STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165324	A. BUILDING ______ B. WING ______	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF PLEASANTVILLE, LLC	909 NORTH STATE STREET PLEASANTVILLE, IA 50225

(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 ✓ ok/CP	INITIAL COMMENTS Correction date: 6/25/2024 The following deficiencies resulted from the facility's Annual Recertification survey and investigation of Complaints #121157-C, #119193-C, 118792-C, conducted June 3, 2024 to June 10, 2024. Complaint # 118792-C was substantiated. Complaint # 119193-C was substantiated See Code of Federal Regulations (42CFR) 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 550 SS=E	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, 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.	F 550	1. In continuing compliance with F 550 Residents Rights/Exercise of Rights, Accura Healthcare of Pleasantville corrected the deficiency by educating Staff D, C, and E on 6/14/2024 that staff will sit during meals, listen, pay attention and converse with residents, keep noise levels to a minimum. If a resident is being inappropriate, cursing or yelling, they are to redirect to a calm, quiet environment for resident #22 and all like residents. 2. To correct the deficiency and to ensure the problem does not recur, all staff were educated by 6/14/2024 by the DON on sitting during meals, listening and paying attention, and conversing with residents, and keeping noise levels to a minimum, as well as redirect resident to a calm, quiet area if they are yelling or cursing. The Executive Director and/or designee will audit for compliance three times weekly for four weeks, two times weekly for four weeks then one time weekly for four weeks and then as needed to ensure continued compliance. 3. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	6/14/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tiffany Michaud	Executive Director	7-11-2024

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

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F 550	Continued From page 1	F 550		

§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 observations, resident interviews, staff interviews and facility policy the facility failed to provide dignity with dining for residents in the main dining room used by up to 20 residents at 3 of 3 meals observed. The facility reported a census of 41 residents.

Findings include:

Observation on 06/03/24 at 08:57 AM of the breakfast meal in the main dining room, Certified Nursing Assistant (CNA) Staff D was at the table with residents needing feeding assistance. Staff D stood and walked around the table, gave one gentleman a bite, saying a bite for you, proceeded to give the next gentleman a bite stating, a bite for you, walked around the table and spoon fed another resident saying a bite for you. Picked up resident cup standing over the resident said, take a drink, to the next resident,

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F 550	Continued From page 2 take a drink and walked around the table feeding five different residents in the same manner, standing over the resident and walking around the table spoon feeding and holding cups for the residents needing assistance. Certified Nursing Assistant, (CNA) Staff C joined and stood between two residents and assisted with spoon feeding also standing over the two residents while feeding. In an interview on 06/05/24 at 5:07 PM with Staff D, CNA queried about feeding residents, Staff D relayed there is usually only the two staff on the two halls in the front section of the facility and in order to get residents fed timely it is usual to stand and feed and walk around the table giving bites and drinks. Staff D relayed at times there is just one available staff and no time to sit and feed. In an interview on 6/5/24 at 5:10 with Staff C, CNA who relayed may be attending to another resident at meal time leaving only one staff to feed up to eight residents and the technique gets them fed. Observation on 06/04/24 at 12:15 to 12:54 PM of dining for lunch meal, Resident #22 at the table with other residents yelling profanity, get your asses out, God dam repeatedly and other words of profanity in addition made loud singing noises then yelling out again profanity throughout the entire meal. Resident #22 Minimum Data Set (MDS) assessment dated 2/29/24 revealed Brief Interview for Mental Status, (BIMS) score for cognition could not be completed and coded behavior present, fluctuates, changes in severity. Diagnoses included non-traumatic brain dysfunction and Alzheimer's disease.	F 550		

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F 550	Continued From page 3 In an interview on 6/4/23 at 1:33 PM the Administrator queried about dining expectation and yelling resident. The Administrator had no concern and stated there are a lot of residents that cannot eat in their rooms. In an interview on 6/4/24 at 1:51 PM with Resident #10 inquired about the dining experience. Resident #10 responded it was the pits, would rather sit somewhere else, relayed Resident #22 yelling bothered her. Resident #10 MDS assessment dated 5/2/24 revealed BIMS score of 9 out of 15 indicating moderate cognitive impairment, documented diagnosis of Multiple sclerosis and revealed Resident #10 dependent on staff. In an interview on 6/4/234 at 3:06 PM with Resident #28 queried about the dining experience, Resident #28 stated, doesn't know why they put resident #22 at my table, had to leave when it gets to be too much. In addition, added the resident desires to sit with her friend cannot just get up and go and it made me feel bad when I had to leave my friend. Resident #28 MDS assessment dated 3/13/24 revealed BIMS score of 14 out of 15 indicated intact cognition. Observation on 6/5/24 at 5:10 to 5:40 PM Resident #22 yelling, included profanity again, loudly could be heard in entire dining room, throughout the dinner meal. In an interview on 6/5/24 at 6:10 PM with the Administrator, relayed usual behavior for Resident #22 in the dining room and had behaviors for years, did not see a problem and felt the other residents are used to it. Relayed	F 550		

