STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165435	A. BUILDING _____ B. WING _____	C 07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF SIOUX CITY, LLC	3800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 ✓ JB	INITIAL COMMENTS Correction date: 8/24/2023 The Nursing Home is not in compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities. The following deficiencies resulted from the facility's annual recertification survey and investigation of intakes #109359-C, #109364-I, #109365-I, #109944-C, #110121-I, #110971-C, #112538-C, #114278-I, and #114312-C conducted July 17, 2023 to July 25, 2023. Complaints #109359, #109944, #110971, #112538, #114312 were substantiated. Facility reported incidents #109364, #109365, #110121, and #114278 were substantiated. Facility Census: 43	F 000	Accura Healthcare of Sioux City 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550	In continuing compliance with F550, Accura Healthcare of Sioux City corrected this deficiency by Providing 1:1 education with Staff N and Staff O on 7/26/2023 by DON on the importance of speaking the preferred language of the resident while in the presence of the Resident #3, #25, and all like residents. To correct the deficiency and ensure the problem does not recur, all staff were educated on the importance of speaking their preferred language in their presence on 7/26/2023 by DON. The ADON will audit staff to ensure that they are speaking the preferred language in the presence of residents and also will audit residents 4x/weekly x4 weeks then, 3x/weekly x4 weeks then, 2x/weekly x2 weeks then, 1x/weekly x2 weeks, and then PRN to ensure continued compliance. As a part of Accura of Sioux City's ongoing commitment to quality assurance the DON or designee will report identified concerns through the community's QA process.	7/26/2023

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

Tara Mennio, RN/LNHA Administrator 8/24/23

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 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, resident, and staff interviews, the facility failed to respect each resident's dignity by speaking a foreign language in the presence of residents for 2 out of 13 residents reviewed (Residents #3 and Resident #25). Findings included: 1. Resident #25's Minimum Data Set (MDS) assessment dated 5/25/23 identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. The MDS listed that Resident #25 could understand others.	F 550		

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F 550	Continued From page 2 On 7/18/23 at 10:01 PM, Resident #25 reported that some staff often spoke Spanish in her presence and during cares. When asked how that made her feel, Resident #25 replied that it made her think they are saying something they don't like about her. She did not know if they thought she could understand them, or if they are trying to tell her to do something. Resident #25 reported that she does not understand Spanish. 2. The Minimum Data Set (MDS) assessment dated 5/12/23 for Resident #3 documented the Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS reflected that Resident #3 could understand others. On 7/19/23 at 9:35 AM, Resident #3 reported that the staff spoke Spanish in her presence regularly. Resident #3 stated, it made her uncomfortable because she thought that they did not want her to know what they are saying, so she felt they must be talking about her. Resident #3 reported more than a couple of Certified Nurse Aides (CNAs) spoke Spanish in her presence and during cares. Resident #3 explained that she did tell her concerns to the Administration. The Grievance Form dated 5/16/23 indicated that Resident #23 reported that Staff N, CNA, and Staff O, CNA, talked a lot and talked in Spanish that they could not understand. Resident #3 explained that they did not appreciate anyone talking in a foreign language while getting them up. They were joking around and laughing for quite a while. The Employee Corrective Action Form dated 5/16/23 identified Staff N, CNA, received an	F 550		

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F 550	Continued From page 3	F 550		

infraction due to a resident's complaint for speaking a language the resident did not understand while providing cares. The form instructed the facility expectations moving forward that staff would speak the preferred language of the resident while in the presence of residents as the facility is their home.

On 7/19/23 at 10:45 AM, Staff B, Activities Director, reported that she received resident complaints, during a Resident Council meeting, that staff spoke Spanish in the presence of residents. Staff B reported the following CNAs to the Administrator: Staff K, Staff L, Staff M, Staff P.

On 7/19/23 at 10:54 AM, Staff I, CNA, reported in the past week she witnessed Staff N and Staff O speak Spanish in the presence of residents.

On 7/19/23 at 1:11 PM the Administrator reported providing past corrective action to staff that spoke Spanish in the presence of residents. The Administrator stated that the staff shouldn't speak Spanish in the resident care areas, including the nurses' station, due to the facility being the residents' home. The Administrator explained that the only time staff can use Spanish is with primarily Spanish speaking residents. The facility had one resident who spoke primarily Spanish.

On 7/19/23 at 5:15 PM, Staff O, CNA, stated she received discipline for speaking Spanish in the presence of residents. Staff O reported that she did not understand why speaking Spanish is not acceptable. Staff O reported that at times staff want to talk about things that are personal and should be able to speak Spanish.

The Resident Rights policy dated November 2016

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F 550	Continued From page 4 identified that residents have the right to be fully informed in language that he or she can understand about his or her total health status including but not limited to, his or her medical condition.	F 550		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing	F 567	In continuing compliance with F 567, Accura Healthcare of Sioux City corrected this deficiency by the Executive Director educating the Business Office Manager and Social Services on 8/21/2023 regarding regulatory standards for resident's personal funds. To correct the deficiency and to ensure the problem does not recur, the Business Office Manager and the Social Services will audit resident personal funds 3 times weekly for 4 weeks, 2 times weekly for 4 weeks, 1 time weekly for 4 weeks and as needed to ensure compliance. As a part of Accura of Sioux City's ongoing commitment to quality assurance the DON or designee will report identified concerns through the community's QA process.	8/21/2023

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F 567	Continued From page 5	F 567		

account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.
This REQUIREMENT is not met as evidenced by:
Based on observations, resident interviews, and staff interviews the facility failed to provide residents with ready access to their personal funds managed by the facility for 5 of 43 residents reviewed (Resident #5, #7, #14, #16, and #18). The facility set a limit of $20 for all residents for their resident trust account for less than 24-hour notice.

Finding include:

1. The Minimum Data Set (MDS) dated 4/27/23 for Resident #7 documented a Brief Interview of Mental Status (BIMS) of 15, indicating no cognitive impairment.

On 7/17/23 at 12:06 PM Resident #7 stated residents at the facility are only allowed to get $20.00 cash a day from their personal funds. Resident #7 stated she wished she could get more than $20.00 at a time.

2. The MDS dated 5/12/23 for Resident #14 documented a BIMS of 14, indicating no cognitive impairment.

On 7/17/23 at 1:33 PM Resident #14 stated there is not staff present on the weekend to give money out from personal funds. Resident #14 stated she

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F 567	Continued From page 6 cannot get money on the weekend. 3. The MDS dated 5/4/23 for Resident #16 documented a BIMS of 13, indicating no cognitive impairment. On 7/17/23 at 1:33 PM Resident #16 stated there is not a staff member at the facility on the weekend to give money out from their personal funds. Resident #14 stated she cannot get money on the weekend. Observation of a document posted on the business office door dated 10/5/22 revealed, Residents trust the business office only keeps a small amount of money in the office. The Business Office will only be able to give $20.00 at one time. Any resident requesting more than $20.00 will need to give a 24 hour notice/request so the business office can go to process the request through the bank. On 7/18/23 at 2:53 PM Staff A, Business Office Manager, stated she is only allowed $220.00 a month in the cash box at the facility. Staff A stated that was the amount given to her as a total when she started at the facility. Staff A stated all the residents had to do was ask for money 24 hours in advance to get more than $20.00. Staff A stated Residents #5, #7, #14, #16, and #18 had trust funds with the facility. Staff A stated the facility had a lock box on the medication cart with $20.00. Staff A added that if the nurses ran out of money in medication cart on the weekend they could call her Staff A, but she lived one and a half hours away. On 7/18/23 at 3:29 PM the Administer stated Staff B, the Social Worker, lives in the town and has	F 567		

