STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165490	A. BUILDING _____ B. WING _____	C 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF CRESCO	701 VERNON ROAD SW CRESCO, IA 52136

(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: 7/12/2024 The following deficiencies resulted from the investigation of complaints #120797-C, #120927-C, #121190-C, and #121237-C conducted June 7, 2024 thru June 18, 2024. All complaints were substantiated, so the facility was not in substantial compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities.	F 000	Accura Healthcare of Cresco 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 necessa The Executive Director	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609	and/or designee will audit for proper functioning of the garage entry door and courtyard flood lights twice weekly for 12 weeks to ensure continued compliance. ry. In continuing compliance with F609 reporting of alleged violations, Accura Healthcare of Cresco corrected the deficiency through staff education to ensure alleged violations are reported appropriately for Resident #4 and all like residents. The Administrator was terminated from the facility on 6/27/2024. Immediate verbal education was provided to Staff E by VP of HR and VP of Clinical Services on properly reporting missing narcotics on 6/4/2024. To correct the deficiency and to ensure the problem does not recur, all staff were educated by 7/1/2024 by the DON on the facility's reporting policy for abuse and related events. The Executive Director and/or designee will audit for compliance with understanding of reporting of alleged violations twice weekly for 12 weeks. As part of Accura Healthcare of Cresco's ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	7/1/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	VP of Operations	7/11/2024

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 609	Continued From page 1 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and review of policy and procedures, the facility failed to ensure all alleged violations involving financial exploitation of a resident and/or residents are reported immediately to management staff per facility policy and to the Iowa Department of Inspections, Appeals, and Licensing for 1 of 6 residents reviewed (Resident #4). The facility reported a census of 27 residents. Findings include: During an interview 6.11.24 at 3:31 p.m. Staff E, Licensed Practical Nurse (LPN) indicated narcotics and muscle relaxers as recently missing and reported to the Administrator however she swept the alleged incidents under the rug. During an interview 6.12.24 at 9:15 a.m. Staff G, Registered Nurse (RN) confirmed she had not taken any concerns to the corporate level because the Administrator told staff they could not call corporate and if it got back to the Administrator the staff member feared retaliation. During an interview 6.7.24 at 9:45 a.m. the Administrator indicated the facility staff failed to report the alleged drug diversion on 5.25.24 to her directly rather a note had been left under her office door which she had not received until 5.28.24 when she arrived at work. The	F 609		

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F 609	Continued From page 2 Administrator confirmed Staff C, LPN had been suspended pending the investigation. According to an email 6.19.24 at 12:42 p.m. the Regional Clinical Quality Specialist had only been informed of discrepancies with Flexeril (muscle relaxer) but no other narcotic and/or medications stored in the facilities narcotic lock boxes. According to an email dated 6.19.24 at 4:03 p.m. the Regional Clinical Quality Specialist confirmed she would have expected the Administrator to have reported the missing and/or unaccounted for narcotics to DIAL, per regulation as well as the Clinical Quality Team as stated below in the policy and procedure. A Controlled Substances policy updated 10.19.22 included the following Purposes: a. A completed physical inventory of narcotics at each change of shift by two (2) nurses to have identified discrepancies and need for reconciliation and accountability. b. Assurance controlled drugs had been handled, stored and disposed of properly. c. Assurance of proper record keeping for controlled drugs. The Procedure included the following: a. Controlled substances had only been available to nurses, pharmacists and medical personnel designated by the Accura Health Care Community. b. One (1) authorized person had been responsible for narcotics utilization every shift. Going off duty and coming on duty authorized persons must have counted and validated	F 609		

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F 609	Continued From page 3 accuracy of narcotics supplied for every resident at the change of every shift. c. Narcotic keys reconciled at the same time. d. After staff counted and justified the supply each nurse must have recorded the dated and his/her signature that verified the count as correct. e. If the count presented as inaccurate, the authorized person going off duty remained on duty until the count had been reconciled or the nursing supervisor approved leaving the Accura Healthcare Community. Discrepancies found at any time, change of shift or other should have been reported immediately to the Director of Nursing (DON). The Director then initiated an investigation to determine the cause of the inaccuracy and called the pharmacist for assistance per Accura Healthcare Community Protocol. Any missing narcotic medication must have been reported to the Resource Center's Clinical Quality Team.	F 609		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657	In continuing compliance with F 657, Care Plan Timing and Revision. Accura Healthcare of Cresco corrected the deficiency by the Regional Clinical Specialist providing education to the DON on care plan timing and revisions on 6/26/2024 for resident # 1 and all like residents. Resident's #1 care plan was updated on 6/7/2024 by the MDS Coordinator. To correct the deficiency and to ensure the problem does not recur the MDS nurse was educated on 6/26/2024 on updating care plans timely by the Regional Clinical Specialist. The DON and/or designee will audit care plans to ensure they are up to date with current plan of care 4 times per week for 4 weeks, 3 times per week for 4 weeks, 2 times per week for 2 weeks, 1 time per week for 2 weeks, then PRN. As part of Accura Healthcare of Cresco ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	6/26/2024

