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

PRINTED: 05/20/2025
FORM APPROVED
OMB NO. 0938-0391

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 ______	05/08/2025

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

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F 000 ✓ ok/CP	INITIAL COMMENTS Correction date: 5/30/2025 The following deficiencies resulted from the facility's Annual Recertification survey and investigation of Complaints #125816-C, #127382-C, and #127388-C Facility Reported Incidents #125936-I, and abuse investigation #125555-A conducted April 28, 2025 to May 8, 2025. Complaint #125816-C, #127382-C, and #127388-C resulted in a deficiency. Facility Reported Incident #125936--I resulted in a deficiency. The findings related to the investigation of #125555- A will be sent at a later date under a separate cover letter. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	PLAN OF CORRECTION 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 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility document review, staff and family interview, the facility failed to meet a resident's need for corrective lenses by failing to schedule an optometrist appointment for replacement eye wear in a reasonable time frame	F 558	1.In continuing compliance with F558 Reasonable Accommodations Needs/Preferences, Accura Healthcare of Pleasantville corrected the deficiency by ensuring resident #34 had prescription glasses and auditing to ensure all residents with vision problems have the requested eyewear. 2.To correct the deficiency and to ensure the problem does not recur, the Executive Director was educated on 5/21/2025 by the Regional Director of Operations to ensure residents needs and preferences are met. The Executive Director and/or designee will audit for compliance 3x/weekly x 4 weeks, then 2x/weekly x 4 weeks, then 1x/weekly x 4 weeks, and then PRN 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.	5/21/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amy Caldwell	Director of Nursing	5/30/25

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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for 1 of 16 residents assessed (Resident #34). The facility reported a census of 45.

Findings include:

The annual minimum data set (MDS) for Resident #34, completed on 03/27/2025, documented the following relevant diagnoses: Non-Alzheimer's dementia (dementia), and amaurosis fugax (temporary blindness). It documented the resident's brief interview for mental status (BIMS) score as 02, indicating severely impaired cognition. It also revealed the resident required corrective lenses for his vision.

Review of a facility provided document titled "Grievance form", with a reported date of 12/20/2024, documented that resident #34 was found wearing glasses that were not his. It documented the administrator searched for the glasses on 12/20/2024 but that they were not found. The grievance form also documented on 03/04/2025 Resident #34 had a doctor's appointment scheduled by the family, with the form being marked as resolved on 03/11/2025.

In an interview on 04/28/2025 at 02:23 PM with a family member, they stated they had filed a grievance with the facility in December of 2024 regarding missing glasses. They stated they had reported this to facility staff earlier than the 12/20/2024 date but did not know exactly when. They stated they had requested a doctor's appointment to replace the eye glasses, but it did not get done. They stated they became upset with how long it was taking to schedule the appointment, so in late February of 2025 they scheduled the appointment themselves. They were unhappy with this, as Resident #34 had

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F 558	Continued From page 2 been without his glasses for over two months at the time of resolution. In an interview on 04/30/2025 at 03:05 PM with the Administrator, she acknowledged that she does not have any documentation as to why the facility did not schedule a doctor's appointment to replace Resident #34's eye glasses, but believed it was family preference	F 558		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the	F 582	1.In continuing compliance with F582 Medicaid/Medicare Coverage/Liability Notice, Accura Healthcare of Pleasantville corrected the deficiency by ensuring resident #99 and all like residents have the right to advanced notices and appeal rights. 2.To correct the deficiency and to ensure the problem does not recur, the Business Office Manager was educated on 5/7/2025 by the Executive Director on ensuring the correct CMS ABN/NOMNC forms are used. The Executive Director and/or designee will audit for compliance 3x/weekly x 4 weeks, 2x/weekly x 4 weeks, then 1x/weekly x 4 weeks, and then PRN 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.	5/30/2025

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Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interview and policy review, the facility failed to provide the appropriate Center for Medicare Services (CMS) Notice of Medicare Non-Coverage (NOMNC) form to address service options and liability for payment for one of two residents reviewed for Advanced Beneficiary Notices (ABN) (Resident #99). The facility reported a census of 45 residents.

Findings include:

A review of the notice of non-coverage form for

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F 582	Continued From page 4 Resident #99 revealed the resident and/or significant other had been notified at least 48 hours prior to skilled services ended and provided information on the right to appeal (CMS form 10123) on 12/18/24. A review of the mandatory skilled nursing facility advanced beneficiary notice of non-coverage form for Resident #99 revealed CMS form #10124-DENC (detailed explanation of noncoverage) was provided to the resident and/or representative instead of CMS form #10055 to indicate the option to receive or decline continued skilled services. During an interview on 4/29/25 at 11:40 AM, the Administrator reported they did not have a social worker at the facility. The Administrator reported she took care of the ABN's. During an interview 4/30/25 at 2:25 PM, the Administrator reported she got the ABN forms in a packet from the Corporate home office. She received an email from Corporate at the beginning of the year regarding the forms to use for the ABN's. There were forms for Medicare Part A and another form for Part B. She thought she used the correct form for Part A for Resident #99. During an interview 5/7/25 at 2:40 PM, the Administrator confirmed the facility had no policy for ABN's.	F 582		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This	F 602	1.In continuing compliance with F602 Free From Misappropriation/Exploitation, Accura Healthcare of Pleasantville corrected the deficiency by ensuring resident # 30 and all like residents will have their resident trust accounts and all receipts accounted for.	5/12/2025

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F 602	Continued From page 5 includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, health record review, review of resident's trust statements, purchased items receipts, staff interviews, and policy review, the facility staff failed to properly handle resident's funds for 1 of 3 (Resident #30) residents reviewed. The facility reported a census of 45. Findings include: Review of Resident #30's Annual Minimum Data Set (MDS) dated 4/3/25 revealed a Brief Interview for Mental Status (BIMS) score of 00 indicating severe cognitive impairment and diagnoses of hypertension, Non-Alzheimer's Dementia, Anxiety Disorder, Schizophrenia, and speech disturbances. Review of Resident #30's Electronic Health Record (EHR) indicated on 4/3/25 Resident #30's height measured 64" (5' 4") and weighed 183.2 pounds on 5/5/25. On 4/30/25 3:21 PM, Staff Q, Certified Nurse's Aide (CNA) reported in an interview, on 12/1/24 Staff R, former Assistant Administrator, used Resident #30's trust to purchase items for Resident #30. Staff Q, verbalized concerns of purchased items being stolen by Staff R, reporting after Staff R purchased items for Resident #30, bagged items were brought to the facility and placed under the nurse's desk, no receipt was provided to the CNA's for the purchased items to be checked in by comparing	F 602	2.To correct the deficiency and to ensure the problem does not recur, the Business Office Manager was educated on 5/12/2025 by the Regional Director of Operations to ensure either the resident or two staff members sign for each transaction and the original receipt is kept in the business office records. The Executive Director and/or designee will audit for compliance 3x/weekly x 4 weeks, then 2x/weekly x 4 weeks, then 1x/weekly x 4 weeks and then PRN 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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the items to the receipt and no signatures were provided on the receipt to validate purchased items were delivered to Resident #30. Staff Q also reported these items were still in bags at the nurse's station on 12/20/24.

Review of facility provided Abuse Investigation revealed on 12/9/24 at 7:01 PM, Staff I, Registered Nurse (RN) reported to the facility Administrator she had received allegations that Staff R, former Assistant Administrator, had purchased items for herself using Resident #30's trust. The facility's Abuse Investigation noted action taken by the facility included investigating the allegation by checking receipts. The credit card was not working at the time of the purchases, checks were used. The documented follow up actions taken by the facility noted when reviewing receipts and resident's room items were accounted for. The credit card was not used for transactions. The items that were supposedly purchased like a queen bed set and brown hair dye were not on the receipt, all hair dyes were accounted for. Checking account transaction statements and photo copies of three partial receipts were provided with the facility's Abuse Investigation documents. First receipt totaled $573.41 timestamped 11/30/24 at 10:32 PM, the second receipt totaled $124.61 timestamped 12/1/24 at 12:27 PM, and third receipt totaled $514.49 timestamped 12/1/24 at 12:26 PM. Review of the Checking account transactions statement indicated Walmart transaction 12/3/24 for $514.49, Walmart transaction 12/3/24 for $124.61, the transaction for $573.41 was not indicated on the transactions statement. The Summary/Conclusion of the investigation revealed the date of incident as 12/9/24, date of the follow up as 12/10/24, person involved as

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F 602	Continued From page 7 Staff R and nature of incident as possible theft. The facility's Abuse Investigation was signed by the facility Administrator on 12/10/24. Review of Staff R's, former Assistant Administrator, Employee Record revealed the following: 1. Education Form: I have been presented with education. My signature verified that I have read, understand, and agree to abide by the Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy. Signed by Staff R on 9/25/24. 2. Background check document, background check completed as of 5/17/22 3. Iowa Department of Health and Human Services, Dependent Adult Abuse Mandatory Reporter Recertification Training completed on 2/12/24 4. Employee Corrective Action Form, Final Written Warning dated 12/18/24. Incident/Infraction on 12/11/24, an employee from Accura HealthCare of Pleasantville contacted Facility Administrator to share their concerns directly related to Staff R, Assistant Administrator, and text message between the two. In the provided text conversation, Staff R was identified as sending messaging indicating that Staff R was "padding her paycheck" as well as messages that are not professional and reflect negatively for Accura HealthCare of Pleasantville given the leadership position that Staff R upholds. During the investigation, it was also identified that Staff R broke confidentiality and shared information that should remain confidential. Expectations Moving Forward, Staff R is to remain respectful and professional when interacting with team members. Staff R needs to remember that she is in a leadership position and must conduct herself	F 602		

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as such. She will maintain confidentiality in all areas including medical, personnel, and similar information. Document signed by Staff R on 12/18/24.

In a confidential staff interview on 5/1/25 at 9:37 AM, staff member verbalized being aware of the facility's investigation related to Resident #30's and Resident #9's purchased items. Staff member stated the Walmart bags with resident's items sat at the nurse's station for weeks. Staff member stated, CNAs and nurses had asked multiple times for the receipts so the items could be given to the residents they were purchased for. Staff member verbalizes frustration with administrative staff due to the investigation being "completed" but the items that were part of the investigation were still in the Walmart bags under the desk at the nurse's station. Staff member was able to provide a picture on her phone that showed approximately 3-5 Walmart bags with items that appear to be clothes in them under the desk at the nurse's station. Staff member was able to show a time stamped date and time picture was taken revealing 12/13/24 at 10:04 PM.

During an interview on 4/30/25 at 5:26 PM, the facility Administrator stated the provided investigation documents are the facility's completed investigation, it was an internal investigation and she did not report the abuse allegations to Iowa Department of Inspections Appeals and Licensing (DIAL). Facility Administrator stated during her investigation, she had independently checked the receipts for Resident #9 (receipt total $124.61 and $573.41) with the items purchased and all items were there.

F 602 | F 602

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Review of facility provided trust statements, dated October 2024 through March 2025, for Resident #30 indicated a Resident Shopping transaction posted on 12/23/24 for $514.49.

On 4/30/25, the facility Administrator provided a receipt for Resident #30's purchased that were made on 12/1/24 for $514.49, the receipt provided was the same copy provided in the facility's Abuse Investigation. The receipt failed to indicate where the purchases had been made (top portion of receipt), unable to identify if all purchased items were shown on copy of the receipt, and the copy of the receipt failed to indicate signatures of purchaser, resident and/or staff to validate items purchased.

During an interview on 4/30/25 at 11:25 AM the Business Office Manager revealed the Activities Director goes shopping once a month for residents. The residents will let the Activities Director know their needs and the items are added to the list. If items are needed at other times of the month the Activities Director will try to get these items for them. When the items are purchased, the receipt is signed by the resident or two staff members as the items are identified and given to the resident. The Business office Manager, stated the only ones (residents) that spend money are the ones that are able to verbally let us know what they need.

In an interview on 4/30/25 at 12:54 PM facility Activities Director stated she started working at the facility on 11/25/24. Her position also includes some Social Services duties, Activity Assessments for residents and inventory of resident belonging. When purchasing items for

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residents she takes the debit card to the store on the second Wednesday of the month to purchase for residents. She has a form that is filled out with the items residents are requesting. If a resident is non-verbal or or unable to communicate needs, the CNA's (Certified Nursing Assistants) will provide a list of items needed for that resident along with sizes. After purchasing items, the receipt is given to the Business Office Manager or the Administrator if the Business Office Manager is not available. When returning to the facility with the purchased items, they are distributed to the resident. The sheet and/or receipt is signed by the Activities Director and resident. If the resident is not able to sign, the CNA that helps distribute the items will sign. She has also shopped on Amazon with residents and their items are delivered to the facility. If making a purchase on Amazon, the Activities Director will sit with the resident to shop, print off the invoice, then give the invoice to the Business Office Manager. Often when residents need to spend down the resident will sit at the desk with the Activities Director and order on Amazon. When a resident has a guardian, Power of Attorney (POA) or representative that person is contacted, they will either purchase items for the resident and deliver to the facility or notify the Activities Director of items to purchase. Activities Director stated she does an inventory of resident's items on admission to the facility, inventories what she is able after purchases but items may be purchased or brought in by family members or visitors, if she is not made aware of these items they may not be added to the resident's inventory sheet.

On 4/30/25 at 5:05 PM an email was sent to the facility Administrator requesting Resident #30's original receipt in the amount of $514.49,

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indicating where the items were purchased and providing the signatures of the employees and/or Resident #30 verifying the purchased items.

During an interview 4/30/25 at 5:15 PM facility Administrator stated these purchases for residents, including Resident #30 were made as their trust accounts needed to be spent down and she was unaware of where the original receipts were but that she still communicated with Staff R and would try to contact her to see if she knew where the receipts could be located.

On 5/1/25 at 6:51 AM the facility Administrator communicated via email stating, attached to the email were copies of receipts, including Resident #30's. With a new office manager, we were not sure where the originals were filed but I went to Walmart last night and they were able to reprint these for me. As per our communication last night, I mentioned we were doing spend downs for residents at this time.

On 5/1/25 at 10:28 AM The facility Administrator stated she was notified at 7:00 PM on 12/9/24 that Staff I, RN was notified of allegations against Staff R, former Assistant Administrator. Staff R, was scheduled off the next day (12/10/24) and was not placed on suspension due to the investigation being completed at a time she was already out of the facility. At the time of the purchases Staff R, was doing the spend down for the residents, she had previously been in the Activities Director position and was familiar with the resident's preferences. Previously when spending down for residents that are unable to make their needs known, a meeting would take place with other staff members and CNAs to discuss the resident's needs and items residents

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F 602	Continued From page 12 would enjoy. The facility Administrator confirmed the residents that were purchased for on 11/30/24 and 12/1/24 were not cognitively able to identify and express their wants and needs. She (facility Administrator) also stated the Police Department was not notified as there was no missing money. In an interview with Staff R, former Assistant Administrator on 5/6/25 at 9:34 AM, Staff R verbalized her position at the facility as Business Office Administrative Assistant. She started working at the facility May 2022 and left January 2025, resigning due to family reasons. Staff R stated she was aware there was an internal investigation be conducted by the facility Administrator related to purchases for Resident #30 and Resident #9. She was made aware of the investigation when she got to work one morning in early December, but was unable to recall the exact date. Staff R, stated she was not suspended during the investigation and was in the facility, but couldn't have access to resident's trust accounts. She was not able to recall how long the investigation lasted but stated it was not the full day. Staff R revealed, during the investigation she was with the facility Administrator and helped go through the resident's belongings and helped identify the items. Staff R stated the facility Administrator and herself went through both Resident's (#30 and #9) and identified all items on the receipts. Staff R, stated she was not always the one to make purchases, it was normally done by the Activity Director. She couldn't remember, at the time of the purchases there either wasn't an Activity Director or she was new and not able to make the purchases. Staff R, stated the way she had always done the purchasing included making sure the funds for the resident were available,	F 602		

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purchase the items, label the items with the resident' s initials, then bring the items to the facility and the CNA's would put the items away. The CNA's are supposed to inventory the items with the receipts and get two signatures, for Resident #30 and Resident #9 two staff signatures would have been needed. Staff R recalled purchasing the items on the weekend and keeping them in her car until she returned to work the following Monday. Staff R stated the items for Resident #30 and Resident #9 were brought in sacks labeled with the resident's initials to the nurse's station and she asked the CNA's to put the items away. Staff R stated she was not aware if the receipts had been signed by anyone. She was not able to recall clothing sizes purchased or identified during the investigation for Resident #30 or Resident #9.

