STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000 Ok ✓ Lg	INITIAL COMMENTS Correction date: 8/16/2024 The following deficiencies resulted from the facility's annual recertification survey and investigation of complaints #121751-C and 121813-C and facility reported incident 121870-I, conducted July 16, 2024 to July 22, 2024 Complaint #121751-C was substantiated. Complaint #121813-C was substantitated. Facility reported incident #121870-I was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	Accura Healthcare of Stanton 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.	7/24/24
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	F 582	1. In continuing compliance with F 582, Medicaid/Medicare Coverage/Liability Notice the Accura healthcare of Stanton corrected the deficiency by staff education to ensure resident #43, #44, and all like residents receive proper ABN/NOMNOC notices. 2. To correct the deficiency and to ensure the problem does not recur the BOM and Administrator were educated on 7/24/24 on NOMNC/ABN process and procedures by DON. The DON and/or designee will audit all residents coming off skilled for accurate NOMNC/ABNs weekly for 12 weeks then PRN to ensure continued compliance. 3. As part of Accura healthcare of Stanton ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process. ✓	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jim r Williams	Executive Director	8/16/24

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 582	Continued From page 1	F 582		

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 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 clinical record review and staff interview, and instructions of CMS form 10123-NOMNC, the facility failed to provide notice within the required 2 calendar days of Medicare Non Coverage for 2 of 3 (Resident #43 and #44) residents reviewed. The facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 582	Continued From page 2	F 582		

reported a census of 42.

Findings include:

The census portion of the Electronic Health Record (EHR) of Resident #43 revealed the Resident began receiving skilled care under Medicare A payer source on 5/2/24 and Medicare continued to pay for her stay through 5/20/24. The facility provided a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) which was signed by the resident representative on 5/17/24. The facility was unable to produce a signed Notice of Medicare Non Coverage (NOMNC) form. The NOMNC form given was the typed name of the resident representative noted as t/o (telephone order) and the date of 5/17/24.

The census portion of the Electronic Health Record (EHR) of Resident #44 revealed the Resident began receiving skilled care under Medicare A payer source on 11/1/23 and Medicare continued to pay for her stay through 1/4/24. The facility provided a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) which was signed by the resident representative on 12/21/23. The facility was unable to produce a signed Notice of Medicare Non Coverage (NOMNC) form. The NOMNC form given was the typed name of the resident representative noted as t/o (telephone order) and the date of 12/21/23.

On 7/19/24 at 12:58 pm the Social Services Director stated she took over the position of Social Services in March of 2023. She said she had been trained that there was only one form, the SNF ABN form. She found out later about the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 582	Continued From page 3 NOMNC. She said when she found out about the NOMNC she called the residents or resident representative after they had all discharged home and told them about the form but dated it the same date as the ABN had been signed. The residents who were discharged during this time frame were not given information of filing an appeal to continue their skilled stay through Medicare.	F 582		
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.	F 607	1. In continuing compliance with F 607, Develop/Implement Abuse/Neglect Policies the Accura healthcare of Stanton corrected the deficiency by Staff L and Staff M completing the required DAA training on 7/24/24 The BOM completed an audit on 7/24/24 to identify any additional noncompliance with DAA training. 2. To correct the deficiency and to ensure the problem does not recur BOM and Social Services were educated on 7/24/24 on the requirements and procedures of completing the dependent adult abuse training as required by the Administrator. The Administrator and/or designee will audit monthly for 3 months then PRN to ensure continued compliance. 3. As part of Accura healthcare of Stanton ongoing commitment to quality assurance, the Executive director and/or designee will report identified concerns through the community's QA Process.	7/24/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 607	Continued From page 4 §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 employee file review, staff interview, and facility policy review the facility failed to ensure 2 of 5 staff members reviewed (Staff L & Staff M) completed the two hour Dependent Adult Abuse training within 6 months of their hire date. The facility reported a census of 42 residents. Findings include: 1. Review of the employee file of Staff L, conducted on 7/19/24, revealed a hire date of 12/8/23. The employee file lacked documentation of Iowa Department of Public Health (IDPH) approved Dependent Adult Abuse Mandatory Reporter training having been completed. 2. Review of the employee file of Staff M, conducted on 7/19/24, revealed a hire date of 1/4/24. The employee file lacked documentation of Iowa Department of Public Health (IDPH) approved Dependent Adult Abuse Mandatory Reporter training having been completed. On 7/19/24 at 2:38 pm the Business Office Manager stated she would search to see if the certificates could be located. On 7/19/24 at 5:00 pm, no certificates had been located. The facility policy titled Nursing Facility Abuse Prevention, Identification, Investigation and	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 607	Continued From page 5 Reporting Policy, dated 1/10/22, documented the following: - Within six months of hire each employee shall be required to complete an initial 2-hour training course provided by the Iowa Department of Human Services relating to the identification and reporting of dependent adult abuse. Each employee will take a 1-hour recertification training within 3 years of the initial training and every three years thereafter.	F 607		
F 609 SS=D	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 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	F 609	1. In continuing compliance with F 609, Reporting of Alleged Violations Accura healthcare of Stanton corrected the deficiency though staff education on the abuse reporting requirements to ensure alleged violations for Resident #21 and all like resident are reported as required. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated by 7/24/24 on State guidelines of reporting possible abuse allegations on time by Executive Director. The executive director and/or designee will audit weekly for 12 weeks to ensure properly compliance with abuse reporting policies. 3. As part of Accura healthcare of Stanton ongoing commitment to quality assurance, the Executive director and/or designee will report identified concerns through the community's QA Process.	7/24/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 609	Continued From page 6	F 609		

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 document review, and staff interview, the facility failed to report timely an allegation of possible abuse or injury of unknown origin for 1 of 1 resident (#21). The facility reported a census of 42 residents.

Findings include:

A facility self-report dated 7/05/24 revealed a resident sustained an injury of unknown origin and accused a staff member of making her fall on 6/26/24.

The admission Minimum Data Set (MDS) dated 6/20/24 revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderately impaired cognition. It included diagnoses of cancer, Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and thoracogenic scoliosis (spinal curvature caused by disease or surgery). It revealed the resident was dependent with toileting hygiene and putting on and removing footwear, required supervision with eating and maximum assistance with all other activities of daily living (ADLs).

The Electronic Health Record (EHR) included a progress note indicating the resident had an X-Ray in response to a left elbow injury.

Facility Investigation notes dated 6/26/24 indicated the facility investigated the accused staff member and terminated her on 7/01/24 for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 609	Continued From page 7 other reasons. The investigation notes indicated the Director of Nursing (DON) contacted the facility's corporate office on 7/01/24 regarding reporting of the incident to the proper State Agency. The notes revealed the State Agency reporting process began on 7/03/24. On 7/19/24 at 5:35 PM, the DON stated she initially thought to report the incident to the state agency but was informed by her corporate administration that it was not a reportable event. She stated she later received direction to report the event to the state agency. On 7/22/24 at 8:35 AM, the Administrator stated the facility should follow the reporting requirements set by the State Agency.	F 609		
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, observations, and staff interviews, the facility failed to assure each resident received an accurate Minimum Data Set (MDS) assessment, reflective of the resident's status at the time of the assessment for 3 of 14 residents reviewed (Resident #25, Resident #33 and Resident #37). The facility reported a census of 42 residents. Findings include:	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 641	Continued From page 8 1. The MDS assessment of Resident #25 documented a Brief Interview of Mental Status (BIMS) score of 13 which indicated cognition intact. The MDS recorded the resident experienced no mood symptoms of feeling down, depressed or hopeless. The MDS documented the resident exhibited no physical or verbal behaviors. The MDS documented diagnoses that included Alzheimer's disease, anxiety disorder, depression and bipolar disorder. The MDS documented the resident took antipsychotic and antidepressant medications during the lookback period. The MDS documented no gradual dose reduction (GDR) of psychotropic medications had been attempted and the physician had not documented a GDR as clinically contraindicated. The MDS documented bed rails were used daily as a restraint. On 7/16/24 at 1.53 pm Resident #25 was observed lying in bed. She had 2 mobility rails in place on her bed. The Side Rail Assessment of Resident #25 dated 2/19/24 documented "Side rails are indicated and serve as an enabler to promote independence". The Medication Administration Record (MAR) for Resident #25 for May of 2024 failed to reveal any documentation of the resident taking any antidepressant medications. The Psychotropic Utilization Detail of Resident #25 for May, 2024 documented GDR's had been declined in August 2023 and October 2023 per the psychiatric progress notes. The encounter Psyche Progress Notes of Resident #25 documented "Dose reductions of	F 641	. 1. In continuing compliance with F 641, Accuracy of Assessments the Accura healthcare of Stanton corrected the deficiency by completing a modification MDS for #25, #33, #37 by 7/26/24 All like residents with bed rails, psychotropic medications, and pressure sores MDS were reviewed to ensure accurate coding by 7/26/24 by DON. 2. To correct the deficiency and to ensure the problem does not recur the MDS coordinator and Social Service Designee was provided education by the DON ensuring MDS are coded accurately to reflect resident current level of status on 7/24/24. The DON and/or designee will audit MDS completed weekly to ensure all bed rails/pressure ulcers/psychotropic medications are coded properly weekly x 12 weeks then PRN to ensure continued compliance. 3. As part of Accura healthcare of Stanton ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	7/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 641	Continued From page 9	F 641		