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F 657	Continued From page 4 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility policy review, the facility failed to maintain a complete and accurate Care Plan for 1 of 3 resident's reviewed (Resident #1). The facility identified a census of 27 residents. Findings include: A Care Plan for Resident #1 revealed the following Focus areas and Interventions as dated: a. An activities of daily living (ADL's) deficit due to (d/t) shortness of breath (SOB) as a result of a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and incontinence. (initiated 8.16.22) 1. I required assistance of one (1) a walker and gait belt. (initiated 8.16.22) A Rehab Communication form dated 5.28.24 directed the facility staff the mobility status of Resident #1 changed to modified independence with a front wheeled walker (FWW) when in the	F 657		

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F 657	Continued From page 5 facility however not outdoors. During an interview 6.18.24 at 1:15 p.m. Staff F, Certified Nursing Assistant (CNA) confirmed resident Care Plans as not accurate. A Comprehensive Care Plans policy revised 1.30.24 included the following: It had been the policy of the facility have developed and implemented a comprehensive person-center care plan for each resident, consistent with resident rights that included measurable objectives and timeframe's to have met a resident's medical, nursing, mental and psychosocial needs identified on the comprehensive assessment. The Policy Explanation and Compliance Guidelines included the following: a. The care plan would have been updated in a timely manner for assurance that the services furnished represented the resident's highest practicable physical, mental, and psychosocial well-being.	F 657	In continuing compliance with F 684, Quality of Care . Accura Healthcare of Cresco corrected the deficiency by the Regional Clinical Specialist providing education to the DON on providing timely assessments/interventions for residents #2, #3, and all like residents on 6/26/2024. Wound measurements were completed by the DON on 6/26/2024 for Resident #2 and #3. To correct the deficiency and to ensure the problem does not all nurses were educated on 7/3/2024 on completing skin assessments/interventions timely by the DON. The DON created a lab tracking system on 6/12/2024 and educated nursing staff on 6/12/2024 on this process. The DON and/or designee will audit wound care administration/ completion/documentation AND compliance with labs4 times per week for 4 weeks, 3 times per week for 4 weeks, 2 times per week for 2 weeks, 1 time per week for 2 weeks, then PRN. As part of Accura Healthcare of Cresco ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	7/3/2024
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		

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F 684	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility policy review, the facility failed to provide an assessment and interventions for 2 of 3 residents with pressure areas (Resident #2 and #3) and the facility failed to to follow physician's orders for 1 of 3 residents reviewed (Resident #3). The facility identified a census of 27 residents. Findings include: 1. Review of the facilities Progress Notes for Resident #2 revealed an entry date of 5.22.24 that staff assessed and documented the resident with an increase in drainage to her right hip and buttocks pressure area on 5.21.24. On 5.21.24 the facility failed to assess the resident's increase in drainage to the same ulcer area. The facility continued to fail to assess the area on 5.23, 5.24, 5.26 and 5.27.2024. 2. Review of the facilities Progress Notes for Resident #3 revealed the facility staff failed to assess the resident's pressure area on her left heel from 4.24.24 until 5.7.24. During an interview 6.11.24 at 2:30 p.m. a Corporate Representative confirmed the facility staff failed to assess the pressure area on the left heel of Resident #3 from 4.24.24 thru 5.6.24. . 3. During an interview 6.11.24 at 10:53 a.m. the Administrator and Director of Nursing (DON) confirmed the facility currently failed to have a system in place to draw resident labs per Physician order.	F 684		

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F 684	Continued From page 7 During an interview 6.11.24 10:05 a.m. Staff D, LPN indicated most of the resident's lab orders are in the computer however she had no knowledge as to how to retrieve them. The staff member indicated the facility utilized a lab calendar and book but it had not been up to date. 4. Medication Administration Audit Report form dated 6.21.24 at 12:34 p.m. included the following Physician ordered medications to have been administered at 7 p.m. for Resident #3. On 6.11.24 Staff H, LPN actually administered the medications at 9:43 p.m.: a. Pregabalin capsule 100 milligrams (mg's) by mouth (PO) one time a day (QD) for repeated anxiety episodes. b. Rosuvastatin Calcium tablet 10 mg PO QD for high cholesterol c. Quetiapine Fumarate tablet 100 mg 2 tablets PO QD for sleep During an interview 6.11.24 at 4 p.m. Resident # 3 indicated last night staff failed to administer her medications prescribed for around 8:30 p.m. until 10:30 p.m. The Resident described herself as damn mad about the situation because she could not sleep at night if her pills had not been administered per Physician's order due to her neuropathy. During an interview 6.12.24 at 2:57 p.m. Staff I, Certified Nursing Assistant (CNA) confirmed the resident had not received her medications on 6.11.24 as prescribed. She reported the resident's concern to Staff H who said Ok, Ok, oh	F 684		

