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 _____	06/29/2023

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 Ok Lg ✓ Correction Date: 7/18/2023 The following deficiencies resulted from the facility's Annual Recertification Survey conducted on June 26, 2023 to June 29, 2023. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	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.	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy	F 585	In continuing compliance with F 585 Grievances, Accura Healthcare of Shenandoah corrected this deficiency on 6/29/2023 by initiating the grievance process for resident #12's concern. The facility will ensure the grievance process is followed for resident #12 and all like residents to ensure there is resolution to resident concerns. To correct the deficiency and to ensure the problem does not recur, the Administrator educated residents and staff on 6/30/23 on the grievance process. The administrator will audit grievances/potential grievances three times a week for four weeks, twice weekly for 4 weeks, one time a week for four weeks, then as needed to ensure compliance. As part of Accura of Shenandoah's ongoing commitment to quality assurance, administrator or designee will report identified concerns through the community's QA process.	6/29/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	7/18/2023

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 585	Continued From page 1 to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by	F 585		

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F 585	Continued From page 2	F 585		

anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based observation, clinical record review, resident and staff interviews the facility failed to follow grievance procedures to ensure that residents had a resolution to concerns for 1 of 12 residents. The facility reported a census of 37 residents.

Findings include:

According to the Minimum Data Set (MDS) dated 5/26/23, Resident #12 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15

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F 585	Continued From page 3 (moderate cognitive deficits). The MDS documented the resident as independent with transfers, walking and toileting and had frequent pain. The Care Plan updated on 4/6/22 documented Resident #12 had chronic pain related to diabetic neuropathy and frequent headaches and was taking routine and as needed opioid pain medications. The Care Plan documented the resident would get upset with staff at times regarding the timing of narcotic medications. On 6/26/23 at 12:18 PM observed Resident #12 tearful and she stated that she had concerns with a staff member that was rude to her while passing her medications. She stated that he would argue with her about what time she could take them and if she didn't like it, she could move to another hallway. The resident stated that she had reported her concerns to the Director of Nursing (DON) and other staff persons. On 6/28/23 at 6:32 AM Certified Medication Aide (CMA), Staff D stated the resident would get upset with him regarding the administration of her pain medications. He said that he had been instructed to first offer the resident the lower risk pain medications before the hydrocodone. He denied ever saying to her that if she didn't like it she could move to a different hallway. Staff D stated the DON had information on the incidents with the resident. On 6/28/23 at 9:08 AM the DON stated she was aware of the interactions and conflict between Staff D and Resident #12 but she hadn't offered a formal grievance to track the investigation. The DON stated she would regularly follow up on	F 585		

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F 585	Continued From page 4 resident concerns but didn't always fill out a grievance form. In the past, the process had been that grievances would go to the Administrator then the DON would follow up and fill out the form. She acknowledged that this process had gone by the wayside. On 6/28/23 at 9:00 AM the Administrator presented grievance reports for the previous six months and there were none for Resident #12. The facility policy Grievance Process, updated January 2023, documented the facility would notify residents individually or through posting the right to file grievance orally or in writing. The policy documented the grievance official as responsible for overseeing the grievances process, receiving and tracking grievances through conclusion and to review within 3 business days. The resident had a right to obtain writing decisions indicating on grievance form.	F 585		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and staff interviews the facility failed to notify the physician of weight gain outside parameters per physician orders for 1 of 12 residents reviewed (Resident #6). The facility reported a census of 37 residents.	F 658	In continuing compliance with F 658, Accura Healthcare of Shenandoah corrected this deficiency by DON auditing current physician parameter orders by 7/5/2023 to ensure orders for resident #6 and all like residents are being followed. To correct the deficiency and to ensure the problem does not recur, the nurse specialist, educated the DON on 6/29/23 on reviewing the 24-hour report daily and ensuring parameters are being followed per physician orders for resident weights. One on one education was also provided to the nurse by DON on 6/30/2023 who originally entered the order on inputting order correctly and following all orders as ordered including parameters. All nurses were educated on following physician orders with parameters by the DON on 6/30/2023.The DON will audit physician orders with parameters three times weekly for 4 weeks, twice weekly for 4 weeks, weekly for 4 weeks, and then as needed to ensure they are completed with all parameters to ensure compliance. As part of Accura of Shenandoah's ongoing commitment to quality assurance, the DON or designee will report identified concerns through the community's QA process.	7/5/2023