A follow up Interview 5/6/25 at 10:05 AM, facility Administrator stated while conducting the facility's Abuse Investigation she could not recall interviewing staff members related to the purchased items for Resident #30 or Resident #9. She stated when she conducted the investigation she reviewed all three receipts finding all the purchased items comparing them to the receipts independently without the help of any staff members. During the follow up interview, at 10:08 AM, the facility Administrator's personnel cell phone (sitting face up on her desk) started ringing with Staff R's name showing on the screen, but the facility Administrator declined the call and continued with the interview.

Review of the facility provided, re-printed receipts from Walmart, revealed all purchased items were legible and Staff R, former Assistant Administrator's, authorization signature from time

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F 602	Continued From page 14 of electronic purchase were on the receipts. On 5/1/24 the provided receipts were uploaded by transaction number onto the Walmart website identifying the specific items, quantity, colors, and sizes purchased. Purchases on Resident #30's receipt totaling $514.49 included the following items: 1. Joyspun Women's and Women's Plus Plush Sleep Jogger Pants (gray, pink plaid, size Small) $9.98 2. Joyspun Women's Velour Notch Collar Top and Pants Pajama Set, 2-piece (red plaid, size 2X) $19.98 3. Joyspun Women's and Women's Plus Plush Sleep Jogger Pants (gray,pink plaid, size 2X) $9.98 4. Joyspun Women's Long Sleeve Tee and Jogger Pants Pajama set, 2-Piece (green top, gray Christmas pant, size 2X) $12.98 5. Joyspun Women's Long Sleeve Tee and Jogger Pants Pajama set, 2-Piece, (gray top, green Christmas pant, size 2X) $12.98 6. Joyspun Women's Long Sleeve Tee and Jogger Pants Pajama set, 2-Piece (black top, black with teddy bear pant, size 2X) $12.98 7. Time and Tru Women's High-Rise Ankle Knit Leggings, 27' inseam (black, size XL) $4.48 8. Time and Tru Women's High-Rise Ankle Knit Leggings, 27' inseam (black, size XL) $4.48 9. Time and Tru Women's High-Rise Ankle Knit Leggings, 27' inseam (gray, size XL) $4.48 10. Joyspun Women's Hacci Knit Jogger Sleep Pants, 29" inseam (pink, blue, yellow plaid, size Medium) $8.43 11. Time and Tru Women's High-Rise Ankle Knit Leggings, 27' inseam (gray, size XL) $4.48 12. Joyspun Women's Hacci Knit Jogger Sleep Pants, 29" (red, green, white plaid, size Small)	F 602		

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F 602	Continued From page 15 $8.43 13. Time and Tru Women's and Women's Plus Zip up fleece jacket with hood (green, size XL) $13.00 14. Time and Tru Women's and Women's Plus Zip up fleece jacket with hood (navy, size XL) $13.00 15. Time and Tru Women's Quilted Fleece Pullover (dark green, size XL) $17.98 16. Time and Tru Women's and Women's Plus Zip up fleece jacket with hood (pink, XL) $13.00 17. Joyspun Women's Velour Notch Collar Top and Pants Pajama Set, 2-piece (gray, pink plaid, size Medium) $19.98 18 Time and Tru Women's Quilted Hoodie with Long Sleeves, (green, size XL) $17.98 19. Fruit of the Loom Women's Tank Style Cotton Sports Bra, 3-pack (white, black, gray, size 42) $14.94 20. Avia Women's Performance Cushioned Low-Cut Sock, 10 pack (black, size 4-9) $9.97 21. Avia Women's Performance Cushioned Low-Cut Sock, 10 pack (black/grays, size 4-9) $9.97 22. Gimme Fine Fit Ponytail Holder Hair Tie, Black 20ct $3.28 23. Scunci Mini Washable Scrunchie Hair Ties, Black, 6ct #3.46 24. Goody Fabric Covered Headbands, Assorted neutral colors, 3ct $4.48 25. Mainstay Abby Microfiber Quilt, Full/Queen-Reversible (blues, pink, cream floral) $24.97 26. Mainstay Cozy textured Plush Throw Blanket, Purple, 50"x 60" $8.46 27. Dearfoams Cozy Comfort Women's waffle and Terry Moccasin Slippers (black, size 7/8) $14.00 28. Dearfoams Cozy Comfort Women's quilted jersey Clog (gray, size 9/10) $14.00	F 602		

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29. Reebok Women's and Women's Plus After Class Crewneck Sweatshirt (black, size Medium) $21.98
30. Reebok Women's and Women's Plus After Class Joggers (black, size Medium) $21.98
31. Reebok Women's and Women's Plus After Class Crewneck Sweatshirt (blue, size Large) $21.98
32. Athletic Works Women's Petite Stretch Cotton Blend Straight Leg Pants (black, size XL) $12.98
33. Reebok Women's and Women's Plus After Class Joggers (white, size XSmall) $21.98
34. Mainstays Cozy Plush Throw Blanket, Multicolor abstract Leopard 50"x 60" $5.96
35. Olay Moisture Ribbons Women's body Wash, Shea+Lavender Oil, 18 fl oz (purple bottle) $6.97
36. Olay Moisture Ribbons Women's body Wash, Shea and Blue Lotus, 18 fl oz (blue bottle) $6.97
37. Olay Moisture Ribbons Women's body Wash, Shea+Lavender Oil, 18 fl oz (purple bottle) $6.97
38. Olay Moisture Ribbons Women's body Wash, Shea+Lavender Oil, 18 fl oz (purple bottle) $6.97
39. Mainstay 5 piece Reversible Bed in a Bag Comforter Set with sheets, Floral, Twin-XL (purple, orange,yellow,blue, pink flowers) $29.96

On 5/05/25 at 11:21 AM observation of Resident #30's room and closet, revealed clothing sized XL, a purple throw blanket and Bed in Bag bedding set in original packaging on the shelf of Resident #30's closet. On the floor a basket held multiple pairs of shoes, slippers were not observed but noted shoes size 8. Resident #30's bed was made with a red and white snowflake fleece blanket.

During an interview on 5/5/25 at 1:24 PM Staff M, CNA stated she works with Resident #30 often

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and is familiar with her cares and needs. Resident #30 does walk with a walker and is confused most of the time. Staff M, CNA states she often assists Resident #30 with her showers and daily cares like getting dressed or changing her clothes. Staff M, CNA stated Resident #30's clothes are sized XL's and there might be a few random 2XL. Staff M, CNA stated she was not aware of Resident #30 having any slippers and that she does not wear slippers, she wears the gripper socks.

During an interview on 5/5/25 at 1:43 PM Staff S, CMA stated Resident #30 wears sizes XL or 2XL clothes and is aware of bedding she had received including a Bed in a Bag set and a soft throw blanket.

During an interview on 5/5/25 at 1:42 PM, Staff K, CNA stated she had worked at the facility on and off for the past 10 years and knows the residents very well. Staff K, CNA stated Resident #30 is a bit bigger on top and wears Xl-XXL size clothes. Resident #30 walks with a walker and tends to shuffle her feet when she walks so she wears gripper socks. If Resident #30 were to wear slippers, it wouldn't be safe. Since she shuffles her feet so much she could end up tripping or cause herself to fall. Staff K stated Resident #30 had not received any other blankets or throws she was aware of other than a bedding set and purple blanket she has not used. Staff K verified when items are purchased for a resident and brought back, somebody has to go through the bag, compare the items with the receipt, and sign the receipt to confirm all items were there.

In a follow up interview on 5/8/25 at 10:05 AM, Staff R, former Assistant Administrator, stated her

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F 602	Continued From page 18 employment at the facility as the Activities Director in May 2022, due to family health concerns she took a leave of absence for a period of time then returned to the facility. When she returned to the facility her designated duty was staffing coordinator, from this position she became the Provisional Administrator in January 2023 until April 2024 when the current facility Administrator started. From the Provisional Administrator position she was assigned as the Business Office Manager. Staff R stated her duties as the Business Office Manager included helping with billing and resident trust statements, posting payments, staffing, new hire orientation, assisting with new resident admissions and helping the facility Administrator get started in her position. Staff R stated for the purchases made on 11/30/24 and 12/1/24, she had been designated to purchase items for residents as she had prior experience doing this in the Activities Director position and she had been notified by the Corporate Office of the residents that needed their trust account spent down. The Activities Director at that time had been hired, but had not started in her position yet. Staff R stated the process for purchasing items for residents was first to verify the funds are available, then go purchase the requested items. When purchasing for more than one resident the items need to be kept separate and paid for individually by the resident. At the time of these purchases the debit card had not been working, so Staff R returned to the facility to get the facility checkbook. After the items are purchased, the items are labeled with the resident's initials then the CNAs would assist with inventorying and putting the resident's items away. Staff R would keep the copies of the purchase receipts and post the charges to the resident's account. Staff R was able to recall she	F 602		

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F 602	Continued From page 19 had shopped for Resident #30 and Resident #9 on Saturday 11/30/24 and Sunday 12/1/24. Staff R verified the re-printed receipts provided by the facility Administrator, indicating the electronic signature on the receipt was hers. Staff R recalled purchasing bedding, blankets, throws, night gowns, pajama sets, pants, and tops for the residents. She stated the sizes for Resident #30 and Resident #9 ranged from Large to XXL. After the items were purchased Staff R stated she had gone back home leaving the items in the trunk of her car. When she returned to work on Monday (12/2/24) the purchased items were brought into the facility. Staff R stated she had labeled the plastic bags with the resident's initials and delivered them to the nurses' stations. She stated not being able to recall the number of bags she had brought into the facility. Staff R, acknowledged the provided picture of the Walmart bagged items at the nurse's station, stating the items in the bag appeared to be the same color schemes of the items she had purchased for Resident #30 and Resident #9. Staff R stated she was off from work on Monday 12/9/24 but had worked from home due to being ill. On Tuesday 12/10/24 upon returning to work she was made aware of the investigation related to the allegation of items being stolen from residents she had purchased items for. Staff R stated on Tuesday 12/10/24 she assisted the facility Administrator with the investigation by physically pointing out the items that had been purchased compared to the purchase receipts and everything was accounted for. Staff R reviewed and verified the Walmart documents that indicated the items purchased with pictures, descriptions, quantity, sizes and prices. When reviewing the sizes of the items purchased, Staff R could not recall what size items she had	F 602		

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purchased and stated she was not sure why there would have been the smaller sizes. Staff R stated after the purchased items were delivered to the resident, it was never brought to her attention of any items that may have not been to correct sizes.

On 5/8/25 at 11:50 AM, Regional Director of Operations verbalized concerns related to the on-site investigation being conducted by the Iowa Department of Inspections Appeals and Licensing (DIAL) related to the items purchased and facility's Abuse investigation for Resident #30. Receipts indicating the purchased items with their sizes for Resident #30, and Resident #9 was reviewed by the Regional Director of Operations. She acknowledged the sizes indicated on Resident #30's receipt, stating the receipt may be inaccurate and would find the items indicated. Copies of the receipts with pictures, item description and sizes, as well as a list of the items that indicated discrepancies in the sizes Resident #30 wears was provided to the Regional Director of Operations and the facility Administrator. The provided list included the following items:
1. Joyspun Women's and Women's Plus Plush Sleep Jogger Pants (gray, pink plaid, size Small)
2. Joyspun Women's Hacci Knit Jogger Sleep Pants, 29" inseam (pink, blue, yellow plaid, size Medium)
3. Joyspun Women's Hacci Knit Jogger Sleep Pants, 29" (red, green, white plaid, size Small)
4. Joyspun Women's Velour Notch Collar Top and Pants Pajama Set, 2-piece (gray, pink plaid, size Medium)
5. Reebok Women's and Women's Plus After Class Crewneck Sweatshirt (black, size Medium)
6. Reebok Women's and Women's Plus After Class Joggers (black, size Medium)

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F 602	Continued From page 21 7. Reebok Women's and Women's Plus After Class Crewneck Sweatshirt (blue, size Large) 8. Reebok Women's and Women's Plus After Class Joggers (white, size XSmall) Review of documents received on 5/12/25 at 1:04 PM, facility Administrator identified Residents #30 and Resident #9's items compared to purchase receipt, the Items of discrepancy (sizes xsmall, small, medium, large) identified for Resident #30 included the following: 1. Reebok jogger pants, cream size XL 2. Reebok crewneck sweatshirt, cream, size XL 3. Reebok crewneck sweatshirt, burgundy, size XL 4. Reebok jogger pants, dark gray, size XL Continued review of provided documents, received by the facility Administrator, revealed the following items listed on Resident #9's purchase receipt that the facility was unable to identify. 1. Reebok Women's and Women's Plus After Class Joggers (cream, size XL) 2. Reebok Women's and Women's Plus After Class Crewneck Sweatshirt (cream, size XL) 3. Reebok Women's and Women's Plus After Class Crewneck Sweatshirt (burgundy, size XL) 4. Reebok Women's transition jogger (dark gray, size XL) The reviewed documents failed to provide the items of discrepancy. Review of facility provided Job Description: Assistant Administrator, revision date 3/22/24, stated the following: Job Summary: The Assistant Administrator reports to and works collaboratively with the Area Executive Director or Executive Director (ED)	F 602		

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F 602	Continued From page 22 supporting the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines and regulations that govern skilled nursing facilities to assure that the highest degree of quality care can always be provided to our residents. Follows all established policies and procedures to include nursing care procedures, safety regulations, human resources policies, departmental policies, and procedures, assuring that quality resident care and an effective operation can be Maintained. Essential Job Functions: 1. With the support of the ED, the Assistant Administrator leads the facility staff in developing and working from a business plan that focuses on all aspects of facility operations, including setting priorities and job assignments. 2. Monitor Human Resources to ensure compliance with employment laws, company policies, and to ensure practices maintain high morale and staff retention, including effective communication, prompt problem resolution, and a proactive work environment. 3. Develop positive relationships on behalf of the company with government regulators, residents, tenants, families, area healthcare providers, physicians, and the community. 4. Manage facility budgets and business practices to include labor costs, payables, and receivables. 5. Ensure a marketing strategy for the facility is developed and implemented that reflects service opportunities, completion, potential market area changes, and maximizes census, payer mix, and ancillary revenues. 6. Support the facility QA committee and ensure compliance with regulations for state of operation. 7. Monitor each department ' s activities, communicate policies, evaluate performance,	F 602		

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F 602	Continued From page 23 provide feedback, assist, and observe, coach and discipline as needed. 8. Develop an environment that allows for creative thinking, problem solving, and empowerment in the development of the facility management team. 9. Oversee and conduct regular rounds to monitor delivery of nursing care, operation of support departments, cleanliness and appearance of the facility, morale of the staff, and ensure resident and tenant needs are being addressed. 10. Exhibit positive customer service both to internal and external customers through the ongoing support and implementation of customer service initiatives and business objectives. 11. Utilize survey and customer satisfaction information to address areas of importance. 12. Ensure consultants and other support resources are appropriately utilized, all staff are appropriately trained, and a high level of interdepartmental teamwork is maintained. 13. Ensure the building and grounds are appropriately maintained and that equipment and work areas are clean, safe, and orderly, and any hazardous conditions are timely addressed. 14. Knowledge and adherence to safety/disaster preparedness plan. 15. In-person attendance is an essential function of this position. 16. All other duties as needed. Code of Conduct: Must adhere to the Company's Code of Conduct policy including documentation and reporting responsibilities. Review of facility provided Nursing Facility Abuse Prevention, Identification, Investigation and	F 602		

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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
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Reporting Policy updated 10/19/22 stated the following:
As members of the Accura team, we all embrace our mission statement "...to be partners in care and family for life." As we strive to deliver on our mission, we will do this by adhering to our values of trust, integrity, accountability, commitment, and kindness.
All Residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms.
1. Exploitation of a dependent adult. "Exploitation" means a caretaker knowingly
obtains, uses, endeavors to obtain to use or who misappropriates a dependent adult's
funds, assets, medications, or property with the intent to temporarily or permanently
deprive a dependent adult of the use, benefit, or possession of the funds, assets,
medication, or property for the benefit of someone other than the dependent adult.
2. "Misappropriation of Resident property" means the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a Resident's belongings or money without the Resident's consent. This includes misappropriation or diversion of resident medications.

