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 _____	03/14/2024

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 000	INITIAL COMMENTS	F 000		
x DC	A health comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 3/14/2024, following an Iowa Department of Inspections and Appeals recertification survey conducted on 2/8/2024. As a result, the facility was found to be not in substantial compliance with requirements for participation. Survey Dates: March 11, 2024 to March 14, 2024 Survey Census: 30 residents Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)			
F 686 SS=D	§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents(R) (R3) received care and treatment necessary to promote the healing of and prevention of	F 686	In continuing compliance with F686, Treatments/SVCS to Prevent/Heal Pressure Ulcer, Accura Health Care of Aurelia corrected the deficiency by the DON educating the MDS on 3/18/2024 on the importance on updating care plans with pressure ulcers and interventions. Resident #3 and all like resident care plans were updated with pressure ulcers and interventions by 4.4.2024. To correct the deficiency and to ensure that the problem does not recur MDS Nurse was educated on 3/18/2024 on updating care plan with pressure ulcer and interventions. The DON and/or designee will audit all care plans 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	

	the further development of		for 2 weeks, then PRN to ensure continued compliance. 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 and make recommendations until substantial compliance is achieved.	4/5/24

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

Jessica Greene | Executive Director | 4/8/2024

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 686	Continued From page 1	F 686		

pressure ulcers. The facility reported a census of 30.

Findings include:

Review of R3's 2/20/2024 quarterly Minimum Data Set (MDS-a federally mandated assessment required to be completed by the facility) recorded he had a Brief Interview for Mental Status (BIMS) of 15 which indicated he was cognitively intact and had the following diagnoses, but not limited to, diabetes mellitus (DM-disease that affects the body's ability to utilize insulin), cerebrovascular accident (CVA-stroke), hemiplegia (paralysis on one side of the body), and chronic obstructive pulmonary disease (COPD-restrictive lung disease that causes difficulty breathing).

Review of R3's 11/28/2023 annual MDS recorded the resident had a BIMS of 14 which indicated that he was cognitively intact and was at risk of developing pressure ulcers, had a pressure relieving device for his bed and his wheelchair, and had an unhealed pressure ulcer. The MDS further recorded the resident was totally dependent on two staff for bed mobility.

Review of R3's 9/1/2023 "Braden Scale for Predicting Pressure Sore Risk" (tool used to assess resident risk for developing a pressure ulcer) recorded R3 was at moderate risk for developing a pressure ulcer.

Review of R3's "Ulcer Skin Assessment" for pressure wounds recorded on 11/15/2023 a facility acquired Stage 3 (Full thickness tissue loss) pressure wound was identified on the right gluteal area (buttock) that measured 1.8 centimeters (cm) by (x) 0.7 cm's. The document

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further recorded on 3/5/2024 the wound measured 2.0 x 2.0 cm's, and on 3/12/2024 the wound measured 3.0 x 3.0 cm's.

Review of R3's "Ulcer Skin Assessment" for pressure wounds recorded that on 11/21/2023 a facility acquired Stage 3 wound was identified on the resident's left buttock that measured 0.9 x 0.6 cm's. The document further recorded that on 3/12/2024 the wound measured 0.1 x 0.1 cm's.

Review of R3's 1/1/2023 comprehensive care plan revised on 12/12/2023 recorded the resident was at risk for impaired skin integrity and/or pressure injury due to his immobility. The care plan lacked documentation of R3's actual pressure wounds on his right gluteal and his left buttock. Wound prevention interventions were listed as follows:

-Assure I have an assist of 2 with rolling et. repositioning during cares (10-18-22)
-Calmoseptine (medicated ointment used for skin irritation/wounds) ointment applied to area (7/28/23)
-Cleanse perirectal area (area between the scrotum and rectum) gently with moistened wipes, pat dry, apply clear aide ointment with ever incontinence episode (2/6/24)
-Educate me on the importance of changing positions PRN for prevention of pressure ulcers.
-Encourage small frequent position changes.
-I have an Air Overlay to my bed (2/25/21)
-I have a ROHO Cushion in my wheelchair (2/25/21)
-I need to be turned/repositioned frequently with staff assist of 2
-I have an air mattress on my bed for pressure reduction (12/10/18)

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-I want the bed to up for my breathing. I prefer to be on my back. Encourage me to lay down and be
propped on my side. I often refuse to lay on my side (5/17/2022)
-Keep HOB elevation to 30 degrees or less

Review of R3's March 2024 Physician Order Summary (POS) recorded the resident was to have an Alternating Air Mattress on his bed and the staff were to ensure the mattress was running properly and always set to 200 pounds three times daily (each shift). The POS further recorded the resident was to have clear aid (ointment) applied to his perirectal area with each incontinent episode.

