STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165451	A. BUILDING _____ B. WING _____	C 07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MARSHALLTOWN	2401 SOUTH SECOND STREET MARSHALLTOWN, IA 50158

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date: 8/16/2024 The Accura Healthcare of Marshalltown Nursing Home is not in compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities due to the following deficiencies written the facility's annual recertification survey with investigation of complaints #120745-C, #121848-C, conducted July 22, 2024 to July 25, 2024. Complaints #120745-C and #121848-C were not substantiated. Total census: 53	F 000	PLAN OF CORRECTION Accura HealthCare of Marshalltown 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 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, and staff interview, the facility failed to accurately assess residents for the need of safety smoking equipment for two of three residents reviewed for smoking (Residents #22 and #56). The facility reported a census of 53 residents. Findings include: 1. Resident #56's Minimum Data Set (MDS) assessment dated 7/26/24 indicated they had unclear speech and usually made themselves understood. The MDS identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognition. Resident #56 utilized	F 641	In continuing compliance with F 641, Accuracy of Assessments, Accura HealthCare of Marshalltown corrected the deficiency by the MDS Coordinator immediately conducting new smoking assessments on 7/26/2024 on Residents #22, #56, and all like residents on To correct the deficiency and ensure the problem does not recur, The Administrator educated the MDS Coordinator on 7/26/2024 on ensuring that all smoking assessments must be accurate and reflected in the resident's care plan. The MDS Coordinator and/or designee will audit smoking assessments to ensure they are accurate 1x weekly X 12 weeks, then PRN to ensured continued compliance. As part of Accura of Marshalltown's ongoing commitment to quality assurance, the MDS Coordinator and/or designee will report identified concerns through the community's QA process.	8/16/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Corey Elliott, NHA, MBA	Area Administrator	8/19/2024

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

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a wheelchair. The MDS included diagnoses of tobacco use, non Alzheimer's dementia, stroke, other psychoactive substance abuse (uncomplicated), and unspecified disorder of psychological development.

The Care Plan Focus dated 7/1/24 indicated that smoking is important to Resident #56. The Interventions directed the staff to assist her with proper supplies to prevent smoking related injuries.

The Smoking Assessment completed 7/1/24 assessed Resident #56 as having no cognitive losses. The Assessment reflected Resident #56 needed adaptive equipment of supervision and a smoking apron.

On 7/23/24 at 4:10 PM and 7/24/24 at 1:10 PM observed Resident #56 not wearing a smoking apron during the staff supervised smoking times.

2. Resident #22's MDS assessment dated 5/8/24 identified a BIMS score of 15, indicating intact cognition. Resident #22 used a manual wheelchair. The MDS included diagnoses of tobacco use, cancer, anemia, end stage renal disease with dialysis, anxiety disorder, bipolar disorder, and age related physical debility.

The Care Plan Focus dated 9/5/19 indicated Resident #22 felt being able to smoke cigarettes is extremely important. He is able to smoke as long as he followed the provided guidelines. The Interventions instructed the facility to complete smoking assessments every quarter.

The Care Plan lacked interventions related to the use of safety smoking equipment or the level of

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supervision.

The smoking assessment completed on 1/16/24 indicated Resident #22 needing supervision, smoking apron, and 1:1 assistance.

The smoking assessment completed on 4/17/24 indicated Resident #22 needing a smoking apron.

The Smoking Assessment completed 5/8/24 indicated Resident #22 needed supervision and a smoking apron.

On 7/23/24 at 4:10 PM and 7/24/24 at 1:10 PM observed Resident #22 not wearing a smoking apron during the staff supervised smoking times.

On 7/24/24 at 1:10 PM Staff I, Certified Nursing Assistant (CNA), denied knowing any residents requiring smoking supplies or safety equipment. Staff I didn't believe the current pocket CNA Care Plan listed any residents needing smoking safety equipment.

On 7/24/24 at 3:00 the Assistant Director of Nursing (ADON), Staff A, Registered Nurse, and Staff H, MDS Coordinator indicated all residents who smoke receive a smoking assessment. If any safety interventions indicated, they update the Care Plan and notify the CNAs via the pocket Care Plans. When asked, all reported there were no residents in need of safety smoking equipment. They learned Residents #22 and #56's most recent smoking assessments reflected they needed smoking aprons. All staff members looked surprised at this information and expressed concern of the inaccurate assessment. All staff members indicated Resident #22 didn't ever wear a smoking safety

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F 641	Continued From page 3 apron. Staff H mentioned the smoking apron may have marked in error with Resident #56's assessment.	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. (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	F 656	In continuing compliance with F 656, Develop/Implement Comprehensive Care plan, Accura HealthCare of Marshalltown corrected the deficiency by placing wanderguard usage on resident #56's care plan and auditing all like residents care plan on 7/26/2024. To correct the deficiency and ensure the problem does not recur, the Administrator educated the MDS Coordinator on 7/26/2024 on ensuring the Care Plan meets all resident needs. The MDS Coordinator and/or designee will audit care revisions 3x weekly X 4 weeks, 2x weekly X 4 weeks, 1x weekly X 4 weeks, and PRN to ensure continued compliance. As part of Accura of Marshalltown's ongoing commitment to quality assurance, the MDS Coordinator and/or designee will report identified concerns through the community's QA process.	8/16/2024

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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 clinical record review, observation and staff interview, the facility failed to develop and implement a comprehensive person centered Care Plan for 1 of 16 residents reviewed (Residents #56), regarding the use and need of a wander guard due to history of exit seeking. The facility reported a census of 53 residents.

Findings include:

Resident #56's Minimum Data Set (MDS) assessment dated 7/26/24 indicated they had unclear speech and usually made themselves understood. The MDS identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognition. Resident #5 didn't exhibit wandering behaviors. Resident #56 utilized a wheelchair. The MDS included diagnoses of tobacco use, non Alzheimer's dementia, stroke, other psychoactive substance abuse (uncomplicated), and unspecified disorder of psychological development.