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F 567	Continued From page 7 access to the resident funds and can come into the facility if needed to give the residents money from their trust fund. The Administrator stated expectation is residents have access to their money when they need it. On 7/19/23 at 4:41 PM Staff B stated she never got personal funds out for any resident and she never gave cash to the residents. She had a card with all the residents' funds on it. Staff B said she never bought anything on the weekend. She must talk to Staff A before she can buy anything for the residents at the facility and denied ever receiving a call on the weekend to get a resident money. She added that she did not have access to the money at the facility. She must fill out a form to get permission for her to get cash out and denied that she ever got cash out of the account, but added that she did have the pin number. No one ever asked for cash but she did not work on the weekends.	F 567		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 580	In continuing compliance with F 580, Accura Healthcare of Sioux City corrected this deficiency by the DON notifying the PCP of weight changes to resident #7 and blood sugar changes to resident # 22 on 7/26/2023 and all like residents by 7/26/2023. To correct the deficiency and to ensure the problem does not recur, nursing staff was educated by the DON on 7/26/2023 regarding when to notify PCP when blood sugars and weights are out of parameters. DON and/or designee will audit blood sugars and weights 4x/weekly x4 weeks then, 3x/weekly x4 weeks then, 2x/weekly x2 weeks then, 1x/weekly x2 weeks, and then PRN to ensure continued compliance. As a part of Accura of Sioux City's ongoing commitment to quality assurance the DON or designee will report identified concerns through the community's QA process.	7/26/2023

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F 580	Continued From page 8 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and document review the facility failed to notify the physician with a change in condition for 2 of 2 residents reviewed (Residents #7 and #22).	F 580		

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F 580	Continued From page 9 Finding include: 1. Resident #7's Minimum Data Set (MDS) dated 4/27/23 for documented a Brief Interview of Mental Status (BIMS) of 15 indicating no cognitive impairment. The MDS included a diagnosis of edema. Resident #7 had a weight loss of 5% or more in the previous month or a loss of 10% or more in the previous six months while not on a physician-prescribed weight-loss regimen. The MDS listed that Resident #7 received a diuretic (medication to remove excess fluids) for seven out of seven days in the lookback period. Resident #7 June 2023 Medication Administration Record (MAR) included the following orders dated 7/22/22: a. Daily weight and notify the physician if weight gain of 2-3 pounds overnight or 4-5 pounds in five days. Notify the physician with any change in condition, chest pain, intolerable pain, unable to tolerate diet, and shortness of breath. The MAR listed the following weights that had a weight gain that required notification to the physician: i. 6/9/23 at 11:37 AM - 150.0 lbs.; 6/10/23 at 1:49 PM - 154.2 lbs. Weight gain of 4.2 lbs. ii. 6/19/23 at 11:55 AM - 150.8 lbs.; 6/20/23 at 7:24 AM - 153.2 lbs. Weight gain 2.4 lbs. iii. 6/21/23 at 11:06 AM - 151.4 lbs.; 6/22/23 at 10:47 AM - 154.0 lbs. Weight gain 2.6 lbs. iv. 6/7/23 at 11:41 AM - 149.4 lbs.; 6/10/23 at 1:49 PM - 154.2 lbs. Weight gain 4.8 lbs. v. 6/19/23 at 11:55 AM - 150.8 lbs.; 6/24/23 at 10:04 AM - 155.0 lbs. Weight gain 4.2 lbs. b. Furosemide Tablet 20 milligrams (MG). Give 1 tablet by mouth one time a day related to unspecified edema.	F 580		

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F 580	Continued From page 10 Resident #7 July 2023 Medication Administration Record (MAR) included the following orders dated 7/22/22: a. Daily weight and notify the physician if weight gain of 2-3 pounds overnight or 4-5 pounds in five days. Notify the physician with any change in condition, chest pain, intolerable pain, unable to tolerate diet, and shortness of breath. The MAR listed the following weights that had a weight gain that required notification to the physician: - 7/1/23 at 7:56 AM - 156.2 lbs.; 7/2/23 at 7:46 AM - 159.4 lbs. Weight gain 3.2 lbs. b. Furosemide Tablet 20 milligrams (MG). Give 1 tablet by mouth one time a day related to unspecified edema. Resident #7's clinical record lacked documentation that the facility notified the physician with weight gain for the months of April, May, June or July. On 7/19/23 at 4:07 PM the Director of Nursing (DON) said she expected the staff notify the physician with fluctuations in weight as ordered by the physician. 2. Resident #22's MDS assessment dated 5/4/23 identified a BIMS score of 13, indicating no cognitive impairment. The MDS included a diagnosis of type 2 diabetes mellitus with diabetic neuropathy (nerve damage caused by elevated blood sugars that cause pain). Resident #22's June 2023 MAR listed an order dated 1/9/23 to notify the physician for blood sugars above 240 for 48 hours or above 350 and does not respond to attempts at correction four times a day for monitoring related to type 2 diabetes mellitus without complications. Call the	F 580		

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F 580	Continued From page 11 doctor for blood sugars greater than 350 or less than 60. a. Blood sugars over 350 on 1, 4, 5, 6, 7, 9, 14, 16, 17, 19, 20, 24, 25, 26, 27, 28, and 29. b. Blood sugars above 240 for 48 hours or longer: i. 6/4/23 at noon through noon on 6/9/23. ii. 6/12/23 at breakfast through breakfast 6/15/23. iii. 6/17/23 at bedtime through the evening meal on 6/21. Resident #22's July 2023 MAR listed an order dated 1/9/23 to notify the physician for blood sugars above 240 for 48 hours or above 350 and does not respond to attempts at correction four times a day for monitoring related to type 2 diabetes mellitus without complications. Call the doctor for blood sugars greater than 350 or less than 60. a. Blood sugars over 350 on 1, 2, 4, 5, 8, 9, 12, 16, 17, and 19. b. Blood sugars above 240 for 48 hours or longer: i. 7/8/23 at bedtime through noon on 7/11/23. ii. 7/13/23 at breakfast through noon on 7/17/23. Resident #22 clinical record lacked documentation that the facility notified the physician of their blood sugar for months of July and June. One time on 6/29/23, Resident #22 had a blood sugar of 424.	F 580	In continuing compliance with F 644, Accura Healthcare of Sioux City corrected this deficiency by the MDS correcting the PASRR for resident # 22 and all like residents on 7/18/2023. To correct the deficiency and to ensure the problem does not recur, the DON provided education on 7/31/2023 to MDS nurse on PASRR process. The DON or designee will audit all current resident's medications and diagnosis 4x/weekly x4 weeks then, 3x/weekly x4 weeks then, 2x/weekly x2 weeks then, x/weekly x2 weeks and then PRN ensure continued compliance. As a part of Accura of Sioux City's ongoing commitment to quality assurance the DON or designee will report identified concerns through the community's QA process.	7/31/2023
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C	F 644		

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F 644	Continued From page 12	F 644		

of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:

§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.

