STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165535	A. BUILDING _____ B. WING _____	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF AURELIA, LLC	401 WEST FIFTH STREET AURELIA, IA 51005

(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: 02/21/2024 X DC The following deficiencies resulted from the facility's annual recertification survey conducted on Feburary 5, 2024 to Feburary 8, 2024. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	PLAN OF CORRECTION Accura Healthcare of Aurelia 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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656	1. In continuing compliance with F 656, Develop/Implement Comprehensive Care plans. Accura Health Care of Aurelia corrected the deficiency by the DON updating Res #23, 32 and like resident's care plans with high-risk medications on 2/8/2024. 2. To correct the deficiency and to ensure that the problem does not recur the MDS nurse was educated on 2/8/2024 on the development/Implementation of comprehensive care plans and timely updates with high-risk medications. The DON and or designee will audit care plans to ensure all high-risk medications are in place 4 times per week for 4 weeks, 3 times per week for 4 weeks, 2 times a week for 2 weeks, 1 time per week for 2 weeks, then PRN. 3. As a part of Accura HealthCare of Aurelia's ongoing commitment to quality assurance the DON and/or designee will report identified concerns through the community's QA Process.	2/8/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Execute Director — (X6) DATE: 2/21/24

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 656	Continued From page 1	F 656		

(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on clinical record, facility policy, and staff interview, the facility failed to develop care plans to reflect side effects of high risk medications insulin and melatonin or an Urinary Tract Infection (UTI) for 2 of 12 residents reviewed (Residents #23 and #32). The facility reported a census of 36 residents.

Findings include:

1. The MDS dated 12/19/23 for Resident #23 revealed a BIMS of 14 which indicated intact cognition. The MDS revealed the resident had diagnoses of diabetes mellitus, insomnia, and generalized muscle weakness.

The Order Summary Report signed by a physician on 1/16/24 revealed an order for melatonin, 3 milligrams (mg) given one time per

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F 656	Continued From page 2 day. In a Nurses Note on 1/11/24 at 8:00 PM, Staff E, Licensed Practical Nurse (LPN) reported, in pertinent part, new order for ATB (antibiotic) for UTI. The Doctor's Orders and Progress Notes signed by an Advanced Practice Registered Nurse (ARNP on 1/11/24 revealed an order for nitrofurantoin (antibiotic) 100 mg BID (twice per day) for 5 days. The Care Plan with an initiated date of 2/7/23 did not contain information related to: a. Melatonin, including side effects. b. UTI diagnosis. The document, What's a care plan in a nursing home?, accessed on 2/07/24 at 10:48 AM from medicare.gov directed, in pertinent part, that the basic care plan include ongoing, regular assessments of a condition to see if health status has changed, with changes to the care plan as needed. In an interview on 2/07/24 at 1:50 PM, the DON reported that she will look into why the resident's infection wasn't on her care plan. When asked why melatonin was not on the resident's care plan, the DON responded by asking what should be on the resident's care plan since she had orders for melatonin. 2. The MDS assessment dated 1/9/24 for Resident #32 documented diagnoses of diabetes mellitus, hypertension and anemia. The MDS showed the BIMS score of 15, indicating no	F 656		

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F 656	Continued From page 3 cognitive impairment. The MDS revealed Resident #32 had taken insulin injections the last 7 out of 7 days in the review period. Review of the Order Summary Report signed by the physician dated 2/2/24 revealed the following orders: a. Humalog injection solution sliding scale three times a day for diabetes with a start date of 11/16/23 b. Humalog kwikpen solution one time a day for diabetes with a start date of 12/5/23 c. Humalog kwikpen solution 2 times a day for diabetes with a start date of 12/4/23 d. Lantus solostar solution one time a day for diabetes with a start date of 11/16/23 Review of the February Medication Administration Record (MAR) revealed the following orders: a. Humalog injection solution sliding scale three times a day with a start date of 11/16/23 b. Humalog kwikpen solution one time a day with a start date of 12/5/23 c. Humalog kwikpen solution 2 times a day with a start date of 12/4/23 d. Lantus solostar solution one time a day with a start date of 11/16/23 Review of the Care Plan with a revision date of 1/25/24 lacked information regarding usage of insulin and signs and symptoms to watch for. Interview on 2/06/24 at 1:56 p.m., with the DON revealed she would expect the care plan to have insulin usage listed and side effects of the medication on the care plan. Interview on 2/06/24 at 3:11 p.m., with the Director of Nursing (DON) revealed the facility	F 656		