Review of R3's March 2024 "Treatment Administration Record" (TAR) recorded staff were to check the air mattress on his bed three times daily to ensure the mattress was running properly and the setting remained at 200 pounds of pressure for skin impairment. The TAR further recorded staff had signed on every shift (3) each day from January 1-March 13th, and on the day shift on 3/14/2024 that the air mattress was in place and at the proper setting of 200 pounds of pressure.

An observation on 3/11/2024 at 5:20 PM showed R3's bed had a mattress overlay in place on top of a regular mattress, with a pump setting of 8. Additionally, the observation showed there was no air mattress in place on R3's bed.

An observation on 3/12/2024 at 10:15 AM showed R3 lying in bed on top of a mattress that had a mattress overlay on top with the pump setting at 8. The bed did not have an alternating

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air mattress in place.

An observation on 3/13/2024 at 10:40 AM showed R3 lying in bed with a mattress overlay on top of his mattress. The bed did not have an alternating air mattress in place.

During an interview on 3/13/2024 at 10:40 AM, Nurse Aide (NA1) indicated that she did not do anything with the resident's overlay on top of his mattress, but she would let the nurse know if it was not inflated. NA1 further indicated she did not know what setting the overlay was supposed to be at.

During an interview on 3/13/2024 at 10:45 AM, Registered Nurse (RN1) indicated that she did not know what the resident's mattress overlay was supposed to be set at without looking at the physician's order but the nurse on each shift would check to make sure it was inflated properly and at the right setting. RN1 further indicated that if the mattress overlay malfunctioned then staff would let the Maintenance Director know and he would repair or replace the overlay. Additionally, RN1 confirmed that the setting on the mattress overlay was at 8 and she did not know if that was comparable to the setting of 200 pounds of pressure as indicated for the air mattress.

During an interview on 3/14/2024 at 2:45 PM, the Director of Nursing (DON) indicated that the resident had not had the alternating air mattress since 2021 and she did not know why it had not been changed on the Physician's orders. The DON further indicated that the facility did not have a process for checking the air mattresses or the mattress overlays to ensure they were programmed at the right setting and that the

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F 686	Continued From page 5 maintenance man might check them, but she was not sure, and she confirmed that she did not know if the setting for the air mattress was the same as the setting for the mattress overlay or if it was comparable to the setting of 200 pounds of pressure as indicated for the air mattress. Additionally, the DON indicated that she was not aware that the resident's care plan lacked documentation and interventions related to his two pressure ulcers, and that the facility did not have an actual process to track and/or audit that the ordered and appropriate interventions were in place and documented appropriately. During an interview on 3/14/24 at 2:55 PM, the Maintenance Director indicated that he did not have a process to check the air mattresses or overlays and the only thing he did with them was if the staff told him that it was not working right, he would check it or replace it if indicated. Review of the 1/20/2023 facility "Weekly Skin Assessment and Documentation" policy recorded the resident's care plan was to be updated and reviewed to ensure that the skin/wound alteration was noted and appropriate interventions had been identified on the care plan.	F 686		
F 689 SS=D	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.	F 689	In continuing compliance with F689, Free of Accident Hazards/Supervision/Devices, Accura Health Care of Aurelia corrected the deficiency by providing 1:1 education with MDS and DON on 4/5/2024 on ensuring that a thorough investigation is completed with falls and that the care plans are updated with fall	

	reduction interventions in a timely manner for R23 and all like residents. Audit completed on R23 and all like resident's care plans to ensure that fall interventions were in place by 4/5/24. To correct the deficiency and to ensure that the problem does not recur nursing staff were educated on 3/28/24 on fall processes/assessments and fall reduction interventions by the DON. The DON and/or designee will audit fall assessments and care plans 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 to ensure continued compliance. 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 and make recommendations until substantial compliance is achieved.	4/5/24

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F 689	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that one resident (R) (R23) received adequate supervision to prevent accidents and failed to conduct a thorough investigation that included a root-cause analysis for one (R23) of two sampled residents. The facility reported a census of 30. Findings include: Review of R23's 12/19/2023 annual Minimum Data Set (MDS-a federally mandated assessment used for care planning) recorded the resident had a Brief Interview for Mental Status (BIMS) of 14 which indicated she was cognitively intact and had the following diagnoses, but not limited to, atrial fibrillation (abnormal heart rhythm), hypertension (high blood pressure), and diabetes mellitus. Review of R23's 1/8/2024 comprehensive care plan recorded the following: Focus: 2/27/2023 The resident was at risk for falls due to weakness. Goals: The resident would be free from falls through the review period ending 6/10/2024. Interventions: Date Initiated: 1/10/2024-Resident educated to request assistance if she falls. Date initiated: 10/16/2023-Resident requests to have the facility mattress removed from her bed. Revision on: 11/29/2023-Observe me quarterly and as needed. Date Initiated: 2/27/2023-PT/OT referral as	F 689		

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needed.
Date Initiated: 2/27/2023-Resident educated on not leaning on her manual recliner as it is not as sturdy as her electric recliner.
Date Initiated: 9/19/2023-Resident educated to ask staff for towels if she needs any.
Date Initiated: 11/28/2023 Revision on: 12/02/2023-Sit in shower chair while showering.
Date Initiated: 9/17/2023-Staff to assist resident to her room after shower.