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F 684	Continued From page 8 my God she had been 2-3 hours behind in her medication administration. A Medication Administration Policy form revised 1.30.24 included the following: Medications administered by licensed nurses or other staff who had been legally authorized to do so in the state and as ordered by the Physician and in accordance with professional standards of practice. The Policy Explanation and Compliance Guidelines included the following: a. Administration of medications within 60 minutes prior to or after scheduled time unless otherwise ordered by a Physician.	F 684	In continuing compliance with F 689, Free of Accidents/Hazards/Supplies/Devices. Accura Healthcare of Cresco corrected the deficiency by the DON providing education to the staff and locking the medication cart on 7/3/2024 for resident # 1 and all like residents. The Maintenance Director secured the garage entry door with 2x4s on 5/24/2024 to ensure resident #1 and all like residents are free from accidents and hazards.	
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, resident interview, staff interview, and photos the facility failed to ensure staff maintained a safe and secure environment for 1 of 3 residents reviewed (Resident #1), and failed to lock medication carts when unattended giving cognitively impaired resident access to the	F 689	To correct the deficiency and to ensure the problem does not recur all nurses and med aides were educated on 7/3/2024 on locking the medication carts when not in use by the DON. The DON and/or designee will audit medication carts being locked when not in use 4 times per week for 4 weeks, 3 times per week for 4 weeks, 2 times per week for 2 weeks, 1 time per week for 2 weeks, then PRN. A new entry door for the courtyard garage will be ordered by 7/12/2024 by the Executive Director. New lights will be placed in the courtyard by 7/12/2024 to help with illumination. The Executive Director and/or designee will audit for proper functioning of the garage entry door and courtyard flood lights twice weekly for 12 weeks to ensure continued compliance. As part of Accura Healthcare of Cresco ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	7/12/2024

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F 689	Continued From page 9 contents. The facility identified a census of 27 residents. Findings include: 1. A Minimum Data Set (MDS) assessment form dated 5.22.24 indicated Resident #1 had diagnoses that included Schizophrenia, Bi-Polar, Depression, Coronary Artery Disease (CAD), Diabetes Mellitus (DM), Arthritis, shortness of breath (SOB), tobacco use and Respiratory Failure. The assessment indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 (moderately impaired cognitive skills), utilized a walker or wheel chair for mobility, required partial to moderate staff assistance for ambulation up to 10 feet, unable to ambulate 50-150 feet and independent with his wheel chair. A Care Plan revealed the following Focus areas and Interventions as dated: a. An activities of daily living (ADL) deficit due to (d/t) SOB secondary to Chronic Obstructive Pulmonary Disease (COPD) and incontinence. (initiated 8.16.22) 1. I require assistance of one (1) a walker and a gait belt assistive device. (initiated 8.16.22) 2. I use a walker and wheel chair for mobility. (initiated 8.16.22) b. I smoke. (revised 3.7.24) c. Limited physical mobility d/t a previous injury to his legs. (revised 3.10.23) d. Behavior problems which included stolen cigarettes from staff, verbal outbursts of cursing/swearing, obtained cigarettes and extra smoke breaks and inappropriate verbalization with female staff. (revised 3.6.23)	F 689	

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F 689	Continued From page 10	F 689		

e. I may have tried to exit seek and wander d/t poor cognition at times related to his behavior and health diagnosis.
f. At risk for falls. (revised 3.10.23)

A Risk Assessment Elopement form dated 5.22.24 at 8:30 p.m. indicated the resident as at high risk for elopement.

A Fall Risk Assessment form dated 5.22.24 at 8:30 p.m. indicated the Resident as at moderate risk for falls.

Review of the Resident's Progress Notes revealed the following entries as dated:

a. 5.13.24 at 12:43 a.m. - Staff A, Registered Nurse (RN) documented the door alarm had sounded, staff responded and noted the resident positioned in a wheel chair on a grassy area in the secured court yard. The Resident refused to return into the facility so the staff left him outside and returned into the facility which had been previously approved by the Administrator. The staff looked at a camera monitor (which had no capacity to record coverage) after a few minutes and noted the resident as not in sight. The Certified Nursing Assistant (CNA) went to check on the resident and found his unoccupied wheel chair on the cement side walk with no resident present. The RN and CNA walked the court yard area. The RN checked the side garage door and found the door unlocked, used her pocket light and noted the Resident positioned on a riding lawn mower in the garage. The Resident told the RN there had been something propped up against the door but it gave away so the resident walked right into the garage. The staff member successfully redirected the Resident back into the

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F 689	Continued From page 11 facility at that time. b. 5.16.24 at 12:00 a.m. - Staff A, RN documented the Resident had been exit seeking earlier in her shift. As herself and a CNA completed cares on another resident she went to check on Resident #1 again and noted he had not been by the the exit door to the court yard. The nurse took out her pocket flashlight and walked the perimeter of the fenced area (courtyard) and found the resident's empty wheel chair by the locked side garage door accessible from the courtyard area. The staff member followed the facilities Elopement Policy and returned inside and called the Administrator who directed her to call the Director of Maintenance who gave her the code to the overhead garage door located outside of the courtyard area. The staff member went to this door and noted the resident's wheel chair as no longer positioned outside the side garage door. The nurse then returned to the North door which accessed the courtyard area from the inside of the building and found the resident as he sat in a wheel chair. The staff member returned the resident into the facility at approximately 11:20 p.m. c. 5.30.24 at 2:49 a.m. - Staff had just started shift change report when the front door alarm sounded. A Licensed Practical Nurse (LPN) ran to the door and observed the resident as he sat outside the exterior door positioned in a wheel chair. Staff returned the resident into the facility. During an interview 6.11.24 at 3:31 p.m. Staff E, LPN confirmed residents as allowed to have entered the facilities courtyard area unattended even at night when dark. The staff member knew this Resident had broke into the side garage door	F 689		