Review of facility provided Resident Trust Fund Policy, updated 3/15/24, stated the following:
Resident Shopping: If shopping for a resident, first verify the funds are available and do not go over the available funds. Then the funds need to be withdrawn from the trust account (either by check or debit card). The resident must sign the

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F 602	Continued From page 25 receipt of the items purchased along with the staff member assigned to make the purchase. A receipt must accompany every transaction.	F 602		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interviews, review of the facility's	F 607	1.In continuing compliance with F607 Develop/Implement Abuse/Neglect Policies, Accura Healthcare of Pleasantville corrected the deficiency by ensuring all residents were free from abuse per the Accura Healthcare Abuse Policy. 2.To correct the deficiency and to ensure the problem does not recur, all staff were educated on or by 5/27/2025 by the Regional Director of Operations and/or designee on Accura Healthcare Abuse Policy. The Executive Director and/or designee will audit for compliance 3x/weekly x 4 weeks, then 2x/weekly x 4 weeks, then 1x/weekly x 4 weeks and then PRN 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.	5/27/2025

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abuse investigation, and policy review, the facility failed to take action to prevent further potential concerns by letting an employee with accusations of abuse continue to have contact with residents while the facility conducted an investigation for allegations of abuse. The facility reported a census of 45 residents.

Findings include:

Review of facility provided Abuse Investigation revealed on 12/9/24 at 7:01 PM, Staff I, RN reported to the facility Administrator she had received allegations that Staff R, former Assistant Administrator, had purchased items for herself using Resident #30 and Resident #9 's trust. The facility's Abuse Investigation noted action taken by the facility included investigating the allegation by checking receipts. The credit card was not working at the time of the purchases, checks were used. The documented follow up actions taken by the facility noted when reviewing receipts and resident's room items were accounted for. The credit card was not used for transactions. The items that were supposedly purchased like a queen bed set and brown hair dye were not on the receipt, all hair dyes were accounted for. Checking account transaction statements and photo copies of three partial receipts were provided with the facility 's Abuse Investigation documents. First receipt totaled $573.41 timestamped 11/30/24 at 10:32 PM, the second receipt totaled $124.61 timestamped 12/1/24 at 12:27 PM, and third receipt totalled $514.49 timestamped 12/1/24 at 12:26 PM. Review of the Checking account transactions statement indicated Walmart transaction 12/3/24 for $514.49, Walmart transaction 12/3/24 for $124.61, the transaction for $573.41 was not

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indicated on the transactions statement. The Summary/Conclusion of the investigation revealed the date of incident as 12/9/24, date of the follow up as 12/10/24, person involved as Staff R and nature of incident as possible theft. The facility's Abuse Investigation was signed by the facility Administrator on 12/10/24.

On 5/1/25 at 10:28 AM The facility Administrator stated she was notified at 7:00 PM on 12/9/24 that Staff I, was notified of allegations against Staff R, former Assistant Administrator. Staff R, was scheduled off the next day (12/10/24) and was not placed on suspension due to the investigation being completed at a time she was already out of the facility.

In an interview with Staff R, former Assistant Administrator on 5/6/25 at 9:34 AM, Staff R verbalized her position at the facility as Business Office Administrative Assistant. She started working at the facility May 2022 and left January 2025, resigning due to family reasons. Staff R stated she was aware there was an internal investigation be conducted by the facility Administrator related to purchases for Resident #30 and Resident #9. She was made aware of the investigation when she got to work one morning in early December, but was unable to recall the exact date. Staff R, stated she was not suspended during the investigation and was in the facility, but couldn't have access to residents' trust accounts. She was not able to recall how long the investigation lasted but stated it was not the full day. Staff R revealed, during the investigation she was with the facility Administrator and helped go through the resident's belongings and helped identify the items. Staff R stated the facility Administrator and

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herself went through both Resident's (#30 and #9) and identified all items on the receipts.

Email communication dated 5/7/25 at 11:54 AM, facility Administrator revealed time cards were not available for Staff R for the dates of 12/9/24 and 12/10/24 as Staff R is a salaried employee with discretionary PTO (paid time off) so Staff R does not have clock in or outs and PTO is not logged in our system.

A follow up interview on 5/8/25 at 10:05 AM, Staff R, former Assistant Administrator, stated she was off from work on Monday 12/9/24 but had worked from home due to being ill. On Tuesday 12/10/24 upon returning to work she was made aware of the investigation related to the allegation of items being stolen from residents she had purchased items for. Staff R stated on Tuesday 12/10/24 she assisted the facility Administrator with the investigation by physically pointing out the items that had been purchased compared to the purchase receipts and everything was accounted for.

Review of facility provided Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy, updated 10/19/22, stated the following:
Investigation Protocols: Should an incident or suspected incident of Resident abuse (as defined above) be reported or observed, the administrator or his/her designee will designate a member of management to investigate the alleged incident.
Initial/Immediate Protection During Facility Investigation:
Upon receiving a report of an allegation of resident abuse, neglect, exploitation or mistreatment, the facility shall immediately

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F 607	Continued From page 29 implement measures to prevent further potential abuse of residents from occurring while the facility investigation is in process. If this involves an allegation of abuse by an employee, this will be accomplished by separating the employee accused of abuse from all residents through the following or a combination of the following, if practicable: (1) suspending the employee; (2) segregating the employee by moving the employee to an area of the facility where there will be no contact with any residents of the facility; and in rare instances (3) separating the employee accused of abuse from the resident alleged to have been abused, but allowing the employee to care for and have contact with other residents, only if there is a second employee who remains with and accompanies the employee accused of abuse at all times to supervise all contacts and interactions with the residents.	F 607		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other	F 609	1.In continuing compliance with F609 Reporting of Alleged Violations, Accura Healthcare of Pleasantville corrected the deficiency by ensuring residents #47, #9, and #30 and all like residents will have all allegations of abuse reported timely per the Accura Healthcare Abuse Policy. 2.To correct the deficiency and to ensure the problem does not recur, all staff were educated on 5/27/2025 by the Regional Director of Operations and/or designee on Accura Healthcare Abuse Policy that includes reporting requirements. The Executive Director and/or designee will audit for compliance 3x/ weekly for 4 weeks, 2x/ weekly for 4 weeks then 1x/weekly for 4 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.	5/27/2025

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officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on facility abuse investigation, record review, staff interviews, and policy review, the facility failed to report allegations of abuse to the Iowa Department of Inspections, Appeals and Licensing (DIAL) within 24 hours for 3 of 3 residents reviewed for abuse (Resident #47, #9, and #30). The facility reported a census of 45 residents.

Findings include:

1. The Admission Minimum Data Set (MDS) assessment dated 1/6/25 revealed Resident # 47 had diagnoses of chronic respiratory failure and diabetes. Resident scored a 15 out 15 for the Brief Interview for Mental Status review, which indicated intact cognitive status. The resident indicated the care of personal belongings or things as somewhat important to her.

The Admission Summary Progress Note dated 1/2/25 at 3:33 PM revealed Resident #47 admitted to the facility from the hospital on 1/2/25 and had diagnoses of weakness and urinary tract

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infection. The resident was alert and oriented to person, place, time, and situation, and responded to questions appropriately.

An Inventory Sheet dated 1/2/25 signed by the resident and Director of Nursing (DON) listed the resident's belongings on the form. The inventory sheet lacked a purse or any money.

An Incident Report revealed on 1/5/25 at 10:18 AM, Staff I (Registered Nurse (RN)) was summoned to the resident's room stating Resident #47 was missing $125 from her purse. The resident said she was unsure when she last saw the money. Resident #47 said she had $131 in her purse when she arrived at the facility but she only had $6 left. The Activities Director and the Administrator did a room search on 1/6/25. The Inventory Sheet of belongings reviewed upon admission had no purse listed on the form. Resident #47 admitted from the hospital on 1/2/25. The Administrator attempted to call family. Sheriff's dispatch was called on 1/10/25 at 2:42 PM.

A Sheriff's Office Call for Service Record dated 1/10/25 at 11:01 AM revealed a resident was missing money. The record lacked a resident's name.

A facility's investigation file revealed the Administrator filled out an abuse investigation on 1/8/25 at 1:41 PM for an incident that occurred on 1/5/25 at 10:15 AM. Resident #47 informed Staff I, RN, on Sunday 1/5/25 that she had $125 missing. An investigation was completed. The money was seen while the resident was at the hospital but no money was accounted for upon arrival to the facility. All staff were interviewed

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about whether they saw the resident's purse and money. No staff saw any money in Resident #47's room but staff reported they saw her purse. The purse had not been out of Resident #47's sight. A family member reported she had counted the money before the resident left the hospital.

In an interview 4/30/25 at 11:50 AM, the Sheriff's Department reported the facility staff called for service on 1/10/25 at 11:01 AM about a resident missing money but the caller told them no officer was needed.

In an interview 4/30/25 at 12:54 PM, the Activities Director (AD) reported she inventoried the residents' belongings whenever a resident admitted to the facility. She recorded the items on a paper inventory form including what was in a resident's wallet or purse/ bag, and the form was placed in the paper chart when completed. The AD reported she inventoried belongings for Resident #47 when she admitted to the facility. She did not have a purse at that time. The resident reported missing money a couple days later. The AD stated she was called in and asked about the purse. She didn't see a purse when Resident #47 first came in, but she saw she had a purse a few days later when she went out for an appointment.

In an interview 4/30/25 at 2:25 PM, the Administrator reported Staff I, RN, called her on a Sunday (1/5/25) about missing money. She asked Staff I to look at the inventory sheet to see if Resident #47 came in with a purse. Staff I checked the form and told her no purse was listed on the inventory sheet. The Administrator told Staff I she would look into it the next day. The Administrator reported Resident #47 was

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confused when she admitted to the facility. She spoke with Resident #47 the following day on Monday (1/6/25). The resident reported she only had $6 in her purse. The Administrator asked her how much money she had. The resident said she had $125 but then changed her story on how much she had. The Administrator stated she tried to call the resident's family but the phone number she had did not work. She called the family for following week on a Wednesday after a case manager gave her a different number. The family member told her she counted the money at the hospital and thought the resident had $200 but she was not sure how much money was in the purse. There was a 12-hour gap between the time when the family member counted the money at the hospital and when the resident entered the facility. The purse and money were not listed on the inventory sheet when the resident admitted to the facility. The Administrator stated she reported the missing money to the DIAL after she spoke with the family member, and then she started an investigation. She asked staff that had worked during that timeframe about the resident's purse and money. She also called the police.

In an interview 5/1/25 at 3:47 PM, Staff I, RN, reported Resident #47 reported a missing purse and money when she went into the resident's room. She looked around the room but couldn't find the purse. Staff I stated she couldn't recall the exact date of the incident. She recalled she called the Administrator on the date the resident reported the missing money. Staff I reported an incident report had been filled out.

In an interview on 5/5/25 at 1:10 PM, Resident #47 reported she brought a purse with her when she admitted to the facility and hung the purse on

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the front side of the bed next to the window. She thought it would be safe there. One time she needed to get something out of her purse and placed the purse on the counter by the sink near the door. She found only six $1 bills inside the purse. There were no $20 bills inside her wallet. She had a total of $131 in her wallet that was inside the purse. The resident reported staff inventoried everything she had brought to the facility on the day she entered the facility but they did not inventory her purse or the contents inside her purse. She didn't think staff saw the purse and she had forgotten about it while staff inventoried her things. Resident #47 stated the Administrator came and talked to her the day after she reported the money missing. The Administrator told her she didn't have the purse with her because it wasn't inventoried or listed on the form. The Administrator tried to convince her she was wrong about having the money. Resident #47 didn't want to suspect who took the money. A lot of staff came in and out of her room, and she only left her room for meals and when she took a shower.

During an interview 5/7/25 at 2:40 PM, the Administrator reported she didn't report the resident's missing money to DIAL right away because she wanted to get ahold of the resident's family to verify if the resident had the money.

The Facility's Abuse Prevention, Identification, Investigation and Reporting policy updated on 10/19/22 revealed all Residents had the right to be free from abuse and misappropriation of resident property. All allegations of Resident abuse and misappropriation should be reported immediately to the charge nurse. The charge nurse immediately reported the allegations of

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F 609	Continued From page 35 abuse to the Administrator, or designated representative. All allegations of misappropriation shall be reported to the Iowa Department of Inspections and Appeals, no later than twenty-four (24) hours if the events that caused the allegation involved misappropriation, but did not result in serious bodily injury.	F 609		
	2. Review of facility provided Abuse Investigation revealed on 12/9/24 at 7:01 PM, Staff I, RN reported to the facility Administrator she had received allegations that Staff R, former Assistant Administrator, had purchased items for herself using Resident #30 and Resident #9's trust. The facility's Abuse Investigation noted action taken by the facility included investigating the allegation by checking receipts. The credit card was not working at the time of the purchases, checks were used. The documented follow up actions taken by the facility noted when reviewing receipts and resident's room items were accounted for. The credit card was not used for transactions. The items that were supposedly purchased like a queen bed set and brown hair dye were not on the receipt, all hair dyes were accounted for. Checking account transaction statements and photo copies of three partial receipts were provided with the facility's Abuse Investigation documents. First receipt totaled $573.41 timestamped 11/30/24 at 10:32 PM, the second receipt totaled $124.61 timestamped 12/1/24 at 12:27 PM, and third receipt totaled $514.49 timestamped 12/1/24 at 12:26 PM. Review of the Checking account transactions statement indicated Walmart transaction 12/3/24			

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F 609	Continued From page 36 for $514.49, Walmart transaction 12/3/24 for $124.61, the transaction for $573.41 was not indicated on the transactions statement. The Summary/Conclusion of the investigation revealed the date of incident as 12/9/24, date of the follow up as 12/10/24, person involved as Staff R and nature of incident as possible theft. The facility's Abuse Investigation was signed by the facility Administrator on 12/10/24. On 4/30/25 3:21 PM, Staff Q reported in an interview, on 12/1/24 Staff R, former Assistant Administrator, used Resident #30 and Resident #9's trust to purchase items for both residents. Staff Q, verbalized concerns of purchased items being stolen by Staff R, reporting after Staff R purchased items for Resident #30 and Resident #9, bagged items were brought to the facility and placed under the nurse's desk, no receipt was provided to the CNAs for the purchased items to be checked in by comparing the items to the receipt and no signatures were provided on the receipt to validate purchased items were delivered to both residents. Staff Q also reported these items were still in bags at the nurse's station on 12/20/24. During an interview on 4/30/25 at 5:26 PM, the facility Administrator stated the provided investigation documents are the facility's completed investigation, it was an internal investigation and she did not report the abuse allegations to DIAL. Facility Administrator stated during her investigation, she had independently checked the receipts for Resident #9 (receipt total $124.61 and $573.41) with the items purchased and all items were there. In a follow up interview on 5/1/25 at 10:28 AM	F 609		

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The facility Administrator stated she was notified at 7:00 PM on 12/9/24 that Staff I, was notified of allegations against Staff R, former Assistant Administrator. At the time of the purchases Staff R was doing the spend down for the residents (Resident #30 and Resident #9), she had previously been in the Activities Director position and was familiar with the resident's preferences. The facility Administrator confirmed the residents that were purchased for on 11/30/24 and 12/1/24 were not cognitively able to identify and express their wants and needs. She (facility Administrator) also stated the Police Department was not notified as there was no missing money.