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F 550	Continued From page 4 would not want to isolate this resident. In an interview on 6/5/24 at 6:30 PM with Corporate Nurse, Staff E, queried about resident #22 yelling profanity, singing and ongoing loudness in the main dining room is a concern. Staff E responded this is something the team is discussing for options. Policy provided titled The Person-Centered Dining Approach documented dining to be a vital part of everyday. Each person will be treated like a special individual. The atmosphere and surrounding should be cheerful, inviting warm and friendly. All individuals to be treated with utmost courtesy, respect and dignity.	F 550		
F 580 SS=D	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, 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	F 580	1. In continuing compliance with F 580 Notify of Changes (Injury/Decline/Room, etc.) the facility corrected the deficiency by educating the DON on best practice for family notification on 6/14/2024 by Regional Nurse Specialist. The facility will ensure responsible parties are notified of changes for resident #94, and all like residents. 2. To correct the deficiency and to ensure the problem does not recur all nurses were educated by 06/12/2024 on family notifications requirements by the DON. The DON and/or designee will audit for responsible party notifications three times weekly for four weeks, two times weekly for four weeks then one time weekly for four weeks and then as needed to ensure continued compliance. 3. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the DON/ADON and/or designee will report identified concerns through the community's QA Process.	6/14/2024

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F 580	Continued From page 5 §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 clinical record review, provider interview and staff interview, the facility failed to provide timely notification of resident evacuation from the facility for 1 of 3 residents reviewed (Resident#94). The facility reported a census of 41 residents. Findings include:	F 580		

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F 580	Continued From page 6 The Minimum Data Set (MDS) assessment for Resident #94 dated 1/18/24 indicated a planned discharge assessment, with return anticipated. A Progress Note dated 1/18/24 7:43 PM documented, facility had to initiate an emergency evacuation this morning at approximately 4:30 AM., transferred to another facility at 9:10 AM. Emergency contact/family was notified at approximately 2:50 PM of the evacuation and transfer. On 6/3/24 at 2:30 PM Hospice staff I reported when she assisted with relocation of Resident#94 there was frustrations with lack of communication to the residents emergency contact. On 06/10/24 at 1:30 PM the Administrator, acknowledged notification expectation is to be timely. No policy was received.	F 580	1. In continuing compliance with F584 Safe/Clean/Comfortable/Homelike Environment, Accura Healthcare of Pleasantville corrected the deficiency by educating all staff on 6/14/2024 that staff will listen, pay attention and converse with residents, keep noise levels to a minimum. If a resident is being inappropriate, cursing or yelling, they will be redirected to a calm, quiet environment, for resident #22 and like residents.	06/14/2024
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 584	2. To correct the deficiency and to ensure the problem does not recur, all staff were educated by 6/14/2024 by the DON on listening and paying attention, and conversing with residents, and keeping noise levels to a minimum, as well as redirect residents to a calm, quiet area if they are yelling or cursing. The Executive Director and/or designee will audit for compliance three times weekly for four weeks, two times weekly for four weeks then one time weekly for four weeks and then as needed to ensure continued compliance. 3. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	

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F 584	Continued From page 7 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews and facility policy the facility failed to offer a home like environment for resident dining experience in the common dining area where up to 20 residents have daily meals for three of three meal observations. The facility reported a census of 41. Findings include: Observation on 06/04/24 at 12:15 to 12:54 PM of dining for lunch meal, Resident #22 at the table with other yelling profanity, get your asses out,	F 584		

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F 584	Continued From page 8 God dam repeatedly and other words of profanity in addition made loud singing noises then yelling out again profanity throughout the entire meal. Resident #22 Minimum Data Set (MDS) assessment dated 2/29/24 revealed Brief Interview for Mental Status, (BIMS) score for cognition could not be completed and coded behavior present, fluctuates, changes in severity. Diagnoses included non-traumatic brain dysfunction and Alzheimer's disease. In an interview on 6/4/23 at 1:33 PM the Administrator queried about dining expectation and yelling resident. The Administrator had no concern and stated there are a lot of residents that cannot eat in their rooms. In an interview on 6/4/24 at 1:51 PM with Resident #10 inquired about the dining experience. Resident #10 responded it was the pits, I would rather sit somewhere else, relayed Resident #22 yelling bothered her. Resident #10 MDS assessment dated 5/2/24 revealed BIMS score of 9 out of 15 indicating moderate cognitive impairment, documented diagnosis of Multiple sclerosis and revealed Resident #10 dependent on staff. In an interview on 6/4/234 at 3:06 PM with Resident #28 queried about the dining experience, Resident #28 stated, doesn't know why they put resident #22 at my table, had to leave when it gets to be too much. In addition, added the resident desires to sit with her friend, cannot just get up and go and it made me feel bad when I had to leave my friend. Resident #28 MDS assessment dated 3/13/24 revealed BIMS score of 14 out of 15 indicated intact cognition.	F 584		

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F 584	Continued From page 9 Observation on 6/5/24 at 5:10 to 5:40 PM Resident #22 yelling profanity again, loudly can be heard in entire dining room, throughout the dinner meal. In an interview on 6/5/24 at 6:10 PM with the Administrator, relayed usual behavior for Resident #22 in the dining room and had behaviors for years, did not see a problem and felt the other residents are used to it. In an interview on 6/5/24 at 6:30 PM with corporate nurse, Staff E, queried about resident #22 yelling profanity, singing and ongoing loudness in the main dining room is a concern. Staff E responded this is something the team is discussing for options. Policy provided titled The Person-Centered Dining Approach documented dining to be a vital part of everyday. The atmosphere and surrounding should be cheerful, inviting warm and friendly.	F 584		
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.	F 657	1. In continuing compliance with F 657 Care Plan Timing and Revision the facility corrected the deficiency by educating the MDS Coordinator on notifying families of care conferences. The facility will ensure responsible parties are notified of care conferences for resident #17, and like residents. 2. To correct the deficiency and to ensure the problem does not recur the MDS Coordinator audited all care plan conferences to ensure compliance. The DON and/or designee will audit for compliance with family notification of care plan conferences 1x weekly for twelve weeks and then as needed to ensure continued compliance. 3. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the DON/ADON and/or designee will report identified concerns through the community's QA Process.	06/05/2024