the psychotropic medications are not clinically indicated due to the patient's psychiatric symptoms as detailed in this progress note. Tapering of the medication would not achieve the desired therapeutic effects and the current dose is necessary to maintain or improve the resident's function, well-being, safety and quality of life."

2. The MDS assessment of Resident #33 dated 5/14/24 documented bed rails were used daily as a restraint.

On 7/16/24 11:54 am Resident #33 was observed lying in bed with 2 mobility rails up.

The Side Rail Assessment of Resident #33 dated 5/10/24 documented "Side rails are indicated and serve as an enabler to promote independence".

On 7/17/24 at 2:02 pm, the MDS Coordinator stated side rails being documented on an MDS is an error. She stated the facility is restraint free. She said rails are needed for bed mobility and to promote independence. She stated she would look at the MDS and make modifications.

On 7/19/23 at 8:00 am, the MDS Coordinator stated the person who had been in her position prior to her had no tracking system in place for GDR's. She stated the Director of Nursing (DON) is now keeping a book to track them. She stated she had no way of knowing if GDR's had been contraindicated due to no tracking system so she marked no on the MDS form.

On 7/19/24 at 12:19 pm, the DON stated MDS should be completed accurately. She stated there is a corporate person who oversees the MDS but she is not aware if each one is checked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 641	Continued From page 10 over as the MDS Coordinator is still in training. #3 The MDS assessment of Resident #37 dated 7/2/24 identified a BIMS score of 7 which indicated severe cognitive impairment. The MDS revealed the resident independent with bed mobility, personal care, transfers, toileting, eating, and dressing. The MDS revealed the resident occasionally incontinent of urine and always continent of bowel. The MDS documented diagnoses that included: unspecified dementia without behavioral, cancer, atrial fibrillation (irregular and often very rapid heart rhythm), hypertension, renal insufficiency, arthritis, anxiety disorder, spinal stenosis lumbar region without neurogenic claud (chronic condition-spinal canal narrows, compressing the spinal cord and nerve roots), and cervicalgia (neck pain). The MDS revealed the resident was not at risk for developing pressure ulcers/injuries and the resident does not have one or more unhealed pressure ulcers/injuries. The Care Plan updated 7/11/24 revealed no documentation of the resident's unstageable pressure ulcer on right lateral foot. The Resident Matrix dated 7/16/24 revealed the resident has an unstageable pressure ulcer. The Physician Order for treatment dated 7/4/24 revealed Promegran Prisma to area on right outer foot. Cover with Mepilex. Change on bath days and as needed until healed. Noted Nursing staff completed treatment as ordered. On 7/19/24 at 8:05 am the MDS Coordinator, RN	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 641	Continued From page 11 revealed she is still learning the process of completing and updated Care Plans for the residents. The MDS Coordinator is still learning the process of each section of MDS. On 7/19/24 at 12:57 pm the DON stated the facility does not have policies for Care Plan and MDS initiating or revising. She stated they follow the regulations.	F 641		
F 656 SS=E	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 F 656, Develop/Implement Comprehensive Care Plan the Accura healthcare of Stanton corrected the deficiency by updating the comprehensive care plan for Resident #3, #6, #25, #29, #32, #40 by 7/26/24 by MDS coordinator. All like resident care plans were audited to ensure they were current and up to date by 7/26/24 2.To correct the deficiency and to ensure the problem does not recur the MDS coordinator was educated on ensuring to develop personalized comprehensive care plans for each resident on 7/24/24 by DON. The DON and/or designee will audit 5 care plans weekly x 12 weeks then PRN to ensure continued compliance. 3. As part of Accura healthcare of Stanton ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	7/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 656	Continued From page 12 (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 clinical record review and staff interviews, the facility failed to fully develop and personalize comprehensive care plans for 6 of 14 residents reviewed. (Residents #3, #6, #25, #29, #32 & #40). The facility reported a census of 42 residents. AND ALL LIKE RESIDENTS Findings include: 1. The Medication Administration Record (MAR) of Resident #6 for July 2024 documented the resident to have an order for Eliquis, an anticoagulant medication (a medication, also called a blood thinner, used to prevent and treat blood clots), twice day due to chronic atrial fibrillation (a type of an irregular heartbeat). The Care Plan revealed a Focus Area of anticoagulant therapy, dated 5/6/24. The only	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 656	Continued From page 13	F 656		

intervention on the focus area stated "Administer anticoagulant medications as ordered by physician. Monitor for side effects and effectiveness every shift."

The Care Plan failed to reveal a reason why the resident takes the medication. The Care Plan failed to reveal what side effects to monitor for or how to monitor for effectiveness.

2. The MAR of Resident #25 for July, 2024 documented the resident to have an order for Quetiapine Fumarate, an antipsychotic medication, daily for bipolar disorder.

The Care Plan of Resident #25 revealed a Focus Area of antipsychotic medications. In parenthesis it stated to specify the medication and then stated "related to" which was left blank. The Focus area was dated 3/5/24. The only intervention on the focus area stated "Administer antipsychotic medications as ordered by physician. Monitor for side effects and effectiveness every shift."

The Care Plan failed to reveal the name of the medication/medications Resident #25 was being administered. The Care Plan failed to reveal a diagnosis related to the order. The Care Plan failed to reveal any personalized information for the resident as to what behaviors have been exhibited correlated to the use of the medication. The Care Plan failed to reveal what side effects to monitor for how or where to monitor the effectiveness.

3. The Census Line of the Electronic Health Record of Resident #40 revealed she had been admitted to the facility under hospice care on 2/19/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 656	Continued From page 14 The Care Plan of Resident #40 revealed a Focus Area of Hospice Services dated 2/19/24. The interventions listed the name of the hospice company. The second intervention stated to notify hospice of any changes in condition. The Care Plan failed to be personalized to the resident to include any other interventions such as pain management, emotional support, end of life education, what goods or services hospice was providing in the facility, or the facility staff working cohesively with the hospice team. On 7/19/24 at 12:19 pm, the Director of Nursing (DON) stated she expects care plans to be personalized. She stated, for instance, for psychotropic medications, specific behaviors should be included on the care plan. She stated when a resident begins a new medication, the nurses do hot charting through progress notes to include behaviors or side effects and those should be carried to the care plan. 4. The MDS of Resident #29 dated 6/25/24 identified a BIMS score of 4 which indicated severe cognitive impairment. The MDS recorded the resident experienced mood symptoms of feeling down, depressed, or hopeless on 2 to 6 days and little interest or pleasure in doing things on 12 to 14 days of the previous 2-week look back period. The MDS did not reveal any wandering or exit seeking behavior. The MDS revealed the resident independent with bed	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 656	Continued From page 15	F 656		

mobility, personal care, transfers, toileting, eating, and dressing. The MDS documented diagnoses that included: type 2 diabetes mellitus, coronary artery disease, hypertension, renal insufficiency, non-Alzheimer's dementia, adjustment disorder with depressed mood, and pancytopenia (low levels of red blood cells, white blood cells, and platelets). The MDS documented the resident received insulin injections on 7 out of 7 days of the assessment reference period and Antidepressant.