§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility failed to refer 1 resident with a negative Level I Preadmission Screening and Resident Review (PASRR), who was later identified with newly evident or possible serious mental disorder, intellectual disability, or other related condition, to the appropriate state-designated authority for a Level II PASRR evaluation and determination for 1 out of 1 residents (Resident #22) reviewed for PASRR requirements.

Finding include:

1. Resident #22's Minimum Data Set (MDS) assessment dated 4/27/23 identified a Brief Interview of Mental Status (BIMS) of 1, indicating no cognitive impairment. The Mood section of the MDS listed a score of 9, indicating mild depression. Resident #22 exhibited a rejection of care for one to three days in the lookback period. The MDS included diagnoses of paranoid

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F 644	Continued From page 13 schizophrenia and bipolar disorder. Resident #22 received an antipsychotic and an antidepressant for five out of the seven day lookback period. The Notice of PASRR Level I Screen Outcome Explanation, dated 3/18/21 reflected a notice of no PASRR Level II Required. The PASRR Level I Identification Screen listed nursing facility placement as appropriate for Resident #22. The PASRR Level I screen remains valid for her stay at the nursing facility and should be transferred with her if she relocated. No further Level I screening is required unless you are known to have or are suspected of having a serious mental illness, an intellectual, or developmental disability and exhibit a significant change in treatment needs. The PASRR listed no mental health diagnoses known or suspected. The Level I screen indicated that a PASRR disability is not present because of the following reason: Resident #22 had no evidence of a PASRR condition of an intellectual or developmental disability or a serious behavioral health condition. If changes occur or new information refutes these findings, a new screen must be submitted. Resident #22's Medical Diagnosis list included diagnoses of paranoid schizophrenia and bipolar disorder diagnosed on 3/19/21. Resident #22's July 2023 Medication Administration Records (MAR) included an order for Aripiprazole (Antipsychotic medication) tablet 15 milligrams (MG). Give 1 tablet by mouth one time a day related to paranoid schizophrenia. Resident #22's chart lacked a follow-up and/or a resubmission of a PASRR with the diagnosis of paranoid schizophrenia and bipolar disorder.	F 644		

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F 644	Continued From page 14 On 7/18/23 at 1:58 PM Staff C, MDS Coordinator, reported that if a resident had a change in diagnosis or medication, the facility would fill out a significant change assessment and submit it to PASRR. Staff C stated someone should have submitted a significant change PASRR for Resident #22. Staff C stated PASRR assessments are completed on everyone that enters the facility. On 7/18/23 at 2:10 PM Staff D, Registered Nurse (RN) / Nurse Consultant, stated the facility had no policy related to PASRRs. Staff D added that the facility followed the state regulations for PASRR submissions.	F 644		
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	F 657	In continuing compliance with F 657, Accura Healthcare of Sioux City corrected this deficiency by the DON auditing all current scheduled care conferences by 8/1/2023 to ensure appropriate notifications have been made prior to the conference and documentation is in place on EHR for resident #33 and all like residents. To correct the deficiency and to ensure the problem does not recur, Regional Specialist providing education to clinical IDT on 7/27/2023 on properly ensuring resident and/or resident POA is notified/invited timely of scheduled care plan conferences/revisions with documentation in place. The DON or designee will audit 4x/weekly x4 weeks then, 3x/weekly x4 weeks then, 2x/weekly x2 weeks then, 1x/weekly x2 weeks, and then PRN to ensure continued compliance. As a part of Accura of Sioux City's ongoing commitment to quality assurance the DON or designee will report identified concerns through the community's QA process.	8/1/2023

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F 657	Continued From page 15 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews, resident family interview, and staff interviews the facility failed to provide an opportunity for a resident and/or a Resident's Representative to participate in a Care Conference to discuss the residents care 1 of 12 residents reviewed (Resident #33). Finding include: Resident #33's Minimum Data Set (MDS) assessment dated 6/1/23 listed an admission date of 7/19/22. The MDS identified a Brief Interview of Mental Status (BIMS) of 9 indicating moderate cognitive impairment. On 7/17/23 at 10:37 AM Resident #33 stated that she did not remember ever attending a Care Conference. On 7/20/23 at 11:07 AM Resident #33's Representative (RR #33) stated the previous Social Worker used to notify her but she never got notified now. RR #33 only got invited to attend two of the reviews since Resident #33 lived at the facility. RR #33 explained that the facility did not send her any letters related Care Conferences. RR #33's explained the facility only notified her the day of or the day before the Care Conference	F 657		

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F 657	Continued From page 16 for the two times they invited her. RR #33 added that she could attend the Care Conference with that little of a notice. The Care Conference Review reflected the following: a. 11/3/22 listed that Resident #33 declined to come and that RR #33 could not attend due to [scribbled out information]. b. The Care Plan Summary Review dated 3/23/23 indicated that Resident #33 declined to participate but lacked documentation of RR #33's response. c. 3/23/23 indicated that the facility attempted to call RR #33 on 3/20/23 but she had a full voicemail box, no documentation of additional attempts to contact her. d. 6/15/23 lacked documentation of an invitation sent to Resident #33 or RR #33. On 7/20/23 at 9:05 AM Staff C, MDS Coordinator / Registered Nurse (RN), stated she attended and entered the note for the Care Conference. On 7/20/23 at 9:18 AM Staff B, Social Worker, stated she had a checklist for the Resident's Representative notification. She sent all letters to the Resident's Representative one month before the Care Conference. Staff B explained that she invited Resident #33 to her Care Conferences but she always refused. Staff B added that she did not document that she sent letters or that she notified the family representatives anywhere. On 7/18/23 at 2:10 PM Staff D, Registered Nurse (RN) / Nurse Consultant, stated the facility did not have a policy for a Comprehensive Care Plan review. Staff D stated the facility followed the state regulations for Comprehensive Care Plan Reviews.	F 657		

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F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and policy review the facility failed to complete a discharge summary after a resident discharged on 1 of 1 resident reviewed (Resident #141). Finding include:	F 661	In continuing compliance with F 661, Accura Healthcare of Sioux City corrected this deficiency by the nurse consultant providing education to the DON on 7/20/2023 regarding assessments for discharged residents. To correct the deficiency and to ensure the problem does not recur, DON provided education on 7/26/2023 to clinical IDT on properly ensuring requirements are met for all discharging residents. The DON or designee will audit 4x/weekly x4 weeks then, 3x/weekly x4 weeks then, 2x/weekly x2 weeks then, 1x/weekly x2 weeks, and then PRN to ensure continued compliance. As a part of Accura of Sioux City's ongoing commitment to quality assurance the DON or designee will report identified concerns through the community's QA process.	7/26/2023