R23's comprehensive care plan lacked development and implementation of fall reduction interventions for the resident's falls on 1/8/2024 and on 1/17/2024.

Review of R23's Electronic Medical Record (EMR) recorded that on 1/8/2024 R23 reported to staff that she had fallen in her room and was able to get herself up in her recliner. The progress notes recorded that on 1/9/2024 the resident was drowsy and disoriented to time and staff encouraged her to drink fluids. The progress notes further recorded that on 1/10/2024 R23 was seen by her health care provider due to her fall on 1/7/2024 and an order was obtained for a urinalysis (test used to detect urinary infection) and on 1/11/2024 she was started on an antibiotic (medication used to treat infection) for a urinary tract infection (UTI).

Review of R23's 1/8/2024 "Fall Scene Investigation Report" recorded the resident reported to staff that she had a fall in her room but was able to get herself up, the resident was sitting in her recliner when staff entered the room, and the resident was unable to provide the detail of what she was doing when she fell. The report further recorded the resident had on slippers at

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the time of her fall and that she was using her gait assistive device but lacked documentation of what device was being used. Additionally, the report recorded that the resident's hearing and vision did not contribute to the fall and to assess the resident for postural hypotension (drop in blood pressure when resident stands up). The report lacked documentation that the resident was assessed for postural hypotension but recorded that hypotension did not contribute to the fall. The report lacked documentation that the resident's blood sugar was checked as recommended for a diabetic resident and documented the blood sugar check was not applicable for this resident. Intervention initiated was that resident was to notify staff and ask for assistance if she fell. The report lacked a root-cause analysis and lacked development and implementation of new interventions aimed at mitigating additional falls.

Review of the Vital Signs tab in the EMR for 1/8/2024 lacked documentation that orthostatic blood pressures were obtained on the resident.

Review of R23's 1/8/2024 "Fall Risk Assessment" score was 10.0 which indicated she was at moderate risk for falls.

Review of R23's 1/17/2024 "Fall Scene Investigation Report" recorded staff found the resident on the floor in her room with her feet by the door and her head by a cabinet, staff assisted resident off the floor and into bed, and her walker was approximately ten feet away from her. The report further recorded that the resident reported she was dizzy and her "feet just went out". Additionally, the report lacked documentation of the resident's mental status at the time of the fall,

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F 689	Continued From page 9	F 689		

recorded there were no predisposing environmental factors, the resident had a gait imbalance and impaired memory, and that she had been using her walker when she fell. The report lacked a root-cause analysis and lacked development and implementation of new interventions aimed at mitigating additional falls.

Additional review of R23's EMR recorded that on 1/17/2024 the resident was found on the floor in her room and the resident reported to staff she was "dizzy and her feet went out". On 1/19/2024 the resident reported to staff she had a sore throat and body aches, and staff noted her to be confused. The resident was subsequently diagnosed with COVID (infectious respiratory disease caused by a virus).

Review of the Vital Signs tab in the EMR for 1/17/2024 lacked documentation that orthostatic blood pressures were obtained on the resident.

Review of R23's 1/17/2024 "Fall Risk Assessment" score was 20.0 which indicated she was at high risk for falls.

Review of the 10/25/2021 facility "Risk Management" policy recorded that all accidents/incidents involving residents would be investigated and reviewed through the facility QAPI process and the Director of Nursing (DON), MDS Coordinator, and the Executive Director were to review risk management daily to identify new incidents and ensure new interventions were appropriate and care planned. Additionally, the policy recorded that any resident who had two or more incidents in 30-days were to be monitored for trends and the need for additional interventions.