The Care Plan revised 10/12/23 identified the resident having anxiety related to dementia. The care plan informed the staff a calendar in his room for orientation and the resident is currently seeing telepsych. The care plan identified the resident having depression related to adjustment disorder. The care plan informed the staff continue therapy, encourage engagement in facility activities, provide 1:1 as needed, and Telehealth for med review and medication changes. The care plan did not reveal any personalized interventions related to dementia, wandering, and anxiety.

5. The MDS assessment of Resident #3 dated 4/7/24 identified a BIMS score of 1 which indicated severe cognitive impairment. The MDS revealed no behaviors. The MDS revealed the resident is dependent with bed mobility, personal care, transfers, toileting, and dressing. The MDS revealed the resident frequently incontinent of urine and bowel. The MDS documented diagnoses that included: Parkinson's Disease, coronary artery disease, hypertension, renal insufficiency, non-Alzheimer's dementia, anxiety, depression, atrial fibrillation, and other personality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 656	Continued From page 16	F 656		

& behavior disorders due to know physiological condition. The MDS revealed the Doctor prescribed the following classification of medications for the resident: antipsychotic, antidepressant, opioid, and antiplatelet.

The Care Plan revised 7/9/24 identified the resident with altered thought process/cognition related to dementia. The care plan informed the staff assess resident upon admission, quarterly or with significant changes to identify decline/further decline in cognitive status, education family or responsible party regarding changes, and reassure resident to decrease frustration. The care plan identified the resident receiving hospice services due to vascular dementia without behavioral disturbance psychotic disturbance, mood disturbance, and anxiety. The care plan informed the staff with Hospice services and notify hospice of changes in my condition. The care plan did not reveal any targeted behavior related to dementia, other personality and behavior disorder, no personalized interventions for hospice care, no focus on depression, anxiety, and Parkinson's Disease.

6. The MDS assessment of Resident #32 dated 6/4/24 identified the resident is rarely or never understood. The MDS revealed no behaviors. The MDS revealed the resident is totally dependent upon 2 person physical assistance for toilet use, bed mobility, and transfers. The MDS revealed the resident frequently incontinent of urine and bowel. The MDS documented diagnoses that included: Alzheimer's Disease, hypertension, cerebrovascular accident, anxiety, depression, chronic obstructive pulmonary disease, unspecified mood disorder, and atrial

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 656	Continued From page 17	F 656		

fibrillation. The MDS revealed the Doctor prescribed the following classification of medications for the resident: antipsychotic, antidepressant, and antiplatelet.

The Care Plan revised 6/10/24 identified the resident potential for behavior/altered coping (actual or history) related to: becoming tearful. The care plan informed the staff move resident to a quiet area to deescalate behavior, provide 1:1 activities as needed, and provide the mechanical cat for resident to help self soothe. The care plan revealed resident with altered thought process/cognition related to dementia, TIA. The care plan informed the staff assess resident upon admission, quarterly or with significant changes to identify decline/ further decline in cognitive status. The care plan revealed potential for depression related to recurrent major depressive episodes, mild (disorder). The care plan informed the staff administer medications as ordered, assess for signs and symptoms of depression and report abnormal's, encourage visits from family members and friends, provide reassurances as needed. The care plan did not reveal any targeted behavior and personalized interventions related to Alzheimer's Disease, cerebrovascular accident, anxiety, and depression.

On 7/19/24 at 8:05 am, the MDS Coordinator, RN revealed she is still learning the process of completing and updated Care Plans for the residents. Stated the residents targeted behaviors should be on their care plan and personal interventions should also be on the care plan. Certified Nurses Aides are educated to complete behavioral tracking for residents having behavior and Nurses are educated to document a progress note for any behaviors that occur. MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 656	Continued From page 18 Coordinator stated she reviews the documentation to complete her Minimum Data Sheets Assessment. On 7/19/24 at 12:57 pm the DON stated the facility does not have policies for Care Plan and MDS initiating or revising. She stated the facility follows the regulations.	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. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657	1. In continuing compliance with F 657, Care Plan Timing and Revision the Accura healthcare of Stanton corrected the deficiency by updating the care plan for #37 and #16 by 7/26/24. All like resident's care plans were reviewed by 7/26/24 to ensure compliance. 2. To correct the deficiency and to ensure the problem does not recur the MDS coordinator was educated on 7/26/24 on ensuring care plans are revised and updated in a timely manner by DON. The DON and/or designee will audit 5 care plans weekly x 12 weeks, then PRN to ensure continued compliance. 3. As part of Accura healthcare of Stanton's ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	7/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 657	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, staff interview, the facility failed to revise and update the care plan for 2 of 14 residents reviewed for care plan revision (Resident # 37, #16). The facility reported a census of 42 residents. Findings include: 1. The Minimum Data Sheet (MDS) assessment of Resident #37, dated 7/2/24, identified a Brief Interview of Mental Status (BIMS) score of 7 which indicated severe cognitive impairment. The MDS revealed the resident independent with bed mobility, personal care, transfers, toileting, eating, and dressing. The MDS revealed the resident occasionally incontinent of urine and always continent of bowel. The MDS documented diagnoses that included: unspecified dementia without behavioral, cancer, atrial fibrillation (irregular and often very rapid heart rhythm), hypertension, renal insufficiency, arthritis, anxiety disorder, spinal stenosis lumbar region without neurogenic claud (chronic condition-spinal canal narrows, compressing the spinal cord and nerve roots), and cervicalgia (neck pain). The MDS revealed the resident was not at risk for developing pressure ulcers/injuries and the resident does not have one or more unhealed pressure ulcers/injuries. The Care Plan, updated 7/11/24 revealed no documentation of the resident's unstageable pressure ulcer on right lateral foot. The Resident Matrix dated 7/16/24 revealed the resident has an unstageable pressure ulcer.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 657	Continued From page 20 The Physician Order for treatment dated 7/4/24 revealed Promegran Prisma to area on right outer foot. Cover with Mepilex. Change on bath days and as needed until healed. Noted Nursing staff completed treatment as ordered. On 7/18/24 at 4:49 PM Staff N, RN reviewed Doctor's order for right lateral foot. The staff gathered supplies, knocked and entered the whirlpool room, set supplies on barrier, hand-washed, gloved, assessed area. Area was closed. The staff stated will talk with Director of Nursing, area appears healed, treatment is to be discontinued if healed. On 7/19/24 at 8:05 am, the MDS Coordinator, RN revealed she is still learning the process of completing and updated Care Plans for the residents. The MDS Coordinator is still learning the process of each section of MDS. 2. On 7/16/24 at 10:52 am, Resident #16 stated she had taken a fall which resulted in a broken tailbone prior to moving to the facility. She stated she still had a lot of pain and although the facility administered pain medication, it was not effective enough. She stated that at that moment, she could hardly stand to sit in the chair due to pain. The MDS of Resident #16 dated 5/21/24 identified a BIMS score of 13 which indicated cognition intact. The Care Plan of Resident #16 documented a Focus Area of Pain initiated 12/11/23. The Care Plan directed staff to administer as needed pain medication as directed by physician and notify the	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 657	Continued From page 21 nurse of any signs of pain. The fax written to the physician on 4/21/24 indicated staff noted the resident complaining of pain and refusing meals. On 4/22/24 the physician ordered scheduled pain medication three times a day. The Medication Administration Record (MAR) for Resident #16 for July of 2024 indicated Acetaminophen, extended release, 650 mg had been given three times a day scheduled since 4/22/24. The Care Plan was not updated to reflect the resident had been ordered scheduled pain medications. On 7/19/24 at 12:57 pm, the Director of Nursing (DON) stated the facility does not have a policy regarding care plans. She stated the facility follows the regulations and standards of care.	F 657	1. In continuing compliance with F 688, Increase/Prevent Decrease in ROM/Mobility the Accura healthcare of Stanton corrected the deficiency by having therapy screen Resident #22 and a restorative program determined by 7/26/24. All residents were reviewed to determine if a restorative program was necessary by 7/26/24. The MDS coordinator was educated on 7/25/24 on Accura restorative process for resident 22.	
F 688 SS=D	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.	F 688	2. To correct the deficiency and to ensure the problem does not recur restorative aids were educated on 7/26/24 of their expectations for the Accura restorative process by DON The DON and/or designee will audit residents to ensure each is completing their current program and documentation is being done appropriately. 3 times a week for 4 weeks, 2 times a week for 4 weeks, 1 time per week for 4 weeks, then PRN to ensure continued compliance. 3. As part of Accura healthcare of Stanton ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	7/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 688	Continued From page 22	F 688		

§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 clinical record review, observation, staff interviews, and policy review, the facility failed to provide restorative activities for 1 of 2 sampled residents in order to maintain a functional range of motion and prevent a decline in activities of daily living (Resident #22). The facility reported a census of 42 residents.