During an interview on 5/8/25 at 8:29 AM, the Clinical Nurse Specialist stated she was not familiar with the incident but would expect the facility to follow the corporate policies and CMS guidelines.

Review of facility provided Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy updated 10/19/22 stated the following:
Reporting:
All allegations of Resident abuse shall be reported to the Iowa Department of Inspections and
Appeals not later than two (2) hours after the allegation is made. All allegations of Resident neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation shall be reported to the Iowa Department of Inspections and Appeals, not later than two (2) hours after the allegation is made, if the events that cause the allegation result in serious bodily injury, or not later than twenty-four (24) hours if the events that cause the allegation involve neglect, exploitation,

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mistreatment, injuries of unknown origin and misappropriation, but do not
result in serious bodily injury. If there is a reasonable suspicion that the allegation of abuse also constitutes a crime committed against the resident by any person, whether or not the alleged perpetrator is employed by the facility, the Elder Justice Act requires the matter must also be reported to law enforcement. While the federal regulations require all abuse allegations be reported to DIA within 2 hours, the Elder Justice Act has a different time frame for reporting to the police/sheriff. If the allegation of abuse (that results from a crime) results in serious bodily injury to a resident, a report must be made to law enforcement not later than two (2) hours after the allegation is made. If the allegation of abuse does not result in serious bodily injury, a report must be made to law enforcement not later than twenty-four (24) hours (See Elder Justice Act requirements on page 9).

Failure to Report:

A person required by this section to report a suspected case of dependent adult abuse who knowingly and willfully fails to do so within twenty-four hours commits a simple misdemeanor. A person required report a suspected case of dependent adult abuse who knowingly fails to do so or who knowingly interferes within the making of such report of applies a requirement that results in such a failure is civilly liable for the damages proximately caused by the failure.

Elder Justice Act:

If the incident prompting the investigation results in serious bodily injury to a resident and there is a reasonable suspicion that the incident was result of a crime committed by any person, whether or not the alleged perpetrator is employed by the

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F 609	Continued From page 39 facility, the Elder Justice Act requires the matter to be reported to law enforcement and DIA within two (2) hours by all persons having knowledge of the matter. "Serious bodily injury" is "an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or requiring surgery, hospitalization, or physical rehabilitation." In the absence of serious bodily injury, but with the reasonable suspicion that a crime has been committed by any person, the matter must be reported to law enforcement and DIA immediately, and in no event, more than 24 hours later, even on weekends and holidays, by all persons having knowledge of the matter. (Note: This does not eliminate the separate legal requirement to report all allegations of abuse to DIA within two (2) hours, even if there is no serious bodily injury).	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 610	1.In continuing compliance with F610 Investigate/Prevent/Correct Alleged Violation, Accura Healthcare of Pleasantville corrected the deficiency by ensuring residents Resident #30 and Resident #9 and all like residents will have all allegations of abuse investigated per the Accura Healthcare Abuse Policy. 2.To correct the deficiency and to ensure the problem does not recur, the Executive Director was educated on 5/7/2025 by the Regional Director of Operations and/or designee on Accura Healthcare Abuse Policy that includes investigation requirements. The Executive Director and/or designee will audit for compliance 3x/weekly x 4 weeks, then 2x/weekly x 4 weeks, then 1x/weekly x 4 weeks, then PRN 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.	5/7/2025

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Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, facility abuse investigation, staff interviews and policy review, the facility failed to provide a thorough investigation into 2 of 2 allegations of misappropriation of resident's (Resident #30 and Resident #9) funds. The facility reported a census of 45 residents.

Findings include:

Review of Resident #30's Minimum Data Set (MDS) dated 4/3/25 revealed a Brief Interview for Mental Status (BIMS) score of 00 indicating severe cognitive impairment and diagnoses of hypertension, Non-Alzheimer's Dementia, Anxiety Disorder, Schizophrenia, and speech disturbances.

Review of Resident #30's Electronic Health Record (EHR) indicated on 4/3/25 Resident #30's height measured 64" (5' 4") and weighed 183.2 pounds on 5/5/25.

Review of Resident #9's MDS dated 3/13/25 revealed a BIMS score of 2 indicating severe cognitive impairment and diagnoses of Renal insufficiency, Hemiplegia, Cerebrovascular Accident, Non-Alzheimer's Dementia, Anxiety Disorder, Depression, and Psychotic Disorder.

Review of facility provided Abuse Investigation revealed on 12/9/24 at 7:01 PM, Staff I, RN reported to the facility Administrator she had received allegations that Staff R, former Assistant

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F 610	Continued From page 41 Administrator, had purchased items for herself using Resident #30 and Resident #9's trust. The facility's Abuse Investigation noted action taken by the facility included investigating the allegation by checking receipts. The credit card was not working at the time of the purchases, checks were used. The documented follow up actions taken by the facility noted when reviewing receipts and resident's room items were accounted for. The credit card was not used for transactions. The items that were supposedly purchased like a queen bed set and brown hair dye were not on the receipt, all hair dyes were accounted for. Checking account transaction statements and photo copies of three partial receipts were provided with the facility's Abuse Investigation documents. First receipt totaled $573.41 timestamped 11/30/24 at 10:32 PM, the second receipt totaled $124.61 timestamped 12/1/24 at 12:27 PM, and third receipt totaled $514.49 timestamped 12/1/24 at 12:26 PM. Review of the Checking account transactions statement indicated Walmart transaction 12/3/24 for $514.49, Walmart transaction 12/3/24 for $124.61, the transaction for $573.41 was not indicated on the transactions statement. The Summary/Conclusion of the investigation revealed the date of incident as 12/9/24, date of the follow up as 12/10/24, person involved as Staff R and nature of incident as possible theft. The facility's Abuse Investigation was signed by the facility Administrator on 12/10/24. During an interview on 4/30/25 at 5:26 PM, the facility Administrator stated the provided investigation documents are the facility's completed investigation, it was an internal investigation and she did not report the abuse allegations to Iowa Department of Inspections	F 610		

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Appeals and Licensing (DIAL). Facility Administrator stated during her investigation, she had independently checked the receipts for Resident #9 (receipt total $124.61 and $573.41) with the items purchased and all items were there.

On 4/30/25 3:21 PM, Staff Q, Certified Nurses Aide (CNA) reported in an interview, on 12/1/24 Staff R, former Assistant Administrator, used Resident #30 and Resident #9's trust to purchase items for both residents. Staff Q, verbalized concerns of purchased items being stolen by Staff R, reporting after Staff R purchased items for Resident #30 and Resident #9, bagged items were brought to the facility and placed under the nurse's desk, no receipt was provided to the CNAs for the purchased items to be checked in by comparing the items to the receipt and no signatures were provided on the receipt to validate purchased items were delivered to both residents. Staff Q also reported these items were still in bags at the nurse's station on 12/20/24.

On 4/30/25, the facility Administrator provided receipts for Resident #30 and Resident #9's purchases that were made on 12/1/24 for $514.49 (Resident #30), 12/1/24 for $124.61 and 11/30/24 for $573.41(Resident #9) The receipts provided were the same copy provided in the facility's Abuse Investigation. The receipts failed to indicate where the purchases had been made (top portion of receipt), unable to identify if all purchased items were shown on copy of the receipts, and the copy of the receipts failed to indicate signatures of purchaser, resident and/or staff to validate items purchased.

On 4/30/25 at 5:05 PM an email was sent to the

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facility Administrator requesting Resident #30 and Resident #9's original receipts for purchase dated 11/30/24 and 12/1/24, indicating where the items were purchased and providing the signatures of the employees and/or Residents verifying the purchased items.

During an interview 4/30/25 at 5:15 PM facility Administrator stated these purchases for Resident #30 and Resident #9 were made as their trust accounts needed to be spent down and she was unaware of where the original receipts were but that she still communicated with Staff R and would try to contact her to see if she knew where the receipts could be located.

On 5/1/25 at 6:51 AM the facility Administrator communicated via email stating, attached to the email were copies of three receipts. With a new office manager, we were not sure where the originals were filed but I went to Walmart last night and they were able to reprint these for me. As per our communication last night, I mentioned we were doing spend downs for residents at this time.

Review of the facility provided, re-printed receipts from Walmart, revealed all purchased items were legible and Staff R, former Assistant Administrator's, authorization signature from time of electronic purchase were on the receipts.

In a follow up interview on 5/1/25 at 10:28 AM The facility Administrator stated she was notified at 7:00 PM on 12/9/24 that Staff I, was notified of allegations against Staff R, former Assistant Administrator. At the time of the purchases Staff R was doing the spend down for the residents (Resident #30 and Resident #9), she had

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previously been in the Activities Director position and was familiar with the resident's preferences. The facility Administrator confirmed the residents that were purchased for on 11/30/24 and 12/1/24 were not cognitively able to identify and express their wants and needs. She (facility Administrator) also stated the Police Department was not notified as there was no missing money.

A follow up Interview 5/6/25 at 10:05 AM, facility Administrator stated while conducting the facility's Abuse Investigation she could not recall interviewing staff members related to the purchased items for Resident #30 or Resident #9. She stated when she conducted the investigation she reviewed all three receipts finding all the purchased items comparing them to the receipts independently without the help of any staff members. During the follow up interview, at 10:08 AM, the facility Administrator's personnel cell phone (sitting face up on her desk) started ringing with Staff R's name showing on the screen, but the facility Administrator declined the call and continued with the interview.

In a confidential staff interview on 5/1/25 at 9:37 AM, staff member verbalizes being aware of the facility's investigation related to Resident #30's and Resident #9's purchased items. Staff member stated the Walmart bags with resident's items sat at the nurse's station for weeks. Staff member stated, CNAs and nurses had asked multiple times for the receipts so the items could be given to the residents they were purchased for. Staff member verbalizes frustration with administrative staff due to the investigation being "completed" but the items that were part of the investigation were still in the Walmart bags under the desk at the nurse's station. Staff member was

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able to provide a picture on her phone that showed approximately 3-5 Walmart bags with items that appear to be clothes in them under the desk at the nurse's station. Staff member was able to show a time stamped date and time picture was taken revealing 12/13/24 at 10:04 PM.

In an interview with Staff R, former Assistant Administrator on 5/6/25 at 9:34 AM, Staff R verbalized her position at the facility as Business Office Administrative Assistant. She started working at the facility May 2022 and left January 2025, resigning due to family reasons. Staff R stated she was aware there was an internal investigation being conducted by the facility Administrator related to purchases for Resident #30 and Resident #9. She was made aware of the investigation when she got to work one morning in early December, but was unable to recall the exact date. Staff R, stated she was not suspended during the investigation and was in the facility, but couldn't have access to resident's trust accounts. She was not able to recall how long the investigation lasted but stated it was not the full day. Staff R revealed, during the investigation she was with the facility Administrator and helped go through the resident's belongings and helped identify the items. Staff R stated the facility Administrator and herself went through both Resident's (#30 and #9) and identified all items on the receipts.

On 5/1/24 the provided re-printed receipts were uploaded by transaction number onto the Walmart website identifying the specific items, quantity, colors, and sizes purchased.

Review of purchases on Resident #30's receipt

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totaling $514.49 revealed discrepancies in clothing sizes. Items of discrepancy included the following:
1. Joyspun Women's and Women's Plus Plush Sleep Jogger Pants (gray,pink plaid, size Small)
2. Joyspun Women's Hacci Knit Jogger Sleep Pants, 29" inseam (pink, blue, yellow plaid, size Medium)
3. Joyspun Women's Hacci Knit Jogger Sleep Pants, 29" (red, green, white plaid, size Small)
4. Joyspun Women's Velour Notch Collar Top and Pants Pajama Set, 2-piece (gray, pink plaid, size Medium)
5. Reebok Women's and Women's Plus After Class Crewneck Sweatshirt (black, size Medium)
6. Reebok Women's and Women's Plus After Class Joggers (black, size Medium)
7. Reebok Women's and Women's Plus After Class Crewneck Sweatshirt (blue, size Large)
8. Reebok Women's and Women's Plus After Class Joggers (white, size XSmall)

During an interview on 5/5/25 at 1:24 PM Staff M, CNA stated she works with Resident #30 often and is familiar with her cares and needs. Resident #30 does walk with a walker and is confused most of the time. Staff M, CNA states she often assists Resident #30 with her showers and daily cares like getting dressed or changing her clothes. Staff M, CNA stated Resident #30's clothes are sized XL's and there might be a few random 2XL.

During an interview on 5/5/25 at 1:43 PM Staff S, CMA stated Resident #30 wears sizes XL or 2XL.

During an interview on 5/5/25 at 1:42 PM, Staff K, CNA stated she had worked at the facility on and off for the past 10 years and knows the residents

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F 610	Continued From page 47 very well. Staff K, CNA stated Resident #30 is a bit bigger on top and wears Xl-XXL size clothes. Review of purchases on Resident #9's receipt totaling $124.61 revealed discrepancies in items purchased and documented findings by the facility Administrator's internal Abuse Investigation. Discrepancies include the following items: 1. Color oops Extra Strength Hair Color Remover $10.47 2. Garnier Nutrisse Nourishing Hair Color Creme, 061 Light Ash Brown Mochaccino $8.47 3. Garnier Nutrisse Nourishing Hair Color Creme, 42 Deep Burgundy Black Cherry $5.50 Discrepancies in items Resident #9's receipt totaling $573.41 included following items: 1. Splat Original Complete kit, Unisex Semi-Permanent Hair Dye with bleach, Lusty Lavender $9.77 2. Splat Original Complete kit, Unisex Semi-Permanent Hair Dye with bleach, Pink Fetish $9.77 Indicating a total of five boxes of hair color or treatment were purchased, color remover, light ash brown mochaccino, deep burgundy black cherry, purple (lavender) and pink. In an interview on 5/6/25 at 10:30 AM, facility Administrator stated she did not recall interviewing staff related to the allegations while conducting the facility's abuse investigation. She (Administrator) stated she had reviewed all 3 receipts and found the items independently without the help of any staff members. The Administrator continued by stating when Staff I called and reported the allegation to her, Staff I asked to please specifically look for brown hair dye and queen bedding and the items were found	F 610		

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when inventoried. Found items included 4 total boxes, three boxes were colored including pink, purple, and black cherry. The fourth box was a color toner. The Queen bedding set was found in Resident #9's closet.

