commissions on veterans affairs. Where appropriate, the facility may also report such information to the Iowa department of human services. In the event that a resident is unable to assist the facility in obtaining the information, the facility shall seek the requested information from the resident's family members or responsible party. For all new admissions, the facility shall collect and report the required information regarding the resident's eligibility or potential eligibility to the Iowa commission on veterans affairs within 30 days of the resident's admission. For residents residing in the facility as of July 1, 2003, and prior to May 5, 2004, the facility shall collect and report the required information regarding the resident' s eligibility or potential eligibility to the Iowa commission on veterans affairs within 90 days after May 5, 2004. If a resident is eligible for benefits through the federal Department of Affairs or other third-party payor, the facility shall seek reimbursement from such benefits to the maximum extent available before seeking reimbursement from the medical	L1093	**L1093** **PLAN OF CORRECTION** Accura Healthcare of Pomeroy denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with L1093, Accura Healthcare of Pomeroy immediately corrected the deficiency by educating BOM on 01/10/2021 by the Administrator on collecting and reporting information on all residents who are eligible or potentially eligible for benefits through the Federal Department of Veterans Affairs for resident #21 and like residents. 2. To ensure the problem does not recur the new business office manager provided education on 01/10/2021 by administrator on how to collect and report information on residents who are eligible or potentially eligible for benefits through the Federal Department of Veterans Affairs. The business was set up with access to the Veteran's website and educated on admission processes by the administrator on 01/11/2021. The Administrator and/or designee will audit daily M-F for 2 weeks, then weekly x 4 weeks and the randomly to ensure continued compliance. 3. As part of Accura Healthcare of Pomeroy's ongoing commitment to quality assurance, the Administrator and/or designee will report identified concerns through the community's QA Process.	

DIVISION OF HEALTH FACILITIES STATE OF IOWA

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

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPUER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0133	A BUILDING: ______ B. WING ______	01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF POMEROY, LLC	303 EAST 7TH STREET POMEROY, IA 50575

(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) COMPLETE DATE
L1093	Continued From page 1 assistance program established under Iowa Code chapter 249A. The provisions of this paragraph shall not apply to the admission of an individual as a resident to a state mental health institute for acute psychiatric care or to the admission of an individual to the Iowa Veterans Home. (11,111) This Statute is not met as evidenced by: Based on record review and staff interviews, the facility failed to update the resident's status as a veteran on the Veteran ' s website within 30 days of a resident's admission to a health care facility receiving reimbursement through the medical assistance program under Iowa Code chapter 249 A for one of four residents reviewed (Residents #21). The facility reported a census of 22 residents. Findings include: The Minimum Data Set (MOS) completed for the resident, showed the resident's admitted to the facility on 11126/20. The facility ' s Current Resident Status lacked documentation indicating the resident was a veteran. The HAWK-*Social Services Initial Assessment v1.1 -V 5 dated 11/27/19 indicated the resident was in the Military Services. On 1/4/21 at 4:52 PM, the Administrator said that they didn't have access to the Veteran's website at the time as the previous person that entered the information terminated their access. On 1/7/21 at 7:50 AM, the Director of Nursing	L1093		

DEPARTMENT OF INSPECTIONS ANDAPPEALS

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	IA0133	A. BUILDING: ________ B. WING ________	01/0712021

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ACCURA HEALTHCARE OF POMEROY, LLC	303 EAST 7TH STREET POMEROY, IA 50575

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1093	Continued From page 2 (DON) said that the previous Administrator or Business Office Manager would enter that information into the system. The current Business Office Manager only started in December. On 1ll/21 08:44 AM, the DON stated she spoke with the previous Administrator. They stated that they would complete the questionnaire on admission and then give the information to the Business Office Manager, that was responsible for entering the information into the system. The DON told the current Administrator who was going to add the resident to the Veteran's website.	L1093		