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F 661	Continued From page 18 Resident #141's Minimum Data Set (MDS) assessment dated 3/28/23 identified a Brief Interview of Mental Status (BIMS) of 14 indicating no cognitive impairment. Resident #141's Electronic Health Record (EHR) and paper chart lacked a discharge summary and personal belongings list for their discharge on 5/2/23. On 7/20/23 at 1:54 PM Staff D, Registered Nurse (RN) / Nurse Consultant, stated a discharge summary was not completed for Resident #141. On 7/20/23 at 2:10 PM Staff D, stated the facility had no policy for completion of a discharge summary, as the facility followed the state regulations for completion of a discharge summary upon a resident's discharge.	F 661		
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. This REQUIREMENT is not met as evidenced by: Based on record review, resident, and staff interviews the facility failed to assess a resident's blood sugar after a drop in level with a low rise rate for over an hour and half (Resident #92). Following this assessment, no staff assessed	F 684	In continuing compliance with F 684, Accura Healthcare of Sioux City corrected this deficiency by obtaining parameters for blood glucose values for resident #92 on 7/20/2023 and all other like residents on 8/24/2023. To correct the deficiency and to ensure the problem does not recur, the DON educated all nurses on 7/26/2023 on ensuring all assessments, interventions and notifications are documented in the resident's EHR. The DON and/or designee will audit progress notes and MARS to ensure documentation for all assessments, interventions and notifications have been recorded with appropriate follow up M-F x4 weeks then, 3x/weekly x4 weeks then, 2x/weekly x2 weeks then, 1x/weekly x2 weeks, and then PRN to ensure continued compliance. As a part of Accura of Sioux City's ongoing commitment to quality assurance the DON or designee will report identified concerns through the community's QA process.	8/24/2023

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Resident #92 for over three hours. Resident #92 developed a change in condition that required an admission to the hospital due to her hypoglycemic (low blood sugar) status.

Findings Included:

Resident #92's Minimum Data Set (MDS) assessment dated 6/26/23 identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS included a diagnosis of diabetes mellitus.

The Care Plan dated 6/19/23 identified Resident #92 as a diabetic with a goal not to have any ill effects from hypoglycemia or hyperglycemia.

On 7/17/23 at 2:05 PM Resident #92 reported that she went to the hospital a few weeks ago for low blood sugars.

The Health Status Note dated 7/5/23 at 2:59 AM indicated that 1:00 AM the nurse observed Resident #92 with her C-Pap (machine to help treat sleep apnea while sleeping) and her leg hanging over the bed. She had slurred speech and did not make sense. Resident #92 had a blood sugar (BS) of 32. The nurse contacted the provider who gave an order for a glucagon injection. The nurse gave Resident #92 the glucagon injection in her right upper arm. The nurse rechecked Resident #92's blood sugar as followed:
a. 1:15 AM - BS of 44 mg/dL.
b. 1:30 AM - BS of 55 mg/dL.
c. 3:00 AM - BS of 74 mg/dL.
- Resident #92 drank 200 milliliters (ML) of juice, had a bite of graham cracker, and three tablespoons of honey.

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d. 5:30 AM - BS of 60 mg/dL.
- Resident #92 vomited after receiving honey, the nurse gave the resident as needed Zofran (anti-nausea medicine).

The Health Status Note dated 7/5/23 at 8:55 AM labeled Late Entry reflected that the charge nurse requested an order to send Resident #92 to the emergency room (ER) from the provider. The provider declined to give an order to send her to the ER, but gave an order to administer glucagon. Resident #92's nurse called the provider's office and spoke with the provider's nurse who directed to give the glucagon at that time and if they did not see an improvement in 30 minutes in her alertness, they could Resident #92 to the ER. At 9:30 AM the provider's nurse called back for an update on Resident #92. The nurse reported her blood sugar as 94 mg/dL, the nurse received an order to send Resident #92 to the ER.

The Health Status Note dated 7/5/23 at 10:07 AM listed that Resident #92 had a blood sugar of 40, she appeared alert but very disoriented. She did not know where she was. Her face looked pale and dusty (gray type coloring). Resident #92 reported to the nurse that she did not feel right. The nurse called the provider who said to give glucagon and if not better within a half hour, they could send to the ER. A half hour later, the nurse checked Resident #92 blood sugar and got a result of 94. Resident #92 reported that she did not feel any better, so the facility sent her to the ER via ambulance.

On 7/20/23 at 10:02 AM, Staff R, Licensed Practical Nurse (LPN), reported that the facility did not have a policy or guidelines for the treatment of hypoglycemia. When asked how

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F 684	Continued From page 21 often blood sugars should be checked, what diet interventions should be used, and when should the provider be notified of hypoglycemia, Staff R responded, that she used her own judgment. On 7/20/23 at 10:02 AM, Staff R, Licensed Practical Nurse (LPN), reported that the facility lacked a policy or guidelines for the treatment of hypoglycemia. When asked how often blood sugars should be checked, what diet interventions should be used, and when should the provider be notified of hypoglycemia, Staff R responded, that she used her own judgment. On 7/20/23 at 11:11 AM, the Director of Nursing (DON), reported the facility lacked a hypoglycemic protocol or policy. The DON reported that she would have done more after 5:30 AM. The DON could not determine, by the nurse's documentation, if the resident was properly assessed or treated. On 7/20/23 at 1:59 PM, the DON reported that if after the first dose of glucagon (medication injected to raise a person blood sugar) Resident #92's blood sugar failed to rise, and stayed at a stable level, she expected the staff to notify the doctor to obtain parameters and request an order to send them to ER if needed.	F 684		
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	F 689	In continuing compliance with F 689, Accura Healthcare of Sioux City corrected this deficiency by the DON providing 1:1 education to Staff O and Staff Q on ensuring the proper use of the mechanical lift for Resident #13 and all like residents on 7/26/2023. To correct the deficiency and to ensure the problem does not recur, DON provided education to all nursing staff on proper resident transfer with a mechanical lift on 7/26/2023. The DON or designee will audit transfers 4x/weekly x4 weeks then, 3x/weekly x4 weeks then, 2x/weekly x2 weeks, 1x/weekly x2 weeks, and then PRN to ensure continued compliance. As a part of Accura of Sioux City's ongoing commitment to quality assurance the DON or designee will report identified concerns through the community's QA process.	7/26/2023

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F 689	Continued From page 22 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews the facility failed to properly use a mechanical lift to avoid hazards and prevent accidents for 1 of 1 residents reviewed (Resident #13). Findings include: Resident #13's Minimum Data Set (MDS) assessment dated 3/11/23 identified a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. Resident #13 required total assistance from two persons for toilet use and extensive assistance from two persons for personal hygiene. The MDS included diagnoses of neurogenic bladder (difficulty with urinating) and renal insufficiency (poor functioning kidneys). The Care Plan Focus revised 8/9/22 indicated that Resident #13 had an activities of daily living (ADL) deficit due to weakness and a history of cerebral (brain) events. The Intervention dated 8/9/22 instructed that Resident #13 required the assistance of two person for transfers with the full body mechanical lift. On 7/18/23 at 12:52 PM observed Staff O, Certified Nurse Aide (CNA), and Staff Q, CNA, transfer Resident #13 with a full-body mechanical lift from her wheelchair to the bed. Staff O and Staff Q failed to lock the brakes of Resident #13's wheelchair before lifting her with the full-body mechanical left.	F 689		