Findings include:

The Minimum Data Set (MDS) assessment dated 4/28/24 revealed Resident #22 to be dependent on staff for bathing, dressing, bed mobility, transferring and toileting. The MDS revealed the resident to have a functional limitation in range of motion on 1 upper extremity and 1 lower extremity. The MDS documented the resident to have diagnoses of hypertension (high blood pressure), diabetes, hemiplegia (paralysis of one side of the body) and a prior stroke. The MDS failed to reveal the resident had received any Speech, Occupational or Physical Therapies or any Restorative Nursing Programs during the lookback period.

The Care Plan revealed a Focus Area of CVA/Stroke, revision date of 3/26/24 which directed staff to perform range of motion exercises several times a day. The Care Plan revealed a Focus Area of Self Care Deficit related to right side hemiparesis which directed staff of the resident needing staff assistance for bathing,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 688	Continued From page 23	F 688		

bed mobility, dressing, toileting and transfers. The Care Plan also directed staff the resident had a Restorative Nursing Program, revised 5/11/21.

On 7/16/24 at 1:32 pm, the resident was observed sitting in his wheelchair in his room resting. His right wrist was noted to be contracted.

On 7/18/24 at 11:19 am, the Social Services director stated Resident #22 is non verbal. She stated he is picky about what staff members work with him and his wrist contracture has been there for a long time. She stated she was unaware of the resident having a Restorative Program. She said the MDS Coordinator also acts as the Restorative Nurse.

On 7/18/24 at 3:16 pm, the Rehabilitation Director stated Resident #22 would be screened that day to see if he is appropriate to receive Medicare Part B therapy services. She stated typically a resident is screened by therapy each quarter during his or her MDS period. She stated she had been the therapy director for a year and Resident #22 had never been screened for therapy during her time as director.

On 7/18/24 at 4:07 pm, the Rehabilitation Director stated she had screened Resident #22 and he had displayed no change in status from when he last received therapy in 2021. She stated he would be able to be picked up for therapy for the purpose of writing a restorative program.

On 7/19/24 at 8:00 am, the MDS Coordinator stated she does not know why Resident #22 does not have a restorative program. She stated there is no reason she is aware of and that he would be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 688	Continued From page 24	F 688		

appropriate for an Activities of Daily Living (ADL) and/or Dressing program.

On 7/19/24 at 12:19 pm, the Director of Nursing (DON) stated any residents who are fully independent do not have a restorative program. She said all other residents should have a program but some may be removed if a resident repeatedly refuses.

The facility policy Restorative Program Process, dated 11/1/19 documented the following:

1. Upon admission, quarterly and with significant change the resident's level of function will be assessed by the licensed nurse or in collaboration with therapy.
2. Based on the results of the assessment the licensed nurse will develop a care plan showing the resident's individual problems, determine approaches/interventions and set goals.
3. The licensed nurse will develop a restorative nursing program with individualized interventions and goals which may include recommendations for strategy and adaptive equipment from therapy.
4. The licensed nurse will educate all direct care staff assigned to the resident(s) on their restorative nursing program.
5. The licensed nurse will monitor staff and resident(s) to ensure compliance with the restorative nurse program.
6. The licensed nurse will monitor the daily restorative nursing program documentation in POC and follow-up with staff as needed.
7. The licensed nurse will write a monthly restorative nursing summary to track the resident(s) progress.
8. The licensed nurse will update the care plan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 688	Continued From page 25 and the restorative nursing program to reflect the resident(s) specific goals and interventions as needed. 9. The licensed nurse will make referrals to therapy as needed. 10. The licensed nurse will develop a discharge plan for the resident(s) who no longer need a restorative nursing program.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility document review, staff interviews, family interview, and facility policy review, the facility failed to supervise and provide a secure environment for 1 of 1 residents reviewed for elopement (Resident #29). The facility reported a census of 42 residents. Finding include: The Minimum Data Sheet (MDS) assessment of Resident #29, dated 10/5/23, identified a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderate cognitive impairment. The MDS recorded the resident experienced mood symptoms of feeling down, depressed, or hopeless on 12 to 14 days of the previous 2-week look back period. The MDS did not reveal any	F 689	1. In continuing compliance with F 689, Free of Accident Hazards/Supervision/Devices the Accura healthcare of Stanton corrected the deficiency by educating the DON on the Accura Elopement processes for resident 29 and all other like residents by 7/26/24. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated on 7/26/24 on Accura's Elopement Policy by the DON. The DON and/or designee will audit elopement drills twice weekly for one month, once weekly for one month and then monthly for 1 month, then PRN to ensure continued compliance. 3. As part of Accura healthcare of Stanton ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	7/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 689	Continued From page 26	F 689		

wandering or exit seeking behavior. The MDS revealed the resident independent with bed mobility, personal care, transfers, toileting, eating, and dressing. The MDS documented diagnoses that included: type 2 diabetes mellitus, coronary artery disease, hypertension, renal insufficiency, and pancytopenia (low levels of red blood cells, white blood cells, and platelets). The MDS documented the resident received insulin injections on 7 out of 7 days of the assessment reference period.

The Care Plan revised 10/3/23 identified the resident as an elopement risk. The care plan informed the staff to check the wander guard every shift, the resident's wander guard on shoelaces, history of removing wander guard, the resident will ask to leave the facility and walk around, and behaviors stating his is not in "prison."

The Wander Guard monitoring for the resident #29 revealed the Staff documented 10/24/23 to 7/17/24, current. The facility initiated, monitor the wander guard device every shift every day, started on 9/28/23. The staff did not complete documentation from 10/24/23 to 7/17/24, current.

The Communication with Physician Progress Note dated 10/11/23 revealed Doctor started Donepezil 5 mg daily for dementia. New diagnosis of unspecified dementia, updated in the residents chart on 10/12/23.

The Nurse Progress Note (PN) dated 10/20/23 revealed the resident left the building for unknown time, stated the resident exited the building between 4:30 PM and 5:00 PM. The staff unaware of the resident absence until the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 689	Continued From page 27	F 689		

resident returned, approximately 5:45 PM. The resident brought to the facility whiskey and sandals. The PN revealed the resident wanted to drive the car to the facility, the resident unable to find the keys. Staff I, LPN stated she asked wife at dinner where the husband was, wife stated she did not know, she forgot. The resident revealed to Staff I that he attempted two other times, staff intervened, the resident waited and succeeded the last attempt. Staff I notified the Administrator, instructions placed wander guard on left ankle, 15 minute visual observations, head to toe assessment, and BIMS assessment.

The sign in and sign out paper on 10/20/23 revealed the resident's daughter took the resident out of the facility at 3:15 PM and returned at 4:10 PM.

The 15 minute visual observations for the resident #29 started 10/20/23 after the incident occurred, to 7/17/24, current. The facility did not provide documentation from 10/20/23 to 11/4/23. The staff did not provide any documentation for 12/1/23 to 12/31/23 and 5/1/24 to 5/31/24. The staff did not complete documentation from 1/1/24 to 4/30/24. The staff documented 6/1/24 to 7/17/24, current.