A follow up interview on 5/8/25 at 10:05 AM, Staff R, former Assistant Administrator, stated for the purchases made on 11/30/24 and 12/1/24, she had been designated to purchase items for residents as she had prior experience doing this in the Activities Director position and she had been notified by the Corporate Office of the residents that needed their trust account spent down. The Activities Director at that time had been hired, but had not started in her position yet. Staff R stated the process for purchasing items for residents was first to verify the funds are available, then go purchase the requested items. When purchasing for more than one resident the items need to be kept separate and paid for individually by the resident. At the time of these purchases the debit card had not been working, so Staff R returned to the facility to get the facility checkbook. After the items are purchased, the items are labelled with the resident's initials then the CNAs would assist with inventorying and putting the resident's items away. Staff R would keep the copies of the purchase receipts and post the charges to the resident's account. Staff R was able to recall she had shopped for Resident #30 and Resident #9 on Saturday 11/30/24 and Sunday 12/1/24. Staff R verified the re-printed receipts provided by the facility Administrator, indicating the electronic signature on the receipt was hers. Staff R recalled purchasing bedding, blankets, throws, night gowns, pajama sets, pants, and tops for the residents. She stated the sizes for Resident #30

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F 610	Continued From page 49 and Resident #9 ranged from Large to XXL. After the items were purchased Staff R stated she had gone back home leaving the items in the trunk of her car. When she returned to work on Monday (12/2/24) the purchased items were brought into the facility. Staff R stated she had labelled the plastic bags with the resident's initials and delivered them to the nurse's stations. She stated not being able to recall the number of bags she had brought into the facility. Staff R, acknowledged the provided picture of the Walmart bagged items at the nurse's station, stating the items in the bag appeared to be the same color schemes of the items she had purchased for Resident #30 and Resident #9. Staff R stated she was off from work on Monday 12/9/24 but had worked from home due to being ill. On Tuesday 12/10/24 upon returning to work she was made aware of the investigation related to the allegation of items being stolen from residents she had purchased items for. Staff R stated on Tuesday 12/10/24 she assisted the facility Administrator with the investigation by physically pointing out the items that had been purchased compared to the purchase receipts and everything was accounted for. Staff R reviewed and verified the Walmart documents that indicated the items purchased with pictures, descriptions, quantity, sizes and prices. When reviewing the sizes of the items purchased, Staff R could not recall what size items she had purchased and stated she was not sure why there would have been the smaller sizes. During an interview on 5/8/25 at 8:29 AM, the Clinical Nurse Specialist stated she was not familiar with the incident but would expect the facility to follow the corporate policies and CMS guidelines.	F 610		

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F 610	Continued From page 50 Review of facility provided Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy, updated 10/19/22, stated the following: Investigation Protocols Should an incident or suspected incident of Resident abuse (as defined above) be reported or observed, the administrator or his/her designee will designate a member of management to investigate the alleged incident. The administrator or designee will complete documentation of the allegation of Resident abuse and collect any supporting documents relative to the alleged incident. a) Review documentation in resident record (including review of assessment if resident injury). b) Assess the resident for injury if the allegation involves physical or sexual abuse; c) Provide proper notifications to primary care provider, responsible party, etc. d) Attempt to obtain witness statements (oral and/or written) from all known witnesses e) If there is physical evidence that can be preserved, attempt to do so, and maintain in a safe location to minimize risk of evidence being tampered with. The facility will establish and enforce an environment that encourages individuals to report allegations of abuse without fear of recrimination or intimidation. Following investigation, the Administrator or designated agent will be responsible for forwarding the results of the investigation to the Department of Inspections & Appeals. This written report shall be forwarded to the Department within five days of the initial report.	F 610		

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F 641	Continued From page 51	F 641		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and policy review, the facility failed to accurately complete a resident's Minimum Data Set (MDS) assessment by not coding Hospice services and diagnosis of Dementia for 1 of 19 Residents reviewed in the sample (Residents #26). The	F 641	1.In continuing compliance with F641 Accuracy of Assessments, Accura Healthcare of Pleasantville corrected the deficiency by resubmitting residents #26's MDS, and auditing all like residents to ensure they're properly coded for dementia and hospice care on 5/1/2025. 2.To correct the deficiency and to ensure the problem does not recur, the MDS coordinator was educated on 5/2/2025 by the Regional Nurse Specialist and/or designee on coding the MDS with accuracy. The Director of Nursing and/or designee will audit for compliance 1x/ weekly x 12 weeks, and then PRN 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.	5/2/2025

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facility reported a census of 45 residents.

Findings include:

Review of Resident #26's Census Report revealed Resident #26's admission to the facility on 9/4/24 and hospice level of care on 11/8/24.

Review of Resident #26's Hospice Admission Plan dated 11/8/24 revealed admission to Hospice services with a diagnosis. of Dementia.

Review of Resident #26 Significant Change MDS dated 11/18/25, revealed BIMS of 00, indicating severe cognitive impairment. The MDS section for special treatments, procedures, and programs indicated Hospice Level of care and active diagnoses including; Atrial Fibrillation, Heart Failure, Hypertension, Stage 4 Chronic Kidney disease, Diabetes Mellitus, Macular Degeneration, and Depression.

Review of Resident #26's Quarterly MDS dated 1/23/25 revealed, Staff Assessment for Mental Status score of 2, indicating moderate impairment (poor decisions, cue/supervision required). Active diagnoses included; Atrial Fibrillation, Heart Failure, Hypertension, Stage 4 Chronic Kidney disease, Diabetes Mellitus, Macular Degeneration, and Depression. The MDS section for special treatments, procedures and programs indicated none of the above.

Review of Resident #26's Quarterly MDS dated 3/20/25 revealed, BIMS of 99, indicating Resident #26 was unable to complete the assessment due to severe cognitive impairment. Active diagnoses included; Atrial Fibrillation, Heart Failure, Hypertension, Stage 4 Chronic Kidney disease,

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Diabetes Mellitus, Macular Degeneration, and Depression. The MDS section for special treatments, procedures and programs indicated none of the above.

During an interview on 5/1/25 at 5:25 PM the Clinical Nurse Specialist acknowledged inaccuracies in the Significant Change MDS, Quarterly MDS dated 1/23/25 and Quarterly MDS dated 3/20/25.

During an interview on 5/07/25 at 10:20 AM, MDS Coordinator revealed she no longer worked at the facility. She started on 1/18/25 and left on 5/4/25. MDS Coordinator stated she had just started doing the MDS assessments, the regional nurse had been doing them prior and was training her. The previous MDS Coordinator started at the facility on 1/16/25 and left. MDS Coordinator stated she had been hired for a different position but after the previous MDS coordinator left she was moved into the MDS position MDS Coordinator stated Resident's Care Plans should be updated as needed, such as if there's new transfer status, falls, hospice services, and new interventions added. The MDS Coordinator stated the Regional Director of Operations had tried to keep up on the Care Plans, but they were not up to date as she (MDS Coordinator) would have expected. She (MDS Coordinator) asked nurses and nurse managers to let her know of things that needed to be updated, she continued by stating, the facility would let anyone go in and put things on the Care Plans, not best practice, but that's how they did it there. MDS Coordinator stated when she took over the Care Plans and MDS, she realized how much trouble they were in, Care Plans were not updated, MDS's were not accurate. Corporate was aware for a long time

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F 641	Continued From page 54 and anticipated they would receive tags. Review of Facility provide policy; Conducting an Accurate Resident Assessment, updated April 2025 Stated the purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident status at the time of the assessment, by staff qualified to assess relevant care areas.	F 641		
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). (iii) 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.	F 656	1.In continuing compliance with F656 Develop/Implement Comprehensive Care Plan, Accura Healthcare of Pleasantville corrected the deficiency by revising residents #26 and 37's care plans to include skin and hospice specific care plans as well as auditing all like residents to ensure they are accurately care planned for skin related treatments and hospice services on 5/8/25. 2.To correct the deficiency and to ensure the problem does not recur, the MDS coordinator was educated on 5/5/025 by the Executive Director and/or designee on completing comprehensive, individualized care plans timely. The Director of Nursing and/or designee will audit for compliance 3x/weekly x 4 weeks, then 2x/weekly x 4 weeks, then 1x/weekly x 4 weeks, and then PRN 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.	5/8/2025

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F 656	Continued From page 55 (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and policy review the facility failed to develop a comprehensive care plan for 2 of 19 residents reviewed for care plans (Resident #26 and #37). The facility reported a census of 45 residents. Findings include: 1. The Quarterly Minimum Data Set (MDS) assessment dated 3/20/25 revealed Resident #37 had diagnosis of diabetes. The MDS revealed the resident had no skin issues. The Care Plan revised on 10/30/24 revealed the resident had a potential for pressure ulcer development related to decreased mobility and incontinence. The Care Plan lacked information about a sore on top of the resident's head or information that pertained to a history of skin	F 656		

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cancer or a chronic skin condition.

The Progress Notes revealed:
a. On 10/9/24 at 12:33 PM (Admission summary) included documentation as follows; resident admitted to the facility. Skin normal.
b. On 1/9/25 at 9:16 PM and 3/20/25 at 7:24 PM, a dietary note documented the resident had a history of skin cancer.
c. On 3/20/25 at 1:18 PM, (Quarterly Nursing Assessment) skin condition dry and had no abnormal skin coloring.
d. On 5/6/25 at 12:08 PM, resident complaining again that the top of his head was hurting. Dermatology appointment set up for 5/15/25 at 1:10 PM.
e. On 5/6/25 at 12:00 PM, a late entry created on 5/7/25 at 3:02 PM (after the surveyor spoke with the DON), revealed a 0.75-centimeter (cm) x 0.75 cm x 0 cm mole to the top of the resident's head today is inflamed and tender to touch. Area is intact with brown mole coloring. No active drainage. The resident reported he's had the mole for "4 or 5 years", and it was previously removed before admission to the facility.

In an interview 4/28/25 at 2:28 PM, Resident #37 reported he had a sore on top of his head. The area came and went over the past 4-5 years. He saw a physician and got the area frozen a couple of times but the area had come back. He mentioned to a physician who saw him at the facility. The physician said he needed to see a dermatologist. The resident stated he had put Vicks on the sore on top of his head to help the pain.

In a follow up interview on 5/1/25 at 9:38 AM, Resident #37 reported he told two physicians

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F 656	Continued From page 57 about the area on his head. They looked at if but that's as far as it went. He also spoke with nurse a month ago about it. She mentioned something about him going to see a dermatologist. He just hoped it was not cancer. In an interview 5/6/25 at 9:47 AM, Staff D, LPN, reported the MDS nurse, DON, and ADON completed the residents' Care Plan. Staff D reported Resident #37 had a skin area on his head removed before he came to the facility. The nurse put triple antibiotic (ATB) ointment or skin prep and a Band-Aid on the area whenever the area flared up. Staff D reported the physician saw the area but there had not been a referral to a dermatologist since the resident had been there. She checked the area and documented a progress note if she saw it looked more irritated. The resident was able to tell staff when it bothered him. In an interview 5/6/25 at 11:30 AM, the DON, reported Resident #37 had a chronic skin area on the top of his head for quite a while. She didn't think there had been any changes to the area since she had worked at the facility. Staff had let the physician know about the area and they had tried different treatments. The area had remained the same after the treatments were done. In an interview 5/7/25 at 10:20 AM, the MDS nurse reported the resident's care plan were updated whenever needed. The MDS nurse reported if a resident had a skin issue or wound, it should be included on the care plan along with the interventions. The MDS nurse reported she spoke with staff about the things that needed to be added to the care plan. The MDS nurse	F 656		

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F 656	Continued From page 58 reported the residents' care plans were not updated as they should be. In an interview 5/8/25 at 1:30 PM, Staff D, LPN, she set up a dermatology appointment for Resident #37 the other day after she spoke with the surveyor. She spoke with the resident and then called the resident's family to inquire about the dermatologist he had seen previously. 2. Review of Resident #26's Significant Change MDS dated 11/18/25, revealed BIMS of 00, which indicated severe cognitive impairment. The MDS indicated Hospice Level of care with active diagnoses including; Atrial Fibrillation, Heart Failure, Hypertension, Stage 4 Chronic Kidney disease, Diabetes Mellitus, Macular Degeneration, and Depression. Review of Resident #26's Census Report indicated Hospice care started on 11/8/24. Review Resident #26's paper chart included a signed Physicians order, dated 11/8/24, for Hospice services to evaluate and treat Resident #26. Review of Resident #26's Hospice Admission Plan dated 11/8/25 indicated diagnosis of Dementia and Senile Degeneration of the brain with Hospice services for end of life care. Review of Resident #26's paper chart included a signed Physician's order dated 3/20/25, requesting a signed order to admit Resident #26 to Hospice as of 11/18/24.	F 656		

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F 656	Continued From page 59	F 656		

Review of Resident #26's Care Plan revealed on 3/24/25 (date initiated) Resident #26 is on Hospice level of care.

During an interview on 5/1/25 at 5:25 PM, the Clinical Nurse Specialist acknowledged the discrepancy in physician order dates, hospice admission date, significant change MDS, and failure to update Resident #26's Care Plan in a timely manner.

During an interview on 5/07/25 at 10:20 AM, MDS Coordinator revealed she no longer worked at the facility. She started on 1/18/25 and left on 5/4/25. MDS Coordinator stated she had just started doing the MDS assessments, the regional nurse had been doing them prior and was training her. The previous MDS Coordinator started at the facility on 1/16/25 and left. MDS Coordinator stated she had been hired for a different position but after the previous MDS coordinator left she was moved into the MDS position. MDS Coordinator stated Resident's Care Plans should be updated as needed, such as if there's new transfer status, falls, hospice services, and new interventions added. The MDS Coordinator stated the Regional Director of Operations had tried to keep up on the Care Plans, but they were not up to date as she (MDS Coordinator) would have expected. She (MDS Coordinator) asked nurses and nurse managers to let her know of things that needed to be updated, she continued by stating, the facility would let anyone go in and put things on the Care Plans, not best practice, but that's how they did it there. MDS Coordinator stated when she took over the Care Plans and MDS, she realized how much trouble they were in, Care Plans were not updated, MDS's were not accurate. Corporate was aware for a long time

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F 656	Continued From page 60	F 656		

Continued From page 60
and anticipated they would receive tags.

Review of facility provided Comprehensive Care Plans Policy, updated April 2025, revealed the following:
It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial need and ALL services that are identified in the resident's comprehensive assessment (MDS) and meet professional standards of quality.

1. The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. All services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality and incorporate culturally competent and trauma-informed care as indicated.

2. The comprehensive Care Plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAA's) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record.

3. Comprehensive care plan will describe, at a minimum, the following:

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F 656	Continued From page 61 a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. b. Any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse the treatment. 4. A comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the 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.	F 657	1.In continuing compliance with F657 Care Plan Timing and Revision, Accura Healthcare of Pleasantville corrected the deficiency by having a care conference for resident #33 on 5/28/25, as well as auditing all like residents to ensure they've had a quarterly care conference on 5/8/2025. 2.To correct the deficiency and to ensure the problem does not recur, the MDS coordinator was educated on 5/2/2025 by the Executive Director and/or designee to plan, implement, and perform care conferences with each quarterly and significant change MDS. The Director of Nursing and/or designee will audit for compliance 1x/weekly x 12 weeks, and then PRN 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.	5/28/2025

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(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on record review, resident and staff interview, the facility failed to ensure care conferences held at least quarterly for one of one residents reviewed for care conferences (Resident #33) and failed to document follow up on the concerns addressed. The facility reported a census of 45 residents.