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F 689	Continued From page 23 The Competency for Hoyer Lift updated 5/11/21 instructed staff to place the chair that the resident will be transferred into in position and make sure the brakes are secured. On 7/18/23 at 1:32 PM, the Administrator and the Director of Nursing reported that they both would have to refer to the lift guide for instructions. The Administrator reported the staff are trained on all mechanical lifts and mechanical stands. They expect the staff to follow the education.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility policy review, the facility failed to manage oxygen usage for 1 out of 1 residents reviewed (Resident #13) for oxygen use. Findings include: Resident #13's Minimum Data Set (MDS) assessment dated 3/11/23 identified a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. Resident #13 required total assistance from two persons for toilet use and extensive assistance	F 695	In continuing compliance with F 695, Accura Healthcare of Sioux City corrected this deficiency by fixing oxygen settings for resident # 13 and all like residents on 7/26/2023 by the DON. To correct the deficiency and to ensure the problem does not recur, the DON educated all nurses on 7/26/2023 on following PCP orders and checking oxygen machine to ensure proper flow rate is set per orders. The DON and/or designee will audit physician orders and O2 settings 4x/weekly x4 weeks then, 3x/weekly x4 weeks then, 2x/weekly x2 weeks then, 1x/weekly x2 weeks, and then PRN to ensure continued compliance. As a part of Accura of Sioux City's ongoing commitment to quality assurance the DON or designee will report identified concerns through the community's QA process.	7/26/2023

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F 695	Continued From page 24	F 695		

from two persons for personal hygiene. The MDS included diagnoses of heart failure, chronic obstructive pulmonary disease (COPD, long-term lung disease that affects breathing), and anemia (low iron levels in the blood). Resident #13 received oxygen therapy in the lookback period.

The Care Plan Focus revised 8/9/22 indicated that Resident #13 had a potential for or actual respiratory abnormalities related to COPD. The Intervention revised 1/8/23 directed oxygen at 3 liters per nasal cannula (3L/NC) while in bed to keep oxygen saturations above 90%.

On 7/17/23 at 1:50 PM witnessed Resident #13's oxygen concentrator set at 3.5 L/NC while she rested in bed.

On 7/18/23 at 1:32 PM observed Resident #13's oxygen concentrator set at 3.5 L/NC while she rested in bed.

Resident #13's Clinical Physician Orders included an order dated 11/16/22 instructing that while she laid in bed, she could have oxygen at 3 L/NC or mask to keep oxygen saturation above 90%.

Resident #13's July 2023 Medication Administration Record listed an order dated 11/16/22 instructing that while she laid in bed, she could have oxygen at 3 L/NC or mask to keep oxygen saturation above 90%.

On 7/19/23 at 2:01 PM, Staff S, Licensed Practical Nurse (LPN), verified that Resident #13's oxygen setting should be at 3 L/NC. After Staff S entered Resident #13's room, she reported Resident #13's oxygen concentrator showed she received 3.5 L/NC of oxygen. Staff S

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F 695	Continued From page 25 reduced the oxygen flow to 3 L/NC. On 7/19/22 at 2:41 PM, the Administrator, reported that she expected residents to receive oxygen as ordered by the provider. The Administrator reported that the facility lacked an oxygen policy.	F 695		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services 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)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents'	F 726	In continuing compliance with F 726, Accura Healthcare of Sioux City corrected this deficiency by DON providing Staff E 1:1 education when to notify nurse when blood pressures are outside of parameters for resident #36 and all like residents on 7/26/2023. To correct the deficiency and to ensure the problem does not recur, the DON provided education on 7/26/2023 to all nursing staff to ensure timely notifications to charge nurses when vital signs are not within normal limits. The DON and/or designee will audit parameters orders/vitals 4x/weekly x4 weeks then, 3x/weekly x4 weeks then, 2x/weekly x2 weeks then, 1x/weekly x2 weeks, and then PRN to ensure continued compliance. As a part of Accura of Sioux City's ongoing commitment to quality assurance the DON or designee will report identified concerns through the community's QA process.	7/26/2023

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F 726	Continued From page 26	F 726		

needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by:
Based on clincial record review and staff interviews, the facility failed to ensure that staff who took a resident's blood pressure knew when to notify the nurse of a low result for one of one residents reviewed (Resident #36).

Findings include:

Resident #36's Minimum Data Set (MDS) assessment dated 6/8/23 identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. The MDS included a diagnosis of hypotension (low blood pressure).

Resident #36's July 2023 MAR listed an order dated 6/3/23 for Midodrine HCl (medication used to raise blood pressure) oral tablet 5 MG. Give two tablets by mouth three times a day before meals for hypotension. The last pill must be given before 6 PM, hold if blood pressure is 130/85 or above.
- 7/19/23 - Staff E, Certified Medication Aide (CMA), documented a blood pressure of 79/49 (average blood pressure for a typical person is 120/80).

On 7/19/23 at 9:35 AM Staff E reported that Resident #36 had a blood pressure within range. The blood pressure was less than 130/85 so the blood pressure was good enough to give the medication this morning. She would only notify the nurse if it was a low blood pressure. She did not know at what blood pressure she would notify the nurse, as she did not know the parameters of

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when to tell them nurse of a low blood pressure. She took their blood pressure earlier that morning with their blood sugar.

On 7/19/23 at 9:30 AM Staff F, Licensed Practical Nurse (LPN), denied notification of any excessively low blood pressure that morning shift.

Electronic record review of blood pressure expectations revealed blood pressure Systolic abnormal high rate is greater than 139. Abnormally low rate is less than 90. Diastolic abnormal high rate is greater than 89. Abnormal low rate is less than 60.

On 7/19/23 at 9:46 AM Staff F stated any blood pressure with a systolic blood pressure less than 80 and diastolic blood pressure less than 60 should be notified to the nurse and would require an assessment. Staff F stated she educated Staff E on parameters for notification of low blood pressures. Staff F stated a blood pressure of 79/49 is a blood pressure that should be told to a nurse. Staff F stated she reassessed Resident #36 that morning shift after educating Staff E on low blood pressures.

On 7/19/23 at 9:50 AM the Director of Nursing (DON) explained that the staff should have notified the nurse for blood pressure of 79/49. The DON reported that if a person had a low blood pressure with another symptom then they would automatically notify the nurse. The staff should notify of anything under 100/60.

On 7/19/23 at 10:30 AM Staff D, Registered Nurse (RN) / Nurse consultant, reported that they expected the staff to follow standards of practice. Staff D added that the facility did not have a policy

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F 726	Continued From page 28 related to notification and follow-up for altered vitals.	F 726		
F 802 SS=E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on document review, observations, policy, and staff interview the facility failed to employ sufficient staff with the appropriate competencies and skills sets to effectively carry out the functions of the food and nutrition service department. The facility reported a census of 43. residents. Findings include: The Diet Spreadsheets labeled Week 3 Wednesday signed by the Dietitian on 4/13/23	F 802	In continuing compliance with F 802, Accura Healthcare of Sioux City corrected this deficiency by Dietary supervisor educating Staff G on 8/23/2023 on proper policy and procedures regarding pureeing foods and hand hygiene in the kitchen by 8/23/2023. To correct the deficiency and to ensure the problem does not recur, the Dietary Supervisor educated dietary staff on proper policy and procedures regarding pureeing foods and hand hygiene in the kitchen by 8/23/2023. Dietary Supervisor to audit dietary staff during pureeing process 3 times weekly for 4 weeks, 2 times weekly for 4 weeks, 1 time weekly for 4 weeks then as needed to ensure continued compliance. As a part of Accura of Sioux City's ongoing commitment to quality assurance the DON or designee will report identified concerns through the community's QA process.	8/23/2023

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provided by Staff J, Dietary Manager, listed the following information:
a. Regular diet: 3 ounces (oz) smoked pork loin, one baked sweet potato, and 4 oz buttered peas.
b. Pureed diet: #8 scoop pureed smoked pork loin, #8 scoop mashed sweet potatoes, and #12 scoop pureed buttered peas.
c. Mechanical soft diet: 3 oz ground smoked pork loin, one baked sweet potato with no skin, and 4 oz scoop creamed corn.