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F 656	Continued From page 4 does not have a policy on care plans.	F 656		
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 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 observation, staff interview and record review, the facility failed to update the resident's care plan to accurately reflect interventions ordered by the physician and accurately list residents current assistance level for 2 of 12	F 657	1. In continuing compliance with F 657, Care Plan Timing and Revision. Accura Health Care of Aurelia corrected the deficiency by the DON updating Res #23, 32 and like resident's care plans with appropriate interventions ordered by the physician on 2/8/2024. 2. To correct the deficiency and to ensure that the problem does not recur, the MDS nurse was educated on 2/8/2024 on care plan timing and revision with interventions ordered by the physician. The DON and or designee will audit care plans to ensure all intervention are in place 4 times per week for 4 weeks, 3 times per week for 4 weeks, 2 times a week for 2 weeks, 1 time per week for 2 weeks, then PRN. 3. As a part of Accura HealthCare of Aurelia's ongoing commitment to quality assurance the DON and/or designee will report identified concerns through the community's QA Process.	2/8/2024

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F 657	Continued From page 5 residents reviewed (Residents #23 and #32). The facility reported a census of 36 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 1/9/24 for Resident #32 documented diagnoses of myositis (a group of rare conditions that can cause muscles to become weak, tired and painful), generalized muscle weakness and radiculopathy (pinched nerve or injury or damage to nerve roots in the area where they leave the spine). The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. The MDS revealed Resident #32 has a pressure ulcer or injury and has one or more unhealed pressure ulcers or injuries. The MDS revealed resident was dependent on staff for bed mobility and transfers to and from bed to chair, and chair to bed. Review of the Care Plan with a revision date of 1/25/24 revealed the following information: Resident #32 required assistance of 2 staff to turn and reposition in bed, required assistance of 2 staff with dressing, required assistance of 2 staff with mechanical lift for transfers, required assistance of 1 staff with all personal hygiene and was independently able to move/ wheel self in wheelchair. Review of Treatment Plan signed 2/1/24 revealed the following information: a. Continue to use ROHO cushion. b. Sit upright in wheelchair or other chair with the cushion, do not recline. c. Sit no more than 1.5 hours at a time for meals, then reposition. Other times should be in bed, on his side. d. Protein supplement per dietician.	F 657		

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F 657	Continued From page 6 e. Heel protectors. Review of the Order Summary Report signed by the physician dated 2/2/24 revealed the following orders: a. Cleanse and dress right heel three times a week and as needed with an order date of 1/15/24. b. Head of Bed no higher than 30 degrees for skin impairment with an order date of 11/16/23. c. Magic cup for wound healing with an order date of 12/4/23. d. Ted hose on during the day and off at night for skin impairment with an order date of 11/16/23. e. Use of better pressure redistribution cushion, sit for no more than one two hours for meals, and reposition on side in bed, turning frequently with an order date of 1/15/24. f. Use Prevalon boots 24 hours a day, remove each shift to check for skin impairment with an order date of 1/15/24. h. When up in wheelchair pressure relief every 15 minutes for skin impairment. i. Arginaid packet daily with an order date of 12/29/23. Review of the February Treatment Administration Record (TAR) revealed the following orders: a. Cleanse and dress right heel three times a week and as needed with a start date of 1/16/24. b. Head of Bed no higher than 30 degrees for skin impairment with a start date of 11/16/23. c. Magic cup for wound healing with a start date of 12/5/23. d. Ted hose on during the day and off at night for skin impairment with a start date of 11/16/23. e. Use of better pressure redistribution cushion, sit for no more than one two hours for meals, and reposition on side in bed, turning frequently with a	F 657		