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F 657	Continued From page 10 (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 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, responsible party interview and staff interviews the facility failed to ensure quarterly interdisciplinary team meeting with inclusion of the resident and/or resident representative to discuss resident changing goals, for care plan review and /or revisions for 1 of 2 (Resident #17) residents reviewed. The facility reported a census of 41 residents. Findings included: The Quarterly Minimum Data Set (MDS) assessment dated 3/7/24 revealed Resident #17 scored a 9 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition moderately impaired. The MDS revealed diagnoses of non-traumatic brain dysfunction, dementia, renal diseases, depression and chronic pain. The Care plan initiated 1/29/24 included interventions to keep resident and my family up to	F 657		

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F 657	Continued From page 11 date on any health conditions, instruct me and family on rationale for continued nursing home placement, encourage ongoing family involvement, discuss with the resident/family any concerns, fears, issues regarding health or other subjects, and to educate resident/family. Interview On 6/5/24 at 9:30 AM with Resident #17 responsible party relayed had never heard of option to participate in a care plan meeting, had not heard of a quarterly care conference and had never been invited by the facility to a meeting, relayed had never received any mail indicating a care conference invite. The responsible party relayed would like to be involved in this process for Resident #17 and planned to follow up with the facility to be more involved. Interview on 06/05/24 at 09:05 AM Nursing Staff H, MDS Coordinator reported, she was new to the facility and is responsible for ensuring the quarterly updates and coordination of care conferences, could not locate any past documentation on care plan conferences. Staff H revealed a new book, and explained a new processes to ensure a systematic process for including resident and/or family in quarterly review care conferences. Staff H state could not address the lack of care plan conferences in the past or during her training months. The facility did not have a policy regarding quarterly care conferences and relayed follows regulatory process.	F 657		
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,	F 658		

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F 658	Continued From page 12 as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interviews, observations and record review, the facility failed to follow professional standards during medication administration for 1 out of 4 residents (Resident #11) reviewed. The facility reported a census of 41. Findings include: The Quarterly Minimum Data Set (MDS) documented that Resident #11 had diagnoses including heart disease, diabetes, anemia, asthma, respiratory failure, anxiety, depression, and kidney disease. Medication Administration Record (MAR) for resident #11 revealed the following: a.Trelegy, 1 puff inhale orally one time a day directed to rinse mouth with water and expectorate after use (used for long term respiratory failure.) Start date 1/6/24 b.Thiamine HCl Oral Tablet 50 milligram, give 1 tablet by mouth one time a day (used to strengthen immune system, and improve the body's ability to withstand stressful conditions). Start date 11/14/23 c.Humulin R Insulin, regular, Inject 5 units subcutaneously three times a day (used to decreased blood sugar levels). Start date 9/1/23 Observation on 6/5/24 at 8:20 AM Staff A, Certified Medication Aide (CMA) reported the medication Thiamine; 50 mg tab was not available and stated would use from the stock bottle. Staff A took Thiamine pill from the stock	F 658	1. In continuing compliance with F 658 Services Provided Meet Professional Standards the facility corrected the deficiency by DON doing one on one education with Staff A on the six rights of medication administration on 6/7/2024 for resident #11 and like residents. 2. To correct the deficiency and to ensure the problem does not recur the nurses and CMAs were educated by 06/07/2024 on the six rights of medication administration; including how to administer an inhaler properly, waste medications appropriately and how to give short acting insulin correctly by DON. The DON and/or designee will audit for compliance three times weekly for four weeks, two times weekly for four weeks then one time weekly for four weeks and then as needed to ensure compliance. 3. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the DON/ADON and/or designee will report identified concerns through the community's QA Process.	6/7/2024

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F 658	Continued From page 13 bottle and added it to the medication dose cup. Surveyor noted the bottle was Thiamine 100 milligram. Staff A, stated she was ready to bring the medications to Resident #11. Surveyor requested verification of the Thiamine dose. Staff A recognized the dose error and took a pill from the dose cup and put it back in the Thiamine 100 mg stock bottle. Observation on 6/5/24 at 8:33 AM Staff A gave resident #11 the Trilogy inhaler. Resident took one puff. Staff A exited the room with the inhaler. Observation on 6/5/23 at 11:35 of insulin, 5 units of Humalog administered by Licensed Practical Nurse, (LPN) Staff B relayed it is fast acting and given 10-15 minutes before a meal. On 6/5/24 at 12:05 PM Resident #11 sat in his room and relayed was still waiting for his meal. In an interview on 06/05/24 at 12:15 PM with the Director of Nurses (DON) relayed the expectation is to not put a medication that was dosed out, back in the pill bottle. The DON also reported the expectation is not to give fast acting insulin unless is sure the meal is about to be served, and stated the expectation is for staff to direct resident to rinse mouth following use of the Trilogy inhaler as per the manufacturer instructions and as directed on the MAR. Facility provided policy titled Medication Administration dated 1/30/24 documented medications are administered as ordered by the physician in accordance with profession standards of practice, in a manner to prevent contamination or infection. Directed staff to refer to the drug reference material if unfamiliar with	F 658		