The Care Plan with a target date of 7/7/24 lacked information related to Resident #56 wandering or

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the need for a wander guard.

The clinical record review completed 7/23/24 didn't show an active order for the use of a wander guard or for staff to check placement of a wander guard.

The Progress Note dated 6/19/24, reflected Resident #56 attempted to leave the facility building on two separate occasions. The facility placed a wander guard.

The Progress Note dated 7/5/24, indicated staff found Resident #56's wander guard in a drawer, it looked cut off. The staff applied a new wander guard.

The Progress Note dated 7/17/24, Resident #56 attempted to go out the front door and needed several staff members to bring her back from the door.

On 7/23/24 and 7/24/24 witnessed Resident #56 wearing a wander guard on her lower right leg.

On 7/23/24 at 3:15 PM Staff A, Registered Nurse, acknowledged Resident #56 had a wander guard. Staff A also recognized Resident #56's Care Plan didn't reflect the use of a wander guard. Staff A added given the fluctuation of Resident #56's exit seeking behaviors and current use of a wander guard, the Care Plan should address the intervention.

Per email confirmation from the facility administrator, the facility does not have a policy or procedure specifically related to wander guard use or Care Plan development.

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F 676	Continued From page 6	F 676		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language,	F 676	In continuing compliance with F 676, Activities Daily Living (ADL's)/Mntn Abilities, Accura HealthCare of Marshalltown corrected the deficiency by the QA Nurse auditing resident #7, #24, and #43 and all like residents restorative program's to ensure they are up to date in PCC with frequency and appropriately documented on 7/26/2024. To correct the deficiency and ensure the problem does not recur, the Administrator educated the QA Nurse and restorative aide on 7/26/2024 on Accura's restorative process and ensuring RA programs are up to date in PCC with frequency and appropriately documented. The QA Nurse and/or designee will audit the restorative process 2x weekly X 12 weeks then PRN to ensure continued compliance. As part of Accura of Marshalltown's ongoing commitment to quality assurance, the MDS Coordinator and/or designee will report identified concerns through the community's QA process.	8/16/2024

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F 676	Continued From page 7 (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on direct observation, resident interviews, staff interviews, and document review the facility failed to provide and document restorative cares for 3 of 3 residents reviewed (Residents #7, #24, and #43). The facility reported a census of 53. Findings include: 1. Resident #7's Minimum Data Set (MDS) assessment dated 6/16/24 identified a Brief Interview for Mental Status score of 15, indicating intact cognition. Resident #7 required full assistance for toilet use and transfers, and required maximal assistance for bed mobility. The MDS recorded Resident #7 didn't have impaired range of motion (ROM) and used a manual wheelchair for mobility. The MDS included diagnoses of congestive heart failure (CHF), respiratory failure, type 2 diabetes, and obesity. Resident #7 started Occupational Therapy (OT) on 6/14/24. Resident #7 received restorative nursing program (RNP) for "0" days in the 30-day look back period. The Care Plan Focus dated 2/12/24 reflected Resident #7 had an activities of daily living (ADL) deficit due to his diagnosis of obesity. The Care Plan Interventions directed the following: a. Resident #7 required assistance with perineal care twice a day and as needed (PRN). b. Resident #7 needed 2 assist with a standing mechanical lift. Resident #7 needed staff assistance with locomotion. c. 2/12/24: Resident #7 worked with Physical Therapy (PT) and OT.	F 676		

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The OT Discharge Summary signed 7/12/24, reflected Resident #7 discharged from OT services on 7/12/24. The OT indicated they established an RNP for Resident #7. He had a good prognosis with consistent staff follow through. The OT recommendations included an RNP and ROM program. The Outcome Risk(s) reflected Resident #7 agreed with the discharge plan to start restorative services.

The RNP dated 7/12/24 included the following:
a. Resident #7 complete upper body exercises with Red/Green TheraBand's (resistance bands) as tolerated. Elbow flexes, elbow extensions, shoulder extension and rotation for 2 3 sets of 10 repetitions.
b. Resident #7 complete continuous cycling for upper and lower body for 15 minutes with level 2 3 resistance as tolerated.
c. Resident #7 complete choice of catch/toss, ring toss, and/or bean bag toss.
d. Noted they should encourage resident to get out of bed and participate in group activities as tolerated.

The Response History related to Active ROM to upper and lower extremities 3-5 times a week at medium level for 5 to 15 minutes reviewed on 7/24/24 at 12:29 PM for the previous 30 days reflected Resident #7 received ROM on 7/23/25 for 15 minutes. The report lacked other documentation to reflect Resident #7 received ROM outside of that day.

The Response History related to Group Exercise Program reviewed on 7/24/24 at 12:38 PM for the previous 20 days lacked documentation to indicate Resident #7 received group exercise.

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The electronic health record (EHR) and paper chart lacked further documentation that Resident #7 performed RNP exercises.

In an interview on 7/24/24 at 11:00 AM Staff J, Restorative Aide, stated she didn't know why Resident #7's clinical record didn't have documentation, as she believed he participated in restorative services.

In an interview on 7/24/24 at 10:32 AM, Resident #7 stated he only participated in restorative services when someone came to get him out of bed and helped him down to the activity room. He indicated he received approximately one opportunity a week to participate in his RNP.

On 7/24/24 at 10:42 AM Staff A, Quality Assurance (QA) Nurse, stated she expected the staff to document all participation in the RNP, including refusals. She stated Resident #7 had an RNP set up as a daily task to ensure he received at least three opportunities to participate a week. She confirmed his record didn't have documentation for the RNP outside of 7/23/24.

