

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/19/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165324	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/01/2023
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NAME OF PROVIDER OR SUPPLIER ACCURA HEALTHCARE OF PLEASANTVILLE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 909 NORTH STATE STREET PLEASANTVILLE, IA 50225
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F 000 ✓ ok/cp	INITIAL COMMENTS Correction date: 6/2/2023 The following deficiencies resulted from investigation of Complaints #113173-C, #112936-C, #112813-C, #112537-C, #111938-C and Facility Reported Incidents #113115-I and conducted May 30, 2023 to June 1, 2023. Complaints #112936-C, and #112813-C and Facility Reported Incident #113115-I was substantiated. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F 000	Accura HealthCare of Pleasantville denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656	In continuing compliance with F656, Develop/Implement Comprehensive Care Plan., Accura Healthcare of Pleasantville corrected the deficiency by providing Staff C and Staff D education on the expectation of following care plan interventions by the ADON on 6/2/2023. The facility will ensure that Resident #1 and all like resident's care plan interventions are in place and followed as stated in their care plan. To correct the deficiency and to ensure the problem does not recur, all nursing staff were educated by ADON by 6/2/2023 on the expectation to following care plan interventions as stated on the care plan. The ADON and/or designee will audit care plan interventions 3x/week for 4 weeks, 2x/week for 4 weeks and 1x/week for 4 weeks and then PRN to ensure continued compliance. As part of Accura HealthCare of Pleasantville ongoing commitment to quality assurance, the ADON and/or designee will report identified concerns through the facility's QA process.	6/2/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Billie Z...</i>	TITLE <i>Administrator</i>	(X6) DATE 06/20/2023
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 656	<p>Continued From page 1</p> <p>(ii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(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.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:</p> <p>Based on clinical record review, hospital record review and staff interviews, the facility failed to follow the safety interventions of the comprehensive care plan for 1 of 3 residents reviewed for falls (Resident #1) which led to the resident suffering a traumatic fall. The facility reported a resident census of 44.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) of Resident #1 dated 5/1/23 documented the resident discharged to an acute care hospital as an unplanned</p>	F 656			

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F 656	<p>Continued From page 2</p> <p>discharge. The MDS revealed the resident required extensive assistance for transfers and did not walk. The MDS documented diagnoses that included Alzheimer's disease, dementia with behavioral disturbance and cerebrovascular disease. The MDS documented that the resident required extensive assistance for transfers, bed mobility, toilet use, personal hygiene, and locomotion on and off the unit. The MDS recorded the resident sustained a major injury related to a fall since the prior MDS assessment.</p> <p>The Care Plan updated 2/8/23 revealed the resident at high risk for falls related to confusion, psychoactive drug use and unawareness of safety needs. The Care Plan directed staff Resident #1 was to be the first resident to be assisted after meals to bed or recliner and the last one up prior to meals.</p> <p>The Fall Risk Assessment dated 5/1/23 documented the resident scored a 23, indicating him to be at high risk for falls.</p> <p>The Progress Notes dated 5/1/23 at 3:39 pm documented the resident was in his room and was heard to call out. The Progress Notes further documented the resident was found lying on his left side with blood under his face. Upon assessment, the resident was observed to have three lacerations above his left eyebrow and two on his left temple. The resident was sent to the Emergency Room for evaluation and treatment.</p> <p>The Physician Discharge Summary dated 5/5/23 documented the resident had active diagnoses in the hospital of fall and intraparenchymal hemorrhage of the brain (bleeding in the brain). The Discharge Summary documented the</p>	F 656		

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F 656	<p>Continued From page 3</p> <p>resident passed away in the hospital on 5/5/23.</p> <p>On 6/1/23 at 10:30 am, Staff C, Certified Nurse Aide (CNA) stated she and Staff, D, CNA provided cares for Resident #1 on 5/1/23 prior to his fall. She stated he was in bed, and she and Staff D provided incontinence cares and transferred him to his wheelchair. She said when cares were complete, they left him in his wheelchair in the doorway of his room. She stated there were still other residents they were getting up for dinner and went to another room. A few minutes later a nurse heard the resident call out and he was found on the floor of his room in front of his window. His wheelchair was backed against the wall as if he had pushed himself from the doorway straight back into the room. Staff C stated she carries a pocket care plan when on duty identifying fall interventions.</p> <p>On 6/1/23 at 10:34 am Staff D, CNA, stated on 5/1/23 she and Staff C assisted Resident #1 to get ready to go to dinner. She stated he was pushed in his wheelchair to the doorway of his room and she and Staff C proceeded to the room across the hallway to get another resident ready for dinner. She said approximately 5 minutes later the nurse heard the resident calling out and she called for Staff C and Staff D to assist. The resident was in his room near his dresser and it appeared he had propelled himself backwards in his wheelchair and fell over. She stated on the Resident Information Sheet (pocket care guide) safety interventions are listed on the right side of the paper.</p> <p>On 6/1/23 at 11:34 am via an email, the Administrator stated the facility does not have a policy regarding following care plan interventions.</p>	F 656		