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F 689	Continued From page 10 During an interview on 3/14/2024 at 1:21 PM, the DON indicated that the floor nurse is required to do the risk management fall report, the fall risk assessment, neurological checks (check mental status), and the fall scene investigation when a resident had a fall. The DON further indicated that the facility management team would discuss the falls in the morning meeting with the therapist and try to update the care plan and put the information into the plan. Additionally, the DON indicated that the management team review of the falls and new interventions were not documented anywhere that "it was all done verbally", because she did not think that information needed to be documented anywhere. The DON confirmed that when R23 fell, her postural blood pressures were not taken and her blood sugar was not checked. The DON further indicated that the resident was diagnosed with a UTI after her first fall and COVID after her second fall and those illnesses likely contributed to her falls and was probably the root cause behind the resident's falls. During a concurrent interview on 3/14/2024 at 1:21 PM the MDS Coordinator indicated that sometimes she would revise the care plans and at other times the DON would do the revisions.	F 689		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 758	In continuing compliance with 758, Free from Unnec Psychotropic Meds/PRN Use CFRs. Accura Health Care of Aurelia corrected the deficiency by the DON ensuring Res #16, 1, 12, 7 and like residents Electronic Health Records were updated with targeted behaviors	

	and documentation of non-pharmacological interventions. Care plans for Res #16,1,12,7 and all like residents were reviewed and updated by 3/20/2024. Education provided to MDS and DON on ensuring careplans addressed targeted behaviors and non-pharmacological interventions on 4/5/2024. To correct the deficiency and to ensure that the problem does not recur nursing staff were educated on 3/15/2024 on proper documentation on charting behaviors/targeted behaviors/utilizing non-pharmacological interventions prior to administering psychotropic medications by the DON. The DON and/or designee will audit nursing documentation 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 to ensure continued compliance. 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.	4/5/24

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F 758	Continued From page 11 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or	F 758		

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prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure four of five residents (R) (R's 16, 1, 12 and 7) sampled for unnecessary medications to whom the facility administered psychotropic medications were monitored for targeted behaviors and failed to utilize non-pharmacological interventions.

Findings include:

1. R16's quarterly Minimum Data Set (MDS) dated 2/13/24 documented the use of a high-risk drug, an antipsychotic and documented R16 did not exhibit any behavioral symptoms.

R16's Comprehensive Care Plan initiated 7/13/20 and revised on 1/9/21 documented the following, "The resident has potential for mood and behavior issues r/t anxiety disorder unspecified. Resident is on medication for anxiety disorder. Family reports, prior to resident coming to this facility, of the resident having paranoia behaviors like such as: people were after her and kept knife under her pillow. There are times where I may refuse a shower or am resistive to cares, etc which I understand is my right to do. Administer medications as ordered. Observe/document for side effects and effectiveness. Encourage resident to voice any feelings, needs, or concerns as she desires. Observe/record/report to MD prn mood and/or behavior patterns s/sx of depression, anxiety, sad mood as needed. Provide reassurance, redirection, validate feelings and give time for resident to express feelings and concerns as she desires.

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Re-approach resident as needed." The care plan lacked information regarding the resident's current specific behaviors targeted by the antipsychotic medication used and lacked resident specific non-pharmacological interventions for those behaviors.

R16's care plan included another focus dated 7/21/20 that documented, "Psychotropic drug use for mood as I get anxious. I will have adequate control of mood and behavior with use of psychotropic medications over the next review period. Target date 2/20/24." The care plan directed to administer R16's antidepressant and antipsychotic as ordered, attempt a gradual dose reduction as ordered, observe for the effectiveness of medications and listed the potential side effects of both the antidepressant and antipsychotic. The care plan did not include what targeted behaviors the medications were treating and what non-pharmacological interventions had been attempted prior to the administration of the antipsychotic medication.

R16's electronic record contained a nurse's note that documented the following, "Order received to increase Risperidone to 0.125 milligrams (mg) twice daily, granddaughter and pharmacy updated."

R16's electronic physician's orders contained an order for Risperdal (a medication used to treat mental and mood disorders) to be administered 0.125 mg by mouth twice a day for dementia with psychotic disturbance. The physician's orders also documented that the resident received Sertraline 50mg daily for anxiety and Remeron 3.75mg daily for major depressive disorder

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R16's clinical record lacked evidence of documented behaviors to justify the need for or increase in the dose of Risperidone.

Observation on 3/13/24 at 9:30 AM, R16 slept in bed.

Observation on 3/13/24 at 12:05 PM, R16 ate lunch in the dining room and exhibited no behaviors.

During an interview on 3/13/24 at 3:00 PM, Nurse Aide (NA1) reported R16 required one person assistance with all activities of daily living, occasionally resisted cares, but if staff reapproach her later or send a different staff later, R16 did not resist the care again. NA1 indicated that R16 did not have any other behaviors.

During an interview on 3/13/24 at 3:10 PM, Registered Nurse (RN1) said R16 very seldom had any behaviors and if she did it usually was due to a urinary tract infection (UTI).