In an interview on 7/25/24 at 11:27 AM the Administrator, stated the facility followed the standards of care for PT, OT, and Restorative services. He acknowledged that meant the facility needed to offer restorative services when recommended.

2. Resident #24's MDS assessment dated 10/23/23 admitted to the facility on 7/17/23. The MDS documented Resident #24 had impaired ROM to their upper and lower extremity on one side. Resident #24 required supervision for eating, partial to moderate assistance for bed

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mobility, and required total assistance from staff for transfers and toilet use. The MDS included diagnoses of cerebrovascular accident (CVA) (stroke), hemiplegia (paralysis on one side), and hemiparesis (muscle weakness) affecting the right side. The MDS reflected Resident #24 didn't have Occupational Therapy (OT), Physical Therapy (PT), or RNP activities during the 7 day look back period.

The Quarterly Nursing Assessment dated 4/2/24 at 1:49 PM, indicated Resident #24 had limitations in ROM to the upper and lower extremities on one side of her body. She didn't participate in an RNP. Resident #24 required extensive assistance of 2 staff for transfers, extensive assistance for dressing, and required assistance for personal hygiene.

Resident #24's MDS assessment dated 4/3/24 reflected she received OT services from 7/18/23 - 7/31/23, PT services from 7/18/23 - 8/2/23, and participated in RNP activities zero ("0") days during the 7 day look back period.

The Care Plan Focus dated 7/17/23 identified Resident #24 had a deficit in ADLs due to weakness and a contracture. The Care Plan directed Resident #24 need 2 staff assist with transfers. The Intervention instructed to get Resident #24 up and ready for participation with OT and PT.

The PT Discharge Summary dated on 8/2/23 reflected Resident #24 required maximum assistance from 2 staff for transfers. The therapist documented Resident #24 actively participated consistently for 15 minutes in a lower extremity exercise program to help enhance her

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coordination and ability to assist with functional transfers. She met the goal on 7/28/23. Resident #24 discharged from PT to a restorative program in order to prevent ADL decline. Resident #24 consistently participated in use of an exercise bicycle (a motorized movement device developed for people with movement restrictions) for her lower extremities. The PT recommended an RNP with the exercise bicycle for 15 minutes at least 2 3 times per week. The Discharge Summary reflected Resident #24 had a good prognosis and ability to maintain her current level of function with consistent staff follow through.

Resident #24's May 2024 Documentation Survey Report lacked an RNP except for group exercises. The Documentation indicated Resident #24 refused all documented activities except on 5/9/24 of bingo and social time.

Resident #24 June 2024 Documentation Survey Report lacked an RNP except for group exercises. The Documentation indicated Resident #24 refused all documented activities except on 6/17/24 (group exercise) and 6/21/24 (tv/movies).

A PT Evaluation and Plan Of Treatment dated 6/25/24 revealed Resident #24 referred to PT due to increased muscle weakness. The PT documented the resident had not previously participated in an RNP. The PT functional mobility assessment revealed the resident had dependence for transfers, and required substantial to maximum assistance for bed mobility.

Resident #24's MDS assessment dated 6/26/24 identified a BIMS score of 14, indicating cognition intact. The MDS indicated Resident #24 had

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impaired ROM to the upper and lower extremities on one side. Resident #24 required partial to moderate assistance with eating, and substantial to maximum assistance for bed mobility, transfers, and toilet use. The MDS recorded OT started on 6/21/24, PT started on 6/25/24, and she participated in the RNP activities "0" days during the 7 day look back period.

The Quarterly Nursing Assessment dated 6/25/24 at 11:26 AM, reflected Resident #24 had limitations in ROM to the upper and lower extremities on one side of her body. Resident #24 didn't participate in an RNP. Resident #24 required extensive assistance for transfers, and needed total assistance from staff for bathing , dressing, and personal hygiene.

On 7/22/24 at 11:36 AM, observed Resident #24 sit in a wheelchair in the dining room with a plate of food in front of her.

On 7/23/24 at 12:29 PM, watched the staff performed cares for Resident #24., noted a contracture to her left hand. The staff offered to place a pillow under her left arm for comfort.

On 7/25/24 at 7:45 AM, witnessed a Certified Nurse Aide (CNA) assist Resident #24 eat breakfast.

During an interview 7/23/24 at 12:57 PM, Staff D, CNA, reported Resident #24 sometimes went to group exercise class but she didn't usually do much exercise in the class. Staff D stated Resident #24 had a RNP with ROM exercises but she didn't know how often or how much she participated in the exercises.

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Resident #24's July 2024 Documentation Survey Report directed the following:
a. Please assist her to all group exercises.
- First documented on 7/23/24
b. Transfer practice wheelchair to bed stand with 2 assist.
- First documented 7/23/24.

During an interview 7/23/24 at 1:06 PM, the Restorative Aide reported Staff A, QA and Restorative Nurse, notified her when a resident had a restorative program and what activities they needed her to work with Resident #24. The Restorative Aide stated they documented the restorative program and activities performed in the electronic health record (EHR) under tasks. The Restorative Aide reported Resident #24 participated in the restorative group exercise class Monday through Friday, she enjoyed playing ball.

During an interview 7/23/24 at 1:21 PM, Staff A reported she tried to get residents on a restorative program or therapy when they first come to the facility. Therapy make recommendations for the residents' restorative program and give her the information. She entered the program into the computer. She talked to the Restorative Aide about the resident and what program of exercises to do. They develop an exercise program according to the resident's preference. Staff A added the CNA's also performed ROM with the residents. Staff A reported the staff request therapy evaluate a resident whenever they notice a change or decline in the resident's status.