The Elopement Drills are completed monthly. The staff provided documentation for every month with exception from 10/1/23 to 2/29/24, the staff was unable to provide documentation.

The Elopement education is provided for staff at orientation and periodically at staff meetings.

Observation on 7/18/24 revealed the resident's house is two and a half blocks north of the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 689	Continued From page 28	F 689		

up a hill. Noted multiple houses, structures, and trees, unable to see the resident's house. South of the facility up the hill about half of a block is a active train track, south of the facility parking lot is an active walking trail.

On 7/17/24 at 3:02 PM the Director of Nursing (DON) stated she was informed from the Regional Vice President of Operations via email about the elopement. The facility did a compliant review on the incident that occurred on 10/20/23 at 5:45 PM. Regional Vice President of Operations stated the resident #29 had higher BIMS upon return from the facility. The resident was educated about signing in & signing out when he wanted to leave the facility. Staff denied education about the code to the door, stated resident already knew the code. DON stated she does not know when staff stopped him from independently leaving at his will and when the wander guard was removed.

On 7/18/24 at 8:06 AM Daughter and POA of the resident #29 recalled the elopement. Staff I updated her about the resident arriving back to facility about 5:45 PM. Staff I informed her the resident left and walked to his house, gathered sandals and whiskey, and walked back. He wanted to drive the car but could not find the keys. Daughter stated the resident is memory impaired, unable to make proper judgement decisions, resulted in placement at the facility. Daughter stated if the resident was able to find the keys to the car, he would have drove it back to the facility, the resident's wife resides at the facility. Stated earlier that day the Social Worker informed her that the resident was anxious, the resident stated to the staff he did not want to be there, his condition was better than others that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 689	Continued From page 29	F 689		

live here. The daughter and social worker made arrangements for the daughter to come and take the resident(s) out for a walk. The daughter stated she took her parents out for a walk on the nearby trail after 3:00 PM and returned after 4:00 PM, stated she completed the sign in and sign out sheet, that would have the exact time. The daughter stated she arrived back to the facility checked parents back in, walked to the front entrance, the resident liked to walk her to the door, she punched the code in and said "bye." The daughter stated he watched her punch in the code and he must have used that to get out. The resident stayed at door while she left. Stated she thought he was not anxious anymore and appeared to be okay. She thought he stole scissors or nail clippers to get the wander guard off. The resident was trying to "prove a point," he wanted to show "us" that he can still do things on his own, that he does not need a nursing home. The daughter stated the resident is being monitored and treated by the telepsych Doctor, is involved in 1:1 activity, brother takes the resident to the farm with his dog, and on medications to help with his anxiety, he has been so much better. The daughter stated he has lived in Stanton his entire life and knows the town and the way home. She feels like he was safe the day he got out.

On 7/18/24 at 2:52 PM Staff J, CNA stated she worked the 2:00 pm to 10:00ppm shift on 10/20/23, she assisted another resident at the time of elopement. Staff J, seen the resident walking from the south nurses station to the north nurse station carrying a black garbage bag, as she was walking from the east wing to the west wing. Staff J denied hearing any alarms that shift. Staff J stated she was informed by other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 689	Continued From page 30	F 689		

staff working that shift that the resident eloped that evening. Staff J denied hearing any pages for lost residents that shift. Staff J stated the resident will be sneaky when attempting to leave the facility, one attempt he wore a coat and sunglasses. Staff stated the education she received, frequent visual checks and redirect the resident when showing signs of increase exit seeking. Staff stated she is "pretty sure," the resident is to always be supervised when outside.

On 7/18/24 at 2:59 PM Staff K, CNA stated she worked the 2:00 pm to 10:00ppm shift on 10/20/23, Staff K aware the resident was out of the facility with his wife and daughter, unaware of the return time. Staff K denied any alarms sounding that shift and denied any pages for lost residents. Staff K updated about the elopement late that shift. Revealed she seen the Nurse laughing about it, shocked that the Nurse did not appeared to be taking the incident serious. The education that was provided redirect the resident when exit seeking, notify the nurse, and supervise the resident when outside.

On 7/18/24 at 3:15 PM Staff I, LPN confirmed she was the nurse supervising the resident on 10/20/23 during the elopement. Staff I stated lots of visitors coming in and going out of the facility that evening. Staff I informed that the resident having increase anxiety, Social Worker spoke with daughter, daughter took wife and the resident out of facility in attempt to decrease anxiety. Staff I stated she seen them arrive back, and seen the daughter, the resident, and a third person walk to the front door (south entrance), she did not stand there to see them walk out the door. Staff I assumed the resident left with daughter. Staff I stated the daughter does not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 689	Continued From page 31	F 689		

always tell the staff when she is taking the resident out of the building. Staff I denied reviewing the sign in and sign out sheet or calling the daughter to verify. Staff I revealed continued doing her tasks. Staff I stated when she assisted the wife at supper she asked the whereabouts of the resident, the wife stated she forgot. Staff I continued to assume the resident was out with the daughter. Staff I was informed by the south nurse that the resident walked back into building holding a sack of items. Staff I asked the resident where he came from, the resident replied I left and went home to take care of a few things. The resident had whiskey and sandals. Staff I stated the resident was approximately gone from 4:30 PM to 5:45 PM. The resident is to have a wander guard on, the resident had different shoes on therefore the wander guard alarm did not sound. The resident revealed to staff I that he waited until he got the chance and then followed someone out. Other residents and their families outside of the facility. The resident ignored the questions asked by the families and kept walking to his house. Staff I stated you can see his house from the window in his room. Staff I revealed the resident wore a long sleeve flannel plaid shirt and jeans. Staff I stated resident appeared to be proud of himself. Staff I reported she called the administrator, the daughter, and the primary care physician. Staff I was instructed to start 15 minute checks, head to toe assessment, and BIMS. Staff I stated the resident recently admitted and did not have a routine yet, nor showed a certain time of day to be more anxious.

The facility policy titled Missing Resident/Elopement Process updated 7/12/21 directed staff:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 689	Continued From page 32 Care Plan will be modified as needed based on risk assessment. An alarm bracelet may be placed on the resident to audibly alert the staff of attempts by the resident to exit the facility. The resident's care plan shall address behaviors using resident specific goals and/or approaches as assessed by the IDT. Staff will encourage activities which the resident enjoys in order to occupy/distract the resident.	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident interview, family interview and staff interviews, the facility failed to provide appropriate pain management for 2 of 2 residents reviewed (Res #16 and Res #21). The facility reported a census of 42 residents. Findings include: The Minimum Data Set (MDS) assessment of Resident #16 dated 5/21/24 identified a Brief Interview of Mental Status (BIMS) score of 13 which indicated cognition intact.	F 697	1. In continuing compliance with F 697, Pain Management, Accura healthcare of Stanton corrected the deficiency by ensuring that Resident #16, #21, and all like residents pain was assessed and interventions implemented by 7/26/24. The DON was educated to ensure pain management is provided to all resident consistent with professional standards of practice on 7/26/24. 2. To correct the deficiency and to ensure the problem does not recur on 7/26/24 all nursing staff were educated regarding pain management and following physicians' orders by Regional Clinical Nurse. The DON and/or designee will audit 24 hour report and MARS for pain management 3 times a week for 4 weeks, 2 times a week for 4 weeks, 1 time per week for 4 weeks then PRN to ensure continued compliance. 3. As part of Accura healthcare of Stanton ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	7/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 697	Continued From page 33	F 697		

The Care Plan of Resident #16 documented a Focus Area of Pain initiated 12/11/23. The Care Plan directed staff to administer as needed pain medication as directed by physician and notify the nurse of any signs of pain.

On 7/16/24 at 10:52 am, Resident #16 stated she had taken a fall which resulted in a broken tailbone prior to moving to the facility. She stated she still had a lot of pain and although the facility administered pain medication, it was not effective enough. She stated that at that moment, she could hardly stand to sit in the chair due to pain.