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F 658	Continued From page 5 Findings include: According to the Minimum Data Set (MDS) dated 5/24/23, Resident #6 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 (moderate cognitive deficits). The MDS documented the resident required extensive assistance with the help of one staff for bed mobility, toileting, dressing and locomotion. The MDS documented he received diuretic medication, and had diagnoses to include renal insufficiency, heart failure and cancer. The Care Plan updated on 9/23/21 directed staff to monitor for side effects of diuretic, edema and report to the doctor with daily weights. On 6/29/23 at 10:10 AM, observed Resident #6 in a recliner sleeping. The Certified Medication Aide, (CMA) Staff C observed his lower legs and made note of an indentation where his ankle socks were and pitting edema (edema caused by excess fluid in the body). A review of the clinical chart reveled on order dated 2/20/23 at 4:03 PM to contact the physician when the residents' weight was less than 305 pounds or higher than 325 pounds. According to the vitals tab in the electronic chart, from 5/1/23 through 6/28/23 the resident weighed over 325 pounds on 38 occasions. The chart lacked documentation that the doctor had been notified. On 6/29/23 at 10:24 AM, the Director of Nursing (DON) stated she was not aware of the order to call the doctor with a weight over 325 pounds. After further review, she stated the order had	F 658		

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F 658	Continued From page 6 been entered into the electronic chart but did not get transferred over to the Medication Administration or Treatment Administration Records. She stated she was going to contact the doctor to see if this were still his wishes or if there were different follow up orders. On 6/28/23 at 2:20 PM the Administrator stated the facility did not have a specific policy for following doctors' orders and that staff were expected to follow standards of care.	F 658		
F 684 SS=G	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 observations, resident and staff interviews and clinical record review the facility failed to provide accurate and timely interventions to prevent hospitalization for 1 of 3 residents. Resident #29 had a diagnosis of Congestive Heart Failure (CHF) and required monitoring of Blood Pressures (BP), Heart Rate (HR) and weights. On 6/27/23 the resident was taken to the hospital for exacerbation of CHF with a BP of 181-126 (normal BP 120/80). A review of the chart revealed that her most recent complete set of vitals had been taken on 6/19/23. The facility reported a census of 37 residents.	F 684	In continuing compliance with F 684, Accura Healthcare of Shenandoah, Accura Healthcare of Shenandoah corrected this deficiency by DON auditing current physician parameter orders by 7/5/2023 to ensure orders for resident #29 and all like residents are being followed. To correct the deficiency and to ensure the problem does not recur, the nurse specialist, educated the DON on 6/29/23 on reviewing the 24-hour report daily and ensuring vital signs are included with SNF and all other pertinent assessments. All nurses received education on 6/29/2023 by DON on ensuring vital signs and skilled assessments are completed daily for skilled residents and physician orders with parameters are followed. The DON will audit nursing assessments and interventions including physician orders with parameters three times weekly for 4 weeks, twice weekly for 4 weeks, weekly for 4 weeks, and then as needed to daily to ensure continued compliance. As part of Accura of Shenandoah's ongoing commitment to quality assurance, the DON or designee will report identified concerns through the community's QA process.	7/5/2023

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F 684	Continued From page 7 Findings include: According to the Minimum Data Set (MDS) dated 6/8/23, Resident #29 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 (intact cognitive ability). The MDS documented she required limited assistance with the help of one staff for transfers, walking and toileting. The MDS documented she had diagnoses to include atrial fibrillation (A-fib), pleural effusion and congestive heart failure (CHF). The Care Plan dated 6/14/23 for Resident #29 included a focus area of altered cardiovascular status related to A-fib, CHF, fluid overload and hypertension. The Care Plan directed staff to assist with edema wear, obtain daily weights and to take vitals monthly or on an as-needed basis. The Clinical Census documented the resident received skilled services 6/1/23 to 6/11/23. The Prescription Fax dated 6/7/23 for the resident documented an order if patient has a 5 pound weight gain OR (capitalized and underlined) systolic blood pressure (BP) greater than 100 to give an extra dose of Lasix 40 milligrams (mg) once and then return to normal dosing. The Clinical Physician's Order for the resident, documented an order dated 6/13/23 at 6:00 AM, for a daily weight and to give an extra dose of Lasix (used to stabilize fluid overload) if the resident had a weight gain of 5 pounds in one week and a systolic blood pressure greater than 100. Staff were to notify the physician if/when these conditions occurred.	F 684		