Findings include:

The Admission Minimum Data Set (MDS) assessment dated 7/25/24 revealed Resident #33 had diagnosis of depression. The MDS recorded the resident had a Brief Interview for Mental Status score of 15 indicating intact cognition. The MDS indicated having family or a close friend involved in discussions about his care as very important.

The electronic health record (EHR) revealed a Care Conference Meeting /Attendance note dated 10/24/24. Two family members attended, and as well as the resident.

The EHR and paper chart lacked documentation of the care conferences held between 11/2024 - 4/30/25.

In an interview 4/28/25 at 1:15 PM, the resident reported he had gone to a care conference meeting in the past several months but he felt it did not do any good to go to the Care Conference because nothing got done about the concerns or

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anything he mentioned. The resident reported the Administrator told him it took time to address things.

In an email on 5/5/25 at 11:55 AM, the Administrator wrote that care conference notes were completed on paper. The Surveyor then requested the care conference notes for Resident #33. At 12:27 PM, the Administrator reported no Care Conference notes found for Resident #33.

In an interview 5/6/25 at 9:47 AM, Staff D, Licensed Practical Nurse, reported the MDS nurse set up the Care Conference meetings.

In an interview 5/7/25 at 10:20 AM, the MDS nurse reported she had worked at the facility 1/18/25 to 5/4/25. No care conferences were held during the time she worked at the facility but she was in the process of working on getting the care conferences set up.

In an interview 5/7/25 at 2:40 PM, the Administrator confirmed no policy for care conferences. The Administrator reported they were trying to get on track for care conference meetings when the MDS nurse came on board. The Administrator reported she had a plan to catch up on the care conferences. The Administrator reported Care Conferences should be held quarterly.

In an interview 5/7/25 at 2:45 PM, the Regional Clinical Director reported the MDS nurse arranged care conference but the MDS nurse had resigned. The Regional Clinical Director reported no Care Conference records or documentation found, including paper sheets.

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F 684	Continued From page 64	F 684		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, resident and staff interviews, the facility failed to complete an assessment and provide an intervention for 3 of 3 residents (Resident #12, #26 and #37). Resident #12 acquired a puncture wound to his right lower calf from a broken wheelchair and the nurse failed to make an assessment 12 or more hours after a CNA reported the incident. The facility failed to monitor Resident #26 after obtaining a burn. The facility reported a census of 47 residents Findings include: 1. The Minimum Data Set (MDS) dated 4/17/25 for Resident #12 revealed a diagnoses of heart failure, renal insufficiency, diabetes mellitus, identified limited range of motion to both lower extremities and inability to walk 10 feet. The MDS failed to identify the use of a wheelchair as a mobility device. The MDS identified a risk for developing pressure ulcers or injuries of the skin and identified two venous/arterial ulcers present on the lower legs which required an application of nonsurgical dressings. The brief interview for	F 684	1.In continuing compliance with F684 Quality of Care, Accura Healthcare of Pleasantville corrected the deficiency by performing skin integrity assessments on residents #12, #26, and #37 as well as all like residents by 5/9/25. 2.To correct the deficiency and to ensure the problem does not recur, all nurses were educated on 5/9/25 by the DON and/or designee on completing resident assessments, interventions, and documentation appropriately. The Director of Nursing and/or designee will audit for compliance 3x/weekly x 4 weeks, then 2x/weekly x 4 weeks, then 1x/weekly x 4 weeks, and then PRN 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.	5/9/2025

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mental status (BIMS) listed a score of 15 which indicated an intact cognition.

Care Plan dated 4/11/25 for Resident #12 instructed staff to monitor skin with cares and alert the nurse of any red/open areas so the nurse can notify the physician.

During an observation on 4/28/25 on 1:12 PM Resident #12 had bloody drainage on the wrap to the right leg that came from a small puncture wound to the back of his calf.

During an interview on 4/28/29 at 1:12 PM Resident #12 stated when he returned from his appointment that morning, a screw on his wheelchair punctured the back of his leg. Resident #12 stated he had informed staff of the injury but no one had assessed it or fixed the wheelchair yet.

During an observation on 4/29/25 at 9:10 AM, the dressing to Resident #12's right lower leg had dried drainage and fresh bloody drainage on the upper posterior calf.

During an interview on 4/29/25 at 9:10 AM Resident #12 stated the nurse did not come yesterday to assess the puncture from the wheelchair. Resident #12 stated the dressing normally was changed every three days it would be completed by the night nurse.

On 4/29/25 at 9:12 AM, the Department of Inspection, Appeals and Licensing Surveyor questioned the Assistant Director of Nursing (ADON) about the puncture wound to the back of Resident #12's right calf and the ADON stated the dressings to his lower legs get changed every

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F 684	Continued From page 66 three days and she was not aware of an injury to his right lower leg that was draining. During an interview on 4/29/25 at 9:17 AM, Staff P, Licensed Practical Nurse (LPN) stated the dressing order for Resident #12's lower legs was change on evening shift every three days and she was not aware that there was an injury from a wheelchair yesterday. Staff P stated the Certified Nursing Assistant (CNA) did not inform her. During an observation on 4/29/25 at 11:32 AM, the Director of Nursing (DON) assessed Resident #12's Right calf and received an order for a treatment. ADON assisted the DON to take measurements of the puncture wound. The dressing to Resident #12's right lower leg was saturated with drainage and was removed. The DON measured a small puncture wound to the back-lateral side of lower right leg .75 x .5 cm with dark colored skin (bruise) around it and cleaned with wound cleanser and had applied a large Telfa dressing. During an interview on 4/29/25 at 11:34 AM, the Assistant Director of Nursing (ADON) stated the maintenance director got the w/c pin replaced to the right pedal as that was why the wheelchair injured Resident #12's right leg. During an interview on 4/30/25 at 2:22 PM, Staff L, Certified Nursing Assistant (CNA) stated on 4/28/25 at 4 PM when he was administering Resident #12's medications, had noticed the dressing to Resident #12's right leg was saturated with blood and serum. Staff L stated he had informed Staff P, Licensed Practical Nurse (LPN). Staff L stated Resident #12 did not complain of pain, administered scheduled Tylenol.	F 684		

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A document titled Non-Ulcer Skin Assessment that identified a puncture wound to Resident #12's right upper lateral calf that measured .75 centimeters (cm) long, .5 cm wide and a depth of 0.1 cm with small serosanguinous (serous fluid and blood) drainage from the wound. The assessment revealed the physician and family was notified on 4/29/25 and an order for zinc oxide, gauze pad and a wrap was applied. The document was signed by the Director of Nursing.

A document titled New Skin Area dated 4/29/25 at 10:30 AM for Resident #12 revealed the resident related his right upper lateral aspect of his calf got poked by a broken piece on his wheelchair pedal. Resident had a .75 cm x .5 cm x .1 cm puncture that was draining clear fluid and saturated his Unna boot. Immediate action taken was that the maintenance repaired the broken piece, area assessed and orders received for treatment. The predisposing environmental factors was a malfunctioning of equipment.

The physician order dated 4/29/25 directed staff to clean the puncture wound to Resident #12's right upper lateral aspect calf with wound cleanser, apply zinc oxide, ABD pad, and gauze roll on top, two times a day for wound care and as needed for soiling.

During an interview on 4/29/25 at 1:37 PM, the Maintenance Director stated the Director of Nursing (DON) notified him today that Resident #12 had a problem with his wheelchair and had punctured his leg on it 4/28/25. The hinge pin to the right foot rest was completely missing and he didn't have one to replace it. The Maintenance Director stated someone had replaced the top pin

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with a bolt with a lock nut on it so he removed the bolt and turned it upside down to turn the tread down and put a bolt in the bottom side turned up so the treads were facing together inside the bracket. The Maintenance Director stated the one bolt in the top of the foot rest caused the locking lever to turn up when opened. The Maintenance Director stated he made sure the locking lever will not swing up and hurt Resident #12. The Maintenance Director stated he had not received a work order for that wheelchair and would expect that if there was an injury due to a piece of equipment then he would want the staff to call him immediately or as soon as he arrived the next business day.

During an interview on 4/29/25 at 12:10 PM, the DON stated the expectation of a new wound assessment was that whomever took the report of an injury would tell the nurse and the nurse would then make an assessment, call the physician, fill out a skin sheet and a risk management form.

2. Review of Resident #26 Quarterly MDS dated 3/20/25, revealed BIMS of 99, indicating Resident #26 was unable to complete the assessment due to severe cognitive impairment. Active diagnoses included Heart Failure, Hypertension, Diabetes Mellitus, Macular Degeneration, and Depression. MDS indicated Resident #26 is able to eat independently.

Review of Resident #26's Care Plan, revision on 3/20/25, indicated risk of visual impairment related to Macular Degeneration with interventions to assess Resident #26's ability to function within limits of visual impairment and communicate where belongings are located. Care

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F 684	Continued From page 69 Plan also indicated, initiated date 8/30/24 Resident #26 had an ADL self-care performance deficit related to confusion with interventions including Resident #26 needing supervision at meals, such as assuring coffee cups have lids and the temperature of the coffee is checked. Review of electronic Health Status Progress Note dated 2/28/25 stated CNA reported Resident #26 spilled hot coffee on her chest. No redness or pain noted to the area. Faxed physician to notify, placed on Hot Chart (nursing charting system, focusing on documentation of resident's condition and progress) to monitor, representative notified. Review of Resident #26's paper chart revealed, faxed document to Resident #26's Physician dated 2/28/25, indicated Resident #26 spilled coffee on her chest this morning, no redness or pain from incident. Will monitor area. Resident #26's Physician responded on 3/6/25, noting the incident and requesting notification of any skin issues that occur. On 3/6/25 an RN signed the form indicating receiving Physicians response and direction. On 3/9/25 a second RN signed the form indicating second check and review of Physicians response. Review of electronic Health Status Progress Note dated 3/6/25 stated Resident #26's Physician noted the coffee incident on 2/28/25. Review of facility provided Incident Report dated 2/28/25 revealed, CNA reported Resident #26 spilled hot coffee on her chest. No redness or pain noted to the area. Resident #26's Physician was faxed and Resident #26 was placed on the Hot Chart to monitor. Mental Status indicated Resident #26 oriented to self, with confusion,	F 684		

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impaired memory, weakness, and contributing diagnoses of 20/20 vision with correction. Incident Report Notes included on 2/28/25 Kitchen Manager to assure Resident #26's coffee cup has a lid and temperature of the coffee will be checked.

Further review of Resident #26's Electronic Health Records (EHR) and paper chart failed to indicate nursing documentation or Hot Charting of assessments and/or monitoring of Resident #26's skin conditions in the area where the hot coffee had spilled.

During an interview on 4/30/25 at 9:51 AM, DON revealed, Hot Charts are noted electronically in Point Click Care (PCC, Electronic Health Record), the process and expectation is that nurses monitor and assess the Hot Chart concerns and document these assessments and finding in a Nursing Progress Note in PCC.

During an interview on 4/30/25 02:51 PM, Staff D, LPN showed this surveyor where Hot Charting is located in PCC. Stuff D, LPN stated when monitoring a resident that is listed on the Hot Chart, the nurse will document the resident's assessments and findings as a Nursing Progress Note in PCC or if the resident is Skilled Level of Care (LOC) it would be documented with the Skilled assessment.

On 05/05/25 12:05 PM, the Facility Administrator provided a copy of Resident #26's Incident Report for the coffee spill on 2/28/25 and stated the Incident Report was the only documentation available, acknowledging if assessments and monitoring for Resident #26 had been completed; they were not documented.

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In an Email on 5/7/25 at 1:25 PM, the Administrator communicated the Facility did not have policies for Resident Assessments or Nursing documentation.
3. The Quarterly MDS assessment dated 3/20/25 revealed Resident #37 had diagnosis of diabetes. The MDS revealed the resident had no skin issues.

The Care Plan revised on 10/30/24 revealed the resident had a potential for pressure ulcer development related to decreased mobility and incontinence. The Care Plan lacked information about a sore on the top of Resident #37's head or information that pertained to a history of skin cancer or a chronic skin condition.

The electronic health record assessments list lacked skin assessments.

The Progress Notes revealed:
a. On 10/9/24 at 12:33 PM (Admission Summary), resident admitted to the facility. Skin normal.
b. On 1/9/25 at 9:16 PM and 3/20/25 at 7:24 PM, a dietary note documented the resident had a history of skin cancer.
c. On 3/20/25 at 1:18 PM (Quarterly Nursing Assessment), skin condition dry and had no abnormal skin coloring.
d. On 5/6/25 at 12:08 PM, resident complained again that the top of his head was hurting. Dermatology appointment set up for 5/15/25.
e. On 5/6/25 at 12:00 PM, a late entry created on 5/7/25 at 3:02 PM (after the surveyor spoke with the DON), revealed a 0.75-centimeter (cm) x 0.75 cm x 0 cm mole to the top of the resident's head is inflamed and tender to touch. Area is intact with

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brown mole coloring. No active drainage. The resident reported he's had the mole for "4 or 5 years" and it was previously removed before admission to the facility.

The paper Shower sheets dated 4/2/25, 4/8/25, 4/11/25, 4/15/25, 4/18/25, 4/22/25, 4/25/25 revealed no skin concerns.

The Non-Pressure Skin Assessments located in the paper chart revealed no information about a skin mole or sore on the top of the resident's head.

Incident Reports reviewed 1/1/25 to 4/27/25 revealed no incident reports regarding any skin conditions or sore on the resident's head.

The Order Summary dated 4/1/25 revealed no referral for dermatology listed.

In an interview 4/28/25 at 2:28 PM, Resident #37 reported he had a sore on top of his head. The area came and went over the past 4-5 years. He saw a physician and got the area frozen a couple of times but the area came back. He mentioned a concern about the area to a physician that saw him at the facility. The physician said he needed to see a dermatologist. The resident stated he put Vicks over the sore to help the pain.

In a follow up interview on 5/1/25 at 9:38 AM, Resident #37 reported he told two physicians about the area on his head. The physicians looked at if but that's as far as it went. He also spoke with nurse a month ago about it. She mentioned something about him going to see a dermatologist. Resident #37 stated he just hoped it was not cancer.

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

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In an interview 5/6/25 at 9:47 AM, Staff D, LPN, reported skin assessment done once a week on each resident. The nurses completed a skin assessment and filled out a skin sheet whenever they found a skin concern. They also placed the resident on the computer hot chart to document any follow-up notes. The DON, ADON and MDS nurse completed the skin assessments. Staff D reported Resident #37 had a skin area on his head removed before he came to the facility. The staff put triple antibiotic (ATB) ointment or skin prep and a Band-Aid on the area whenever the area flared up. Staff D reported the physician saw it but there had not been a referral to the dermatologist since the resident had been there. She checked the area and documented a progress note if she saw it looked more irritated. The resident could tell staff when it bothered him.

In an interview 5/6/25 at 11:30 AM, the DON, reported she performed skin assessments weekly. The nurse filled out a skin assessment on paper if a new skin concern developed. Resident #37 had a chronic skin area on the top of his head for quite a while. She didn't think there had been any changes to the area since she had worked at the facility. Staff had let the Dr know about the area and they had tried different treatments. The area had remained the same after the treatments were done.

In an interview 5/7/25 at 2:40 PM, the Administrator confirmed no policy for change in condition.