During an interview on 3/13/24 at 3:15 PM, the Director of Nursing (DON) said that R16 was agitated and heard voices, so she informed the physician. The physician checked R16's blood work for an infection, but the blood work came back normal, so the physician gave an order to increase the Risperidone to 0.125 mg twice a day due to increased agitation. She said the facility did not document resident's behaviors, did not monitor for targeted behaviors and did not document non-pharmacological interventions prior to the use of antipsychotic medications, but that may be something they would begin doing in the future.

2. Review of R1's 2/6/2024 annual MDS recorded

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the resident had a BIMS of 13 which indicated he was cognitively intact and had the following diagnoses, but not limited to, schizophrenia (mental condition that involves a breakdown of thought, emotion, and behavior leading to faulty perception and inappropriate actions and feelings), dementia, anxiety, and depression. The MDS further recorded the resident received antipsychotic (medication used to treat schizophrenia), antianxiety, and antidepressant medications.

Review of R1's 2/6/2024 comprehensive care plan recorded the following interventions for use of psychotropic medications related to his schizoaffective bipolar disorder and major depression:
-He will be free of signs and symptoms of psychotropic drug related complications through next care review.
-Administer anti-depressants (medications used to treat depression), anti-anxiety (medications used to treat anxiety), and antipsychotics (medications used to treat schizophrenia and bipolar) as prescribed by my Physician.
-AIMS monitoring per facility guidelines. Pharmacy review as needed.
-BIMS per facility protocol.
-Consult with the physician to consider dosage reduction when clinically appropriate at least quarterly, also for continued use/need for med.
-Routine visits with Telehealth Encounter for my psychiatric needs.
-Observe the resident for safety. The resident is taking ANTI-ANXIETY meds which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia and increases risk of falls, broken hips, and legs.

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-Observe/document/report PRN (as needed) adverse reactions to ANTIDEPRESSANT therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, weight loss, nausea/vomiting, dry mouth, and dry eyes.
-Observe/document/report PRN any adverse reactions of antipsychotic medications: unsteady gait, tardive dyskinesia, shuffling gait, rigid muscles, shaking, frequent falls, increased depression, suicidal ideations, behavior symptoms not usual to me.
-Move resident to a quiet area to deescalate behavior.
-Observe for contributing factors for behavior.
-Observe for effectiveness/side effects of psychoactive medications.
-Provide 1:1 activity as needed.

Additional review of the comprehensive care plan showed the care plan lacked the residents target behavior for the use of specific medications and lacked resident specific non-pharmacological interventions aimed at decreasing and/or preventing untoward behavior by the resident. Additionally, the care plan failed to identify specific triggers or contributing factors for resident behavior.

Review of R1's February 2024 "Physician Order Summary" (POS) recorded the resident received the following psychoactive medications:
-ativan 0.25 milligrams (mgs) by mouth one time daily at 5:30 PM for schizoaffective disorder and

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bipolar type mood disorder.
-ativan 0.25 mgs by mouth one time daily at bedtime for schizoaffective disorder and bipolar type mood disorder.
-carbamazepine chewable tablet 100 mgs by mouth three times daily for schizoaffective disorder.
-risperidone 2 mgs one tablet by mouth one time daily for schizoaffective disorder.
-sertraline 100 mgs one tablet by mouth two times daily for schizoaffective disorder.

Review of R1's March 2024 "Physician Order Summary" (POS) recorded the following:
-ativan 0.25 milligrams (mgs) by mouth one time daily at 5:30 PM for schizoaffective disorder and bipolar type mood disorder.
-ativan 0.25 mgs by mouth one time daily at bedtime for schizoaffective disorder and bipolar type mood disorder.
-carbamazepine chewable tablet 100 mgs by mouth three times daily for schizoaffective disorder.
-risperidone 2 mgs one tablet by mouth one time daily for schizoaffective disorder.
-sertraline 100 mgs one tablet by mouth two times daily for schizoaffective disorder.

Review of the resident's Electronic Medical Record (EMR) lacked documentation of behavior monitoring and non-pharmacological interventions for the use of antidepressant, antianxiety, and antipsychotic medications.

An observation on 3/11/2024 at 5:00 PM showed R1 seated in the dining room eating supper and asking each person who passed by him for help.

During an interview on 3/11/2024 at 5:03 PM,

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Registered Nurse (RN2) indicated that the resident would frequently get restless in the dining room waiting for supper and would begin to call out to each person who went by him. RN2 further indicated that she had just given the resident his antianxiety medication so he should calm down shortly.

An observation on 3/12/2024 from 12:10-12:35 PM showed R1 seated at the dining room table eating lunch. R1 did not display any behaviors during this observation period.

An observation on 3/13/2024 at 10:05 AM showed R1 resting quietly in bed and speaking calmly to staff that entered his room.