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F 684	Continued From page 8 The Progress Note for the resident documented the following: On 6/7/23 at 4:21 PM the facility received a signed fax with an order if the resident has a 5 pound weight gain in one week or systolic BP greater than 100 give an extra dose of Lasix 40 mg once and then return to normal dosing. On 6/12/23 at 3:01 PM received electronically signed fax with clarification: If in one week's time there is a 5 pound weight gain and patient's systolic BP on that day is greater than 200 administer 40 mg of lasix extra dose x 1 and then return to regular dosing schedule. On 6/13/23 at 1:02 AM Correction - if resident systolic BP is greater than 100 not 200. On 6/26/23 at 1:01 PM observed the resident walk back to her room from the dining area and by the time she got to her room she was short of breath and had difficulty talking. On 6/27/23 at 9:07 AM observed the resident up in her recliner in her room and she stated that she was feeling bad and did not want to visit. Review of the facility BP Summary revealed the staff documented a daily BP 6/1/23 through 6/12/23 except for the days of 6/3/23 and 6/5/23. The Summary lacked any other BP after 6/12/23 except for 6/19/23. Review of the facility Weight Summary revealed the staff documented a weight every day except for 6/5, 6/6, 6/18, 6/23 and 6/27/23. The Progress Note dated 6/27/23 at 9:24 AM documented the staff got her out of bed and dressed that morning and the resident complained of shortness of breath and was	F 684		

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F 684	Continued From page 9	F 684		

panting. Staff assessed her vitals with her blood pressure 181/126, heart rate 134 beats per minute, and oxygen saturation 87% (normal oxygen level is >90%). They gave her supplemental oxygen and called for an ambulance. The Progress Notes lack any documentation on 6/26/23.

The Emergency Room Report dated 6/27/23 at 9:40 AM documented Resident #29 admitted to the hospital with diagnosis of diastolic congestive heart failure, atrial fibrillation and was given intravenous (IV) Lasix for diuresis (to remove access fluids).

On 6/28/23 at 11:51 AM, Certified Medication Aide (CMA), Staff C, stated she went in to get the resident up for the morning and the resident was panting, and struggling to breath. Staff C paged Registered Nurse (RN), Staff B, to come to the resident's room and assess her. They took her BP, HR and oxygen, and all were outside the normal range. Staff C did not know if the resident was supposed to have daily vital signs completed but if she did, it would have triggered on the electronic chart.

On 6/28/23 at 11:53 AM, Registered Nurse (RN), Staff B, stated Staff C had gotten the resident up in the morning and paged for her to come assess her. The resident was panting and her oxygen level was low, which was unusual for her. The Director of Nursing (DON) brought supplemental oxygen and they had to convince the resident to go to the hospital. Staff B stated that she hadn't seen the resident struggle to catch her breath that way before and she was a relatively new resident. She said that the resident was no longer on skilled services and when a resident is on skilled,