On 7/19/23 observed Staff G's, Cook, scoops used for the lunch meal revealed:
a. Pureed wax beans size # 16 scoop, pureed meat 3 oz scoop, and pureed sweet potato 3 oz scoop.
b. Regular sweet potato 3 oz slotted scoop, peas 3 oz slotted scoop, and wax beans 3 oz slotted scoop.
c. Mechanical soft meat size #16 scoop.

On 7/19/23 at 11:55 AM observed a pureed diet portion chart behind the food processor in the kitchen.

The Menu Substitution Log provided by Staff J revealed a blank document.

On 7/19/23 at 11:42 AM Staff G stated she just eyeballs the amount of meat for serving size prior to using the food processor for puree. Watched Staff G use a scoop spoon to empty the food processor. After Staff G, finished observed a large amount of food left in the food processor. The scoop spoon could not reach the large amount of food in the corner of the food processor.

On 7/19/23 at 12:21 PM during the continuous

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observation of the lunch service witnessed Staff G fill the scoops used to serve the mechanical soft diet and the pureed diets only partially full. Witnessed Staff G picked up a peanut butter and jelly sandwich with gloved hands, placed the sandwich on a plate then picked up tongs for pork, placed pork on plate, picked up strainer spoon for sweet potatoes, and then picked up the lids for room trays. Then with the same gloves and without hand hygiene, Staff G picked up bread, picked up a plate, placed the bread on the plate, picked up the room tray lid, applied the lid to the plate, picked up the strawberry cobblers, and put the cobblers on the tray. Staff G used both hands for each task and repeated these tasks through the entire lunch service without changing her gloves or performing hand hygiene.

The Hand Hygiene procedure document updated 10/19/22 provided by the Administrator directed that staff should always complete hand hygiene before and after work, before donning (applying) gloves and after removing gloves, after handling contaminated items and equipment, and whenever their hands become physically soiled.

On 7/19/23 at 1:36 PM Staff J reported that the kitchen had a substitution sheet that they submit to the Dietitian. Staff J explained that she substitutes whatever the facility has in the kitchen that is of equal nutritional value. The meat portion on the pork loin is determined where the net on the uncooked meat lines up, that is where the portion is cut from. Staff J added that while she worked at the facility, they never had a working scale. Staff J stated she sliced meat to make the plate look full. Staff J explained that they make substitutions about two to three times a week. Substitutions are made because she forgets to

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order the food, there is a change in census, and/or the facility did not have enough of that food for all the residents. Staff J stated the facility's expectation is to follow the pureed portion chart posted on the wall and added that they did not have #8 sized scoops. Staff J reported that the facility expected gloves are changed when hands are soiled or when they moved from any contaminated surface and food. Staff J stated that the substitution sheet was for a couple months and she expected that it would be filled out properly. Staff J stated the substitution document should not be blank.

On 7/20/23 at 12:34 PM the Dietitian stated new gloves should be applied whenever gloves are dirty. The Dietitian stated she would like no glove use during meal service and that tongs would have been ideal. The Dietitian stated she expected the staff to use a scale to determine the serving size of pork loin.

On 7/22/23 at 10:25 AM the Administrator reported the expectation of the facility is to use the correct size to serve the food. The serving size should be determined by the size that is suggested by the pureed food chart, size suggested by the dietitian, and serving size specified on the menu. The Administrator stated she did not mind if the cook substituted foods off the menu. The Administrator explained that they expected that the food would be substituted appropriately. The Administrator stated the facility's expectation for glove use in the kitchen is clean touches clean and soiled touches soiled. The Administrator stated the facility's expectation is that if any of these are not correct, the staff washes their hands and applies new gloves.

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F 803	Continued From page 32	F 803		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, document review and staff interview the facility failed to follow the menu and prepare food to meet the nutritional needs of the residents. The facility reported a census of 43 residents. Findings include:	F 803	In continuing compliance with F 803, Accura Healthcare of Sioux City corrected this deficiency by Dietary supervisor educating Staff G on 8/23/2023 on proper policy and procedures regarding pureeing foods by 8/23/2023. To correct the deficiency and to ensure the problem does not recur, the Dietary Supervisor educated dietary staff on proper policy and procedures regarding pureeing foods by 8/23/2023.The Dietary Supervisor will audit puree process 3 times weekly for 4 weeks, 2 times weekly for 4 weeks, 1 time weekly for 4 weeks and then as needed to ensure continued compliance. As a part of Accura of Sioux City's ongoing commitment to quality assurance the DON or designee will report identified concerns through the community's QA process.	8/23/2023

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F 803	Continued From page 33 Review untitled document titled Week 3 menu for Wednesday provided by Staff J revealed a. regular diet: 3 oz smoked pork loin, 1 baked sweet potato, and 4 oz buttered peas b. pureed diet: #8 scoop pureed smoked pork loin, #8 scoop mashed sweet potatoes, and pureed buttered peas. c. Mechanical soft diet: 3 oz ground smoked pork loin, 1 baked sweet potato with no skin, and creamed corn. Observation of scoops used by Staff G for lunch meal for 7/19/23 revealed: pureed wax beans size # 16 scoop, pureed meat 3 oz scoop, pureed sweet potato 3 oz scoop, regular sweet potato 3 oz slotted scoop, mechanical soft meat size #16 scoop, Pea 3 oz slotted scoop, wax beans 3 oz slotted scoop. An observation on 7/19/23 at 11:55 AM revealed a pureed diet portion chart behind the food processor in the kitchen. On 7/19/23 at 11:42 AM Staff G stated she just eyeballs the amount of meat for serving size prior to using the food processor for puree. Watched Staff G use a scoop spoon to empty the food processor. After Staff G, finished observed a large amount of food left in the food processor. The scoop spoon could not reach the large amount of food in the corner of the food processor. A continuous observation of the lunch meal revealed the scoop used to serve mechanical soft meat only partially filled when serving residents' portions and the scoop used to serve pureed food only partially filled when serving residents who received pureed diets.	F 803		