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	165490	A. BUILDING _____ B. WING _____	C 06/18/2024

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F 689	Continued From page 12 accessible from the gated court yard area because Staff A reported to her she found him seated on a lawn mower positioned in the middle of the garage. Staff A reported to her the door alarm sounded which lead into the courtyard so staff responded. The staff members performed a head count and noted the Resident as unaccounted for for 5-10 minutes. During an interview 6.12.24 at 9:56 a.m. Staff A indicated the Resident actually left the courtyard area 2 times on the night shift. One night she heard the door alarm as it sounded and responded. The staff member went out in court yard and performed a visual sweep but could not find any resident. The staff member then followed the side walk and found the Resident in the garage as he sat on a riding lawn mower. The staff member confirmed it had been dark enough outside that it inhibited someone from getting around. The staff member confirmed both herself and the only CNA in the building went out of the building as they searched for the resident which left the rest of the residents unattended. When the resident had been found he exhibited no outward appearance that he had fallen as his clothes had not been dirty and he had no signs of injury. According to an Event Report concerning the facilities garage door dated 5.24.24 included the following documentation as dated from the Maintenance Director: a. 5/11/24 - The side door to the garage was noted to be in disrepair. The latching presented unreliable. The Maintenance Director used a board under the knob to temporarily secure until	F 689	

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F 689	Continued From page 13	F 689		

the proper repairs occurred

b. 5/14/24 - Staff reported to the Maintenance Director, Staff A, left a resident outside to smoke and upon her return the resident had not been in sight. The staff member expressed finding the resident in the garage as he sat on the riding mower.

c. 5/15/24 - A new latch set and door repair plate had been installed and the door secured.

d. 5/15/24 at 11:11 p.m. - The Maintenance Director received a telephone call at which Staff A requested the code for the main garage door who expressed that she had brought a resident outside to smoke. When she returned, she could not find him and suspected him to have been in the garage, but she could not open the side garage door she suspected the resident to have used to enter the area. The staff member then reported she found the resident in the fenced courtyard and not in the garage.

e. 5/24/24 - Staff A called the Maintenance Director and expressed that she had completed a perimeter check of the courtyard and found the side garage door opened. The Maintenance Director expressed to the staff member that she must have hit it pretty hard and intentional excessive force on a door would have made it open. The Maintenance Director returned to the facility and found the door jam broken. The Director secured the door with a 2x4 across the door and construction screws until a new door could be installed.

During an interview 6.11.24 at 11:40 a.m. the Maintenance Director confirmed, with the

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F 689	Continued From page 14 Administrator present, the switch to the flood light outside and above the side garage door which would have lit up the court yard area as non functional and turned to the off position. According to an email 6.19.24 at 12:42 p.m. the Regional Clinical Quality Specialist confirmed the Administrator failed to notify the corporate office related to the malfunctioning garage access door from the courtyard area and the nonfunctional flood lights. 2. A Progress Note entry dated 4.12.24 at 8:30 p.m. included the following entry by Staff B, Licensed Practical Nurse (LPN): This writer had left the med cart to get dressing supplies, thought she hit the lock button on the way but must not have. When she attempted to get the cigarettes for Resident #1 out of the med cart they were already gone. The Resident accessed the unlocked medication cart and took them and himself outside for a smoke. Then at 9 o'clock, his scheduled smoke break the Resident became upset and swore at this writer because she wouldn't take him out again. The Resident set off the door alarm, as he stated he planned to leave. The Resident sat outside for about 10 minutes then returned to his room. An observation 6.7.24 at 12:05 p.m. revealed the South medication cart as unlocked and unattended positioned parallel to the South wall in the dining room. An observation 6.12.4 at approximately 2 p.m. revealed an unlocked unattended medication cart positioned along the South portion of the nurse's station with residents in the general area.	F 689		

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F 689	Continued From page 15 During an email 6.18.24 at 11:33 a.m. the Director of Nursing (DON) identified 6 residents cognitively impaired who wandered.	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, Resident Council Minutes, and facility policy	F 725	In continuing compliance with F 725, Sufficient Nursing Staff. Accura Healthcare of Cresco corrected the deficiency by the Regional Clinical Specialist providing education to the DON on answering call lights timely and ensuring restorative programs are completed on 6/26/2024 for resident #3 and all like residents. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated on 7/3/2024 on answering the call lights timely and completing restorative programs as indicated. The DON and/or designee will audit the completion of restorative programs and call light response times 4 times per week for 4 weeks, 3 times per week for 4 weeks, 2 times per week for 2 weeks, 1 time per week for 2 weeks, then PRN. As part of Accura Healthcare of Cresco ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	7/3/2024