During an interview 7/25/24 at 12:56 PM, the Assistant Director of Nursing (ADON), reported

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Staff A as the responsible person for the restorative program. When Resident #24 arrived to the facility, she couldn't walk and had a contracture in her hand. The staff did all of her ADL's. The ADON explained the staff tried to encourage her to eat but they often had to assist her with eating.

During an interview 7/25/24 at 1:02 PM, Staff A reported she didn't find an RNP for Resident #24 prior to July 2024. Staff A stated she added the restorative activity under the tasks in the EHR whenever she received the restorative program information for a resident. She then put the restorative program recommendations from therapy in a folder. Staff A acknowledged Resident #24's EHR didn't have the paper document scanned in, but thought that was a good idea to start doing that. She let the Restorative Aide know whenever they had a new resident for the program. Staff A reported the goal of a restorative program was to maintain the resident's level of function and potentially increase their ability to do better than what they could do. Staff A stated the Restorative Aide documented when the resident performed or refused the RNP in the EHR under tasks.

3. Resident #43's admission MDS assessment dated 3/16/23 admitted to the facility on 3/9/23. Resident #43 required supervision and touch assistance with eating. In addition, Resident #43 needed extensive assistance of two staff for bed mobility and transfers. The MDS included diagnoses of CVA and a hip fracture. The MDS recorded Resident #43 started PT and OT on 3/13/23, and didn't have RNP activities during the 7 day look back period.

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Resident #43's MDS assessment dated 2/14/24 reflected he didn't have impaired ROM. Resident #43 required set up assistance for eating, and substantial to maximum assistance for bed mobility and transfers. The MDS recorded Resident #4 had two or more falls without injury during the look back period. The MDS documented PT and OT started on 1/23/24, and he had no RNP activities during the 7 day look back period.

Resident #43's MDS assessment dated 5/1/24 reflected he didn't have impaired ROM. Resident #43 required set up assistance for eating. He needed substantial to maximum assistance for bed mobility and total assistance with transfers. The MDS recorded Resident #43 received OT services from 1/23/24 4/10/24 and PT 1/23/24 - 2/28/24. Resident #43 didn't have RNP activities during the 7 day look back period.

The Care Plan Focuses initiated 3/9/23 described Resident #43 with:
a. Revised 7/28/23: limited physical mobility related to neurological deficits and weakness. The Care Plan directed:
i. Group exercise
ii. 7/28/23: Nursing Rehab/Restorative: Exercise bike for lower body level 5 for 15 minutes.
b. an ADL deficit due to a history of CVA, anoxic brain damage, and weakness. The Care Plan directed staff
i. Do a stand pivot transfer.
ii. Assist of 2 staff for bed mobility
iii. Encourage Resident #43 to participate in group exercises, and a nursing rehabilitation restorative program with the exercise bike for the lower body for 5 to 15 minutes. The Care Plan lacked the frequency for RNP or group exercises.

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The PT Discharge Summary dated 2/28/24 reflected Resident #43 had weakness and required partial to moderate assistance for bed mobility. In addition, Resident #43 required substantial to maximum assistance of 1 2 staff for transfers. The PT recommended an RNP and assistance of 1 2 staff for transfers. PT documented they established a RNP for ROM that included a reciprocal activity for the bilateral lower extremities for 5 for 15 minutes. The note reflected the maintenance of Resident #43's current level of function as good with consistent staff follow through on the RNP.

Resident #43's March 2024 Documentation Survey Report lacked RNP activities. The Group Exercise Program directed time to complete exercise as Night 10:00 PM - 6:00 AM. All documentation reflected not applicable.

Resident #43's April 2024 Documentation Survey Report lacked RNP activities. The Group Exercise Program directed time to complete exercise as Night 10:00 PM - 6:00 AM. The one-time staff documented, reflected not applicable.

Resident #43's May 2024 Documentation Survey Report lacked RNP activities. The Activities Participation reflected Resident #43 actively participated in group exercise on 5/13/24. The report didn't contain additional restorative activities.

Resident #43's June 2024 Documentation Survey Report directed the following:
a. Active ROM (AROM) to the upper body and use the exercise bike for 15 minutes.

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F 676	Continued From page 17 -First Documented 6/19/24.documented six times in 6/2024. b. Group exercise program - Only documented on 6/5/24, 6/21/24, 6/25/24, and 6/28/24. On 7/25/24 at 11:05 AM, watched Staff E, CNA, and Staff F, CNA, sit Resident #43 on the edge of the bed, placed a gait belt around his waist, and then assisted him to stand, pivot, and transfer into the wheelchair. Staff E used a washcloth and washed his face. Staff E then took a foam swab and provided oral cares for Resident #43. During an interview on 7/23/24 at 1:06 PM, the Restorative Aide reported she performed ROM exercises with Resident #43. He used the exercise bike occasionally but it depended on the day and his mood. She documented his restorative exercise activity performed in his EHR. During an interview on 7/25/24 at 10:55 AM, the Administrator reported the facility didn't have a restorative policy, they followed the standards of care. The Administrator defined the standards of care as the facility should offer restorative programs for residents and the staff should document the resident's restorative activities completed. During an interview 7/25/24 at 12:56 PM, the ADON reported Resident #43 had his days. He could be pretty easy going, but he also had times when he became combative and non compliant for cares. The staff had to perform ADL's for him, except he rarely allowed staff to help him eat.	F 676		
F 692 SS=D	Nutrition/Hydration Status Maintenance	F 692		

