STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165408	A. BUILDING _____ B. WING _____	12/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF BANCROFT	648 EAST RAMSEY STREET BANCROFT, IA 50517

(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 12.30.21 The following deficiencies relates to the annual health survey conducted December 8-13, 2021. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C)	F 000		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on personnel file reviews, staff interviews, and facility policy review, the facility failed to obtain an evaluation by the Department of Human Services (DHS) prior to hire to determine if an employee with a criminal history could work in the facility for 1 of 5 current employees sampled (Staff C, Licensed Practical Nurse (LPN)) and ensure staff completed dependent adult abuse training within six months of hire (Staff D, Certified Nursing Assistant (CNA)). The facility reported a census of 19 residents. Findings include:	F 607	F 607 PLAN OF CORRECTION Accura Healthcare of Bancroft 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 607, Develop/Implement Abuse/Neglect Policies, Accura Healthcare of Bancroft corrected the deficiency by ensuring Staff D completed Dependent Adult Abuse training on 12/23/2021, and Staff C is in compliance with full criminal background check completion on 10/01/2021. Then ensured all other dependent adult abuse training and criminal background checks were all up to date by review of all employee files on 12/14/2021.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sheila Weier — TITLE: Executive Director — (X6) DATE: 1/6/22

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

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F 607	Continued From page 1 1. The personnel file for Staff C, LPN documented a hire date of 9/30/2021. The Single Contact License and Background Check(SING) dated 9/29/2021 indicated a possible criminal hit for Staff C, LPN which required the Department of Criminal Investigation (DCI) to clarify if the prospective employee did or did not have a criminal history. The personnel record revealed Staff C, LPN received clearance on 10/1/21. Review of the Nursing schedule for September 2021 revealed Staff C, LPN scheduled for September 30, 2021. Interview on 12/13/21 at 2:39 p.m., with the Director of Nursing (DON) revealed Staff C, LPN worked the evening shift on 9/30/21. Review of facility provided policy titled Abuse Prevention, Identification, Investigation and reporting policy with an effective and updated date of 4/14/17 revealed the following information: * The facility shall screen all potential employees for a history of abuse, neglect, exploitation, misappropriation of property or mistreatment of residents. * This will be accomplished through the following (including maintaining documentation of such results): a. The facility will conduct an Iowa criminal record check and dependent adult/child abuse registry check on all prospective employees and other individuals engaged to provide services to residents, prior to hire, in the manner prescribed under 481 Iowa Administrative Code 58.11(3). The facility will conduct a crimnal record check and dependent adult/child abuse registry check	F 607	2. To correct the deficiency and to ensure the problem does not recur administrative assistant was educated on Dependent Adult Abuse training and completion of criminal background checks for employees according to the state regulations by Executive Director on 12/14/2021. The administrative assistant and/or designee will audit criminal background check completion, and dependent adult abuse training on all employee's 3x per week times four weeks, then 2x per week times four weeks, then PRN to ensure compliance. 3. As part of Accura Healthcare of Bancroft ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	

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F 607	Continued From page 2 on all current employees and other individuals engaged to provide services to residents. Interview on 12/13/21 at 2:59 p.m., with the Administrator revealed the facility does not use a third party vendor for background checks and the facility did not have the clearance to have Staff C, LPN working. 2. On 12/13/21 at 1:56 PM a review of Staff D's employee file revealed no Dependent Adult Abuse Training certification on file. Staff D had a hire date of 5/12/21. On 12/13/21 at 2:40 PM in an interview with the DON, the DON stated it is the expectation staff have completed the dependent adult abuse training within six months of hire. On 12/13/21 at 2:40 PM in an interview with the Business Office Manager (BOM), she stated she was aware the certification was absent from Staff D's file. The BOM stated it is the expectation to have the certificate on file within the employee files within six months of hire. The facility policy labeled Abuse Prevention, Identification, Investigation, and Reporting Policy dated 04/14/17, stated each employee shall be required to complete two hours of training related to the identification and reporting of dependent adult abuse within six months of initial employment.	F 607		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination.	F 644		