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F 725	Continued From page 16 review the facility failed to answer resident call lights within the allotted professional standard of 15 minutes for 1 of 3 residents reviewed (Resident #3) and failed to provide restorative exercises according to the resident's individual plan of care for 1 of 3 residents reviewed (Resident #3). The facility identified a census of 27 residents. Findings include: 1. During an interview 6.12.24 at 4 p.m. Resident #3 described the facility as a "shit show". The Resident indicated yesterday she waited for 45 minutes in the morning for someone to answer her call light and she finally called the nurse's station for assistance and had been told staff were busy getting residents up for breakfast and with assistance in the dining room. The Resident indicated as she waited for staff assistance for so long it made her feel unwanted and like no one knew or cared she lived at the facility. During an interview 6.11.24 10:05 a.m. Staff D, Licensed Practical Nurse (LPN) indicated call lights as not always answered within 15 minutes due to staffing issues. During an interview 6.11.24 at 3:31 p.m. Staff E, LPN confirmed staff failed to answer resident call lights within 15 minutes at all times but it all depended on the amount of staff and the facility failed to consistently provide enough staff to have met the individual needs of the residents. Review of the facilities Resident Council minutes revealed concerns with the facility staffs failure to answer resident call lights timely on 5.2.24 at 1:30 p.m. and 6.6.24 at 10:15 a.m.	F 725		

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F 725	Continued From page 17 2. During an interview Resident #3, identified as interviewable by the facility, indicated she received no therapy services as arranged. During an interview 6.11.24 at 1:30 p.m. the Administrator and the Regional Clinical Quality Specialist confirmed the facility failed to maintain an active restorative program. During an interview 6.11.24 10:05 a.m. Staff D, Licensed Practical Nurse (LPN) indicated the facility failed to provide the residents a restorative program due to low staffing. During an interview 6.11.24 3:31 p.m. Staff E, LPN confirmed staff failed to provide the residents with their individual restorative programs as set up. During an interview 6.18.24 at 1:15 p.m. Staff F, Certified Nursing Assistant (CNA) confirmed she had been hired as a restorative aide but had been pulled to the floor as a CNA due to low census and staffing issues. The same staff member confirmed the facility staff as unable to answer resident call lights within 15 minutes due to staffing levels. The staff member confirmed residents who required staff assistance got up independently because staff had been unable to answer resident call lights timely however she had been unaware of any falls or a serious type injury as a result During an interview 6.18.24 at 12 p.m. the Director of Rehabilitation Services confirmed when they discharged residents from therapy services their department wrote up a restorative	F 725		

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F 725	Continued From page 18 program as appropriate and expected the facility staff to have followed through accordingly. The Director confirmed the restorative aide failed to follow the programs as she had been pulled to work the floor frequently.	F 725		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on time card review and staff interviews the facility failed to provide a Registered Nurse (RN) in the facility for eight (8) consecutive hours per day as required by Federal Regulations. The facility identified a census of 27 residents. Findings include: Review of all Registered Nurse (RN) Timesheets from 5.26.24 thru 6.6.24 revealed the facility failed to staff an RN on the following dates: 5.27.24 and 6.4 thru 6.6.24. During an interview 6.7.24 at 3:15 p.m. the	F 727	In continuing compliance with F727 RN 8 Hrs/7 days/wk Accura Healthcare of Cresco corrected the deficiency by staff education to ensure the facility provides a RN in the facility for 8 consecutive hours per day. To correct the deficiency and to ensure the problem does not recur, the VP of Operations educated the DON on 7/1/2024 on the requirements to staff an RN in the facility for 8 consecutive hours per day. The Executive Director and/or designee will audit for proper staffing twice weekly for 12 weeks to ensure continued compliance. As part of Accura Healthcare of Cresco's ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	7/1/2024

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F 727	Continued From page 19 Administrator confirmed the facility failed to provide 8 hours of RN coverage every day.	F 727		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview, and facility policy review, the facility failed to properly count, store, and secure the safety and accessibility of resident narcotic medications. The facility identified a census of 27 residents.	F 761	In continuing compliance with F 761, Label/Storage Drugs Biologicals. Accura Healthcare of Cresco corrected the deficiency by the Regional Clinical Specialist providing education to the DON on the controlled substance process and locking medication cart on 6/26/2024 for resident #6 and all like residents. To correct the deficiency and to ensure the problem does not recur all nurses were educated by 7/3/2023 on the controlled substance process and locking medication carts by the DON. The DON and/or designee will audit controlled substance process and the locking of medication carts 4 times per week for 4 weeks, 3 times per week for 4 weeks, 2 times per week for 2 weeks, 1 time per week for 2 weeks, then PRN. As part of Accura Healthcare of Cresco ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	7/3/2023

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F 761	Continued From page 20 Findings include: 1. Review of a Controlled Drug Administration Record form not dated indicated Resident #6 received a supply of Baclofen 5 milligrams to have been administered one (1) by mouth (PO) at bedtime (HS). On a date unknown at 7:23 p.m. 1 Baclofen pill had been administered which left 2 pills remaining with no nurse's signature to validate who administered the medications. 2. Controlled Drug Count Record forms revealed staff failed to sign the form to validate narcotics had been counted on the dates and shifts as follows: a. June 1, 2024 on the North cart for the 10 p.m. to 6 a.m. shift had not been signed by the nurse who went off duty. b. May 1st a medication cart not identified, the nurse coming on shift failed to sign on the 10 p.m. to 6 a.m. shift. c. May 6th and 7th, on the same medication cart not identified, the nurse going off shift failed to sign on 6 a.m. to 2 p.m. shift. d. May 17th, 24th, and 30th on the same unidentified medication cart the nurse going off the 10 p.m. to 6 a.m. shift failed to sign. e. May 31st on the same cart as above the nurse coming on the 2 p.m. - 10 p.m. shift failed to sign. f. May 23rd and 31st on the same cart as above the nurse going off the 2 p.m. - 10 p.m. shift failed to sign. 3. During an interview 6.11.24 at 3:31 p.m. Staff E, LPN confirmed muscle relaxers and narcotics as recently missing however the situation had	F 761		