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F 684	Continued From page 10 they are triggered in the electronic charting to conduct vitals every shift (twice daily). On 6/28/23 at 10:55 AM, the facility nurse consultant agreed that skilled assessments should include at least one set of vitals a day. On 6/28/23 at 3:53 PM, the Nurse Practitioner (NP) from the hospital that cared for the resident stated the resident came into the hospital with a "perfect storm" of A-fib and high blood pressure. She had a high heart rate (HR) and blood pressure (BP) and with the IV medication, those vitals had become more stable. She stated they had been working with her to get this under control since March and had tried different medications. She acknowledged that if they had known about the BP or HR out of the normal ranges they could have tried something before she ended up being hospitalized. On 6/28/23 at 5:19 PM, the Cardiac Nurse Practitioner (CNP) stated she gave the order for weekly weights and blood pressure parameters. She stated a family member had told her on 6/7/23 that the facility had been doing vital signs twice a day and monitoring the weights weekly. That was the last time she had information about the resident's care and assumed that the facility had continued that level of monitoring. She stated that had she known that they were not doing vitals very often, she would have requested it be done twice a day. She stated that she could only make decisions based on the data that she received and if there had been vitals out of the norm she may have made some medication adjustments. She stated she couldn't say for sure if it could have prevented the hospitalization but she can only respond to the information that she	F 684		

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F 684	Continued From page 11 got from the staff and family. On 6/29/23 at 10:25 AM, the DON stated the nurses understood the order to mean that if the resident had a 5-pound weight gain, then they would take her BP to see if she had a systolic reading over 100. The DON acknowledged that with the diagnosis of A-fib and fluid overload a more regular assessment with vitals could have tipped them off sooner and the doctor may have tried different medication before having to go to the hospital. On 6/28/23 at 2:20 PM the Administrator stated that they did not have a specific policy for following doctors' orders and staff are expected to follow standards of care.	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 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and clinical record review the facility failed to ensure the safety of the residents by failing to ensure the facility doors were properly alarmed. The facility reported 2 of 37 residents were at high risk for elopement (Resident #2 and #18). The facility reported a census of 37 residents.	F 689	In continuing compliance with F 689, Accura Healthcare of Shenandoah corrected this deficiency on 6/28/29 by maintenance director repairing the kitchen door alarm to ensure doors are properly alarmed for the safety of resident #2, #18, and all like residents. To correct the deficiency and to ensure the problem does not recur, the administrator educated the environmental services supervisor on 6/29/23 on the requirement of daily door alarm checks. Education provided by the administrator to all staff that door alarms must not be tampered with on 6/29/23. The administrator will audit door alarm checks three times weekly for four weeks, twice weekly for four weeks, once weekly for 4 weeks, and then as needed to ensure compliance. As part of Accura of Shenandoah's ongoing commitment to quality assurance, the administrator or designee will report identified concerns through the community's QA process.	6/30/2023

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 _____	06/29/2023

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

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F 689	Continued From page 12 Findings include: According to a Risk Assessment for Elopement (RAE) dated 6/5/23 at 8:45 AM, Resident #18 was at high risk for elopement. The RAE dated 4/12/23 at 8:11 AM for Resident #2 documented she was also a high elopement risk. In an observation of the kitchen on 6/27/23 at 1:25 PM it was discovered that the back door exiting to the outside had the alarm disconnected with wires hanging above the frame. Dietary Aide, Staff A said she was not aware that it was disconnected and that she was just in the habit of punching in the number code before opening the door. She said that she was not aware of any residents that had ever gotten into the kitchen, and all of the kitchen doors into the kitchen were kept locked at night. On 6/28/23 at 7:45 AM the Administrator looked at the door and the hanging wires and stated she was unaware that it was disconnected and she would get maintenance staff to reattach the alarm. On 6/29/23 at 9:40 AM the Maintenance Supervisor stated they checked the door alarms to the outside once a week. A review of the alarm check spreadsheet revealed that the last time the kitchen door to the outside had been checked was on 6/23/23. He stated when he reattached the alarm, it did not look to be damaged but the screws were loose and it looked like it had been loosened. He stated he suspected that staff may have disconnected the wires.	F 689		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7)	F 730		