3. Review of R7's 2/6/2024 annual MDS recorded the resident had a BIMS of 5 which indicated that she was severely cognitively impaired and had the following diagnoses, but not limited to, Alzheimer's disease and dementia. The MDS further recorded the resident had not displayed hallucinations or delusions, physical or verbal behavioral symptoms, and the resident received antipsychotic and antidepressant medications.

Review of R7's 2/12/2024 comprehensive care plan showed the care plan lacked R7's target behaviors for the use of antipsychotic medications and lacked resident-specific non-pharmacological interventions for staff to implement prior to the use of psychotropic medications. The care plan further recorded the resident focus was as follows:
Focus: 6/15/2022 initiated, revised 2/12/2024 Psychotropic med use for mood, and the resident could become jealous and accusatory towards staff when staff assisted or interacted with her

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F 758	Continued From page 19 husband. Goal: The resident would have no drug related side effects over the next review period and the resident would be accepting of redirection/reeducation regarding staff assisting her husband. The care plan lacked any goals or interventions for when the resident displayed this behavior other than to redirect and educate the resident and administer psychotropic medications for her behavior. Focus: Behavior issues r/t (related to) Alzheimer's disease, major depressive disorder, dementia, behavioral disturbance, anxiety disorder, and agitation, and delusions. Resident is currently on medications for paranoia, delusions, depression, and dementia. Goal: The resident would voice feelings and concerns as she desired over the next review period. Interventions: -Encourage resident's children and other family members to remain supportive and visit resident as she does appear to enjoy this. -Explain procedures prior to providing cares. -If resident is resistive to cares, re-approach at a later time if able. -Observe/record/report to physician mood patterns, signs/symptoms of depression, anxiety, sad mood as needed. -Provide reassurance, redirection, validate feelings, and give time for resident to express feelings and concerns as she desires. -Administer antidepressant as ordered.	F 758		

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-Administer Antipsychotic as prescribed.
-Attempt GDR per physician orders.
-Observe/document/report PRN adverse reactions to antidepressant.
behavior/mood/cognition;
hallucinations/delusions; social isolation, suicidal thoughts, withdrawal;
decline in AOL ability, continence, no voiding;
constipation, impaction, diarrhea; gait changes, rigid muscles, balance probs, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, weight loss, nausea/vomiting, and dry mouth, and dry eyes.
-Observe/document/report PRN any adverse reactions of antipsychotic medications: unsteady gait, tardive dyskinesia, shuffling gait, rigid muscles, frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms.
-Provide re-direction and re-education on reasoning for staff assisting husband as needed.
-Psych consult as needed/ordered.
-Report significant side effects to physician as needed.
-Shares room with spouse per her family's choice.

Review of R7's March 2024 POS recorded the resident had the following diagnoses but not limited to, Alzheimer's disease, dementia with behavioral disturbance and hallucinations, anxiety, and depression. The POS further recorded the resident received the following psychotropic medications:
-memantine 10 mgs two times daily for

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Alzheimer's disease
-seroquel tablet 25 mgs 2 tablets (50 mgs) one time daily for major depressive disorder
-donezepil 10 mgs one tablet at bedtime for cognition enhancing
-mirtazapine 15 mgs one tablet at bedtime for depression
-sertraline 50 mgs one time daily at bedtime

Review of the resident's Electronic Medical Record (EMR) lacked documentation of behavior monitoring and non-pharmacological interventions for the use of antidepressant and antipsychotic medications.

An observation on 3/11/2024 at 4:35 PM showed R7 seated in her recliner in her room. Resident was calm, smiled, and spoke calmly with interviewer.

An observation on 3/12/2024 at 9:55 AM showed R7 seated in her recliner in her room visiting calmly with her husband and this interviewer.

During an interview on 3/13/2024 at 12:50 PM, NA1 indicated that R7 spent most of her time in her room and "at times" would get agitated with staff but the behavior did not happen frequently.

During an interview on 3/13/2024 at 12:55 PM, LPN1 indicated that R7 would get upset when she did not know where her husband was but she would usually calm down once he was near her.

4. Review of R12's 11/28/2023 annual MDS recorded the resident had a BIMS of 4 which indicated that she was severely cognitively impaired and had the following diagnoses, but not limited to, Alzheimer's disease and anxiety. The

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MDS further recorded the resident received antipsychotic, antianxiety, and antidepressant medication.

Review of R12's 2/20/2024 quarterly MDS assessment recorded the resident had a BIMS of 4 which indicated she was severely cognitively impaired and had the following diagnoses, but not limited to, Alzheimer's disease and anxiety.

Review of R12's 1/25/2024 comprehensive care plan recorded the following:
Focus: The resident has a behavior problem related Alzheimer's disease and dementia with behavioral disturbance.

Goal: The resident will have fewer behavioral episodes by the review date.

