STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165529	A. BUILDING _____ B. WING _____	03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF SHENANDOAH	1203 SOUTH ELM STREET SHENANDOAH, IA 51601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	Accura Healthcare of Shenandoah 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.	04/08/2022
JS/	Correction date: 04/08/2022 The following deficiencies resulted from the facility's annual recertification survey conducted on March 28 to March 31, 2022. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.			
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which	F 625	In continuing compliance with F 625, Notice of Bed-Hold Policy Before/Upon Trnsfr, Accura Healthcare of Shenandoah corrected the deficiency by the Social Service Director was educated by the Executive Director on 03/31/2022 on ensuring that bed holds are completed for Resident #6 and all like residents when they are transferred from the facility to the hospital. To correct the deficiency and to ensure the problem does not recur all nurses were educated on the bed hold policy on 4/4/2022 by DON. The ED and/or designee will audit bed holds for completion 3x/weekly x4 weeks, then 2x/weekly x2 weeks, and then PRN to ensure continued compliance. As part of Accura Healthcare of Shenandoah ongoing commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process.	04/04/20222

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ashley Anderson | TITLE: Administrator | (X6) DATE: 5/19/22

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

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F 625	Continued From page 1 specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, and facility policy review, the facility failed to ensure staff provided a bed hold notice to 1 of 3 residents (or their responsible person) reviewed when the resident transferred from the facility to the hospital (Resident #6). The facility reported a census of 36 residents. Findings include: The Minimum Data Set (MDS) assessment tool dated 1/6/22 documented Resident #6 had diagnoses of heart failure, diabetes mellitus and hypertension. The MDS showed the Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. A progress note dated 3/25/22 at 2:16 p.m., documented Resident #6 sent to Emergency Room (ER) for evaluation. A progress note dated 3/26/22 at 1:15 p.m., revealed Resident #6 left the hospital and readmitted to the facility. . Review of the progress notes showed the facility did not provide information related to bed hold until 3/28/22 at 10:14 a.m. (after the resident returned from the hospital). The resident's record failed to contain a bedhold notice issued on 3/25/22, as required. The record revealed a verbal Bed Hold Notice provided by the Social Worker dated after the resident's readmission to the facility. Review of Bed Hold Policy and Return revised	F 625		

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F 625	Continued From page 2 11/2017 revealed the facility agreed to hold the bed of any resident upon the return of a signed bed hold agreement or the verbal confirmation obtained by the facility. The policy directed staff to provide the bedhold and return policies to the resident or their responsible party upon admission to the facility and again prior to a hospital transfer or therapeutic leave. In an interview on 03/30/22 at 01:37 p.m., the Director of Nursing revealed she expected staff to provide a bed hold notice at the time the resident leaves the facility.	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656	In continuing compliance with F 656, Develop/Implement Comprehensive Care Plan., Accura Healthcare of Shenandoah corrected the deficiency by auditing res #35 and all like resident's care plans to ensure all high-risk medications had been care planned appropriately by 4/8/22 by the MDS Coordinator. To correct the deficiency and to ensure the problem does not recur, the MDS Coordinator was provided one on one education on timely revision of care plans by Regional Nurse Specialist on 3/31/22. MDS Coordinator and or designee will audit 3x/weekly x4 weeks, then 2x/weekly x2 weeks, and then PRN to ensure continued compliance. As part of Accura Healthcare of Shenandoah ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	04/08/2022

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F 656	Continued From page 3 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record and staff interview, the facility failed to update the care plan to include high risk medications for 1 of 12 residents reviewed (Resident #35). The facility reported a census of 36 residents. Findings include: According to the Minimum Data Set (MDS) assessment tool dated 03/11/22, Resident #35 scored 6 of 15 possible points on the Brief Interview of Mental Status (BIMS) test, which meant the resident demonstrated severe cognitive impairment. The MDS documented the resident had diagnoses that included senile degeneration of the brain, dorsalgia, and collapsed vertebrae. The MDS also documented the resident required extensive assist of 2 staff for bed mobility, transfers, and toilet use.	F 656		

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F 656	Continued From page 4 Record review revealed Resident #35's physician ordered staff to administer morphine sulfate and lorazepam starting 3/05/22. The Care Plan initiated on 03/04/22 failed to contain interventions that directed staff to monitor Resident #35 for side effects related to morphine sulfate and lorazepam. In an interview on 03/30/22 at 02: 47 PM Staff A, Regional Nurse Specialist, reported that although the facility did not have a specific policy related to care plans, she expected staff to follow the professional standard of practice related to the creation and revision of care plans. She acknowledged that the care plan should include directives and information for staff related to morphine sulfate and lorazepam including the side effects of these medications.	F 656		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on clinical record and staff interview, the facility failed to complete required dialysis assessments for 1 of 1 residents reviewed that underwent dialysis (Resident #16). The facility reported a census of 36 residents. Findings include:	F 698	In continuing compliance with F 698, Dialysis, Accura Healthcare of Shenandoah corrected the deficiency on 3/31/2022 by educating DON on requirements and timely completion of pre/post dialysis assessments with each dialysis treatment for resident # 16 and all like residents by Regional Nurse Specialist. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated on 4/04/2022 by DON on requirements and timely completion of pre-post dialysis assessments with each dialysis treatment. The DON and/or designee will audit dialysis assessments for completion of the pre/post dialysis assessments 3x/weekly x4 weeks, then 2x/weekly for 2 weeks, and then PRN to ensure continued compliance.	04/04/2022