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F 761	Continued From page 21 been swept under the rug. 4. During an interview 6.11.24 at 10:05 a.m. Staff D, Licensed Practical Nurse (LPN) indicated she failed to count narcotics when she handed her keys over to another nurse if she went uptown during her mealtime break. Additionally, this staff member confirmed the Assistant Director of Nursing (ADON) had her own keys to the medication room, medication cart, and the narcotic drawer in the medication cart and she accessed all three (3) areas at her own discretion. The ADON told this staff member quite frequently after she returned from break that such and such resident requested a pain pill so she accessed the medication cart and narcotic drawer and administered the medication. During an interview 6.11.24 at 3:31 p.m. Staff E, LPN confirmed the nurse who went off shift counted the narcotics and/or all medications stored in the narcotic drawer and the nurse who came on shift reviewed the actual count on the narcotic sheets. This staff member indicated she always made sure the process had been completed when she worked. The staff member indicated there had been times the ADON worked alone and signed narcotics and other medications stored in the narcotic drawer off on the Controlled Drug sheets so they appeared accurate when counted but failed do document administration of the same drugs on the MARS so they appeared inaccurate. This staff member observed the ADON access her assigned medication cart and asked what she had been doing. The ADON just coughed, shut the medication cart and locked it. During an interview 6.12.24 at 9:15 a.m. Staff G, RN stated she observed the ADON as she	F 761		

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F 761	Continued From page 22 attempted to access her assigned medication cart and intervened. 5. During an interview 6.13.24 at 11:16 a.m. the ADON confirmed she carried the spare keys to medication cart, narcotic box located inside the medication cart, and the medication room. When the staff member had not been on duty she left the keys in her locked office According to an email dated 6.13.24 at 12:41 p.m. the Administrator confirmed the spare key to the door of the Assistant Director of Nursing's office as on the key ring of the charge nurses. The ADON indicated she felt the biggest reason for any medication errors occurred had been because multiple nurses had access to the medication carts. During an interview 6.7.24 at 2:43 p.m. the Administrator confirmed she currently had the spare keys to the North and South medication carts and narcotic boxes located in those carts. Prior to the alleged diversion Staff C had them in her possession. 6. A Progress Note entry dated 4.12.24 at 8:30 p.m. included the following entry by Staff B, Licensed Practical Nurse (LPN): This writer had left the med cart to get dressing supplies, thought she hit the lock button on the way but must not have. When she attempted to get the cigarettes for Resident #1 out of the med cart they were already gone. The Resident accessed the unlocked medication cart and took them and himself outside for a smoke. Then at 9 o'clock, his scheduled smoke break,	F 761	

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F 761	Continued From page 23	F 761		

the Resident became upset and swore at this writer because she wouldn't take him out again. The Resident set off the door alarm, as he stated he planned to leave. The Resident sat outside for about 10 minutes then returned to his room.

7. A Controlled Substances policy updated 10.19.22 included the following Purposes:

a. A completed physical inventory of narcotics at each change of shift by two (2) nurses to have identified discrepancies and need for reconciliation and accountability.
b. Assurance controlled drugs had been handled, stored and disposed of properly.
c. Assurance of proper record keeping for controlled drugs.

The Procedure included the following:

a. Controlled substances had only been available to nurses, pharmacists and medical personnel designated by the Accura Health Care Community.
b. One (1) authorized person had been responsible for narcotics utilization every shift. Going off duty and coming on duty authorized persons must have counted and validated accuracy of narcotics supplied for every resident at the change of every shift.
c. Narcotic keys reconciled at the same time.
d. After staff counted and justified the supply each nurse must have recorded the dated and his/her signature that verified the count as correct.
e. If the count presented as inaccurate, the authorized person going off duty remained on duty until the count had been reconciled or the nursing supervisor approved leaving the Accura

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F 761	Continued From page 24 Healthcare Community. Discrepancies found at any time, change of shift or other should have been reported immediately to the Director of Nursing (DON). The Director then initiated an investigation to determine the cause of the inaccuracy and called the pharmacist for assistance per Accura Healthcare Community Protocol. Any missing narcotic medication must have been reported to the Resource Center's Clinical Quality Team.	F 761		
F 835 SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, professional record review, and staff interview, at the time of the investigation, the facility failed to ensure sufficient supplies to meet the treatment needs of 2 residents (Resident #2 and # 3) and failed to provide a policy and procedure book readily accessible to staff to reference as needed. The facility identified a census of 27 residents. Findings include: 1. During an interview 6.11.24 10:05 a.m. Staff D, Licensed Practical Nurse (LPN) confirmed the facility failed to provide the necessary treatment supplies for various residents. Review of a Treatment Administration Record	F 835	In continuing compliance with F 835, Administration. Accura Healthcare of Cresco corrected the deficiency by the Regional Clinical Specialist providing education to the DON on ensuring supplies are available to complete wound care orders on 6/26/2024 for resident #2, #3, and all like residents. The DON also corrected the deficiency by providing policies at the nurse's station on 6/12/2024. To correct the deficiency and to ensure the problem does not recur all nurses were educated on 7/3/2024 on ensuring all supplies are available to complete orders and the location of policies by the DON. The DON and/or designee will audit wound care supplies 4 times per week for 4 weeks, 3 times per week for 4 weeks, 2 times per week for 2 weeks, 1 time per week for 2 weeks, then PRN. As part of Accura Healthcare of Cresco ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	7/3/2024