In an interview 5/8/25 at 1:30 PM, Staff D, LPN, acknowledged she set up a dermatology appointment for Resident #37 the couple days

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F 684	Continued From page 74 ago after she spoke with the surveyor. She spoke with the resident and then called the resident's son to inquire about the dermatologist he had seen previously.	F 684		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, and policy review the facility failed to carry out therapy recommendations and provide restorative exercises for 4 of 6 residents reviewed for restorative services and/or limited range of motion (Resident #3, #18, #33, and #37). The facility reported a census of 45 residents. Findings include:	F 688	1.In continuing compliance with F688 Increase/Prevent Decrease in ROM/Mobility, Accura Healthcare of Pleasantville corrected the deficiency by auditing that resident # 3, 18, 33, and 37 have appropriate restorative programs in place, as well as all like residents on 5/8/2025. 2.To correct the deficiency and to ensure the problem does not recur, all nursing staff were educated on or by 5/20/2025 by the Director of Nursing and/or designee on performing and accurately documenting restorative exercise programs as prompted. The Director of Nursing and/or designee will audit for compliance 3x/weekly x 4 weeks, then 2x/weekly x 4 weeks, then 1x/weekly x 4 weeks, and then PRN 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.	5/20/2025

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1. The Admission Minimum Data Set (MDS) assessment dated 2/27/24 revealed Resident #3 had diagnoses of multiple sclerosis, abnormal gait and mobility and muscle weakness. The MDS revealed the resident had impaired range of motion (ROM) to the upper and lower extremities. The MDS indicated the resident required substantial to maximum assistance for bed mobility, transfers and toileting. The MDS recorded the resident had no therapy services, and had a Restorative Nursing Program (RNP) that included passive range of motion (PROM) performed one day during the look-back period.

The Quarterly MDS assessment dated 11/11/24 revealed the resident had dependence on staff for bed mobility, dressing, transfers and toileting. The resident had occupational therapy (OT) services 3/23/24 to 4/7/24, and zero (0) days of RNP during the look-back period.

The Annual MDS assessment dated 2/6/25 revealed the resident had dependence on staff for bed mobility, dressing, transfers and toileting. The MDS recorded the resident participated in a RNP for 0 days during the look-back period.

The Care Plan revised on 5/3/24 revealed Resident #3 had a self-care deficit in activities of daily living (ADL's) related to impaired mobility, multiple sclerosis and weakness. The Care Plan directed staff to perform PROM to the lower extremities 5 to 7 times a week to maintain his ROM.

The OT Evaluation and Plan of Treatment dated 2/4/25 revealed Resident #3 referred for therapy for evaluation and treatment of contractures. The OT documented nursing was managing the

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F 688	Continued From page 76 resident's contracture impairment. The Documentation Survey Report revealed a restorative program for PROM to the lower extremities 5 to 7 times a week was documented on the following: 2/2025: 17 times. 8 days were left blank, and 3 days recorded as "NA" (not applicable) 3/2025: 20 times. 8 days were left blank and 2 days recorded as NA. 4/2025: 16 times. 5 days were left blank and 6 days recorded as NA. The Quarterly Nursing Assessment Progress Notes revealed the following: a. On 11/11/24 at 12:44 AM, resident does not participate in a RNP at this time. b. On 2/6/25 at 11:26 AM, resident does not participate in a RNP at this time. He had dependence on two staff for assistance. c. On 4/29/25 at 1:24 PM, the resident participates in a RNP. 2. The Quarterly MDS assessment dated 11/26/24 revealed Resident #18 had diagnoses of a stroke, hemiplegia and right foot drop. The MDS revealed the resident had impaired ROM on one side. The resident required supervision for transfers, toileting and dressing. He also required set up assistance for bed mobility, and had independence for eating. The MDS revealed the resident had participated in a RNP Active Range of Motion (AROM) activities for two days during the look-back period, and no therapy services. The Quarterly MDS assessment dated 1/20/25 revealed the resident had diagnoses of muscle weakness, right foot drop and hemiplegia. The MDS recorded the resident required set up	F 688		

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assistance for eating, substantial to maximum assistance for toileting, dressing, bed mobility and transfers. The MDS indicated the resident had Physical Therapy (PT) services started on 1/16/25 and OT services started on 1/17/25.

The Care Plan revised on 2/17/25 revealed Resident #18 had an ADL self-care deficit related to hemiplegia, right hand contracture, and muscle wasting. The Care Plan listed a PT and OT evaluation and treatment as ordered. AROM to the upper body for 15 minutes for one to seven times per week was added to the Care Plan on 4/24/25 (during the survey week).

The PT Discharge Summary dated 2/13/25 revealed the resident had reached his maximum potential with skilled services and recommended a functional maintenance program (FMP) or group exercises.

The Documentation Survey Report revealed a restorative program for AROM to the upper body for 15 minutes one to seven times a week documented for the following:
2/2025: 3 times
3/2025: 0 times
4/1- 4/13/25: not listed
4/14 - 4/28/25: 2 days; left blank 4 times, and NA recorded on 5 days.

The Progress Notes revealed the resident participated in exercise seven times in 2/2025, 2 times in 3/2025, and 0 times in 4/2025.

The Quarterly Nursing Assessment Progress Notes revealed the following:
a. On 11/11/24 at 12:44 AM, resident does not participate in a RNP. He is totally dependent on

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two staff for physical assistance.
b. On 2/6/25 at 11:26 AM, resident does not participate in a RNP. He is totally dependent on two staff for physical assistance and is non-weight bearing status.

During observation on 4/29/25 at 10:16 AM, Resident #18 sat in a motorized wheelchair. The resident had a contracture to his right hand.

3. The Admission MDS assessment dated 7/26/24 revealed Resident #33 had diagnoses of arthritis and sciatica. The resident had dependence on staff for dressing, toileting, bed mobility, and transfers. The MDS recorded the resident had PT and OT services.

The MDS assessment dated 3/20/25 revealed the resident required substantial to maximum assistance for transfers, and had dependence for toileting. The MDS recorded the resident participated in a RNP for 0 days during the look-back period.

The Care Plan revised on 1/13/25 revealed Resident #33 had an ADL self-care deficit related to impaired balance. The Care Plan directed staff to encourage the resident to ambulate to and from meals (added 1/13/25) and perform AROM to the upper and lower body for 15 minutes one to seven times a week added on 4/24/25 (during the survey week).

The PT Discharge Summary dated 3/6/25 revealed therapy recommendations for a RNP restorative. The PT documented a ROM program in place, and prognosis was good with consistent staff follow through. The resident required assistance of two staff and a walker for transfers.

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The Documentation Survey Report revealed the following documented on a restorative program for ambulation with a front wheeled walker and gait belt one to three times a day:
2/2025: 3 times. NA documented 8 times, and the box left blank 6 times
3/2025: 2 times. NA documented 8 times, and the box left blank 11 times
4/2025: 0 times. NA documented 8 times, and the box left blank 6 times.

The Progress Notes revealed:
a. On1/8/25 at 4:20 PM, resident participates in a RNP.
b. On 3/20/25 at 11:21 AM, resident does not participate in a RNP at this time. He is able to ambulate in the corridor with a walker and assistance of one staff

In an interview 4/28/25 at 1:01 PM, Resident #33 reported he needed therapy so he could walk. The resident reported he had a concern that he had gained weight. He thought walking would help get his weight down.

In an interview 5/8/25 at 9:04 AM, the Regional Clinical Director reported staff told her Resident # 33 refused to walk at least since 1/2025.

4. The Admission MDS dated 10/16/24 revealed Resident #37 had diagnoses of spinal stenosis, repeated falls, and low back pain. The resident required partial to moderate assistance for bed mobility, toileting and transfers. The MDS recorded the resident participated in a RNP for 0 days.

The Quarterly MDS assessment dated 3/20/25

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F 688	Continued From page 80 revealed the resident had intact cognition. The MDS indicated the resident required partial to moderate assistance for bed mobility, toileting and transfers. The MDS recorded the resident participated 2 days in a RNP during the look-back period. The Care Plan revised on 3/17/25 revealed Resident #37 had an ADL self-care performance deficit related to impaired balance and chronic pain. The Care Plan directed staff to ambulate the resident 25 to 50 feet with a gait belt one to three times a day, AROM to extremities for 15 minutes one to seven times a day and use the Nustep (bike) for 15 minutes one to seven times a week. These Care Plan directives were all added to the Care Plan on 4/24/25. A PT Discharge Summary dated 12/4/24 revealed Resident #37 referred for a Functional Maintence Program (FMP) such as walking and lower extremity exercises. The Progress Notes revealed on 3/2025 at 1:18 PM resident does not participate in a RNP at this time. The Documentation Survey Report revealed the following documented on a restorative program: a. Group Exercise Program 2/2025: 7 times 3/2025: 3 times 4/2025: 4 times. b. AROM to the upper and lower body for 15 minutes one to seven times per week: 2/2025: 11 times 3/2025: 7 times 4/2025: 4 times	F 688		

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c. Ambulation 25-50 feet one to three times a day:
9:00 AM
2/2025: 19 times
3/2025: 26 times
4/2025: 24 times

1:00 PM
2/2025: 17 times
3/2025: 23 times
4/2025: 23 times

6:00 PM
2/2025: 3 times
3/2025: 3 times
4/2025: 5 times

d. Nustep x 15 minutes one to seven days per week was added on 4/24/25.

Observations revealed the following:
a. On 4/30/25 at 1:30 PM, Resident #37 sat in wheelchair in the dining room by the Director of Nursing (DON's) office.
b. On 04/29/25 at 1:49 PM, therapy room door closed. No staff in the room. Sign on door revealed for residents to ask for help if they needed weighed. A table and chair sat in the middle of the room.
c. On 4/30/25 at 2:00 PM, Resident #37 sat in a wheelchair in the dining room. Dishes sat on the table in the Therapy Room.
d. On 4/30/25 at 2:24 PM, therapy room door closed and lights off in the room.
e. On 5/7/25 at 7:45 AM, Resident #37 sat in a wheelchair in the hallway outside of his room.

In an interview 4/29/25 at 10:25 AM, Resident

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#37 reported staff walked with him from his room to the dining room but he felt like his legs may give out sometimes. He wanted to ride the bike to maintain his ability to walk but the staff won't let him unless the facility had staff available. The resident reported he went to the front area and waited until staff let him into the therapy room.

In an interview 5/1/25 at 9:38 AM, Resident #37 reported he wanted to ride the bike in order to build up the strength in his legs, besides just walking. He reported he went down and sat in the dining room and waited for staff so he could go ride the bike in the therapy room. He watched staff go back and forth until someone got freed up and could be with him in the therapy room, but sometimes that didn't happen because staff were too busy or the facility did not have enough staff.

On 5/7/25 at 7:45 AM, Resident #37 sat in a wheelchair in the hallway outside of his room. The resident reported he was waiting for someone to come and help him walk. Resident #37 stated he wanted to ride the bike for 10-15 minutes but he only got to ride the bike twice the week of 4/28/25.

In an interview 4/30/25 at 1:23 PM, Staff K, certified medication aide (CMA), reported anybody at the facility did restorative. Therapy staff evaluated residents on how they should transfer. Staff K reported the restorative activities (RA) performed were documented in the computer. Staff K reported Resident #37 would go into therapy to ride the bike but staff had to be in the therapy room whenever a resident was in the therapy room.

In an interview 5/5/25 at 12:01 PM, the Rehab

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F 688	Continued From page 83 Therapy Director reported he came to the facility whenever they had a resident on skilled therapy services. He sent emails to communicate with the Director of Nursing (DON) and the Administrator about therapy services ending and the therapist's recommendations. The Therapy Director reported it was his understanding the facility had a "CNA lead restorative", but no actual RNP. No certain person was assigned as the restorative aide. The Therapy Director stated a RNP would be beneficial for the residents. The Therapy Director confirmed he had residents referred back to therapy due to a decline. The Therapy Director reported he expected nursing services to follow through on therapy recommendations whenever a resident had discharged from therapy. In an interview 5/6/25 at 9:47 AM, Staff D, Licensed Practical Nurse (LPN) reported the CNA's did the restorative exercises with the residents. The facility did not have an assigned restorative aide because the person did not last long after they were hired. The restorative aide got pulled to work as a CNA due to staffing needs. In an interview 5/6/25 at 11:30 AM, the DON reported the PT came up with tasks for the CNA to document RA in the computer. In an interview 5/7/25 at 10:20 AM, the MDS nurse reported no restorative program at the facility. She was told the CNA's did the exercises with residents. The ADON looked into putting tasks on the computer for the CNA to document walk to dine and other things. The MDS nurse reported she saw a decline in the residents' ADL's. The MDS nurse reported she expected to	F 688		

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F 688	Continued From page 84 see residents up and moving more if they had a restorative person. In an interview 5/7/25 at 2:15 PM, Staff C, CNA, reported the facility did not have a designated restorative aide. The CNA was supposed perform ROM when they got a resident up or dressed the resident. Staff C reported only a few residents were on a walk to dine program. Staff C reported she did what she could but when she was the only aide working, it was all they could do to get residents up, provide showers, and feed residents. In an interview 5/7/25 at 2:40 PM, the Administrator reported restorative activity added in 2/2025 for staff to document things done. The Administrator reported some RA done last year but they had a lot of new staff since then. RA discussed and identified as an area to improve. In an interview 5/8/25 at 7:40 AM, the Regional Clinical Nurse reported she was assigned to the facility in 1/2025. She looked at systems such as restorative and what the facility had done for RA. She reviewed the resident's restorative and noted several of the programs were outdated or not applicable for residents so she discontinued or updated the computer so staff could document what they were doing and take credit for the things they were doing. The Regional Clinical Nurse reported the facility had been in the process of working on restorative. The facility did not have a designated restorative aide, the CNA's did the RA. A Restorative Program Process policy updated 10/26/21 revealed a restorative program ensured residents achieved and maintained their highest	F 688		

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F 688	Continued From page 85 level of function. The nurse or therapy assessed the resident's level of function upon admission, quarterly and with significant changes. The licenses nurse developed a RNP with individualized interventions and goals for the residents. The nurse wrote a monthly restorative nursing summary to track the resident's progress.	F 688		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (f) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge	F 725	1.In continuing compliance with F725 Sufficient Nursing Staff, Accura Healthcare of Pleasantville corrected the deficiency by ensuring all resident needs are being met. 2.To correct the deficiency and to ensure the problem does not recur, all staff were educated on or by 5/21/2025 by the Executive Director and/or designee on answering call lights in under 15 minutes. The Executive Director and/or designee will audit for compliance 3x/weekly x 4 weeks, then 2x/weekly x 4 weeks, then1x/weekly x 4 weeks, and then PRN 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.	5/21/2025

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

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F 725	Continued From page 86	F 725		

nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on record review, and resident and staff interviews, the facility failed to ensure staff responded and answered residents' call lights within 15 minutes, and met residents' needs in a timely manner for one of two units. The facility reported a census of 45 residents.

Findings include:

Resident Council Meeting notes reviewed 2/2025 to 4/2025 revealed the residents voiced concerns about delayed call light response times, staffing shortages and delays in getting their laundry returned.

The Grievance Forms dated 1/1/25 to 4/27/25 revealed:
a. On 2/3/25, a resident complained about the shortage of staff. He waited a long time for his call light to be answered and also waited a long time to get coffee. Staff were reminded to answer call lights even if it is to tell the resident they will get someone to assist.
b. On 3/3/25, a family member reported concerns about a resident's blood sugar not checked until after a meal and the resident received medications late. The staff had gone on breaks together.
c. On 4/1/25, concerns voiced about rooms not cleaned for 2-3 days.