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F 658	Continued From page 14 the medication including mechanism for action or common side effects. Administer medication as ordered in accordance with the manufacturer specifications, to appropriate amount of food or fluid.	F 658		
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:	F 661	1. In continuing compliance with F 661 Discharge Summary the facility corrected the deficiency by reviewing all discharges in the last three months to ensure they are completed per Accura Healthcare discharge process by the DON for residents #43, #94 and like residents. 2. To correct the deficiency and to ensure the problem does not recur the nurses were educated by 06/07/2024 on discharge planning review process by the DON. The DON and/or designee will audit for compliance three times weekly for four weeks, two times weekly for four weeks then one time weekly for four weeks and then as needed to ensure compliance. 3. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the DON/ADON and/or designee will report identified concerns through the community's QA Process.	6/7/2024

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F 661	Continued From page 15	F 661		

Based on record review and staff interviews the facility failed to complete a discharge summary for 2 of 2 residents (#43, and #94) reviewed. The facility reported a census of 41 residents.

Findings include:

1. On 6/05/24 at 10:45 AM, Resident #43's the Electronic Health Record (EHR) was reviewed for a patient-initiated discharge.

The EHR revealed Resident #43 was admitted to the facility on 3/26/24 for skilled services.

The discharge Minimum Data Set (MDS) dated 5/22/24 indicated Resident #43 had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated moderately impaired cognition. It also revealed he was independent in all Activities of Daily Living (ADLs) but required only supervision for bathing. The EHR included diagnoses of Major Depressive disorder and alcohol-induced dementia with anxiety.

The EHR progress notes lacked discharge documentation.

On 6/05/24, the Director of Nursing (DON) stated Resident #43's care was managed by the Program of All-inclusive Care for the Elderly (PACE). She stated his discharge documentation was completed by the PACE program staff and was stored in a separate system.

On 6/05/24 at 5:10 PM, the DON provided documentation of the resident's discharge order communication, discharge care instructions, discharge medication list, and discharge care plan. The discharge summary was not provided.

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F 661	Continued From page 16 On 6/06/24 at 9:45 AM, the DON stated the facility did not meet the discharge summary requirement. On 6/07/24 @ 12:16 PM, the Administrator stated the staff should have completed a discharge summary even if entered as a late entry. A policy for discharge summaries was not available. 2. The Minimum Data Set (MDS) assessment for Resident #94 dated 1/18/24 indicated a planned discharge assessment, with return anticipated. A Progress Note dated 1/18/24 documented resident transferred from the facility to another facility on 1/18/24 for an emergency evacuation. The record lacked additional information or completed discharge summary, no recapitulation of residents stay followed the transfer notes. In an interview on 06/06/24 at 10:40 AM, Corporate Nurse, Staff #E confirmed Resident #94 record did not contain a discharge summary and it should of been done. Staff E, reported a former staff was responsible, it just wasn't done and would work to correct this.	F 661		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing	F 679		

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F 679	Continued From page 17 program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on facility activity calendars, resident interview, staff interview and facility assessment the facility failed to provide a program to include resident activities catered for resident interests for resident's physical, mental and psychosocial wellbeing. The facility reported a census of 41. Findings include: A Document reviewed, April 2024 reflected the facility activity calendar which included the following; a. 8 days without activities b. 7 days with Bingo as the only activity (every Tuesday & Friday) c. 2 days with Shopping as the only activity for those days d. 1 entry for resident council as the only activity for that day e. 2 entries for movie as the only activity for those days f. 1 entry for Church as the only activity for that day g. 2 days with manicures as the only activity listed h. 5 entries for crafts, but the only activity documented for those days i. 3 entries for color/puzzle packet, the only activity available for those days j. One day listed as a monthly birthday party, with	F 679	1. In continuing compliance with F 679 Activities Meet Interest/Needs Each Resident hiring a new Life Enrichment Director on 6/10/2024. The new Life Enrichment Director is registered to attend the activities professional's qualification course that starts 8/1/2024. The Activity calendar was recreated on 6/20/24 by the Activity Director to support resident choice of activities and to meet the interests of and support the physical, mental, and psychosocial well-being of the residents #3, #9, #2 and all like resident to enjoy. 2. To correct the deficiency and to ensure the problem does not recur the Executive Director was educated on 6/12/2024 on the importance of hiring a Qualified Life Enrichment Director, and that the Activity calendar is to support resident choice of activities to meet the interests of and support the physical, mental, and psychosocial well-being of the residents by [redacted], Area Director. The Executive Director and/or designee will audit for compliance three times weekly for four weeks, two times weekly for four weeks then one time weekly for four weeks and then as needed to ensure compliance. 3. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	6/20/2024

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F 679	Continued From page 18	F 679		

nothing else offered that day
k. One day the only activity documented was titled a day to plant flowers.
The calendar had only 6 entries with a specific time.