The Treatment Administration Record (TAR) of Resident #16 for the months of May, June and July of 2024 were reviewed. The TAR revealed the resident had an order for a lidocaine patch, 4% for lower back pain. It was not signed off as being utilized at all for the months reviewed.

The Medication Administration Record (MAR) for Resident #16 for July of 2024 indicated Acetaminophen, extended release, 650 mg had been given three times a day scheduled since 4/22/24.

Neither the MAR or the TAR for any of the months reviewed revealed any staff had documented a pain level for the resident at any time.

The Weights & Vitals portion of the Electronic Health Record revealed a numerical pain assessment had last been documented on 4/7/24.

The Progress Notes indicated the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 697	Continued From page 34	F 697		

5/20/24: Pain: Indicators of Pain: None

5/25/24: Resident denies shoulder pain and no bruising noted to left deltoid from B12 injection.

No other progress notes were found indicating a pain assessment since 5/25/24.

On 7/18/24 at 10:24 am, Staff O, Certified Nurse Aide (CNA) stated the resident complained of back pain earlier that morning during cares. She stated the resident complains of pain every day, sometimes more than once a day. She stated she notifies the nurse to see if the resident has anything available for pain.

On 7/18/24 at 10:26 am, Staff P, Registered Nurse (RN) stated Resident #16 has chronic pain. She said her pain level ranges day to day anywhere from stating her pain is 0 as high as a 7 or 8 on a 1-10 pain scale. She explained pain should be monitored three times a day with the scheduled acetaminophen and she would update the order to add pain monitoring into the MAR. She stated she knows the resident has increased pain when she is in her chair. She said the family is looking at hospice care and she hoped the resident could obtain better pain management once she enrolled in hospice care. She also stated some days the resident refuses to get out of bed due to her pain being so high. She said she is not aware if the physician had ever been notified of the resident's pain not being appropriately managed.

On 7/18/24 at 10:37 am the Director of Nursing (DON) stated pain management documentation is individualized for the resident. She stated if a resident who generally does not have pain and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 697	Continued From page 35	F 697		

has no scheduled pain medication, it should be monitored at minimum once a month along with monthly vital signs. She stated for any resident who is on any scheduled pain medication, it should be documented with each administration of the medication. All residents receive a quarterly pain assessment as part of the MDS as well.

On 7/19/24 at 12:19 pm, the DON stated if staff is noting a resident to have increased pain, especially to the point of not being able to get out of bed, she would expect the nurse to notify the physician so the pain medication regimen could be evaluated by the physician.

2. On 7/16/24 at 1:20 PM, Resident #21's relative confirmed the resident was under hospice care and had not had her morning pain medication.

The Pain Interview dated 6/15/24 revealed the resident reported she had almost constant pain within the preceding five (5) days.

The admission Minimum Data Set (MDS) assessment dated 6/20/24 revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderately impaired cognition. It included diagnoses of cancer, Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and thoracogenic scoliosis (spinal curvature caused by disease or surgery). It revealed the resident was dependent with toileting hygiene and putting on and removing footwear, required supervision with eating and maximum assistance with all other Activities of Daily Living (ADLs).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 697	Continued From page 36 The Electronic Health Record (EHR) included a physician order dated 6/13/24 and reordered on 6/26/24 for Hydrocodone-Acetaminophen Oral tablet 10-325 mg and directed staff to give 2 tablets by mouth three times a day for pain and give 1 tablet by mouth every 24 hours as needed for pain. The Medication Administration Record (MAR) indicated the resident's Hydrocodone-Acetaminophen order was to be administered at breakfast, mid AM, and at bedtime. The Medication Administration Audit Report revealed the resident's Hydrocodone-Acetaminophen was administered late 41 times out of 105 doses when following the standard administration schedule or 19 times out of 105 doses when following the custom administration schedule (3-hour time range for each ordered dose). A Pain Scale rating review indicated the resident had an average pain rating of 4.8 out of 10. The Care Plan dated 6/13/24 included pain due to arthritis and scoliosis and directed staff to administer pain medication as directed by the physician. On 7/19/24 at 12:57 PM, the Director of Nursing stated the facility did not have a policy directly addressing pain management. She stated the facility followed regulations.	F 697		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)	F 732		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 732	Continued From page 37 §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 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 document review and staff interview,	F 732	1. In continuing compliance with F 732, Posted Nurse Staffing Information Accura healthcare of Stanton corrected the deficiency by educating nursing staff on 7/24/24. 2. To correct the deficiency and to ensure the problem does not recur nurses were educated on 7/24/24 on the proper way to fill out the daily staffing sheet by DON. The DON and/or designee will audit nurse staffing posting 3 times per week for 4 weeks, 2 times week for 4 weeks, and 1 time per week for 4 weeks, then PRN to ensure continued compliance. 3. As part of Accura healthcare of Stanton ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	7/24/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 732	Continued From page 38 the facility failed to complete and post nurse staffing information at the beginning of each shift. The facility reported a census of 42 residents. Findings include: On 7/19/24 at 12:45 PM, the posted staffing sheet revealed incomplete day and evening shift staffing data. On 7/19/24 at 2:30 PM, a nurse staffing information binder review revealed 17 out of 17 staffing sheets for July 2024 were incomplete. There was no staffing sheet for July 17, 2024. On 7/19/24 at 3:15 PM, the Director of Nursing (DON) stated the staffing information sheet is initiated during night shift and the nurse for each shift was expected to complete and post the staffing information. On 7/22/24 at 8:35 AM, the DON stated the facility did not have a policy regarding posting of staffing data.	F 732		
F 801 SS=E	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes:	F 801		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 801	Continued From page 39 §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following	F 801	1. In continuing compliance with F 801, Qualified Dietary Staff Accura Healthcare of Stanton corrected the deficiency by enrolling in a state certified program on 7/24/24 and completing by 8/16/2024. 2. To correct the deficiency and to ensure the problem does not recur-the Executive Director was educated on 7/24/2024 by the VP of Operations on the requirements for qualified dietary staff. The Executive Director and/or designee will audit dietary staff qualifications weekly for 12 weeks to ensure qualified dietary staff are employed. 3. As part of Accura Healthcare of Stanton's' ongoing commitment to quality assurance, the Administrator and/or designee will report identified concerns through the community's QA Process.	8/16/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 801	Continued From page 40	F 801		

qualifications-
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or
(E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.
This REQUIREMENT is not met as evidenced by:
Based on document review and staff interview, the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service by not having a certified dietary manager. The facility reported a census of 42 residents.

Findings include:

On 7/17/24 at 11:30 AM, the Dietary Manager

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 801	Continued From page 41 (DM) stated she passed the certification test but hadn't purchased the license. On 7/18/24 at 1:15 PM, a course completion certificate revealed she was not certified as an approved nutrition and food service manager. On 7/18/24 at 1:19 PM, the DM stated she did not have a national certification. A policy titled "Personnel - General" dated 2021 indicated the food and nutrition services department will be staffed to assure that sufficient, competent, supportive personnel carry out the functions of the department. On 7/22/24 at 8:35 AM, the Administrator stated the Dietary Manager was expected to have the correct dietary management certification.	F 801		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 803	Continued From page 42 §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, menu review, and staff interview, the facility failed to properly prepare pureed diets for 2 of 2 residents (Resident #27 & #20) reviewed. The facility also failed to serve the appropriate portions for 11 residents who received regular diets and 3 residents who received carbohydrate-controlled (4 CHO) diets (Resident #17, #22, and #29). The facility reported a census of 42. Findings include: The facility's Menu for lunch for 7/18/24 identified the following items to be served as part of the planned pureed textured diet: #12 scoop (2 2/3 oz) of pureed ribs #8 scoop (4 oz) of pureed macaroni & cheese #12 scoop (2 2/3 oz) of pureed green beans, no bacon #20 scoop (1 5/8 oz) of pureed bread & margarine #12 scoop (4 oz) of pureed gooey butter cake 8 fluid oz milk The facility's Menu also identified a 2-oz serving for 4 CHO diets.	F 803	1. In continuing compliance with F 803, Menus Meet Resident Needs/Prep in Adv/Followed, Accura healthcare of Stanton corrected the deficiency by educating all kitchen Staff by 7/26/24 to ensure Resident #27, #20, #17, #22, and #29 receive properly prepared meals according to their diets and menu. 2. To correct the deficiency and to ensure the problem does not recur all kitchen staff were educated on 7/26/24 by the dietary manager on the puree process and appropriate serving sizes/portions. The Dietary manager and/or designee will audit puree process and portion control 3 times a week for four weeks, 2 times a week for four weeks, and 1 time a week for four weeks, and then as needed to ensure continued compliance. 3. As part of Accura healthcare of Stanton ongoing commitment to quality assurance, the Executive director and/or designee will report identified concerns through the community's QA Process.	7/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 803	Continued From page 43	F 803		

Record review of the Diet Orders for Residents #20 and #27 revealed both had an order for regular diet, puree texture and Residents #17, #22, and #29 had an order for 4 CHO (carbohydrate controlled) diet.