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F 656	Continued From page 4 She stated they follow the standards of care related to this. On 6/1/23 at 11:57 am, the Regional Clinical Reimbursement Specialist stated her expectation is that all staff, regardless of appointment in the facility, would have knowledge of reading the care plan resident information sheet and abide by the safety standards to keep the residents safe.	F 656		
F 689 SS=G	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 clinical record review, hospital record review and staff interviews, the facility failed ensure staff followed safety interventions for 1 of 3 residents reviewed for falls (Resident #1). This resulted in harm to Resident #1 who suffered a traumatic fall leading to hospitalization. Resident #1 died 4 days following the fall. Findings include: The Minimum Data Set (MDS) of Resident #1 dated 5/1/23 documented the resident discharged to an acute care hospital as an unplanned discharge. The MDS revealed the resident required extensive assistance for transfers and did not walk. The MDS documented diagnoses	F 689	In continuing compliance with F698, Free of Accident Hazards/Supervision/Devices, Accura Healthcare of Pleasantville corrected the deficiency by providing Staff C and Staff D education on the expectation of following care plan interventions by the ADON on 6/2/2023. The facility will ensure that Resident #1 and all like resident's care plan interventions are in place and followed as stated in their care plan. To correct the deficiency and to ensure the problem does not recur, all nursing staff were educated by ADON by 6/2/2023 on the expectation to following care plan interventions as stated on the care plan. The ADON and/or designee will audit care plan interventions 3x/week for 4 weeks, 2x/week for 4 weeks and 1x/week for 4 weeks and then PRN to ensure continued compliance. As part of Accura HealthCare of Pleasantville ongoing commitment to quality assurance, the ADON and/or designee will report identified concerns through the facility's QA process.	6/2/2023

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F 689	<p>Continued From page 5</p> <p>that included Alzheimer ' s disease, dementia with behavioral disturbance and cerebrovascular disease. The MDS recorded the resident sustained a major injury related to a fall since the prior MDS assessment.</p> <p>The Care Plan updated 2/8/23 revealed the resident at high risk for falls related to confusion, psychoactive drug use and unawareness of safety needs. The Care Plan directed staff Resident #1 was to be the first resident to be assisted after meals to bed or recliner and the last one up prior to meals.</p> <p>The Fall Risk Assessment dated 5/1/23 documented the resident scored a 23, indicating him to be at high risk for falls.</p> <p>The Progress Notes dated 5/1/23 at 3:39 pm documented the resident was in his room and was heard to call out. The Progress Notes further documented the resident was found lying on his left side with blood under his face. Upon assessment, the resident was observed to have three lacerations above his left eyebrow and two on his left temple. The resident was sent to the Emergency Room for evaluation and treatment.</p> <p>Trauma Surgeon Progress Notes dated 5/1/23 at 9:21 pm identified the resident as having presented to the hospital following an unwitnessed fall from a wheelchair found to have intracranial bleeding (bleeding inside the skull). The Note stated the resident had a poor prognosis with an injury that posed a direct threat to his life.</p> <p>A Surgery Progress Note dated 5/1/23 11:51 pm Medical alert called to Intensive Care Unit room</p>	F 689		

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F 689	<p>Continued From page 6</p> <p>for destaurations and apnea. Upon arrival to the room, patient has agonal breathing, approximately 5-10 respirations a minute. Respiratory therapy was present and had placed a bite-block and was successfully bag-value-mask the patient with adequate saturations. Patient is nonresponsive, however this is not far off from the patients baseline on evaluation roughly 5-6 hours prior. We are aware that there has been interval increase in size of this hemorrhage. However, through conversation with neurosurgery, it is unlikely that this is a salvageable situation with any procedure.</p> <p>A computed tomography scan (CT scan) of the head on 5/1/23 at 10:05 pm noted a prior exam performed on 6/1/22. In comparison, the CT scan noted an increase in a right parietal-occipital intraparenchymal hematoma (bleeding in the brain) from the prior exam and a large amount of intraventricular hemorrhage (bleeding around the ventricles of the brain) now present.</p> <p>The Physician Discharge Summary dated 5/5/23 documented the resident had active diagnoses in the hospital of fall and intraparenchymal hemorrhage of the brain. The Discharge Summary documented the resident passed away in the hospital on 5/5/23.</p> <p>Hospital Progress Notes dated 5/5/23 at 11:36 am documented the direct cause of death the Resident #1 was respiratory depression and hypoxia likely secondary to traumatic intracranial hemorrhage which occurred as a result of fall.</p> <p>On 6/1/23 at 10:30 am, Staff C, Certified Nurse Aide (CNA) stated she and Staff, D, CNA provided cares for Resident #1 on 5/1/23 prior to</p>	F 689			

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F 689	<p>Continued From page 7</p> <p>his fall. She stated he was in bed, and she and Staff D provided incontinence cares and transferred him to his wheelchair. She said when cares were complete, they left him in his wheelchair in the doorway of his room. She stated there were still other residents they were getting up for dinner and went to another room. A few minutes later a nurse heard the resident call out and he was found on the floor of his room in front of his window. His wheelchair was backed against the wall as if he had pushed himself from the doorway straight back into the room. Staff C stated she carries a pocket care plan when on duty identifying fall interventions.</p> <p>On 6/1/23 at 10:34 am Staff D, CNA, stated on 5/1/23 she and Staff C assisted Resident #1 to get ready to go to dinner. She stated he was pushed in his wheelchair to the doorway of his room and she and Staff C proceeded to the room across the hallway to get another resident ready for dinner. She said approximately 5 minutes later the nurse heard the resident calling out and she called for Staff C and Staff D to assist. The resident was in his room near his dresser and it appeared he had propelled himself backwards in his wheelchair and fell over. She stated on the Resident Information Sheet (pocket care guide) safety interventions are listed on the right side of the paper.</p> <p>On 6/1/23 at 11:34 am via an email, the Administrator stated the facility does not have a policy regarding following care plan interventions. She stated they follow the standards of care related to this.</p> <p>On 6/1/23 at 11:57 am, the Regional Clinical Reimbursement Specialist stated her expectation</p>	F 689		

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F 689	Continued From page 8 is that all staff, regardless of appointment in the facility, would have knowledge of reading the care plan resident information sheet and abide by the safety standards to keep the residents safe.	F 689			