A Document titled, May 2024 calendar contained one daily activity choice which included; 8 days Bingo with no time. Several color or puzzle packets no times noted and 2 shopping days.

On 06/04/24 at 10:28 AM Resident # 3 relayed they have not had a music activity in a long time, stated it is the same old thing every day, bingo is about all for activities and doesn't like it. Staff #3 reported it had been many months since there was any other daily activity for residents, there was not a resident council and excuses about no transportation for outings. Minimum Data Set (MDS) assessment (MDS) dated 5/16/24 indicated Resident #3 Brief Interview for Mental Status (BIMS) score 15 of 15, reflected intact cognition.

On 06/03/24 at 2:25 PM Resident #9 reported a staff may do an activity on Mondays, and the nursing staff try but there is just not enough. Resident #9 referred to an activity calendar for May acknowledged that is all we have and is not always accurate and times can vary as to when an activity may be held. MDS dated 5/7/24 indicated Resident#9's BIMS score 15 out of 15 reflected intact cognition.

On 6/5/24 at 1:30 PM family of Resident #2 reported there is no Activity Director (AD) and residents should not just have to sit all day. Relayed Resident #2 sits most all day with no activities, and is not able to play bingo. MDS

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F 679	Continued From page 19	F 679		

dated 5/23/24 for Resident #2 coded 99 indicated resident not able to complete the cognitive assessment.

On 6/4/24 at 5:55 PM The Administrator confirmed they did not have a June calendar or an Activity Director (AD), acknowledged there are no set times for activities and staff try to fit in activities when possible. The Administrator stated in January there was water damage and no activity calendar as a result, also relayed the facility did not find an activity calendar for February or March. The administrator provided an April and May calendar with little noted and lacked time frames. The Administrator acknowledged the facility did not have a completed calendar for June.

On 6/6/24 at 10:55 PM, the Director of Nurses (DON) stated nursing staff try to fill in to ensure residents have an activity and joy by bringing pets in when they can and or children of staff. Acknowledged an AD is needed and nursing staff tried the best they can to do activities with the residents.

On 6/10/24 at 2:10 PM, Licensed Practical Nurse (LPN) Staff #J relayed there is a large white erase board staff can write for activities, it is not always accurate and confirmed, there is no Activity Director. Staff J relayed we do the same thing usually Bingo and when weather permits we try to take residents outside.

Facility assessment updated 1/15/24 documented under category of psycho/social/spiritual support the facility to provide opportunities for social activities, life enrichment, individual small group and community. Activities and religious services

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F 679	Continued From page 20 to meet the needs of the residents. Facility positions to include a full time Activities Director. Job Description: Director of Life Enrichment with revision date 2/25/24 documented Essential Job Functions which included; *Direct the development, implementation, supervision, and ongoing evaluation of the activities program designed to meet the social, psychosocial, and therapeutic needs of the resident. *Ensure that scheduled program activities are carried out seven days per week * Ensure that each resident is offered at least one cognitive activity, two recreational activities three activities of daily living. Activities are to be tailored to the resident's unique requirements and skills. *Ensure that at least on individual activity is planned for residents who are unable to or unwilling to participate in group activities daily. *Prepare a monthly calendar of activities written in large print and posted in a prominent location that is visible to residents and visitors. *Properly document MDS reports and progress notes *Assess resident needs and develop resident activities goals for the written care plan *Encourage resident participation in activities and document outcomes	F 679		
F 680 SS=F	Qualifications of Activity Professional	F 680		

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F 680	Continued From page 21 CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on facility activity calendars, resident interview, staff interview and facility assessment the facility failed to employ a Activities Director (AD). The residents activity choices did not reflect a well round choice that catered to the residents interests for their physical, mental and psychosocial wellbeing. The facility reported a census of 41 residents. Findings include: The Facility Assessment updated 1/15/24 documented under category of psycho/social/spiritual support the facility to provide opportunities for social activities, life enrichment, individual small group and	F 680	1. In continuing compliance with F 679 Activities Meet Interest/Needs Each Resident hiring a new Life Enrichment Director on 6/10/2024. The new Life Enrichment Director is registered to attend the activities professional's qualification course that starts 8/1/2024. The Activity calendar was recreated on 6/20/24 to contain activities of resident choice that cater to the resident's interests for their physical, mental and psychosocial well-being for residents #3, #9, #2 and all like residents to enjoy. 2. To correct the deficiency and to ensure the problem does not recur the Executive Director was educated on 6/12/2024 on importance of hiring a Qualified Life Enrichment Director, and the Activity calendar is to support resident choice of activities and to meet the interests of and support the physical, mental, and psychosocial well-being of the residents by [redacted] Area Director. The Executive Director and/or designee will audit for compliance three times weekly for four weeks, two times weekly for four weeks then one time weekly for four weeks and then as needed to ensure compliance. 3. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	6/20/2024

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F 680	Continued From page 22	F 680		

community. Support community integration if resident desires. Activities and religious services to meet the needs of the residents. Facility positions to include a full time Activities Director. The Assessment documented under resources needed to provide competent support and care for the residents every day included the following; Activities Director, volunteers, and religious groups. Services listed in the Facility Assessment included; religious services, exercise services, recreational music.