Continuous observation of lunch preparation and service began on 7/18/24 at 10:50 pm.

On 7/18/24 at 10:50 AM, Staff A, Cook, used a basting spoon to place four (4) unmeasured servings of carrots into the blender. He added an unmeasured amount of 2% milk. He blended the mixture and divided the total amount into two (2) small bowls. He covered the bowls with cellophane and placed them in the microwave. No measurement of volume was done.

At 11:07 AM, Staff A placed one (1) slice of bread, two (2) pork ribs, and an unmeasured amount of milk into the blender. He blended the items and added more unmeasured milk to the blender. He divided the total volume into two (2) separate bowls and placed them in a pan on the steam table. No measurement of volume was done.

At 11:25 AM, Staff A placed an unknown amount of macaroni into the blender with a basting spoon. He added an unmeasured amount of milk and blended it. He divided the mixture into two (2) bowls and placed them in a pan on the steam table. He took the carrots from the microwave and placed them in a pan on the steam table. No measurement of volume was done.

At 12:00 PM, Staff A began preparing residents' lunch plates. The first 11 plates were prepared with partially full 4-oz servings of macaroni & cheese, green beans, and mixed vegetables.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 803	Continued From page 44 Throughout lunch service, a 4-oz serving scoop was used for every resident plate prepared with macaroni & cheese. On 7/19/24 at 5:15 PM, the Dietary Manager stated the facility did not have a policy specifically for the puree process but staff should follow the designated (Martin Brothers) puree process. An undated document titled "Puree Process" directed staff to measure the total volume of food after it has been pureed and divide the total volume of the pureed food by the original number of portions using the Puree Scoop Chart. A policy titled "Accuracy and Quality of Tray Line Service" dated 2021 indicated the meal will be checked against the therapeutic diet spreadsheet to assure that foods are served as listed on the menu and each meal will be checked for proper portion sizes. On 7/22/24 at 8:47 AM, the Dietary Manager stated staff should follow the diet spreadsheet.	F 803		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced	F 804		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 804	Continued From page 45 by: Based on observation, staff interview, and policy review, the facility failed to provide food served by a method to maintain a safe and appetizing temperature. The facility reported a census of 42. Findings include: On 7/19/24 at 11:50 AM, Staff A, Cook, prepared pork ribs, carrots, and macaroni & cheese for two (2) pureed lunch menus. He divided each menu item into separate bowls, heated the pureed carrots, and placed all six (6) bowls in a pan on the steam table. The temperatures were not checked for any of the pureed items before being placed in the steam table pan. At 12:22 PM, Staff A put one (1) of each item on a plate for Staff B, Dietary Aide (DA) to deliver to the resident. Both Staff A and Staff B indicated the lunch plate was being delivered to the resident. A temperature check of each item was performed with the following results. a) Pureed pork ribs were 129.4° Fahrenheit (F). b) Pureed macaroni & cheese was 80.1° F. Staff A gave Staff B the plate and she took it to the resident. A policy titled "Food Temperatures" dated 2021indicated all hot food items must be cooked to appropriate internal temperatures, held, and served at a temperature of at least 135 degrees Fahrenheit.	F 804	1. In continuing compliance with F 804, Nutritive Value/Appear, Palatable/Prefer Temp, Accura healthcare of Stanton corrected the deficiency by educating dietary staff on 7/26/24 on food temperature requirements. 2. To correct the deficiency and to ensure the problem does not recur all dietary staff were educated by 7/26/24 on food temperature policies and procedures and monitoring temp logs by the dietary manager. The Executive director and/or designee will audit food temperatures during meals 3 times a week for four weeks, 2 times a week for four weeks, and 1 time a week for four weeks, and then as needed to ensure continued compliance. 3. As part of Accura healthcare of Stanton ongoing commitment to quality assurance, the Executive director and/or designee will report identified concerns through the community's QA Process.	7/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 804	Continued From page 46 On 7/22/24 at 8:47 AM, the Dietary Manager stated staff should follow the safe food temperature ranges.	F 804	1. In continuing compliance with F 812, Food Procurement, Store/Prepare/Serve-Sanitary the Accura healthcare of Stanton corrected the deficiency by the Dietary Manager removing the undated and unlabeled food items from the arctic air refrigerator on 7/16/24, removing the undated and unlabeled food items from the arctic American panel refrigerator on 7/16/24, disposing of the opened box of chicken on the floor on 7/16/24, disposing of the open box of beef patties on 7/16/24, disposing of the package of hot buns in dry storage on 7/16/24, and disposing of the open spices in dry storage on 7/16/24. On 7/16/24, the unopened and unlabeled items in the arctic air refrigerator, American panel refrigerator, American panel freezer, and dry storage room were disposed of by the Dietary Manager. 2. To correct the deficiency and to ensure the problem does not recur all kitchen staff were educated by 7/25/24 by the dietary manager on food storage requirements, kitchen sanitation policies, hand hygiene processes, and dish washer appropriate Ph levels. The Administrator and/or designee will audit 3 times a week for four weeks, 2 times a week for four weeks, 1 time a week for four weeks, and then as needed to ensure continued compliance. 3. As part of Accura healthcare of Stanton ongoing commitment to quality assurance, the Executive director and/or designee will report identified concerns through the community's QA Process.	7/25/24
F 812 SS=E	Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility policy review, the facility failed to maintain sanitary practices by improperly storing and serving food. The facility reported a census of 42 residents. Findings include: On 7/16/24 at 8:25 AM, an initial kitchen observation identified the following findings:	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 47	F 812		

An Arctic Air refrigerator contained:
1) An unlabeled, undated clear container with sliced orange items.
2) An undated, previously opened bottle of tomato juice.
3) An unlabeled pouch of round, yellow items.

An American Panel refrigerator contained:
1) An unlabeled, clear package of chopped meat.
2) An undated, partially closed, clear storage bag of sliced Swiss and American cheese.
3) An undated, previously opened jar of minced garlic.
4) An undated, previously opened bottle of Sweet and Smokey BBQ sauce.

An American Panel freezer contained:
1) A box of packaged breaded chicken chunks stored on the floor.
2) An open box of exposed beef patties.

The dry goods storage contained:
1) An opened box of packaged hot dog buns stored on the floor.
2) A shelf of seasonings with an opened container of black pepper and garlic powder.

On 7/16/24 at 8:25 AM, Staff A, Cook, propped his left, gloved hand on the garbage can rim with his fingers touching the inside. He walked over to the serving steam table, repositioned the lids of two pans of food, grabbed a rag, and wiped the food serving table area. He did not change gloves nor perform hand hygiene throughout the process.

On 7/16/24 at 8:45 AM, Staff A laid a pair of gloves on the steam table platform where resident meal plates were previously prepared.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 48	F 812		

He donned the gloves, staged two styrofoam plates in the same area on the platform, and put a serving of oatmeal on each plate. He grabbed a black marker, wrote something on the styrofoam plate used as a plate cover, and put the black marker on the steam table platform. He grabbed another plate, sliced a banana, put the slices on the plate, and gave it to the food service aide to served it to a resident. He did not change gloves nor perform hand hygiene throughout the process.