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F 835	Continued From page 25 (TAR) form dated 6.1.24 thru 6.31.24 indicated Resident #2 had a treatment order that directed the facility staff to have cleansed the Resident's right hip and buttock wound with wound cleanser, followed by an application of Silversorb external gel, covered with collagen powder and an ABD pad every day (QD). The facility staff failed to perform the complete treatment to the Resident's stage IV pressure area on her right hip and gluteal region due to no supply of Silversorb on 6.8.24 and 6.9.24. Review of a TAR form dated 6.1.24 thru 6.31.24 indicated Resident #3 had a treatment order that directed the facility staff to have cleansed the Residents right medial 3rd toe with normal saline, paint area with Betadine and left open to air. The facility staff failed to perform the treatment on 6.7.24 and 6.9.24 due to no supply of treatment items. 2. During an interview 6.11.24 at 3:31 p.m. Staff E, LPN confirmed there had been no policy/procedure book accessible to staff. During an interview 6.12.24 at 9:15 a.m. Staff G, RN stated she had begged and begged for a policy/procedure book for reference and the Administrator kept handing her an employee handbook as the Administrator indicated to the staff member that there had been no policy and procedure book available. According to an email 6.19.24 at 11:06 a.m. the Administrator indicated when a facility staff requested a policy she went to the P drive on a computer and retrieved the policy for the staff member.	F 835		

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F 835	Continued From page 26 According to an email 6.19.24 at 4:31 p.m. the Administrator confirmed she had been aware the facility failed to allow direct facility staff access to the P drive. According to an email 6.19.24 at 4:53 p.m. the Administrator indicated approximately 3 weeks ago she found out the facility failed to allow the direct facility staff access to the P drive and that had been why the Assistant Director of Nursing had been working on the organization of a policy and procedure book. According to an email 6.19.24 at 4:31 p.m. the Regional Clinical Quality Specialist indicated she became aware the facility failed to allow nurse's access to the P drive on their nurse's computers and the Director of Nursing printed and provided a copy for the facility staff.	F 835		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, photo review, resident interview, and staff interview the facility failed to maintain a safe and secure environment for all residents. The facility identified a census of 27 residents. Findings include: 1. A Minimum Data Set (MDS) assessment form dated 5.22.24 indicated Resident #1 had	F 921	In continuing compliance with F921 Safe, functional, comfortable environment, Accura Healthcare of Cresco corrected the deficiency by the Maintenance Director securing the door with 2x4s on 5/24/2024 to ensure resident #1 and all like residents are provided a safe environment. To correct the deficiency and to ensure the problem does not recur, a new door for the courtyard garage will be ordered by 7/12/2024 by the Executive Director. New lights will be placed in the courtyard by 7/12/2024 to help with illumination. The Executive Director and/or designee will audit for proper functioning of the garage entry door and courtyard flood lights twice weekly for 12 weeks to ensure continued compliance. As part of Accura Healthcare of Cresco's ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	7/12/2024

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F 921	Continued From page 27 diagnoses that included Schizophrenia, Bi-Polar, Depression, Coronary Artery Disease (CAD) , Diabetes Mellitus (DM), Arthritis, shortness of breath (SOB), tobacco use and Respiratory Failure. The assessment indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 (moderately impaired cognitive skills), utilized a walker or wheel chair for mobility, required partial to moderate staff assistance for ambulation up to 10 feet, unable to ambulate 50-150 feet and independent with his wheel chair. A Care Plan revealed the following Focus areas and Interventions as dated: a. An activities of daily living (ADL) deficit due to (d/t) SOB (Shortness of Breath) secondary to Chronic Obstructive Pulmonary Disease (COPD) and incontinence. (initiated 8.16.22) 1. I require assistance of one (1) a walker and a gait belt assistive device. (initiated 8.16.22) 2. I use a walker and wheel chair for mobility. (initiated 8.16.22) b. I smoke. (revised 3.7.24) c. Limited physical mobility d/t a previous injury to his legs. (revised 3.10.23) d. Behavior problems which included stolen cigarettes from staff, verbal outbursts of cursing/swearing, obtained cigarettes and extra smoke breaks, and inappropriate verbalization with female staff. (revised 3.6.23) e. I may have tried to exit seek and wander d/t poor cognition at times related to his behavior and health diagnosis. f. At risk for falls. (revised 3.10.23) A Risk Assessment Elopement form dated 5.22.24 at 8:30 p.m. indicated the resident as at	F 921		