During confidential resident interviews on 4/28/25 to 4/29/25, 4 of 7 interview able residents with a Brief Interview for Mental Status score of 13-15 (indicating cognition intact) reported it took staff 30 minutes to 2 hours before anyone responded

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F 725	Continued From page 87 to their call light and provided assistance. The residents reported the facility didn't have enough staff. One resident reported he had waited several hours to get the medication he requested and the treatments he needed. During an interview 4/29/25 at 11:30 AM. the Director of Nursing (DON) reported she had worked at the facility since 1/2/25. The DON reported she worked the floor usually when she took call over the weekend. The DON reported the number of staff during the week and on weekends included the following: a. On the 6 AM - 2 PM and 2 PM -10 PM shifts: Front hall - 2 Certified Nursing Assistants (CNA) and 1 nurse Back (Memory Care Unit) hall -2 CNA's, 1 Certified Medication Aide (CMA) or 1 nurse b. On the 10 PM - 6 AM shift: Front Hall: 2 CNA's and 1 nurse Back Hall: 2 CNA's	F 725		
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	F 812	1.In continuing compliance with F812 Food Procurement,Store/Prepare/Serve-Sanitary, Accura Healthcare of Pleasantville corrected the deficiency by throwing away food items: inside the danger zone as well as throwing away any items identified as unlabeled, undated, and unsealed. The dish machine was thoroughly cleaned. The leaking sink was fixed and staff member did sanitize hands prior to assisting residents with meal service. 2.To correct the deficiency and to ensure the problem does not recur, all staff were educated on handling ready-to-eat food as well as the dietary department was educated on Food Procurement,Store/Prepare/Serve by the Executive Director and/or designee on or by 5/6/2025. The Executive Director and/or designee will audit for compliance 3x/weekly x 4 weeks, then 2x/weekly x 4 weeks, then 1x/weekly x 4 weeks, and then PRN to ensure continued compliance.	5/8/2025

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F 812	Continued From page 88 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 direct observation, facility record review, staff interviews, and policy review the facility failed to store and handle foods in a safe and hygienic manner, and failed to provide a clean and hygienic kitchen to cook and serve food. The facility reported a census of 45. Findings include: A direct observation on 04/28/2025 at 11:15 AM of the Kitchen and Dry storage revealed the following: A black residential style combination refrigerator and freezer with a note that states "Freezer does not hold temps - Do not use" contained three beef roasts that had been placed to thaw in the unit overnight. The thermometer inside of the refrigerator portion of the unit read 56 degrees Fahrenheit. The roasts were visibly bloated in their packaging, appearing ball-like. Staff A, Cook, stated he did not know how long the temperature in the refrigerator had been above 40 degrees for, but confirmed they were for dinner service that evening. It also revealed the following items were unlabeled, undated, and unsealed in the numerous chest style freezers: 1 bag of what appeared to be cooked eggs. 1 bag of what appeared to be French fries - these were spilled inside of the freezer. 1 bag of what appeared to be chicken or poultry meat.	F 812	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 812	Continued From page 89	F 812		

1 bag of what appeared to be carrots.
1 bag of what appeared to be tater tots.
The following items lacked a label or date:
2 bags of what appeared to be poultry meat.
1 bag of what appeared to be carrots.

It also revealed significant buildup in the trap of the dish washing unit.

A direct observation on 04/29/2025 at 03:40 PM revealed the dish washing unit trap had still not been cleared of the debris from the day before. It revealed a leaking sink pipe under the kitchen sink with a significant amount of black buildup and a large bucket of foul-smelling water with what appeared to be an organic film. Pictures were taken at this time.

In a direct observation on 04/30/2025 at 12:33 PM Staff D, Licensed Practical Nurse (LPN), was observed picking up the garlic bread of a resident who required assistance eating with her bare hands, tearing it into multiple pieces, and placing the bites of food into the resident's mouth. Hand sanitation was not witnessed before or after.

In an interview on 04/30/2025 at 10:25 AM with Staff A, Cook, stated he had reported the conditions of the space under the sink to management shortly after he first started - he believed this was towards the end of February 2025 or early March 2025. He was told it had been taken care of and that he did not need to worry about the space. In a further interview, at 02:30 PM of the same day, Staff A stated all kitchen staff are responsible or labeling , dating, and sealing items that are being put away. He stated bags should never be open to the air, and when items are spilled they are to be cleaned

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F 812	Continued From page 90	F 812		

immediately. He stated that meats should be thawed at or below 41 degrees Fahrenheit and not above. He stated the dishwasher trap should be cleaned after every shift.

In an interview on 04/30/2025 at 02:30 PM with Staff E, Dietary Aide, she stated the sink had been leaking for months, but she had been told it was taken care of and she was not in the habit of checking the area. She agreed they are all responsible for labeling, dating, and ensuring items stored in the freezer are properly sealed.

In an interview on 04/30/2025 at 02:10 PM with Staff C, Certified Nurse Aide (CNA), she stated they are to avoid touching the lips of plates and utensils when serving residents. She stated they are never allowed to directly touch a resident's food bare handed, and if they do they should replace the food item.

In an interview on 04/30/2025 at 02:16 PM with Staff B, Certified Medication Aide, she stated staff are to avoid touching food when serving residents.

In an interview on 04/30/2025 at 01:53 PM with Staff D, LPN, she stated she knows she isn't supposed to touch resident food directly with her hand but was on autopilot and didn't think about it.

In an interview on 04/30/2025 at 03:05 PM the Administrator, stated she believed the sink issue had been addressed on 03/12/2025, and acknowledged she had directed her staff to address it immediately. She confirmed this was the job of the maintenance department. She confirmed staff were not asked to clean this

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F 812	Continued From page 91 because she had thought the issue was resolved. In an interview on 04/30/2025 at 03:31 PM with the Clinical Nurse Specialist, she stated her expectation is for staff to never make bare hand contact with a resident's food. If they do, they are to replace the food and not allow the resident to eat it. In an interview on 05/05/2025 at 02:10 PM the Dietary Manager, acknowledged all foods require a label identifying the food and a date identifying when the item was opened. It should be resealed before storage. In a policy titled "Food Storage" with a date of 2021, it stated all foods should be covered, labeled, and dated. It also documented safe holding temperatures for refrigerated foods as 41 degrees or less. In a policy titled "Bare hand contact with food and use of plastic gloves", with a date of 2021, it documented staff should use clean barriers, such as single-use gloves, when handling resident food.	F 812		
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must:	F 865	1.In continuing compliance with F865 QAPI Prgm/Plan, Disclosure/Good Faith Attempt, Accura Healthcare of Pleasantville corrected the deficiency by the Regional Director of Operations providing education to the Executive Director on the QAPI Process and Plan on 5/12/25. 2.To correct the deficiency and to ensure the problem does not recur, the Executive Director was educated on the QAPI Process and Plan on 5/12/2025. The Executive Director and/or designee will audit QAPI meetings monthly to ensure compliance with historical tags for four months 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.	5/12/2025

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F 865	Continued From page 92 §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice;	F 865		

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§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.

§483.75(f) Governance and leadership.
The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:

§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.

§483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;
§483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;

§483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.

§483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and

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F 865	Continued From page 94 §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of CMS-2567 reports, staff interview and facility policy review, the facility failed to have an effective QAPI (Quality Assurance Performance Improvement) process to address previously identified quality deficiencies to assist in the provision of quality care for residents and attain substantial compliance with Federal regulations and State rules. The facility had several repeat deficiencies identified on the facility's current recertification and complaints survey. The facility reported a census of 45 residents. Findings include: Review of the Department of Inspections, Appeals and Licensing (DIAL) website under the facility's visit history revealed repeated deficient practices identified during the facility's annual survey 3/20/23 and 6/24/24, complaint investigations completed 3/20/23, 2/20/24 and 9/30/24, and the current survey and complaint investigations. The repeat deficiencies cited	F 865		

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included:
F609 cited 3/30/23 and during the current survey.
F610 cited 3/30/23 and during the current survey.
F641 cited 9/30/24 and during the current survey.
F656 cited 9/30/24 and during the current survey.
F657 cited 6/24/24 and during the current survey.
F684 cited 3/20/23, 2/26/24, 9/30/24 and during the current survey.
F688 cited 9/30/24 and during the current survey.
F725 cited 3/30/23, 2/26/24, 9/30/24 and during the current survey.
F812 cited 3/30/23, 6/24/24 and during the current survey.
F880 cited 2/26/24, 9/30/24 and during the current survey.

The Payroll Based Journal (PBJ) Staffing Data Report for 10/1/24 to 12/31/24 (Quarter 1) revealed the facility had a 1 Star Staffing Rating.

In an interview 5/7/25 at 2:40 PM, the Administrator reported she believed the PBJ 1-star rating was due to staff turnover. The facility had a high turnover in nursing leadership, including the Director of Nursing, the Assistant Director of Nursing, and the MDS nurse.

On 5/7/25 at 3:15 PM, the Administrator reported the Quality Assurance Committee met quarterly and had identified areas they needed to work on. The Administrator acknowledged awareness of repeat deficiencies and stated the facility had a turnover of their entire nursing department in 1/2025. Prior to this, the previous ADON was part of the plan of correction in 9/2024, and it took a long time to fill the ADON position. The Administrator reported she had only worked at the facility since 4/22/24. The facility had worked on staff hiring and retention strategies, as well as

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F 865	Continued From page 96 staff education to address resident concerns. A Quality Assurance and Performance Improvement Plan (QAPI)) Plan updated 5/23/23 revealed the QAPI is a systematic approach for improving quality of care and services provided to the residents. The QAPI focused on systems and processes, identified system gaps, and identified root causes of concern as well as opportunities for improvement, which lead to improvement in the lives of residents, through continuous attention to quality of care, quality of life, and resident safety. The Root Cause Analysis was used to identify improvement opportunities and understand how to improve on them. The QAPI Committee monitored progress and ensured interventions or actions were implemented, and effective and sustained improvements were made.	F 865		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880	F880 1) In continuing compliance with F880 Infection Prevention & Control, Accura Healthcare of Pleasantville corrected the deficiency by educating all staff on infection control guidelines when providing cares to resident #18 and all like residents, as well as providing education to all staff on disinfecting equipment between resident use on 5/9/25. 2) To correct the deficiency and to ensure the problem does not recur, all staff were educated on hand hygiene, glove usage, and disinfecting equipment on or by 5/9/25. The Director of Nursing and/or designee will audit for compliance 3x/weekly for 4 weeks, 2x/ times weekly for 4 weeks then 1x/ weekly for 4 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	5/9/2025

identified concerns through the community's QA Process.

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(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 97 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 §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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	165324	A. BUILDING ______ B. WING ______	05/08/2025

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F 880	Continued From page 98 §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 record review, observations, staff interviews, and policy review the facility staff failed to change gloves when performed cares and then touched other objects for one of four residents sampled for cares (Resident #18). The facility staff also failed to disinfect a mechanical lift after use for one of three residents observed for transfers. The facility reported a census of 45 residents. Findings include: 1. The Quarterly Minimum Data Set (MDS) Assessment dated 4/17/25 revealed Resident #18 had diagnoses of cerebrovascular accident (CVA)(stroke), hemiplegia (paralysis on one side of the body) and neurogenic bladder (loss of bladder control). The MDS recorded the resident had an indwelling catheter. The MDS documented the resident required partial to moderate assistance for toileting hygiene and substantial to maximum assistance for lower body dressing. The Care Plan revised 2/17/25 revealed the resident required Assistance with activities of Daily Living (ADL's) related to cerebral infarction and hemiplegia and had a catheter. The Care	F 880		

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F 880	Continued From page 99 Plan revealed the resident transferred and moved in bed independently and required staff assistance as needed. The Care Plan directed staff to use enhanced barrier precautions related to the catheter. During observations on 5/1/25 at 10:25 AM, Staff G, Certified Nursing Assistant (CNA) and Staff B, Certified Medication Aide (CMA) washed their hands, then donned a gown, mask with a face shield, and gloves. Staff G removed Resident #18's brief tabs, then took disposable wipes as Staff B handed the wipes to her and cleansed the resident's peri-area and groin. Staff assisted the resident to roll onto his right side. Staff G changed her gloves, then took disposable wipes and cleansed the buttocks area. Staff B placed a clean brief under the resident and staff assisted the resident to roll onto his left side. Staff G continued to wear the same gloves and touched the back of the resident's shirt as she supported the resident and as Staff B cleansed the buttocks. The resident rolled onto his back and the brief tabs were attached. Staff G placed a blanket over the resident, placed the call light by the resident, then handed the resident a grabber device. Staff B picked up a beverage mug and offered the resident a drink of water. Staff G and Staff B removed their gown and gloves. Staff B then reached into her uniform pocket and applied hand sanitizer to her hands. The Assistant Director of Nursing stood in the room and observed staff with the surveyor. In an interview 5/6/25 at 9:47 AM, Staff D, Licensed Practical Nurse (LPN) reported gloves changed whenever staff did cares and went and did something else.	F 880		

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F 880	Continued From page 100	F 880		

In an interview 5/6/25 at 11:30 AM, the Director of Nursing (DON) reported she expected staff changed gloves before and after cares, and anytime staff went from a dirty to a clean task or area.

In an interview 5/7/25 at 2:40 PM, the Administrator confirmed no other policy for glove changes found.

A Using Gloves policy updated on 11/13/24 revealed gloves worn to prevent contamination of the employee's hands whenever services provided to the resident. Gloves must be replaced as soon as practical when contaminated.

2. During continuous observations on 4/30/25 at 2:01 PM, Staff H, CNA wore gloves as she pushed a mechanical lift out of Room 17 into the hallway. Staff H parked the mechanical lift along the hallway railing, then told the resident to have a good nap. Staff H walked back into the room and removed the gloves from her hands. At 2:03 PM, a hospice CNA took the mechanical lift and pushed the lift into Room 15. The mechanical lift was not disinfected before or after use.

In an interview 5/6/25 at 9:47 AM, Staff D, Licensed Practical Nurse (LPN) reported equipment such as a mechanical lift needed to be disinfected after use.

In an interview 5/6/25 at 11:30 AM, the DON reported equipment such as mechanical lifts needed disinfected before and after use.

An untitled facility policy updated on 11/13/24 under "Miscellaneous" revealed equipment

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F 880	Continued From page 101 cleaned and sanitized prior to using in other areas.	F 880		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on employee roster review, education transcript review and staff interviews, the facility staff failed to complete a minimum of 12 hours of regular in-service education for 3 of 4 Certified Nursing Assistants (CNAs) sampled who had worked at the facility greater than 1 year (Staff G, Staff M, and Staff N). The facility identified a census of 45. Findings include:	F 947	F947 1) In continuing compliance with F947 Required In-Service Training for Nurse Aides, Accura Healthcare of Pleasantville corrected the deficiency by ensuring employees Staff G, Staff M, Staff N and all like staff were educated on completing Relias training. 2) To correct the deficiency and to ensure the problem does not recur, all staff were educated on completing Relias training on The Executive Director and/or designee will audit for compliance 3x/weekly for 4 weeks, 2x/weekly for 4 weeks then 1x/weekly for 4 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.	5/10/2025

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F 947	Continued From page 102 1. A CNA-CMA Roster revealed Staff G, CNA, had a hire date 5/20/21, Staff M, CNA, had a hire date of 10/9/23 and Staff N, CNA, had a hire date 7/6/22. The Relias Education Transcripts reviewed 5/2024 - 4/2025 revealed the education and number of hours completed for the following: Staff G =8.95 hours completed Staff M = 1.0 hours completed Staff N = 0 hours completed During interview on 5/6/25 at 11:30 AM, the Director of Nursing reported mandatory staff in-services held monthly and education courses set up on Relias for staff to complete. The DON reported staff needed to complete at least 12 hours of education each year. During an interview on 5/7/25 at 11:10 AM, the Administrator reported the staff who worked nights don't attend the staff meetings and in-service training. She tried to get the staff to attend the meetings/in-services but when they worked nights, it was hard.	F 947		