A Document reviewed, April 2024 reflected the facility activity calendar which included the following;
a. 8 days without activities
b. 7 days with Bingo as the only activity (every Tuesday & Friday)
c. 2 days with Shopping as the only activity for those days
d. 1 entry for resident council as the only activity for that day
e. 2 entries for movie as the only activity for those days
f. 1 entry for Church as the only activity for that day
g. 2 days with manicures as the only activity listed
h. 5 entries for crafts, but the only activity documented for those days
i. 3 entries for color/puzzle packet, the only activity available for those days
j. One day listed as a monthly birthday party, with nothing else offered that day
k. One day the only activity documented was titled a day to plant flowers.
The calendar had only 6 entries with a specific time.

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F 680	Continued From page 23 A Document titled, May 2024 calendar contained one daily activity choice which included; 8 days Bingo with no time. Several color or puzzle packets no times noted and 2 shopping days. On 06/04/24 at 10:28 AM Resident # 3 relayed they have not had a music activity in a long time, stated it is the same old thing every day, bingo is about all for activities and doesn't like it. Staff #3 reported it had been many months since there was any other daily activity for residents, there was not a resident council and excuses about no transportation for outings. Minimum Data Set (MDS) assessment (MDS) dated 5/16/24 indicated Resident #3 Brief Interview for Mental Status (BIMS) score 15 of 15, reflected intact cognition. The Annual MDS dated 8/24/24 documented that Resident#3 found the following to be very important to him; music, news, going outside, and participation in his favorite activities. On 06/03/24 at 2:25 PM Resident #9 reported a staff may do an activity on Mondays, and the nursing staff try but there is just not enough. Resident #9 referred to an activity calendar for May acknowledged that is all we have and is not always accurate and times can vary as to when an activity may be held. MDS dated 5/7/24 indicated Resident#9's BIMS score 15 out of 15 reflected intact cognition. The Significant Change MDS dated 2/4/24 documented that Resident#9 found the following to be very important to her; group activities, music, going outside, and participation in her favorite activities. On 6/5/24 at 1:30 PM family of Resident #2 reported there is no Activity Director (AD) and residents should not just have to sit all day. Relayed Resident #2 sits most all day with no	F 680		

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F 680	Continued From page 24 activities, and is not able to play bingo. MDS dated 5/23/24 for Resident #2 coded 99 indicated resident not able to complete the cognitive assessment. The 14-Day MDS dated 2/27/24 for Resident#2 lacked documentation of the residents preferences of activities. On 6/4/24 at 5:55 PM The Administrator confirmed they did not have a June calendar or an Activity Director (AD), acknowledged there are no set times for activities and staff try to fit in activities when possible. The Administrator stated in January there was water damage and no activity calendar as a result, also relayed the facility did not find an activity calendar for February or March. The administrator provided an April and May calendar with little noted and lacked time frames. The Administrator acknowledged the facility did not have a completed calendar for June. On 6/6/24 at 10:55 PM, the Director of Nurses (DON) stated nursing staff try to fill in to ensure residents have an activity and joy by bringing pets in when they can and or children of staff. Acknowledged an AD is needed and nursing staff tried the best they can to do activities with the residents. On 6/10/24 at 2:10 PM, Licensed Practical Nurse (LPN) Staff #J relayed there is a large white erase board staff can write for activities, it is not always accurate and confirmed, there is no Activity Director. Staff J relayed we do the same thing usually Bingo and when weather permits we try to take residents outside.	F 680		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		

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F 690	Continued From page 25 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, family interview, staff interview and facility policy	F 690	1. In continuing compliance with F 690 Bowel/Bladder Incontinence, Catheter, UTI the facility corrected the deficiency by DON educating Staff J on infection control guidelines concerning catheter care of resident #2 and like residents. 2. To correct the deficiency and to ensure the problem does not recur the nurses and CNAs were educated by 06/14/2024 on catheter care, understanding that drainage bags must be kept in a dignity/privacy bad and must be always kept off the floor by DON. The DON and/or designee will audit for compliance three times weekly for four weeks, two times weekly for four weeks then one time weekly for four weeks and then as needed to ensure compliance. 3. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the DON/ADON and/or designee will report identified concerns through the community's QA Process.	6/14/2024

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F 690	Continued From page 26 the facility failed to provide appropriate intervention and catheter care to minimize or prevent complications from the occurrence of urinary tract infections for 1 of 3 residents reviewed (Residents #2). The facility reported a census of 41 residents. Findings include: The Quarterly Minimum Data Set (MDS) dated 5/23/24 documented Resident#2 had an indwelling catheter. Diagnoses included seizure disorders, cerebral infarction, intellectual disability, renal disease and neurogenic bladder. The MDS documented that the resident required maximum assistance for personal hygiene, and dressing. The Care plan for Resident #2 revised 3/12/24 documented, the resident had a suprapubic catheter with the goal to be freed from catheter related trauma. Observation on 06/03/24 at 1:44 PM Resident #2 sat in a chair in her room, observed the catheter bag on the floor. Observation on 06/04/24 at 1:17 PM Resident #2 sat in a wheel chair in the dining room, Certified Nurses Assistants, (CNA) Staff #J assisted Resident #2 back to residents room, Staff J pushed the wheelchair catheter bags was dragging under the wheel chair. In an interview on 6/4/24 at 1:24 with Staff J, surveyor pointed out concern of bag that dragged on the floor, Staff J stated, should have leaned the wheel chair back and demonstrated when she tilted the chair back the catheter bag no longer	F 690		