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F 803	Continued From page 34 On 7/19/23 at 1:36 PM Staff J reported that the meat portion on the pork loin is determined where the net on the uncooked meat lines up, that is where the portion is cut from. Staff J added that while she worked at the facility, they never had a working scale. Staff J stated she sliced meat to make the plate look full. Staff J stated the facility's expectation is to follow the pureed portion chart posted on the wall and added that they did not have #8 sized scoops. On 7/20/23 at 12:34 PM the Dietitian stated The Dietitian stated she expected the staff to use a scale to determine the serving size of pork loin. She expected the staff to use correct size utensils to serve the items on the menu. On 7/22/23 at 10:25 AM the Administrator reported the expectation of the facility is to use the correct size to serve the food. The serving size should be determined by the size that is suggested by the pureed food chart, size suggested by the dietitian, and serving size specified on the menu.	F 803	In continuing compliance with F 812, Accura Healthcare of Sioux City corrected this deficiency by Dietary Supervisor disposing of the undated items on 7/17/2023 identified by the surveyor. The Dietary Supervisor addressed the concerns with cleanliness identified by the surveyor on 7/17/2023 by cleaning the kitchen floor, open shelves, double door fridge, portable cart, and stove top. To correct the deficiency and to ensure the problem does not recur, the Dietary Supervisor educate dietary staff regarding policy and procedures for keeping the kitchen clean and all check lists completed, and proper hand hygiene in the kitchen by 8/23/2023. Dietary Supervisor will audit kitchen cleanliness 3 times weekly for 4 weeks, 2 times weekly for 4 weeks, 1 time weekly for 4 weeks and then as needed to ensure continued compliance. DON or designee will audit dietary staff for proper handwashing competency and knowledge of when hand washing should be completed 3 times a week for 4 weeks, 2 times a week for 4 weeks, 1 time a week for 4 weeks and then as needed to ensure continues compliance. As a part of Accura of Sioux City's ongoing commitment to quality assurance the DON or designee will report identified concerns through the community's QA process.	8/23/2023
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	F 812		

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F 812	Continued From page 35 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to label food with dates after opening, failed to maintain a clean kitchen, perform hand hygiene, and change gloves after touching dirty items. The facility identified a census of 43 residents. Findings included: 1. An initial kitchen tour conducted on 7/17/23 at 10:54 AM, revealed the following previously open items stored in the refrigerator without an open date: a. Ranch dressing b. French dressing c. Italian dressing d. An unlabeled bottle of Mayonnaise e. Barbeque sauce f. Minced garlic In addition, observed eggs stored directly on top of juice bottles. 2. Observed the following concerns with cleanliness: a. The kitchen floor felt sticky with the appearance of dried food and food debris on it. b. Open shelves covered with dust and found with scattered food debris. c. Bottom of double door fridge found with	F 812		

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scattered food debris and dried on food.
d. Dishware stored on a portable cart. Cart located within the tape on the floor marking the dirty side of the kitchen. Dishware not covered or inverted.
e. Stove top, griddle, and oven revealed brown baked on grease buildup and a variety of food debris.

The Food Safety and Sanitation policy dated 2021 identified that the environment health service of the local public health department would routinely inspect the department following their accepted standards and regulations. The Director of food and nutrition services will have a copy of the applicable regulations on file to meet the regulations. The food and nutrition services department will follow regulations as outlined by other official health and organizations with jurisdiction over the facility. The section labeled Food Storage instructed that when a food package is opened the food item should be marked to indicate the opened date. The date is used to determine when to discard the food.

The Food Safety - Director of Food and Nutrition Services' Responsibilities policy dated 2021 instructed that the Director of food and nutrition services should assure sanitary conditions will be maintained in the food storage, preparation, and serving areas.

On 7/17/23 at 11:31 AM, the Dietary Manager (DM), reported that the staff who worked the last weekend failed to complete their assigned cleaning duties. The DM reported that she expected all areas of the kitchen to be clean and sanitary. The DM reported that she expected staff to complete all assigned cleaning duties. The DM

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also stated that she expected staff to label food packages and containers with an opened date.
2. On 7/19/23 at 12:21 PM during the continuous observation of the lunch service witnessed Staff G fill the scoops used to serve the mechanical soft diet and the pureed diets only partially full. Witnessed Staff G picked up a peanut butter and jelly sandwich with gloved hands, placed the sandwich on a plate then picked up tongs for pork, placed pork on plate, picked up strainer spoon for sweet potatoes, and then picked up the lids for room trays. Then with the same gloves and without hand hygiene, Staff G picked up bread, picked up a plate, placed the bread on the plate, picked up the room tray lid, applied the lid to the plate, picked up the strawberry cobblers, and put the cobblers on the tray. Staff G used both hands for each task and repeated these tasks through the entire lunch service without changing her gloves or performing hand hygiene.

On 7/19/23 at 1:36 PM Staff J, Dietary Manager, stated the facility's expectation is that gloves are changed when hands are soiled or when moving from any contaminated surface and food.

On 7/20/23 at 12:34 PM the Dietitian stated new gloves should be applied whenever gloves are dirty. The Dietitian stated she would like no glove use during meal service and that tongs would have been ideal.

On 7/22/23 at 10:25 AM Administrator stated the facility's expectation for glove use in the kitchen is clean touches clean and soiled touches soiled. The Administrator stated the facility's expectation is that if any of these are not correct, the staff washes their hands and applies new gloves.

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F 812	Continued From page 38 The Hand Hygiene procedure document updated 10/19/22 provided by the Administrator directed that staff should always complete hand hygiene before and after work, before donning (applying) gloves and after removing gloves, after handling contaminated items and equipment, and whenever their hands become physically soiled.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care	F 842	In continuing compliance with F 684, Accura Healthcare of Sioux City corrected this deficiency by obtaining parameters for blood glucose values for resident #92 on 7/20/2023 and all other like residents on 8/24/2023. To correct the deficiency and to ensure the problem does not recur, the DON educated all nurses on 7/26/2023 on ensuring all assessments, interventions and notifications are documented in the resident's EHR. The DON and/or designee will audit progress notes and MARS to ensure documentation for all assessments, interventions and notifications have been recorded with appropriate follow up M-F x4 weeks then, 3x/weekly x4 weeks then, 2x/weekly x2 weeks then, 1x/weekly x2 weeks, and then PRN to ensure continued compliance. As a part of Accura of Sioux City's ongoing commitment to quality assurance the DON or designee will report identified concerns through the community's QA process.	8/24/2023

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F 842	Continued From page 39 operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to maintain accurate medical records	F 842		

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F 842	Continued From page 40 for 1 out of 13 residents reviewed (Resident #92). Findings Included: Resident #92's Minimum Data Set (MDS) assessment dated 6/26/23 identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS included a diagnosis of diabetes mellitus. The Care Plan dated 6/19/23 identified Resident #92 as a diabetic with a goal not to have any ill effects from hypoglycemia or hyperglycemia. On 7/17/23 at 2:05 PM Resident #92 reported that she went to the hospital a few weeks ago for low blood sugars. The Health Status Note dated 7/5/23 at 2:59 AM indicated that 1:00 AM the nurse observed Resident #92 with her C-Pap (machine to help treat sleep apnea while sleeping) and her leg hanging over the bed. She had slurred speech and did not make sense. Resident #92 had a blood sugar (BS) of 32. The nurse contacted the provider who gave an order for a glucagon injection. The nurse gave Resident #92 the Glucagon injection in her right upper arm. The nurse rechecked Resident #92's blood sugar as followed: a. 1:15 AM - BS of 44 mg/dL. b. 1:30 AM - BS of 55 mg/dL. c. 3:00 AM - BS of 74 mg/dL. - Resident #92 drank 200 milliliters (ML) of juice, had a bite of graham cracker, and three tablespoons of honey. d. 5:30 AM - BS of 60 mg/dL. - Resident #92 vomited after receiving honey, the nurse gave the resident as needed Zofran	F 842		

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(anti-nausea medicine).