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F 730	Continued From page 13 §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on personnel record review, staff interview, and facility policy review the facility failed to complete an employee performance review at least once every 12 months. The facility reported a census of 37 residents. Findings include: Review of 5 employee files revealed 4 of the 5 (Staff G, H, I and J) did not have a performance evaluation completed annually. The Employee Handbook, undated, documented under section Performance Evaluation: Your job performance will be reviewed annually on your anniversary date by your supervisor. At these intervals, a written evaluation form will be completed and discussed with you. The emphasis is to be placed on constructively reviewing your strengths and weaknesses and to work together to establish goals for specific areas of improvement. On 6/28/23 at 11:36 AM Staff K stated no performance evaluations were completed last year. On 6/28/23 at 3:43 PM the Administrator stated the facility's expectation was that a performance	F 730	In continuing compliance with F 730, Accura Healthcare of Shenandoah corrected this deficiency on 6/29/23 by BOM auditing current employee files to ensure staff G, H, I, J, and all facility staff receive annual performance reviews. To correct the deficiency and to ensure the problem does not recur, the administrator educated the business office manager on 6/29/23 on the requirements of performance reviews being completed for all employees every 12 months/annually. All annual performance reviews were brought up to date by 7/18/2023. The administrator will audit for staff requiring annual reviews three times weekly for four weeks, twice weekly for 4 weeks, once weekly for 4 weeks, and then as needed to ensure compliance. As part of Accura of Shenandoah's ongoing commitment to quality assurance, the business office manager or designee will report identified concerns through the community's QA process.	7/18/2023

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F 730	Continued From page 14 evaluation would be completed yearly for each employee.	F 730		
F 801 SS=E	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §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) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by	F 801	In continuing compliance with F 801, Accura Healthcare of Shenandoah corrected this deficiency on 6/28/23 by signing up dietary manager for DMACC's CDM certification class on 6/28/23. The Dietary manager started the CDM course 7/3/23. To correct the deficiency and to ensure the problem does not recur, the administrator was educated on 6/28/23 on the requirement of having a certified dietary manager on site full time. The administrator will audit for appropriate qualified dietary personnel monthly for 6 months and then as needed to ensure continued compliance. As part of Accura of Shenandoah's ongoing commitment to quality assurance, the administrator will report identified concerns through the community's QA process.	6/30/2023

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F 801	Continued From page 15 the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers,	F 801		

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F 801	Continued From page 16 meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on document review, policy review, and staff interview the facility failed to employ a clinically qualified nutrition professional by not having a certified dietary manager. The facility reported a census of 37 residents. Findings include: Interview on 6/26/23 at 11:50 AM with Staff E revealed she was not certified as a dietary manager and did not have a dietary manager certificate. The facility policy Director of Food and Nutrition Services, with copyright date of 2021, provided by the Administrator documented the following: The director of food and nutrition services will be qualified according to the position's job description and guidelines put forth by the agency that regulates the facility. Is a certified dietary manager or is a certified food service manager or has a similar national certification for food service management and safety from a national certifying body or has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management from an accredited institution of higher learning and in stated that have established standards for food service managers or dietary managers, must meet state requirements for food service managers or dietary managers.	F 801		

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F 801	Continued From page 17 Interview on 6/29/23 at 8:13 AM the Administrator stated she thought there was a grace period to obtain dietary manager certification. The Administrator stated the facility's expectation is that the dietary manager would be certified.	F 801		
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 facility menu review, observations and	F 803	In continuing compliance with F 803, Accura Healthcare of Shenandoah corrected this deficiency on 6/29/23 through education of Staff A to ensure menus are followed as approved by the dietician. To correct the deficiency and to ensure the problem does not recur, the administrator educated all kitchen staff on 6/29/23 on the requirements of following the dietician approved menus at all times. The administrator will audit compliance with following menus three times weekly for 4 weeks, twice weekly for 4 weeks, once weekly for 4 weeks, and then as needed to ensure compliance. As part of Accura of Shenandoah's ongoing commitment to quality assurance, the administrator will report identified concerns through the community's QA process.	6/30/2023