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F 692	Continued From page 18 CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, observations, and policy review the facility failed to implement consistent supplement serving amounts for 1 of 3 residents reviewed (Resident #43) for nutrition and weight loss. The facility reported a census of 53 residents. Findings include: Resident #43's MDS assessment dated 5/1/24 listed an admission date of 3/9/23. The MDS identified a Brief Interview for Mental Status (BIMS) score of 4, indicating severely impaired cognition. Resident #43 required supervision and	F 692	In continuing compliance with F 692, Nutrition/Hydration Status Maintenance, Accura HealthCare of Marshalltown corrected the deficiency by obtaining a order to ensure consistent supplement serving amounts for resident #43 and all like residents. The Administrator educated the QA nurse on 7/26/2024 on ensuring that there is an amount on a supplement order for resident #43 and all like residents. To correct the deficiency and ensure the problem does not recur, the QA Nurse educated all nurses on 7/26/2024 on ensuring there is an amount when receiving a supplement order. The ADON and/or designee will audit dietary supplement orders to ensure there is an amount to be given included in the order 3x weekly X 4 weeks, 2x weekly X 4 weeks, and 1x weekly X 4 weeks, then PRN to ensure continued compliance. As part of Accura of Marshalltown's ongoing commitment to quality assurance, the MDS Coordinator and/or designee will report identified concerns through the community's QA process.	8/16/2024

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touch assistance with eating. In addition, Resident #43 needed extensive assistance of two staff for bed mobility and transfers. The MDS included diagnoses of anemia, hypertension (high blood pressure), heart failure (heart muscle does not pump enough blood), renal disease, diabetes mellitus, cerebrovascular accident (CVA), non Alzheimer's disease, malnutrition, dysphagia (difficulty swallowing), and anoxic brain damage (lack of oxygen to the brain). The MDS reflected Resident #43 didn't have a 5% weight loss in the last month or 10% weight loss in the last 6 months. The MDS indicated Resident #43 ate a mechanically altered diet and had a therapeutic diet.

The Care Plan Focus revised 3/9/23 indicated Resident #43 had an alteration in his nutrition due to his potential for weight loss due to the diagnosis of anoxic brain damage. The Care Plan directed staff to serve supplements as ordered .

Resident 43's weight summary revealed the following weights from 1/10/24 to 7/1/24:
a. 1/10/24 = 155 lbs. (pounds)
b. 2/2/24 = 150 lbs.
c. 2/29/24 = 148 lbs.
d. 3/11/24 = 148 lbs.
e. 4/3/24 = 146 lbs.
f. 5/3/24 = 145 lbs.
g. 6/4/24 = 136 lbs.
h. 7/1/24 = 131 lbs.

Resident #43's Physician Order dated 10/3/23 directed staff to administer a thickened house supplement one time a day for weight management. The order lacked direction on how much of the supplement to give.

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Resident #43's Physician Order dated 5/1/24 directed staff to administer a thickened house supplement two times a day for weight management. The order lacked direction on the amount to give.

Resident #43's February 2024 to July 2024's Medication Administration Records (MAR) reflected the house supplement documented, indicating staff administered it but lacked documentation on how much Resident #43 received or consumed of the supplement.

A Progress Note titled Nutrition/Dietary dated 2/15/24 at 8:18 PM reflected Resident #43's annual nutritional assessment revealed a current weight of 150 lbs. with a body mass index (BMI) of 21.5%. The assessment documented a weight loss of 3.2% in 30 and 90 days and 4.5% in 180 days. Resident #43's diet order consisted of a general diet, pureed textures, and nectar thickened liquids. The note documented Resident #43 had an order for house supplement every day with good acceptance and meal intakes averaging 50% or less.

A Progress Note titled Nutrition/Dietary dated 3/11/24 documented Resident #43 triggered a significant weight loss of 10.3% in 180 days. Resident #43 current weight of 148 lbs. with a BMI of 21.2%. Resident #43's diet order consisted of a general diet, pureed textures, and nectar thickened liquids. The note documented Resident #43 had an order for house supplement 8 ounces every day with good acceptance per the MAR and meal intakes averaging 50% or less with 240 milliliters of fluid at every meal. The note recommended starting one scoop of protein powder three times a day at meals for unintended

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weight loss.

A Progress Note titled Nutrition/Dietary dated 4/29/24 documented Resident #43's quarterly assessment revealed a current weight of 146 lbs. with a BMI of 20.9%. The noted documented Resident #43 didn't have a significant weight change, but her weight did trend downward. Resident #43's diet order consisted of a general diet, pureed textures and nectar thickened liquids. The note documented Resident #43 had an order for house supplement every day with good acceptance per MAR and meal intakes averaging 50%. The note recommended increasing house supplement to twice a day related to subpar intakes and a trending down weight status.

A Progress Note dated 5/1/24 documented the Dietitian recommended to increase house supplement from daily to twice a day due to subpar intakes and weight trending downward. The note documented the facility received a verbal order and updated the MAR.

A Progress Note titled Nutrition/Dietary dated 7/23/24 documented Resident #43's quarterly assessment revealed a current weight of 131 lbs. with a BMI of 18.8%. The EHR reflected a significant weight loss of 10.2% in 90 days and 12.6% weight loss in 180 days. Resident #43's diet order consisted of a general diet, pureed textures and nectar thickened liquids. The note documented Resident #43 received a house supplement twice a day with meal intakes averaging 50% 75%. The note recommended increasing house supplement to 4 ounces three times a day.

On 7/24/24 at 4 PM, the Director of Nursing

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(DON) reported the Dietitian directed them to have the house supplement's physician order written generically, as the facility had different types of supplement available at different times such as ensure and boost. The DON acknowledged Resident #43's house supplement orders didn't state how much of the supplement to give. The DON reported the nurses usually give a Styrofoam cup full of the house supplement.

On 7/24/23 at 4:05 PM, Staff A, Quality Assurance (QA) Nurse, reported when she received training, her trainer directed her to give a cup full of the house supplement. Staff A stated she watched the residents take the house supplement to make sure they consumed it. Staff A stated she treated the supplement as a medication order and agreed a medication order should have the amount/dose included in the directions of the order.