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F 657	Continued From page 7 start date of 1/15/24. f. Use Prevalon boots 24 hours a day, remove each shift to check for skin impairment with an start date of 1/15/24. h. When up in wheelchair pressure relief every 15 minutes for skin impairment with a start date of 11/17/23. i. Arginaid packet daily with a start date of 12/29/23. Review of the Care Plan with a revision date of 1/25/24 revealed a focus area the resident has potential or actual impairment to skin integrity. The focus area lacked current interventions ordered by the physician. Interview on 2/06/24 at 1:55 p.m., with the DON revealed she would expect all current interventions to be listed on the care plan and would expect the interventions to be updated as they are changed. 2. The MDS dated 12/19/23 for Resident #23 revealed a BIMS of 14 which indicated intact cognition. The MDS revealed the resident had diagnoses of diabetes mellitus, insomnia, and generalized muscle weakness. The resident had 2 falls since the last comprehensive MDS assessment. The Care Plan revealed in pertinent part: a. ADL (Activities of Daily Living) Focus Area intervention initiated 2/27/23 and revised on 2/5/24 revealed that for transfers, the resident was independent with 4WW (4 wheeled walker), assist of one as needed. b. Fall Focus Area intervention initiated 1/19/24 revealed that the therapy department changed the resident to assist of 1 with transfers.	F 657		

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F 657	Continued From page 8 In an interview on 2/07/24 at 8:45 AM, Staff A, Certified Nurse Assistant (CNA) reported the resident was an assist of 1 with personal cares, but that the resident reported that she performs cares independently instead of putting her call light on for assistance. When Staff A assisted the resident, she charted the task performed as provided with assistance, when the resident reported she performed a task independently, Staff A charts this as independently performed. Staff A reported she was not sure what level of assistance the resident required with care as she has observed the resident walking independently in the hall with only the assistance of her walker since she has required the assistance of 1 with personal cares. In an interview on 2/7/24 at 1:50 PM, the Director of Nursing (DON), reported that the resident was independent, she had required assistance of 1 for ADLs when she received physical therapy (PT) services. The DON reported that we need to update the resident's care plan now because it's not relevant any more. In an interview on 2/6/24 at 3:10 PM, the Director of Nursing (DON) reported that the facility does not have a policy for Care Plans.	F 657		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	F 688	1. In continuing compliance with F 688, Increase/Prevent Decrease in ROM/Mobility. Accura Health Care of Aurelia corrected the deficiency by correcting Res #20 and like residents EHR documentation for restorative programs on 2/8/2024 by the DON.	2/8/2024

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F 688	Continued From page 9 §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on clinical record, facility policy, and staff interview, the facility failed to provide a restorative exercise program for 1 of 1 resident reviewed (Resident #20). The facility reported a census of 36 residents. Findings include: The Minimum Data Set (MDS) dated 11/14/23 for Resident #20 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS revealed the resident had diagnoses of osteoarthritis to his left knee, osteoporosis (loss of bone strength), and muscle weakness. In an interview on 2/05/24 at 10:40 AM, the resident reported that his physical therapy (PT) ended last week and that he was waiting for someone to come to his room this week to show him the exercises he is supposed to do on his own. The resident reported that he goes to a group exercise held in the facility, but that he would like individual assistance with an exercise program to maintain the progress he made in PT.	F 688	2. To correct the deficiency and to ensure that the problem does not recur the DON provided education to the MDS Nurse on 2/8/2024 on ensuring documentation of restorative programs are completed as indicated. The DON and or designee will audit restorative charting for 4 times per week for 4 weeks, 3 times per week for 4 weeks, 2 times a week for 2 weeks, 1 time per week for 2 weeks, then PRN. 3. As a part of Accura HealthCare of Aurelia'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 688	Continued From page 10 The PT Discharge Summary signed by a PT on 2/1/24 directed, in pertinent part, that the resident: 1. Will continue with ambulation 5-7 times per week with 4 wheeled walker with assist of 1. 2. Will continue to do seated and standing exercises on a modified independent basis. The Care Plan intervention initiated 8/18/22 and revised 12/7/22 directed the following with ambulation: please assist to breakfast with my 4 wheeled walker, with bilateral AFO's (Ankle Foot Orthosis, medical device) on lower extremity. The Task List revealed, in pertinent part, walk to one meal a day with 4 wheeled walker, with bilateral AFO's on lower extremity. In a concurrent record review and interview on 2/07/24 at 9:42 AM, Staff A, Certified Nurse Assistant (CNA), demonstrated where she charts the tasks the resident receives. The task to walk to one meal a day was not present on Staff 's electronic charting device. Staff A reported no other place existed to chart against the task to walk the resident to one meal per day. The Clinical Record lacked documentation that the resident had assistance with seated and standing exercises on a modified independent basis after his PT discharge on 2/1/24. In an interview on 2/07/24 at 1:50 PM, the Director of Nursing (DON) reported that when a resident discharged from therapy services with a restorative exercise program, she adds those to the task list for the CNAs to chart against. The DON reported that the resident was discharged from PT with only a walk to dine program. The	F 688		