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F 644	Continued From page 3 A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to refer 1 resident with a negative Level I result for the PreAdmission Screening and Resident Review (PASRR), who was later identified with newly evident or possible serious mental disorder, intellectual disability, or other related condition, to the appropriate state-designated authority for Level II PASRR evaluation and determination for 1 out of 1 residents (Resident #1) reviewed for PASRR requirements. The facility reported a census of 19 residents. Findings include: The Minimum Data Set (MDS) assessment dated 10/8/21 for Resident #1 documented diagnoses of hypertension, depression, and schizophrenia. The MDS showed a Brief Interview for Mental	F 644	F 644 **PLAN OF CORRECTION** **Accura Healthcare of Bancroft** 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 644, Coordination of PASRR and Assessments, Accura Healthcare of Bancroft corrected the deficiency by completing a new PASRR with accurate information on Resident #1 on 12/09/2021. The DON audited all PASRR's to ensure that all like residents PASSR's are current and up to date by 12/30/2021. 2. To correct the deficiency and to ensure the problem does not recur, the DON was educated on 12/14/2021 on rules and regulations of PASRR by nurse specialist. The DON and/or designee will audit new orders/new dx, and new admits 3x per week times four weeks, then 2x per week times four weeks, then PRN to ensure compliance. 3. As part of Accura Healthcare of Bancroft ongoing commitment to quality assurance, the Director of nursing and/or designee will report identified concerns through the community's QA Process.	

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F 644	Continued From page 4 Status (BIMS) score of 5, indicating severe cognitive impairment. Review of the clinical record revealed a Notice of Negative Level I Screen Outcome dated 4/19/2018 revealed the PASRR level 1 screen remains valid for your stay at the nursing facility and should be transferred with you if you relocate. No further level 1 screening is required unless you are known to have or are suspected of having a major mental illness or an intellectual or developmental disability and exhibit a significant change in treatment needs. Further review revealed question #1- Does the individual have any of the following Major Mental Illnesses, which included schizophrenia. The box was marked no. Review of the MDS dated 4/27/2018 revealed an active diagnosis of schizophrenia. Review of hospital discharge notes dated 11/20/19 at 8:41 a.m., revealed active diagnosis of schizophrenia. Review of Medication Review Report dated 8/24/2020 signed by the physician 8/26/20 revealed active diagnosis of schizophrenia. Review of Resident #1's chart lacked a follow-up and resubmission of a PASRR with the diagnosis of schizophrenia. Interview on 12/09/21 at 9:34 a.m., with the Director of Nursing (DON) revealed Resident #1 does have a diagnosis of schizophrenia and the PASRR should have been resubmitted to include the schizophrenia diagnosis. Interview on 12/13/21 at 12:52 p.m., with the	F 644		

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F 644	Continued From page 5 DON revealed the facility does not have a policy on PASARR as they follow the regulations.	F 644		
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 resident 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 ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as	F 690	F 690 **PLAN OF CORRECTION** **Accura Healthcare of Bancroft** 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 690, Bowel/Bladder Incontinence, Catheter, UTI CFR Care, Accura Healthcare of Bancroft corrected the deficiency by ensuring Resident #15 and all like residents are receiving complete incontinence cares and completing competencies on all CNA's by the DON and/or designee by 12/21/2021. 2. To correct the deficiency and to ensure the problem does not recur, all CNA's were educated on incontinence cares on 12/14/2021 by the DON. The DON and/or designee will audit incontinence cares 3x per week times four weeks, 2x per week times four weeks, then PRN to ensure compliance. 3. As part of Accura health care of Bancroft ongoing commitment to quality assurance, the Director of nursing and/or designee will report identified concerns through the community's QA Process.	

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F 690	Continued From page 6 possible. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff interview and facility policy, the facility failed to provide complete and appropriate incontinence care in a manner to prevent urinary tract infections for 1 of 2 residents observed (Resident #15). The facility reported a census of 19 residents. Findings include: The Minimum Data Set (MDS) assessment dated 11/24/21 for Resident #15 documented diagnoses of diabetes mellitus, urinary incontinence, and non-Alzheimer's dementia. The MDS showed the Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. Observation on 12/08/21 at 1:20 p.m., Staff A, Certified Nursing Assistant (CNA) and Staff B, CNA explained to Resident #15 they were going to assist Staff #15 to the bathroom. Staff A and Staff B assisted Resident #15 into the bathroom. Staff A applied gloves and removed soiled incontinence pad. Staff A removed gloves without performing hand hygiene. Staff A applied a clean incontinence brief and applied another male pad inside the brief. Staff B assisted Resident #15 to a standing position. Staff A took out a disposable wipe and wiped the right side of the groin from the top of the pelvis down to perineum with one stroke and disposed of the wipe. Staff A took a disposable wipe and wiped down the left side of the groin area from the pelvis down to the perineum with one stroke and disposed of the wipe. Staff A took a disposable wipe and wiped	F 690		