On 7/25/24 at 7:50 AM, Staff B, RN (Registered Nurse) reported she administered the house supplement according to the directions of the physician order. Staff B reviewed Resident #43's house supplement order and verified the order didn't give directions on how much of the supplement to give. Staff B confirmed the physician order should state how much to give. Staff B stated she had worked at the facility a long time and the house supplement orders always have stated how much to give.

On 7/25/24 at 8:35 AM, Staff C, Licensed Practical Nurse (LPN), reported when she administered a house supplement she looked at the MAR to see how much to give and then measured the supplement with a medication cup.

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Staff C acknowledged Resident #43's house supplement order didn't state how much to give. Staff C stated she usually gave Resident #43 what the other residents got. Staff C stated she usually gave Resident #43 4 8 ounces of the house supplement depending on his mood and what he was willing to take. Staff C stated Resident #43 had thrown the cup of supplement at her before and she does not want to wear it. Staff C verified a Styrofoam cup on the medication cart held 6 ounces.

On 7/25/24 at 9:30 AM, the DON recognized the concern with Resident #43's house supplement related to inconsistent serving amounts, lack of directions in the physician order, and weight loss. The DON reported she had a concern when the Dietitian requested to change the house supplement orders. She went through all of the resident's physicians' orders for house supplements and updated the orders to include 4 ounces.

On 7/25/24 at 11:30 AM, the Administrator reported he expected the house supplement orders to include an amount to give. He also expected the Dietitian to know that.

A facility policy titled Resource: Nutrition Interventions for Unintended Weight loss dated 2021 documented the following conclusions about unintended weight changes that may include, but not limited to:
*A target range for weight based on the individual's overall condition, goals, prognosis, usual body weight, etc.
*Approximate calorie, protein, and other nutrient needs.
*Whether and to what extent to anticipate weight

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F 692	Continued From page 24 stabilization or improvement. *Whether altered weight or nutritional status could be related to an underlying medical condition (e.g., fluid, and electrolyte imbalance, medication related anorexia, or an infection). *Determine if the information obtained is supporting documentation to suggest a malnutrition diagnosis. Based on analysis of relevant information, the facility should identify a clinically pertinent basis for any conclusion that an individual cannot attain or maintain acceptable parameters of nutrition status.	F 692		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to	F 732	In continuing compliance with F 732, Posted Nurse Staffing Information, Accura HealthCare of Marshalltown immediately corrected the deficiency by posting the facilities nursing staffing information on 7/23/2024 near the beauty shop in the facility. The Administrator educated the QA Nurse on 7/26/2024 on ensuring that staffing information is posted daily. To correct the deficiency and ensure the problem does not recur, The QA nurse educated all nurses on ensuring that the nursing staffing information is posted and updated daily on 7/26/2024. The QA Nurse and/or designee will audit daily staffing sheet information weekly M-F X 12 weeks then PRN to ensure continued compliance. As part of Accura of Marshalltown's ongoing commitment to quality assurance, the MDS Coordinator and/or designee will report identified concerns through the community's QA process.	8/16/2024

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	165451	A. BUILDING _____ B. WING _____	C 07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MARSHALLTOWN	2401 SOUTH SECOND STREET MARSHALLTOWN, IA 50158

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F 732	Continued From page 25	F 732		

residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interviews, the facility failed to post the daily nurse staffing information. The facility reported a census of 53 residents.

Findings include:

On 7/23/24 at 11:50 AM, observed the facility didn't have the daily nurse staffing information posted.

On 7/23/24 at 12:00 PM, The Administrator acknowledged and confirmed the facility didn't post the daily nurse staffing information and that they didn't have the information readily accessible to residents and visitors. The Administrator reported they kept the daily nurse schedules in a binder at the nurses' station. The Regional Nurse Consultant (RNC) reported the facility would correct the issue and post the daily nurse staffing information.

On 7/23/24 at 1:00 PM, The Administrator reported the facility didn't have a policy regarding

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F 732	Continued From page 26 the daily nurse staffing postings. He stated the facility follows the standard of care in which this case the facility didn't.	F 732		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, facility documents, and policy review, the dietary staff failed to label and store food items in order to maintain food quality and reduce the risk of contamination and food borne illness. The facility also failed to ensure resident dishes and kitchen equipment reached the appropriate sanitizing temperature when utilizing the dish machine to reduce the risk of bacteria growth and cross contamination. The facility reported a census of 53 residents.	F 812	In continuing compliance with F 812, Food Procurement/Prepare/Serve-Sanitary, Accura HealthCare of Marshalltown corrected the deficiency by: washing the squirt bottle of ranch dressing, washing the bottle of French dressing, discarding the bacon bits in the garbage, labeling the cereal, labeling the containers under the prep table, labeling and dating all bags of cereal in the dry storage area, securing the bags of pasta, and separating the bags of cocoa powder and labeling them on 7/22/2024. The dietary manager conducted a complete audit of the kitchen on 7/22/2024 ensuring that all food is labeled and dated correctly. Accura HealthCare of Marshalltown corrected the deficiency by the dietary manager performing dishwasher temperatures on 7/22/2024. To correct the deficiency and ensure the problem does not recur, The Administrator educated the dietary manager on 7/26/2024 on ensuring that food is properly labeled, dated, and stored. The Administrator also educated the Dietary Manager on 7/26/2024 on ensuring that dishwasher temperatures are completed 3x daily, once during breakfast dishes, once lunch dishes, and once evening dishes. The Dietary Manager educated all kitchen staff on 7/26/2024 ensuring that dishwasher temperatures are completed 3x daily, and that food is properly labeled, dated, and stored. The Dietary Manager and/or designee will audit dishwasher temperatures and food storage 3x weekly X 4 weeks, 2x weekly X 4 weeks, and 1x weekly X 4 weeks to ensure continued compliance. As part of Accura of Marshalltown's ongoing commitment to quality assurance, the MDS Coordinator and/or designee will report identified concerns through the community's QA process.	8/16/2024