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F 690	Continued From page 27 touched the floor. Staff J relayed, I didn't think it would touch the floor when the chair was straight up. In an interview on 6/5/24 at 1:00 PM with Resident #2 responsible party, stated recent facility notification included resident #2 had urinary tract infection and was being treated with antibiotics. In an interview on 6/6/24 at 10:45 with the Director of Nursing (DON) confirmed the catheter bag should not be on the floor. The Director of Nursing (DON) stated the goal is to avoid urinary tract infections and realized the associated risks. On 6/6/24 at 9:48 AM the Administrator reported the facility did not have a policy addressing urinary catheter bags, and the facility follows standards of care. A facility policy titled Catheter Care, updated 5/6/24 included, the purpose of catheter care is to prevent infection.	F 690		
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	F 803	1. In continuing compliance with F 803 Menus Meet Resident Nds/Prep in Adv/Followed the facility corrected the deficiency by Dietary Manager educating Staff F on menu posting, alternate menu posting, and education all cooks on portion control of residents #9, 11, 12, and like residents. 2. To correct the deficiency and to ensure the problem does not recur the Cooks and Dietary assistants were educated by 06/13/2024 on menu posting, alternate menu posting, and education all cooks on portion control by Dietary Manager. The Dietary Manager and/or designee will audit for compliance three times weekly for four weeks, two times weekly for four weeks then one time weekly for four weeks and then as needed to ensure compliance. 3. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Dietary Manager and/or designee will report identified concerns through the community's QA Process.	6/13/2024

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F 803	Continued From page 28 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, dietary documents, staff interview, resident interview and policy review, the facility failed to prepare appropriate portions for six (6) residents who received pureed meals, and nine (9) residents who received mechanical soft diets. The facility failed to serve appropriate portions for multiple residents who received tater tots. The facility failed to post menus or offer residents alternative options. The facility reported a census of 41 residents. Findings include: 1. On 6/05/24 at 11:25 AM, Staff F, Cook was observed placing seven (7) serving portions of ham loaf into a blender to prepare nine (9) mechanical soft diets. He placed the contents into a measuring cup and verbalized three (3) cups of prepared mechanical soft ham loaf. The prepared amount was observed to be two (2) cups. Staff F referred to the dietary conversion chart and stated it lacked a column for 9 servings, so he used the 8 servings column and indicated a #10 (3 ¼ ounce) serving scoop was required.	F 803		

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F 803	Continued From page 29	F 803		

At 11:37 AM, Staff F was observed placing 5 ham loaf serving portions of ham loaf into a blender to prepare six (6) pureed diets. Staff F referred to the dietary conversion chart and stated it required a #16 (2 ounce) serving scoop was required.

At 11:50 AM, Staff G, Dietary Aide (DA) pureed the mandarin oranges and emptied the contents directly into the "tulip cup" serving bowls without measuring the portion sizes.

At 12:00 PM, Staff F was observed placing two (2) full 4-ounce scoops and two (2) half-full 4-ounce scoops of tator tots into a blender for 6 pureed diet servings. Staff F referred to the dietary conversion chart and stated a #10 SH (slightly heaping) serving scoop was required.

At 12:15 PM, continuous meal service observation revealed all pureed diet and mechanical soft ham loaf servings were less than a full portion scoop and all tater tot serving portions were less than a full scoop.

At 12:40 PM, three (3) pureed meals were observed receiving a half-scoop of tater tots and the last three (3) regular diet trays received a bag of potato chips due to a lack of tater tots.

At 1:20 PM, observation revealed a portion of mechanical soft ham loaf remained in the steam table serving bowl.

At 1:30 PM, Staff F, Cook verbalized he didn't prepare enough tater tots. He also stated he didn't know what SH meant on the dietary conversion chart

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F 803	Continued From page 30	F 803		

On 6/05/24, a document titled "diet spreadsheet" dated for 6/05/24 revealed the dietician identified 4-ounces of tater tots was to be served for regular, mechanical soft, and pureed diets. It also indicated a #8 (4-ounce) serving scoop was to be used for pureed ham loaf portions.

On 6/07/24 at 12;13 PM, the Administrator stated the staff should prepare more food than needed to ensure each resident received the appropriate amount of food required.

A policy titled "Portion Control" dated 2021 indicated individuals will receive the appropriate portions of food as outlined on the menu.

2. On 6/3/24 at 12:45 PM Resident#11 reported he preferred to eat in his room and eats what is served. Resident #11 stated there is no choice or alternatives. The resident reported that he asked for extra servings at times and usually is told they don't have any. The resident stated he wanted choices but, had to accept what is given. Resident #11 relayed there is no printed menus and does not know what is on the menu until it is served. Minimum Data Set (MDS) assessment dated 5/16/24 coded Resident#11's cognitive status as 15 which indicated cognition intact.