Interventions:
-Administer medications as ordered and observe for side effects.
-Intervene as necessary to protect the rights and safety of others. Remove from situation and take to alternate location as needed.
-Minimize the potential for the resident's disruptive behaviors by offering tasks which divert attention.
-Approach in a calm manner.
-Resident is repetitive and fixates on things around her.

Additionally, the care plan lacked the residents target behavior for the use of psychotropic medications, lacked a description of her disruptive behaviors, and lacked resident-specific non-pharmacological interventions for staff to implement prior to the use of psychotropic medications.

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Review of R12's March 2024 POS recorded the resident received the following psychotropic medications:
-seroquel (antipsychotic medication used to treat schizophrenia and bipolar disorder) 25 mgs one time daily at breakfast, one and one-half tablets (37.5 mg) one time daily in afternoon, and 50 mgs one time daily at bedtime for dementia with behavioral disturbances.
-rexulti (medication used to treat depression) 0.5 mg one time daily for 7 days, then 1 mg one time daily at bedtime.
-buspirone (psychotropic medication used to treat anxiety) 2 mgs three times daily for anxiety.
-celexa (psychotropic medication used to treat depression)10 mgs one time daily on 3/1, 3/2, and 3/3/2024, then Celexa 5 mgs one tablet daily on 3/4, 3/5, and 3/6/2024, then Celexa 5 mgs every other day for 3 doses on 3/8, 3/10, and 3/12/2024, then discontinue medication.

An observation on 3/13/2024 at 10:30 AM showed R12 resting quietly in bed and no behaviors displayed.

An observation on 3/13/2024 at 12:15 PM showed R12 seated in the main dining room eating lunch with her peers and no behavior displayed.

During an interview on 3/13/2024 at 1:00 PM, NA1 indicated that R12 would "sometimes" call out or wander into other resident's room but she [R12] was usually easily redirected.

During an interview on 3/13/2024 LPN1 indicated that R12 would get agitated at times and look for her mother but could usually be redirected by

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F 758	Continued From page 24 involving her in an activity or by calling the resident's daughter. During an interview on 3/14/2023 at 4:15 PM, the MDS Coordinator indicated that she did not list target behaviors or resident-specific non-pharmacological interventions on the resident's care plans because she did not know she needed to. During an interview on 3/14/2024 at 4:38 PM, the DON indicated that the facility did not do routine behavior monitoring and documentation and the only documentation on behaviors would be in the nurse's progress notes if the resident had a behavior. The DON further indicated that the facility did not identify specific behaviors for the resident's use of psychoactive medications in the care plan and she expected the nursing staff to put a progress note in each time the resident had a behavior. Additionally, the DON indicated that she did not identify on the care plan what non-pharmacological interventions the staff were to try prior to the administration of psychotropic medications. The DON agreed that educating a cognitively impaired resident was not an effective intervention.	F 758		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform	F 851	In continuing compliance with F 851, Payroll Based Journal. Accura Health Care of Aurelia corrected the deficiency on 4/2/24 by changing the nurses' shifts to 8.5 hours. All nurses were educated on the importance related having 24-hour nursing coverage due CMS taking an automatic half hour break off the shift regardless of if it was taken.	

	To correct the deficiency and to ensure that the problem does not recur nurses were educated on 3/28/24 that their shifts will be changed to 8.5 hours. BOM and/or designee will audit hours every payroll to ensure compliance. As a part of Accura HealthCare of Aurelia's ongoing commitment to quality assurance the BOM and/or designee will continue verify hours for accuracy before each quarter submitted and will report and identified any concerns through the community's QA Process and make recommendations until substantial compliance is achieved.	4/5/24

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	165535	A. BUILDING _____ B. WING _____	03/14/2024

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F 851	Continued From page 25 format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through	F 851		

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F 851	Continued From page 26 an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to accurately report Payroll Based Journal (PBJ) for licensed nursing staff during the fourth quarter of fiscal year 2023. The facility reported a census of 30. Findings include: Review of the PBJ report provided by the Centers for Medicare and Medicaid Services (CMS) for Fiscal year (FY) 2023 quarter four, indicated the facility did not have licensed nurse coverage 24 hours a day, seven days a week. Review of the facility provided staffing information documented the facility had a licensed nurse 24 hours a day, seven days a week during the quarter listed on the PBJ report. During an interview on 3/14/24 at 3:36 PM, Business Office Manager (BOM) indicated that her data entry hours for the PBJ were correct, so there must have been a problem from when the facilities corporate office reported the hours to CMS.	F 851		