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F 812	Continued From page 27	F 812		

Findings include:

Initial tour of the main kitchen on 7/22/24 at 10:15 AM revealed the following concerns:
a. July 2024's dish machine temperature log lacked entries for seven days, two of the three required entries for four days, and one of the three required entries for one day.
b. Several labels reflecting outdated food items found in the cooler:
i. Squirt bottle of ranch dated 7/8/24
ii. Squirt bottle of French dated 6/30/24
iii. Bag of bacon bits dated 7/13/24
c. Four of five plastic containers of cereal didn't have a label or had an outdated label
d. Plastic containers under the prep table had an incomplete label or no label
e. Undated and unlabeled bags of cereal in dry storage
f. Two unsecured plastic bags of pasta
g. Box labeled "cocoa powder" had another bag placed on top of a partial opened bag of cocoa powder

In an interview on 7/22/25 at 10:14 AM, the Dietary Manager confirmed the lack of documented temperatures for the dish machine. They said the kitchen staff should document the temperatures three times day to correlate with meal service.

In an interview on 7/24/25 at 9:40 AM, the Dietary Manager acknowledged the presence of the outdated food items in the cooler, the unlabeled cereal containers/bags as well as the containers under the prep table, the unsecured pasta, and cocoa powder in dry storage. The Dietary Manager reported they expected the facility

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F 812	Continued From page 28 shouldn't keep food in the coolers longer than three days (then discard it) and food should also have a proper label, date, and securely sealed. An undated policy titled "Food Storage" revealed the following: a. Food should have a date when placed on the shelves b. Must use plastic containers with tight fitting covers or sealable plastic bags for storing grain products, sugar, dried vegetables, and broken lots of bulk foods, or opened packages. c. All containers or storage bags must be legible and accurately labeled and dated. d. Use or discard leftover food within 7 days.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880	In continuing compliance with F 880, Infection Prevention & Control, Accura HealthCare of Marshalltown corrected the deficiency by education of staff. The ADON Educated Staff G on 7/26/2024 on ensuring that she is wearing Personal Protective Equipment and rinsing resident equipment after use for resident #52 and all like residents. To correct the deficiency and ensure the problem does not recur, The ADON educated all nursing staff on Enhanced Precaution Barriers on 7/26/2024 and the DON educated all nursing staff on 8/14/2024 on ensuring resident equipment is rinsed after use. On 8/14/2024, the Administrator, DON, and ADON conducted Root Cause Analysis (RCA) on the F 880 Citation to include a root cause for the citation, corrective action to ensure problem does not recur, responsible party for auditing, and completion deadline. The ADON and/or designee will audit Enhanced Precaution Barriers and proper rinsing of resident equipment 3x weekly X 4 weeks, 2x weekly X 4 weeks, and 1x weekly X 4 weeks, then PRN to ensure continued compliance. As part of Accura of Marshalltown's ongoing commitment to quality assurance, the MDS Coordinator and/or designee will report identified concerns through the community's QA process.	8/16/2024

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F 880	Continued From page 29 conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	F 880		

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F 880	Continued From page 30 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, the Centers for Disease Control and Prevention (CDC) and facility policy review, the facility staff failed to follow infection control practices in order to prevent and control the onset and spread of infection within the facility by not wearing the required personal protection equipment and rinsing resident equipment after use for one of one resident observed (Resident #52). The facility reported a census of 53 residents. Findings include: 1. Resident #52's Minimum Data Set (MDS) assessment dated 5/12/24 identified a Brief Interview for Mental Status (BIMS) score of 0, indicating severely impaired cognition. Resident #52 required total staff assistance for toilet use and personal hygiene. The MDS reflected Resident #52 had a urinary catheter. The MDS included diagnoses of non Alzheimer's dementia, metabolic encephalopathy (swelling on the brain due to imbalances in the body), and urinary retention. The MDS listed active infections of septicemia (blood infection) and urinary tract infection (UTI). The Care Plan identified Resident #52 used a catheter due to urinary retention. The Interventions directed the protocol for UTI, monitoring signs and symptoms of UTI, providing catheter cares two times daily, and use of	F 880		

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F 880	Continued From page 31	F 880		

enhanced barrier precautions (EBP).

During observation on 7/25/24 at 1:20 PM, Staff G, certified nursing assistant (CNA), completed hand hygiene upon entering Resident #52's room to empty the urinary bag. Staff G donned only gloves, no gown, and proceed to gather the necessary supplies. Staff G placed a towel barrier on the floor, put the supplies on the towel, and used an alcohol swab to sanitize the nozzle. Staff G proceed to empty the urinary bag into Resident #52's labeled graduate without the nozzle coming in contact with the graduate. Staff G used a new alcohol swab to sanitize the nozzle afterwards. Staff H gathered the used supplies and threw away disposable items. Staff G emptied the graduate into the toilet and verbalized they couldn't find a cup or another graduate to rinse out the used one. Staff G didn't prefer to rinse out the graduate under the bathroom sink and would get a cup to rinse it out. Without rinsing the graduate, Staff G placed the used graduate by the toilet. Approximately ten minutes after watching Staff G complete the urinary bag cares, observed the used graduate with a small amount of urine present, indicating no one rinsed it out after using.

In an interview 7/25/24 at 1:50 PM, the Assistant Director of Nursing (ADON) reported Staff G self reported not wearing a gown during emptying of the urinary bag, signifying non adherence with the EBP standards. The ADON acknowledged Staff G's preference for using a cup to rinse out the used graduate, but didn't know if they did it that time.