On 6/4/24 at 1:00 PM Resident #12 reported does not know what will be served day to day, and there is no advance menu posted or given. Resident #12 stated he was not aware of choice or alternative food items. The MDS assessment coded resident cognitive status as # 14 out of 15

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F 803	Continued From page 31 which indicated cognition intact. On 06/04/24 at 12:48 PM Resident #9 stated the meal is never known, staff will write it on the white board just before the meal and that's what you get, we do not get a regular menu or an alternative menu option. The MDS assessment coded Resident #9 cognitive status as # 14 out of 15 which indicated cognition intact. On 06/04/24 at 1:33 PM the -Administrator queried about menu options and posting of menus for residents, The Administrator pointed to the white erase board and revealed the menu items are posted there before each meal and acknowledged a full menu is not posted in advance. The Administrator reported residents can get an alternative such as a grilled cheese and felt resident knew about other options, and acknowledged there were no written menus of postings for alternative options. In an interview on 06/05/24 at 5:33 PM with the facility Dietician relayed, as far as alternative for residents, it is at the cook's discretion for alternative choices, much depends on what is on hand they can offer such things as cottage cheese, a fruit cup, or eggs. Policy provided titled Displaying the Menu dated 2021, documented, the food and nutrition service staff will post planned written menus in a designated area that is easily viewed by all individuals. Policy provided titled The Person-Centered Dining Approach, dated 2021 documented all individuals to be treated as a special individual with a focus on individualizing interactions and	F 803		

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F 803	Continued From page 32 interventions including nutrition care food and beverages.	F 803		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, the facility failed to provide food served by a method to maintain a safe and appetizing temperature. The facility reported a census of 41. Findings include: On 6/05/24 at 11:15 AM, Staff F, Cook, checked the temperature of the lunch menu items. The Ham Loaf temperature was recorded at 139.5° Fahrenheit (F). The lettuce temperature was recorded at 40.8° F. During food service, Staff F served lettuce at room temperature from the serving bowl on the counter. On 6/5/24 at 1:20 PM, Staff F checked the temperature of the remaining lunch menu items. The Ham Loaf temperature was recorded at 129.5° F.	F 804	1. In continuing compliance with F 804 Nutritive Value/Appear, Palatable/Prefer Temp the facility corrected the deficiency by Dietary Manager educating Staff F educating on food temperature policy and holding food temperatures. 2. To correct the deficiency and to ensure the problem does not recur the Cooks were educated by 06/13/2024 on food temperature policy and hold food temperatures by Dietary Manager. The Dietary Manager and/or designee will audit for compliance three times weekly for four weeks, two times weekly for four weeks then one time weekly for four weeks and then as needed to ensure compliance. 3. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Dietary Manager and/or designee will report identified concerns through the community's QA Process.	6/13/2024

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F 804	Continued From page 33 On 6/07/24 at 12:21 PM, the Administrator stated staff should follow the facility policy regarding food service temperatures. A policy titled "Food Temperatures" dated 2021 indicated temperatures should be taken periodically to assure hot foods stay above 135° F and cold foods stay below 41° F during the holding and plating process and until food leaves the service area.	F 804		
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, staff interviews, and facility policy review, the facility failed to maintain sanitary practices by failing to properly contain	F 812	1. In continuing compliance with F 812 Food Procurement Store/Prepare/Serve-Sanitary the facility corrected the deficiency by Dietary Manager educating Staff F on the beard and hairnet policy, and cooks on general food preparation and handling policy to prevent cross contamination. 2. To correct the deficiency and to ensure the problem does not recur all dietary staff on the beard and hairnet policy, and cooks on general food preparation and handling policy to prevent cross contamination. by Dietary Manager by 06/13/2024. The Dietary Manager and/or designee will audit for compliance three times weekly for four weeks, two times weekly for four weeks then one time weekly for four weeks and then as needed to ensure compliance. 3. As part of Accura Healthcare of Pleasantville's ongoing commitment to quality assurance, the Dietary Manager and/or designee will report identified concerns through the community's QA Process.	06/13/2024

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F 812	Continued From page 34	F 812		

hair in the food preparation area and failing to prevent cross-contamination during food service. The facility reported a census of 41 residents.

Findings include:

On 6/05/24 at 11:15 AM, Staff F, Cook was observed in the food preparation area with an uncovered mustache and goatee. His head cap also failed to contain all of his hair.

At 11:25 AM, Staff F sliced tomatoes with bare hands and placed the tomatoes in the serving dishes. Staff F also retrieved a serving scoop from a supply drawer and laid it face-down on the counter used to store food preparation equipment.

At 11:50 AM, Staff F filled a dressing dispenser and the nozzle tip touched the ungloved palm of his hand.

At 12:40 PM, Staff F placed lettuce from a bowl onto a resident's plate. He put the lettuce back into the main bowl then reached back in the main bowl and placed the lettuce back onto the resident's plate.

At 1:10 PM, Staff F used bare hands placed buttered bread in a skillet, reached into a bag of cheddar cheese and placed some on the bread, then cut the cooked sandwich on a plate.

On 6/07/24 at 12:12 PM, the Administrator stated staff F should be wearing a beard and hair nets. Gloves should be worn for all meal preparation.

A policy titled "General Food Preparation and Handling" dated 2021 indicated bare hands

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ACCURA HEALTHCARE OF PLEASANTVILLE, LLC	**909 NORTH STATE STREET** **PLEASANTVILLE, IA 50225**

(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 812	Continued From page 35 should never touch ready to eat raw food directly. Disposable gloves are a single use item and should be discarded after each use. Employees should wash hands prior to putting gloves on and after removing gloves. It also directed staff that tongs or other serving utensils will be used to serve breads or other items to avoid bare hand contact with food.	F 812		