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F 803	Continued From page 18 staff interviews the facility failed to serve meals according to the menu. Staff failed to serve bread and butter to all of the residents during the lunch meal and provided rice instead of mashed potatoes to the 5 residents on mechanical soft diets. The facility reported a census of 37 residents. Findings include: On 6/27/23 the Diet Spreadsheet for week 2, signed by the Dietician, included honey chicken, lemon pepper rice, tossed salad with dressing, bread with margarine, turtle cake and milk. The mechanical soft diet included substitutions of mashed potatoes for the rice and shredded lettuce instead of leaf lettuce. On 6/27/23 at 12:15 PM observed Dietary Aide, Staff A, prepare and serve the lunch meal but did not include bread with margarine on any of the plates. Staff A served the rice instead of mashed potatoes to the 5 residents on mechanical soft diets. On 6/27/23 at 1:30 PM observed Staff A finish serving residents, look at the menu and verbalize she made an error. She stated she didn't realize that they should have had bread and thought the rice was okay for the mechanical soft diet. On 6/29/23 at 10:02 AM, the Dietary Manager stated she would follow up with Staff A and remind staff to follow the menu as it was written.	F 803		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		

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F 812	Continued From page 19 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, facility policy review and staff interviews the facility failed to store food in accordance with professional standards by not labeling foods that were open with open dates and not preventing physical contamination of food by wearing hair restraints improperly. The facility reported a census of 37 residents. Findings include: 1) On 6/26/23 from 10:30 AM through 10:50 AM a continuous observation during the initial kitchen tour revealed: a. Stand up white freezer had a bag of garlic bread without an open date. b. Stand up white freezer had a bag of frozen cookies without an open date. c. Reach in freezer had a bag of chicken strips without an open date.	F 812	In continuing compliance with F 812, Accura Healthcare of Shenandoah corrected this deficiency on 6/29/23 by Dietary Manager disposing of the undated bag of garlic, frozen cookies, chicken strips, garlic bread, brown gravy, chicken gravy, croutons, hamburger buns, and ranch dressing mix. Staff A, the Dietary Manager, and male employee, were also educated by Administrator by 7/3/2023, on the requirements for hair restraints. The facility will ensure that food is stored and prepared in a sanitary environment. To correct the deficiency and to ensure the problem does not recur, the Administrator educated all kitchen staff on 7/3/23 on the requirements of hair/beard net use and dating food items upon opening. The administrator will audit dating of foods and hair/beard net use three times weekly for 4 weeks, twice weekly for four weeks, once weekly for 4 weeks, and then as needed to ensure compliance. As part of Accura of Shenandoah's ongoing commitment to quality assurance, the administrator will report identified concerns through the community's QA process.	7/3/23

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F 812	Continued From page 20 d. Reach in freezer had a bag of garlic bread without an open date. e. Dry storage had a bag of brown gravy with no open date. f. Dry storage had a bag of chicken gravy with no open date. g. Dry storage had a large bag of croutons with no open date. h. Dry storage had 2 bags of hamburger buns with no open date. i. Dry storage had a bag of ranch dressing mix with no open date. The facility policy Food Storage dated 2021, provided by the Administrator documented the following: Refrigerated food storage: Every refrigerator must be equipped with an internal thermometer. All foods should be covered, labeled, and dated and routinely monitored to assure that foods will be consumed by their safe use by dates, or frozen or discarded. Frozen Foods: All foods should be covered, labeled, and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded. During an interview on 6/26/23 at 11:06 AM Staff E stated the expectation was that all food items that are open should have an open date. During an interview on 6/26/23 at 11:15 AM the Administrator stated the facility's expectation was for everything in the kitchen to have an open date when opened. 2) On 6/27/23 at 11:40 AM during the lunch	F 812		