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F 690	Continued From page 7 the front of the pelvis down to the perineum with one stroke and disposed of the wipe. Staff A removed gloves and without performing hand hygiene pulled up Resident #15's incontinent brief and Resident #15's pants. Staff A and Staff B then assisted Resident #15 into bed and laid down. Review of Resident #15's Care Plan with a revision date 5/19/21 revealed Resident #15 was incontinent of urine and required an assistance of 2 with toileting. Review of facility provided document titled Competency for Peri Care updated 4/20/2021 revealed staff to cleanse penis by pushing back foreskin- gently wash around glans of penis, shaft, and scrotum. Wash anal area, front to back using facilty choice of solution and cloths or wipes, and wash buttocks and both hips. Interview on 12/13/21 at 1:46 p.m., the Director of Nursing (DON) stated expects the groin area and buttocks area to be fully cleansed, all areas the soiled brief could touch should be cleansed.	F 690		
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	F 812		

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F 812	Continued From page 8 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 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility policy reviews the facility failed to ensure food was stored and prepared under sanitary conditions. The facility identified a census of 57 residents. Findings include: An initial kitchen tour conduct on 12/8/21 at 10:27 a.m., revealed the following observations: 1. The following items stored in the refrigerator ready for service: 2 open ranch dressing lacked an open date. Open baking soda lacked an open date. Open enchilada sauce lacked an open date. Open salsa lacked an open date. Open bag of shredded swiss cheese with hard dried pieces lacked an open date. Open bottle of taco sauce lacked an open date. Open container of orange juice lacked an open date. Open container of pink lemonade lacked an open date. Open jug milk lacked an open date. Open container of tea lacked an open date. Water container lacked an open date.	F 812	**F 812** **PLAN OF CORRECTION** **Accura Healthcare of Bancroft** 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, Food Procurement, Store/Prepare/Serve-Sanitary, Accura Healthcare of Bancroft corrected the deficiency by the dietary manager removing all food items in dry storage, refrigerators, and freezers that were outdated, and dating all opened food items on 12/08/2021. 2. To correct the deficiency and to ensure the problem does not recur the dietary manager was educated on the regulations of proper food storage by Executive Director on 12/14/2021. The Dietary Manager then educated dietary staff of regulations of proper food storage on 12/14/2021. The dietary manager and/or designee will audit dry storage, refrigerators, and freezers to ensure all food items are dated when opened and items are not expired, 3x per week times four weeks, then 2x per week times four weeks, then PRN to ensure compliance. 3. As part of Accura Healthcare of Bancroft ongoing commitment to quality assurance, the Dietary Manager and/or designee will report identified concerns through the community's QA Process.	

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F 812	Continued From page 9 Open bottle of thickened kiwi strawberry lacked an open date. Open bag of cheddar cheese lacked an open date. Open bottle of nectar thick water lacked an open date. Open bottle of thickened apple juice lacked an open date. Open bottle of lemon juice lacked an open date. 2. The following items stored in the freezer ready for service: Pound cake with frost approx 1/8 inch around sides and top of package. Frozen Hubbard squash x2 with frost build up approx 1/8 inch around container. Hot dogs open with no open date frost build up in the bottom of bag. Open meat in a blue bag with frost buildup in the bag lacked a label of contents and lacked an open date no label. Open bag of chicken pieces with frost build up in the bag lacked an open date. Open bag of brats lacked an open date. Green yellow diced food with frost build up in bag labeled 10/18- lacked item label. Open bag of frozen bacon crumbles lacked an open date. Open bag of meatballs lacked an open date. Two bags of cubed meat lacked a label of contents. 3. The following items were stored and ready for service in the dry storage: Unopened potato casserole Au gratin potatoes with an expiration date of 11/24/21. 24 boxes of unopened boxes of baking soda with an expiration date of 7/30/21. 2 bags of Mini M&M's with an expiration date of 9/2021.	F 812		

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F 812	Continued From page 10 Open bag of navy beans lacked an open date. Open bag of long grain rice lacked an open date. 4. The following items were stored and ready for service in the kitchen: Open bag of brown sugar lacked an open date. Open bag of instant breakfast with an open date of 2-19, was hard to the touch. Open box of baking powder lacked an open date. Open bottle of worcestershire sauce lacked an open date. Open bag of chicken gravy lacked an open date. Open bottle of soybean pan grill oil lacked an open date. Open bottle of syrup bottle lacked an open date. Open bottle of sugar free syrup lacked an open date . 2 containers of muffins- in cabinet no date on label. Open container of sugar lacked an open date. Open container of flour lacked an open date. Bag of three pieces of buttered banana bread in a bag with no label of item or date. (kitchen staff confirmed it was banana bread). 3 rolls in bag ready to be served noted 1 roll with a spot of black debri with fuzzy edges and 1 roll with 2 spots of black debri with fuzzy edges. Interview on 12/08/21 at 11:17 p.m., the Dietary Manager revealed she expects all items to be labeled and have open dates if they have been open.	F 812		

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F 812	Continued From page 11 Interview on 12/13/21 at 12:40 p.m., the Administrator revealed the facility does not have a policy regarding food storage, the facility is to follow the food code regulations.	F 812		