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F 851	Continued From page 27 The facility provided a policy entitled "PBJ Compliance Document" without a date documented, " ....Data is to be submitted to CMS on a quarterly basis and must be submitted 45 days after the end of a quarter. The Director of Legal Services as the Company's Resource Center will handle the technical submission of the data once the data is reviewed and has been determined accurate. The review of the data will be completed by the operations team in the resource center, and facility staff and other parties as necessary. On a daily basis, the leadership staff at the facility must ensure that the guidelines and practices in this document are followed by all in-house and contracted staff to ensure the quarterly data is accurate. The accuracy of the data is reviewed by routinely running the alerts and errors report in the PrimeView Dashboard, along with the monthly hours review report, and accurately coding hours to direct care when needed by facilities Business Office Manger or Executive Director. When reviewing the reports, attention needs to be paid to the hours reported, the accuracy of contracted hours and overall compliance with Company's time keeping guidelines ....."	F 851		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880	In continuing compliance with 880, Infection prevention and control program. Accura Health Care of Aurelia corrected the deficiency by the DON ensuring Infection Control log for March was updated on 3/24/24.	

	Education was provided on 3/15/2024 to Infection preventionist on the importance of updating the infection log in a timely manner. Education was provided to Maintenance Supervisor on the assessment for facility water system on 3/18/24. To correct the deficiency and to ensure that the problem does not recur Infection Preventionist was educated on 3/15/2024 on the importance of updating the infection log in a timely manner. Education was provided to Maintenance Supervisor on the assessment for facility water system on 3/18/24. The DON and or designee will audit infection log 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. Resource center will conduct water system assessment annually during Life Safety inspection to be incompliance. 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 and make recommendations until substantial compliance is achieved.	4/5/24

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program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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F 880	Continued From page 29 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement an ongoing system of surveillance designed to identify possible trends of communicable diseases in the facility. The facility's failure to have a system to timely identify clusters of infections of the same organism, had the potential to negatively impact the ability to prevent the transmission of these diseases through containment or staff education in an effort to prevent the spread of infections to other persons in the facility promptly. The facility also failed to assess the building water systems to identify risks where Legionella and other waterborne pathogens could grow, failed to perform visual inspections or conduct monitoring measures to prevent growth of legionella. These failures had the potential to effect the facility reported census of 30 residents. Findings include:	F 880		

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Review of the facility's infection control tracking and trending sheets and antibiotic stewardship sheets on 3/14/24 documented the facility had stopped tracking infections and antibiotics in February 2024. The sheets lacked any information regarding infections for the month of March 2024.

During an interview on 3/14/24 at 2:00 PM, the Administrator indicated that the facility ran water in random resident rooms and check hot water temperatures. The facility did not make an assessment of the building to identify high risk areas for water born pathogens to grow and spread. The facility did not initiate control measures or inspections or initiate the use of disinfectants other than random running water in some resident rooms and flushing of some toilets. The Administrator said they had a policy for water management, but did not have a water management plan.

During an interview on 3/14/24 at 2:10 PM, Maintenance Supervisor (M1) indicated he did not have a facility assessment of the water system, no inspection for or identification of risks related to water born pathogens. He indicated that at times he did run water and flush toilets in some resident rooms, but that was not based on any risk assessment and he did not conduct any inspections, use any other protocols and had nothing documented. M1 indicated he had no knowledge of a facility water management plan.

During an interview on 3/14/24 at 3:30 PM, the Director of Nursing (DON) indicated that for the month of March 2024, one resident admitted to the facility with Clostridioides difficile or (C. difficile a germ/bacterium that causes diarrhea

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and colitis, an inflammation of the colon). The tracking and trending logs for March, 2024 were not completed yet as she did not track or trend infections or antibiotics until the end of the month. The log was not due to be turned in until the end of each month.

The facility provided a policy entitled Legionella without a date that documented, "Accura HealthCare will utilize sound clinical and infection control practices to quickly identify and treat any potential Legionnaires' related illnesses. Sound engineering, preventative maintenance and housekeeping practices will be utilized to minimize the risk of exposing residents and team members to the legionella bacteria." The policy documented the facility would do the following:

"4.0 Minimizing Growth of Legionella in the Domestic Water System:

4.1 Do not use shower rooms as permanent storage unless the unused piping has been capped-off.

4.2 Flush toilets and run faucets for a minimum of 30 seconds in all vacant resident rooms periodically (monthly).

4.3 For resident rooms, or other rooms with plumbing fixtures that are used for offices and/or storage, flush toilets and run faucets and showerheads for a minimum of 30 seconds periodically (monthly).

4.4 Visually inspect all decorative fountains on a quarterly basis for biofilm or slime build-up. If biofilm or slime is noted, drain the fountain, clean and disinfect. Fountains with live fish are exempt.

4.5 Facility will follow the recommendation of the Health Department for results testing positive."