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F 812	Continued From page 21 service observations, Kitchen Staff A was found to have a hair net on her head but it did not completely cover the hair in front. The Dietary Manager was wearing a hair net with long hair outside the net on the back of her head. On 6/28/23 at 2:32 PM, observed a male staff member with a beard leaning over the counter preparing food in the kitchen. He did not have any protective covering over the beard. On 6/29/23 at 10:02 AM the Dietary Manager stated the male that was working the previous day had been a new hire and they did not have any beard nets. She stated she had just ordered some for him to use. According to Employee Sanitary Practiced dated 2021 all employees will wear hair nets and/or beard to prevent hair from contacting exposed food.	F 812		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility policy review the facility failed to properly dispose of room trays with left-over food in a timely manner. In two separate observations it was discovered that the dinner trays from evening meals were on a rack in the hallway by resident rooms the following mornings. The facility reported a census of 37 residents. Findings include:	F 814	In continuing compliance with F 814, Accura Healthcare of Shenandoah corrected this deficiency by 7/18/2023 through education with all dietary and CNA staff to ensure compliance with proper disposal of leftover food/food trays. To correct the deficiency and to ensure the problem does not recur, the administrator educated kitchen and CNA staff by 7/18/2023 on the requirements of properly disposing of/proper storage of leftover food and garbage on room tray rack, as well as the location of the key to the kitchen that can be used to unlock it after kitchen staff are gone. The administrator will audit for compliance three times weekly for 4 weeks, twice weekly for four weeks, once weekly for 4 weeks, and then as needed to ensure compliance. As part of Accura of Shenandoah's ongoing commitment to quality assurance, the administrator will report identified concerns through the community's QA process.	7/18/2023

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F 814	Continued From page 22 On 6/27/23 at 6:20 AM and on 6/28/23 at 6:30 AM observed room trays with old, dried food sitting on a cart in the hallway. On 6/28/23 at 6:38 AM a kitchen staff person pulled the cart into the kitchen area. On 6/28/23 at 6:35 AM Certified Medication Aide (CMA), Staff D, sated they always left the evening meal plates on the cart and when the morning kitchen shift came in they would pull the dirty dishes into the kitchen to wash them. He stated the kitchen door was kept locked through the night but the nurses had a key to the kitchen doors. On 6/29/23 at 10:02 AM, the Dietary Manager stated the trays from the evening meal were left out because the kitchen staff would leave for the day before the residents were all done. She stated they kept the kitchen locked so no one gets in overnight. She stated she would look into having those taken into the kitchen so roaming residents wouldn't get into the old food. According to Employee Sanitary Practices dated 2021 Waste Disposal; garbage would be disposed of as needed throughout the day and at the end of the day.	F 814		
F 880 SS=E	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	F 880	In continuing compliance with F 880, Accura Healthcare of Shenandoah corrected this deficiency on 6/28/23 by Environmental Services Supervisor separating soiled linens from clean linens properly in the laundry room to allow for proper infection prevention practices. To correct the deficiency and to ensure the problem does not recur, the administrator provided one on one education to environmental supervisor on 6/28/23 on the requirements of appropriate separation of soiled and clean linens in laundry room. Staff in-service education provided to housekeeping staff regarding compliance with laundry separation on 6/28/2023 by the Environmental Services Supervisor. The administrator will audit three times weekly for 4 weeks, twice weekly for four weeks, once weekly for 4 weeks, and then as needed to ensure compliance. As part of Accura of Shenandoah's ongoing commitment to quality assurance, the administrator will report identified concerns through the community's QA process.	6/30/2023

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 _____	06/29/2023

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 880	Continued From page 23 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 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	F 880	

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F 880	Continued From page 24	F 880		

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 and staff interviews the facility failed to provide appropriate infection prevention practices by not providing separation between clean and dirty linen in the laundry department. The facility reported a census of 37 residents.

Findings included:

On 6/28/23 at 9:19 AM an observation of the laundry room revealed the following:
Entering the laundry room dirty laundry barrels were kept to the right of the entrance and clean personal linens were kept on shelves to the left of the entrance in baskets open to the air.
Observed one L-shaped laundry room with no separation between the dirty and clean linen.
Clean linen folded on a table with the dirty linen

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F 880	Continued From page 25 and washing machine across from the clean linen folding table. Undergarments / personals on racks with open baskets as dirty linen is brought into the laundry room and across from the dirty laundry bins. Dirty linen sorted about 4-6 feet from the folding table and dirty linen wheeled into the room with clean linen to the left within a foot. Must walk by dirty linen to put clean linen in baskets. On 6/28/23 at 9:19 AM Staff F stated the facility had the folding table for laundry set up there since he had started. Staff F stated he started in September of 2020. On 6/28/23 at 9:45 AM the Administrator stated it would be the facility's expectation that the dirty linen be sorted and transported away from clean linen. The Administrator stated facility uses state and federal regulations for guidance.	F 880		