The Health Status Note dated 7/5/23 at 8:55 AM labeled Late Entry reflected that the charge nurse requested an order to send Resident #92 to the emergency room (ER) from the provider. The provider declined to give an order to send her to the ER, but gave an order to administer Glucagon. Resident #92's nurse called the provider's office and spoke with the provider's nurse who directed to give the Glucagon at that time and if they did not see an improvement in 30 minutes in her alertness, they could Resident #92 to the ER. At 9:30 AM the provider's nurse called back for an update on Resident #92. The nurse reported her blood sugar as 94 mg/dL, the nurse received an order to send Resident #92 to the ER.

The Health Status Note dated 7/5/23 at 10:07 AM listed that Resident #92 had a blood sugar of 40, she appeared alert but very disoriented. She did not know where she was. Her face looked pale and dusty (gray type coloring). Resident #92 reported to the nurse that she did not feel right. The nurse called the provider who said to give Glucagon and if not better within a half hour, they could send to the ER. A half hour later, the nurse checked Resident #92 blood sugar and got a result of 94. Resident #92 reported that she did not feel any better, so the facility sent her to the ER via ambulance.

On 7/20/23 at 10:02 AM, Staff R, Licensed Practical Nurse (LPN), reported that the facility did not have a policy or guidelines for the treatment of hypoglycemia. When asked how often blood sugars should be checked, what diet interventions should be used, and when should

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F 842	Continued From page 42 the provider be notified of hypoglycemia, Staff R responded, that she used her own judgment. On 7/20/23 at 10:02 AM, Staff R, Licensed Practical Nurse (LPN), reported that she practiced to stay with the resident until their blood sugars stabilize. She usually tests the resident's blood sugars about every 15-20 minutes until they are stable. Staff R added that her normal practice is to assess the resident and take their vital signs every time that she checks their blood sugar. Staff R reported that she documented blood sugar results, vital signs, medication administration, and physician communication in the electronic chart. Staff R recalled coming to work on 7/5/23 and taking care of Resident #92 during the hypoglycemic episode. Staff R reported Resident #92's blood sugar to be 130 milligrams per deciliter (mg/dL) at 7:00 AM. Staff R reported that she took another blood sugar at 7:30 AM, and another employee checked Resident #92's blood sugar shortly after. After reviewing her documentation, Staff R responded, I must not have documented everything that day. Staff R reported that she was very busy that day, as she sent another resident to the hospital that morning. On 7/20/23 at 11:11 AM, the Director of Nursing (DON), reported the facility lacked a hypoglycemic protocol or policy. The DON could not determine, by the nurse's documentation, if the resident was properly assessed or treated. The DON reported the facility lacked a documentation policy. The DON acknowledged that she expected staff to document detailed information during a hypoglycemic event.	F 842		
F 880 SS=E	Infection Prevention & Control	F 880		

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F 880	Continued From page 43 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 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	F 880	In continuing compliance with F 880, Accura Healthcare of Sioux City corrected this deficiency by the DON providing education to Staff O and Staff Q on proper catheter cares for resident #13 and all like residents on 7/26/2023 and education to Staff E on proper hand hygiene and glove use during medication pass on 7/26/2023. To correct the deficiency and to ensure the problem does not recur, DON provided education to all nursing staff for proper hand hygiene and glove use during catheter cares and medication pass on 7/26/2023. The DON or designee will audit catheter care and medication pass 4x/weekly for 4 weeks then, 3x/weekly x4 weeks then, 2x/weekly x2 weeks then, 1x/weekly x2 weeks, and then PRN to ensure continued compliance. As a part of Accura of Sioux City's ongoing commitment to quality assurance the DON or designee will report identified concerns through the community's QA process.	7/26/2023

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F 880	Continued From page 44 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 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 observations, record review, staff interviews, and policy reviews, the facility failed to provide proper hand hygiene after catheter care for 1 of 1 residents reviewed (Resident #13). In addition, the facility failed to complete hand hygiene during a medication administration for 1 out of 3 residents reviewed (Resident #17). Findings include:	F 880		

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F 880	Continued From page 45 1. Resident #13's Minimum Data Set (MDS) assessment dated 3/11/23 identified a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. Resident #13 required total assistance from two persons for toilet use and extensive assistance from two persons for personal hygiene. The MDS included diagnoses of neurogenic bladder (difficulty with urinating) and renal insufficiency (poor functioning kidneys). On 7/18/23 at 1:04 PM watched Staff Q, Certified Nursing Assistant (CNA), empty Resident #13's urine collection bag into a container, wiped the tip of the drain with an alcohol wipe, replaced the drain into the holder. Without removing her gloves after touching the urine collection bag, Staff Q touched the privacy bag, bed controls, and a package of wipes. Staff O, CNA, then emptied the urine from the container, removed her gloves then failed to perform hand hygiene before touching the wheelchair handles and repositioning Resident #13's arms and blankets. The Hand Hygiene policy updated 10/19/23 instructed to perform hand hygiene immediately after glove removal, after contact with blood, body fluids, or contaminated surfaces. On 7/18/23 at 1:32 PM, the Director of Nursing (DON), acknowledged that she expected staff to remove their gloves, and perform hand hygiene after emptying the urine collection bag, emptying urine from a container, or any time after providing resident care. The DON expressed there is some room for improvement. 2. Resident #36's MDS assessment dated 6/8/23 identified a BIMS score of 11, indicating moderate	F 880		

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cognitive impairment. The MDS included a diagnosis of hypotension (low blood pressure).

On 7/19/23 at 7:37 AM during a continuous observation of Staff E, Certified Medication Aide, doing a medication pass, Staff E failed to complete hand hygiene at the cart prior to removal of medications from the medication card. Staff E cut the pain relief patches open with scissors, then locked the medication cart, walked to the room, and knocked on the door. Before and after entering Resident #36's room, Staff E failed to complete hand hygiene. Resident #36 requested lukewarm water from the tap to take their medication with. Staff E obtained water from the sink and gave Resident #36 their medication without any hand hygiene. Without hand hygiene, Staff E applied gloves, then applied Resident #36's lidocaine patches. Staff E applied initials and date to both patches. Staff E removed gloves and then did hand hygiene. Staff E handed Resident #36 a medicated inhaler, who inhaled two puffs. Staff E walked out of Resident #36's room returned to the medication cart and then walked down to the dining room.

The Hand Hygiene policy updated 10/19/22 provided by the Administrator instructed that staff should always complete hand hygiene before and after work, before performing any invasive procedures, before donning gloves and after removing gloves, after handling contaminated items and equipment, between resident care sites, and whenever your hands become physically soiled.

On 7/19/23 at 4:17 PM the DON reported she expected the staff to perform hand hygiene prior to and after medication administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165435	A. BUILDING _____ B. WING _____	C 07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF SIOUX CITY, LLC	3800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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