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F 688	Continued From page 11 DON reported that the electronic health record (EHR) has had some recent glitches, that may be the reason the charting for the resident's walk to dine program was not visible. When the DON was made aware that the walk to dine task started in December 2022, she responded by saying she would make sure to find the documentation and that the only location documentation existed was in the EHR. In an interview on 2/7/24 at 2:20 PM, the DON reported that the walk to dine task was entered into the EHR incorrectly and she could not produce documentation that the task occurred. The facility did not have a policy for restorative therapy.	F 688		
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 serve food in accordance with professional standards for food service safety.	F 812	1.Continuing compliance with F 812, Food Procurement, Store/Prepare/Serve-Sanitary. Accura Healthcare of Aurelia corrected the deficiency by the CDM ensuring food was properly stored. Education was provided on 2/21/2024 to all dietary staff in 2022 Food Code & Food Storage Policy.	02/21/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165535	A. BUILDING _____ B. WING _____	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF AURELIA, LLC	401 WEST FIFTH STREET AURELIA, IA 51005

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F 812	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observations, facility policy, 2022 Food Code, and staff interview, the facility failed to store kitchenware and utensils in a manner to prevent contamination; failed to store a measuring scoop in a clean manner; bulk foods did not have an open date labeled; provide covered trash cans; cover food stored in a freezer. The facility reported a census of 36 residents. Findings include: Observation on 2/05/24 at 9:13 AM of dry storage room revealed: 1. Two muffin baking pans turned right side up. 2. A powdered drink mix canister with scoop inside. Observation on 2/05/24 at 9:13 AM of main area of kitchen revealed: 1. Two boxes of disposable silverware not closed. 2. Two containers of silverware without eating end of the utensil covered. 3. Shelf storing cutting boards not laying vertically. 4. Reusable and disposable dishware stored right side up and not covered. 5. Two uncovered trash cans. 6. No open date on bulk storage of sugar, flour, and breadcrumbs. 7. Utensils for food preparation and serving stored uncovered on hooks on the wall. Observation on 2/05/24 at 9:16 AM of 2 door freezer revealed a tray of individual dishes of ice cream with no cover.	F 812	2. To correct the deficiency and to ensure that the problem does not recur all dietary staff were educated on 2/21/2024 on the importance of 2022 Food Code & Food Storage Policy. The CDM and or designee will audit storage on kitchenware and utensils in a manner to prevent contamination, measuring scoop in a clean manner, bulk foods did not have an open date labeled, trash cans covered, food covered in the freezer for 4 times per week for 4 weeks, 3 times per week for 4 weeks, 2 times a week for 2 weeks, once per week for 2 weeks, then PRN. 3. As a part of Accura HealthCare of Aurelia's ongoing commitment to quality assurance the CDM and/or designee will report identified concerns through the community's QA Process.	

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F 812	Continued From page 13 The 2022 Food Code directed, in pertinent part, that receptacles and waste handling units for refuse shall be kept covered inside the food establishment if the receptacle contained food resident and was not in continuous use. The Food Storage Policy dated 2021 directed in pertinent part: 1. Food will be stored in an area that is clean, dry, and free from contaminants. Food will be stored, at appropriate temperatures and by methods designed to prevent contamination or cross contamination. 2. Plastic containers with tight-fitting covers or sealable plastic bags must be used for storing grain products, sugar, dried vegetables, and broken lots of bulk foods or opened packages. All containers or storage bags must be legible and accurately labeled and dated. 3. Scoops must be provided for bulk foods (such as sugar, flour, and spices). Scoops should be kept covered in a protected area near the containers rather than in the containers. Scoops should be washed and sanitized on a regular basis. 4. All (frozen) foods should be covered, labeled, and dated. In an interview on 2/05/24 at 9:26 AM, the Dietary Manager (DM) reported she hadn't thought to date opened bulk sugar, flour, or breadcrumbs. In an interview on 2/07/24 at 1:09 PM, the Dietary Manager reported that a new dietary employee left the scoop in the container of drink mix, that she had lids to the trash cans but the lids did not have pieces to cover the trash cans, that she was the staff member that did not cover the individual portions of ice cream found in the freezer, and	F 812		

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F 812	Continued From page 14 that she was aware that utensils and kitchenware needed to be covered.	F 812		