The Enhanced Barrier Precaution policy, dated 5/6/24, instructed the staff to initiate the use of

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F 880	Continued From page 32 EBP for residents with an indwelling medical device (urinary catheters). Personal protective equipment (PPE) included gowns and gloves. In addition, observed EBP signage on Resident #52's door which summarizes when staff is to implement EBP and required PPE. The CDC website related to the Guideline for Prevention of Catheter-Associated Urinary Tract Infections (2009) dated 3/25/24 directed to empty the collecting bag regularly using a separate, clean collection container for each patient.	F 880		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the	F 887	In continuing compliance with F 887, Covid-19 Immunization, Accura HealthCare of Marshalltown corrected the deficiency by the ADON immediately contacting the facilities pharmacy to schedule a Covid-19 immunization clinic on 7/26/2024. The ADON will obtain vaccine consents for #23, #43, #22 and all like residents by 8/16/2024. The Clinic is scheduled for 8/28/2024. To correct the deficiency and ensure the problem does not recur, the Administrator educated the ADON on 7/26/2024 on ensuring all residents are offered the newest Covid-19 booster. On 8/14/2024, the Administrator, DON, and ADON conducted a Root Cause Analysis (RCA) on the F 887 Citation to include a root cause for the citation, corrective action to ensure problem does not recur, responsible party for auditing, and completion deadline. The ADON and/or designee will audit all residents that consent to the Covid-19 booster have had the booster and immunizations are documented under the immunization tab in PCC 1x weekly X 12 weeks then PRN to ensure continued compliance. As part of Accura of Marshalltown's ongoing commitment to quality assurance, the MDS Coordinator and/or designee will report identified concerns through the community's QA process.	8/16/2024

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F 887	Continued From page 33 benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, Centers for Disease Control and Prevention (CDC) guidelines and facility policy review, the facility failed to screen for eligibility, offer, provide education and document vaccine consent or refusal for the COVID 19 (coronavirus disease)	F 887		

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F 887	Continued From page 34	F 887		

immunization for 3 of 5 resident reviewed (Resident #23, #43, #22). The facility reported a census of 53 residents.

Findings include:

1. Resident #23's Minimum Data Set (MDS) dated 7/3/24 assessment identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.

Review of the clinical record revealed Resident #23 had received a COVID vaccination on 8/11/22. The clinical record lacked documentation of education with a consent or refusal provided to Resident #23 for an additional COVID-19 vaccination after 8/11/22.

Review of the CDC recommendations for adults aged 65 years and older recommended individuals to get one updated COVID 19 vaccine followed by one additional dose of an updated COVID 19 vaccine at least 4 months after the previous updated dose. The CDC and NHSN (National Healthcare Safety Network) documented adults aged 65 years or older are up to date when the individual had received 2 doses of the updated 2023 2024 COVID 19 vaccine, or received 1 dose of the updated 2023 2024 COVID-19 vaccine within the past 4 months.

2. Resident #43's Minimum Data Set (MDS) dated 5/1/24 assessment identified a Brief Interview for Mental Status (BIMS) score of 4, indicating severely impaired cognition.

Review of the clinical record revealed Resident #43 had received a COVID vaccination on 8/10/22. The clinical record lacked documentation

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of education with a consent or refusal provided to Resident #43 of an additional COVID-19 vaccination after 8/10/22.

The CDC's Website related to Use of an Additional Updated 2023-2024 COVID-19 Vaccine Dose for Adults Aged 65 Years and older: Recommendations of the Advisory Committee on Immunization Practices - United States, 2024 dated 4/25/24 indicated the CDC's Advisory Committee on Immunization Practices (ACIP) recommended that all persons aged 65 years and older receive 1 additional dose of any updated COVID-19 vaccine. The CDC recommended the additional dose given at least 4 months after the previous updated dose. The CDC and NHSN documented adults aged 65 years or older are up to date when the individual had received 2 doses of the updated 2023 2024 COVID 19 vaccine, or received 1 dose of the updated 2023 2024 COVID 19 vaccine within the past 4 months.

3. Resident #22's Minimum Data Set (MDS) dated 5/8/24 assessment identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.

Review of the clinical record revealed Resident #22 had received a COVID vaccination on 8/11/22. The clinical record lacked documentation of education with a consent or refusal provided to Resident #8 of an additional COVID 19 vaccination after 8/11/22.

The CDC website related to Stay Up to Date with COVID-19 Vaccines last reviewed 5/14/24 recommended people aged 12 years and older who got COVID-19 vaccines before September 12, 2023, should get 1 updated COVID-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165451	A. BUILDING _____ B. WING _____	C 07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF MARSHALLTOWN	2401 SOUTH SECOND STREET MARSHALLTOWN, IA 50158

(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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vaccine.

On 7/24/24 at 9:00 AM, The Administrator reported the facility didn't have any COVID-19 vaccination clinics to offer the 2023 2024 COVID vaccine.

On 7/24/24 at 9:29 AM, the ADON (Assistant Director of Nursing) reported August 2022 as the last COVID 19 vaccination clinic the facility had.

On 7/24/24 at 12:35 PM, Staff A, QA (Quality Assurance) Nurse, reported March 2023 as the last documented conversation she had with the Pharmacy to set up a vaccination clinic for the COVID 19 vaccine.

On 7/24/24 at 1:10 PM, the Administrator stated he expected the staff offer the residents a COVID 19 vaccination any time a new vaccine comes out.

On 7/25/24 at 8:25 AM, the ADON verified the facility didn't offer Residents #23, #22, and #43 the updated COVID 19 vaccine.

The facility policy titled COVID 19 Vaccination updated 5/6/24 reflected the facility would provide all residents with the opportunity and encouragement to receive the COVID 19 vaccinations. The policy further documented that if the resident would like to be up to date on the COVID 19 vaccine but is not, the facility would contact the primary physician to get an order, if not contraindicated.