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F 921	Continued From page 28 high risk for elopement. A Fall Risk Assessment form dated 5.22.24 at 8:30 p.m. indicated the Resident as at moderate risk for falls. Review of the Resident's Progress Notes revealed the following entries as dated: a. 5.13.24 at 12:43 a.m. - Staff A, Registered Nurse (RN) documented the door alarm had sounded, staff responded and noted the resident positioned in a wheel chair on a grassy area in the secured court yard. The Resident refused to return into the facility so the staff left him outside and returned into the facility which had been previously approved by the Administrator. The staff looked at a camera monitor (which had no capacity to record coverage) after a few minutes and noted the resident as not in sight. The Certified Nursing Assistant (CNA) went to check on the resident and found his unoccupied wheel chair on the cement side walk with no resident present. The RN and CNA walked the court yard area. The RN checked the side garage door and found the door unlocked, used her pocket light and noted the Resident positioned on a riding lawn mower in the garage. The Resident told the RN there had been something propped up against the door but it gave away so the resident walked right into the garage. The staff member successfully redirected the Resident back into the facility at that time. b. 5.16.24 at 12:00 a.m. - Staff A, RN documented the Resident had been exit seeking earlier in her shift. As herself and a CNA completed cares on another resident she went to check on Resident #1 again and noted he had not	F 921		

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F 921	Continued From page 29 been by the the exit door to the court yard. The nurse took out her pocket flashlight and walked the perimeter of the fenced area (courtyard) and found the resident's empty wheel chair by the locked side garage door accessible from the courtyard area. The staff member followed the facilities Elopement Policy and returned inside and called the Administrator who directed her to call the Director of Maintenance who gave her the code to the overhead garage door located outside of the courtyard area. The staff member went to this door and noted the resident's wheel chair as no longer positioned outside the side garage door. The nurse then returned to the North door which accessed the courtyard area from the inside of the building and found the resident as he sat in a wheel chair. The staff member returned the resident into the facility at approximately 11:20 p.m. c. 5.30.24 at 2:49 a.m. - Staff had just started shift change report when the front door alarm sounded. A Licensed Practical Nurse (LPN) ran to the door and observed the resident as he sat outside the exterior door positioned in a wheel chair. Staff returned the resident into the facility. During an interview 6.11.24 at 3:31 p.m. Staff E, LPN confirmed residents as allowed to have entered the facilities courtyard area unattended even at night when dark. The staff member knew this Resident had broke into the side garage door accessible from the gated court yard area because Staff A reported to her she found him seated on a lawn mower positioned in the middle of the garage. Staff A reported to her the door alarm sounded which lead into the courtyard so staff responded. The staff members performed a head count and noted the Resident as	F 921		

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F 921	Continued From page 30 unaccounted for for 5-10 minutes. During an interview 6.12.24 at 9:56 a.m. Staff A indicated the Resident actually left the courtyard area 2 times on the night shift. One night she heard the door alarm as it sounded and responded. The staff member went out in court yard and performed a visual sweep but could not find any resident. The staff member then followed the side walk and found the Resident in the garage as he sat on a riding lawn mower. The staff member confirmed it had been dark enough outside that it inhibited someone from getting around. The staff member confirmed both herself and the only CNA in the building went out of the building as they searched for the resident which left the rest of the residents unattended. When the resident had been found he exhibited no outward appearance that he had fallen as his clothes had not been dirty and he had no signs of injury. According to an Event Report concerning the facilities garage door dated 5.24.24 included the following documentation as dated from the Maintenance Director: a. 5/11/24 - The side door to the garage was noted to be in disrepair. The latching presented unreliable. The Maintenance Director used a board under the knob to temporarily secure until the proper repairs occurred b. 5/14/24 - Staff reported to the Maintenance Director, Staff A, left a resident outside to smoke and upon her return the resident had not been in sight. The staff member expressed finding the resident in the garage as he sat on the riding	F 921		

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F 921	Continued From page 31 mower. c. 5/15/24 - A new latch set and door repair plate had been installed and the door secured. d. 5/15/24 at 11:11 p.m. - The Maintenance Director received a telephone call at which Staff A requested the code for the main garage door who expressed that she had brought a resident outside to smoke. When she returned, she could not find him and suspected him to have been in the garage, but she could not open the side garage door she suspected the resident to have used to enter the area. The staff member then reported she found the resident in the fenced courtyard and not in the garage. e. 5/24/24 - Staff A called the Maintenance Director and expressed that she had completed a perimeter check of the courtyard and found the side garage door opened. The Maintenance Director expressed to the staff member that she must have hit it pretty hard and intentional excessive force on a door would have made it open. The Maintenance Director returned to the facility and found the door jam broken. The Director secured the door with a 2x4 across the door and construction screws until a new door could have been installed. During an interview 6.11.24 at 11:40 a.m. the Maintenance Director confirmed, with the Administrator present, the switch to the flood light outside and above the side garage door which would have lit up the court yard area as non functional and turned to the off position. According to an email 6.19.24 at 12:42 p.m. the Regional Clinical Quality Specialist confirmed the	F 921		

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F 921	Continued From page 32 Administrator failed to notify the corporate office related to the malfunctioning garage access door from the courtyard area and the nonfunctional flood lights. 2. During an email 6.18.24 at 11:33 a.m. the Director of Nursing (DON) identified 6 residents cognitively impaired who wandered.	F 921		