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F 698	Continued From page 5 The Minimum Data Set (MDS) dated 11/15/21 revealed Resident #16 scored 11 of 15 possible points on the Brief Interview of Mental Status (BIMS) test, which meant the resident demonstrated moderately impaired cognitive abilities. The MDS documented the resident had diagnoses that included vascular dementia with behavior disturbance and end stage renal disease. The MDS also documented Resident #16 required extensive assist of 2 staff for bed mobility and transfers. A physician's order directed staff to complete pre and post dialysis assessments and a daily assessment of fistula site for bruit. The Care Plan initiated on 11/12/21 directed nurses to auscultate dialysis access site with stethoscope for bruit every am and every night. A physician's order dated 02/05/22 directed nurses to complete pre and post dialysis assessments every Tuesday, Thursday, and Saturday. The January 2022 Treatment Administration Record revealed staff failed to conduct a post dialysis assessment for the resident for 5 of 13 dialysis days. The March 2022 TAR revealed staff last assessed the resident's fistula on 03/04/22. The Census record documented a hospitalization for Resident #16 from 02/28/22 - 03/11/22. In an interview on 03/28/22 at 01:42 PM, the Administrator stated that the facility was not	F 698	As part of Accura Healthcare of Shenandoah, ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process	

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F 698	Continued From page 6 required to have policies and procedures related to residents that underwent dialysis. In an interview on 03/30/22, Staff A, Regional Nurse Specialist, reported she expected staff to follow standards of practice for guidance related to dialysis care. She stated staff should assess the resident's fistula and check for bruit and thrill once daily.	F 698		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure food was stored under sanitary conditions. The facility identified a census of 36 residents.	F 812	In continuing compliance with F 812, Food Procurement, Store/Prepare/Serve-Sanitary, Accura Healthcare of Shenandoah corrected the deficiency on 4/4/2022 by Dietary Manager and Activities Director disposing of flour, powdered sugar, oat and honey granola, walnuts, granulated sugar, brown sugar, chocolate chips, pretzels, rolos, baking soda, baking cocoa, baking powder, rice chex cereal, 2 jars of peanut butter, caramel syrup, chocolate syrup, whipped topping, gallon 2% milk, half gallon of 2% milk, and expired gallon tea. The Dietary Managers removed the scoops from the thick it power and Benefiber and placed them into Ziplock bags and stored next to the thick it powder and Benefiber. To correct the deficiency and to ensure the problem does not recur all staff were educated on 04/04/2022 to not leave serving scoops in food/powder and to date all opened food and drink by dietary manager. The dietary manager and/or designee will audit 3x/weekly for 4 weeks, then 2x/weekly x 2 weeks, and then PRN to ensure continued compliance. As part of Accura Healthcare of Shenandoah ongoing commitment to quality assurance, the dietary manager and/or designee will report identified concerns through the community's QA Process.	04/04/2022

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F 812	Continued From page 7 Findings include: 1. An initial kitchen tour conducted of the kitchenette in the activity area on 03/28/22 at 11:47 a.m., revealed these items ready for service: a. One bag each of opened products that failed to contain a date that showed show when staff opened them: flour, powered sugar, oat and honey granola, walnuts, granulated sugar, brown sugar, chocolate chips, pretzels, and rolos. b. An open bag of sugar with an open date of 7/5/19 and a best by date of 10/21/20. c. One unopened bag each of flour (expired 5/14/20) and powdered sugar (best by 12/8/19) d. One open container each of the following products that lacked open dates: salt, baking soda, baking cocoa, baking powder, and rice chex cereal. e. Two open jars of creamy peanut butter with no open dates. 2. The kitchenette refrigerator contained the following opened items without open dates that were ready for service: a. One container each of caramel syrup, chocolate syrup, and whipped topping. b. One gallon of 2% milk. c. One half gallon of 2% milk with an expiration date of 3/23/22 d. Open gallon of tea with an expiration date of 1/15/22	F 812		

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F 812	Continued From page 8 3. The following items were found in the kitchen with the scoops stored inside the container and ready for service: One each of Thick-It powder and Benefiber. In an interview on 03/30/22 at 01:55 p.m., the Corporate Consultant revealed the facility staff follow the food code rather than a facility policy with regard to food storage. On 03/28/22 at 03:15 p.m., the Dietary Manager stated staff should not store scoops in food containers and should label (date) food items when opened.	F 812		
F 880 SS=D	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 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	F 880	In continuing compliance with F 880, Infection Prevention & Control, Accura Healthcare of Shenandoah corrected the deficiency on 3/31/2022 by providing one on one education with Staff D and Staff C regarding proper hand hygiene by DON. To correct the deficiency and to ensure the problem does not recur all nurses were educated on 4/04/2022 on proper hand hygiene with medication pass by DON. The DON and/or designee will audit 3x/weekly x 4 weeks, then 2x/weekly x2 weeks, and then PRN to ensure continued compliance. As part of Accura Healthcare of Shenandoah ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	04/04/2022

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F 880	Continued From page 9 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 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	F 880		

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F 880	Continued From page 10 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 observation, facility policy, and staff interview, the facility failed to ensure staff completed hand hygiene during medication administration. The facility reported a census of 36 residents. Findings include: Observation on 03/30/22 at 11:26 AM Staff C, Registered Nurse (RN), administered insulin for Resident #33. After preparing the insulin administration supplies at the medication cart, Staff C entered the resident's room, donned gloves without completing hand hygiene, and injected insulin into the resident's left upper arm. Observation on 03/30/22 at 12:56 PM revealed Staff D, RN administered Resident #4's Refresh eye drops. Staff D entered the resident's room, donned gloves without performing hand hygiene, and then administered the resident's eye drops. The Hand Hygiene Policy dated 06/21/21 directed staff to use alcohol-based hand sanitizer immediately before touching a resident. In an interview on 03/31/22 at 10:25 AM, Staff E, Director of Nursing, reported she expected staff to complete hand hygiene prior to caring for a resident.	F 880		