On 7/16/24 at 12:00 PM, a large baking sheet with serving bowls of sherbet was observed on a wooden table with a baking sheet of sherbet bowls lying directly on top of the lower bowls.

On 7/17/24 at 8:40 AM, Staff C, Registered Nurse (RN) took uncovered styrofoam cups of coffee and breakfast trays on a cart to room 43.

On 7/17/24 at 8:55 AM, Staff D, Certified Medicine Aide (CMA) took an uncovered bowl of cereal to a resident in the rear lobby. She was observed feeding the resident a piece of toast with her bare hands.

On 7/17/24 at 10:35 AM, a follow-up kitchen observation revealed the following findings:
An Arctic Air refrigerator contained:
1) An opened, unlabeled, and undated package with a disc-shaped item.
2) An opened, unlabeled storage bag of square, thinly sliced, orange items.
3) An unlabeled baking sheet of meat.

An American Panel refrigerator contained:
1) An undated, unlabeled, clear bag of chopped meat.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 49 2) An undated, clear storage bag of sliced Swiss and American cheese. 3) An undated, previously opened jar of minced garlic. 4) An undated, previously opened bottle of Sweet and Smokey BBQ sauce. 5) An undated, unlabeled sealed package of round meat. 6) An unlabeled, previously opened white bag. 7) Two unlabeled pitchers of brown liquid. An American Panel freezer contained: 1) An unlabeled baking sheet of tube-shaped meat. 2) An unlabeled, undated previously opened white bag. The dry goods storage contained: 1) An undated, unlabeled previously opened, opaque bag of small, doughnut shaped item. 2) An unlabeled, clear storage On 7/17/24 at 11:40 AM, Staff E, Dietary Aide (DA) performed a sanitizer test on two (2) buckets of solution used to clean the food preparation area. She got a piece of Hydrion Chlorine test strip and submerged it in the first bucket, held in the solution for 10 seconds, removed it and stated it should be documented at 10 parts per million (ppm). She repeated the process for the second bucket and yielded the same results of 10 ppm. The manufacturer's quaternary sanitizer solution recommendations indicate levels below 50 ppm should be discarded. At 12:42 PM, Staff F, Environmental Services (EVS) entered the kitchen area, walked to the coffee maker, grabbed the pot of coffee and took	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 50	F 812		

it out of the kitchen area. No hand hygiene was performed throughout the process. The Dietary Manager confirmed the coffee maker was within the kitchen area and stated staff should wash their hands upon entering the kitchen.

On 7/18/24 at 10:40 AM, a kitchen observation revealed a portable fan on the serving counter blowing air into a cut out section in the ceiling directly above the food serving area. Staff B, Dietary Aide (DA) was sweeping pieces of ceiling insulation from beneath the serving steam table.

At 10:55 AM, the Maintenance Director laid a piece of sheet metal on the food preparation counter to use for repairing the ceiling.

At 11:00 AM, Staff A, Cook, placed a strainer in the sink designated for washing dirty dishes, poured cooked macaroni into the strainer, placed the strained macaroni back into the pot, and returned the pot back on the stove.

At 11:07 AM, he used tongs to place pork ribs into a blender and laid the tongs on the sheet metal lying on the food preparation counter. He used milk with a best buy date of 7/17/24 to prepare two (2) pureed diets.

At 11:30 AM, Staff A placed several small paper plates on the food preparation counter. His thumb touched the center food area side of every plate.

A policy titled "Food Storage" dated 2021 indicated food should be dated as it is placed on the shelves if required by state regulation. It also indicated all foods should be stored off the floor.

A policy titled "General Food Preparation and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 51 Handling" dated 2021 indicated food items will be prepared to conserve maximum nutritive value, develop, and enhance flavor and keep free of harmful organisms and substances. It also indicated disposable gloves should be discarded after each use and food should be prepared and served with clean utensils. On 7/22/24 at 8:51 AM, the Dietary Manager stated staff should follow the facility's policies regarding food storage, hand hygiene, and prevention of cross-contamination.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880	1. In continuing compliance with F 880, Infection Prevention and Control Accura Healthcare of Stanton corrected the deficiency by the Executive Director implementing the required Legionella Water Management on 7/25/24 to ensure compliance. DON educated all staff on proper use of PPE and hand hygiene on 7/26/24. . 2.To correct the deficiency and to ensure the problem does not recur, the maintenance director was educated on 7//25/24 on The Legionella Water Management policy and procedures for compliance by the Executive director. All staff were educated on 7/26/24 on proper doffing of PPE and hand hygiene by the DON and ADON/IC. The Executive Director and/or designee will audit Legionella Processes weekly for the next 12 weeks, then PRN to ensure continued compliance. The ADON/IC will audit hand hygiene and donning/doffing PPE 3 times a week for 4 weeks, then 2 times a week x 4 weeks, then 1 time per week x 4 weeks, then PRN to ensure continued compliance. 3. As part of Accura Healthcare of Stanton ongoing commitment to quality assurance, the Administrator and/or designee will report identified concerns through the community's QA Process.	7/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 52 §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 infection. §483.80(f) Annual review.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 53	F 880		

The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:

Based on observations, staff interviews, record reviews, and policy review, the facility failed to implement the Infection Prevention and Control Program (IPCP) by staff not discarding Personal Protective Equipment (PPE) immediately after use nor appropriately performing hand hygiene. The facility also failed to identify areas or devices in the building to reduce the risk and prevent the growth of Legionella or other waterborne pathogens. The facility reported a census of 42 residents.

Findings include:

On 7/16/24 at 12:45 PM, a covered, yellow isolation container in the northeast hall had PPE (isolation gowns) hanging out of it.

On 7/17/24 at 8:20 AM, Staff G, Certified Nurse Aide (CNA) picked up a resident's meal ticket off of the floor in front of the service window, put it on the counter, then grabbed 2 packs of plastic utensils wrapped in paper towel and took it to the residents in room 38. No hand hygiene was observed.

On 7/17/24 at 8:23 AM, an observation revealed a covered isolation bin near room 36 had PPE gown straps hanging out of the top. A PPE gown was observed hanging on the outside of room 35's door.

On 7/17/24 at 9:50 AM, the Infection Preventionist (IP) stated the bin for used PPE should be covered and PPE should not be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 54 hanging out of it. On 7/17/24 at 2:20 PM, a document titled "General Information Prevention and Control - Nursing Standards" updated 5/06/24 revealed single-use disposable equipment or devices labeled by the manufacturer for single-use are not to be reused. The IP stated interpreted the policy to indicate the gowns should not be reused. On 7/18/24 at 2:15 PM, the Maintenance Director stated he was not familiar with the facility's water flow diagram and was not able to verbalize the water flow system. A visual observation of the maintenance department utility room revealed a water heater with a set-point of 118 degrees Fahrenheit and two (2) tanks labeled "water storage tanks" with a set-point of 112 degrees F. The facility also had a water softener. On 7/18/24 at 3:04 PM, the Maintenance Director stated the facility did not have a water management plan, a water flow diagram, nor measures to assess the risk of or prevent the growth of Legionella or other waterborne pathogens. He stated his water temperature checks in resident rooms is what he used for high risk area checks. On 7/18/24 at 3:44 PM, the Maintenance Director provided blank templates dated 8/23 for water system flow and Legionella risk areas and stated he didn't have completed versions. On 7/18/24 at 4:43 PM, Staff H, CNA exited room 35 in PPE (gown, mask, and gloves) and walked to the other end of the unit hall, removed it, and placed it in a trash bin. He donned new PPE and walked back down the hall to room 34.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. BUILDING _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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 55 On 7/19/24 at 11:42 AM, the Maintenance Director provided completed water system flow and a Legionella Risk Area documents dated for 7/18/24. A policy titled "Transmission-Based Precautions" updated 4/01/24 directed staff to use contact precautions on those residents who are known or show are suspected to be infected or colonized with epidemiological organisms. It also directed staff to remove gown and gloves prior to leaving a room. A policy titled "Legionella" dated 10/24/23 indicated sound engineering, preventative maintenance and housekeeping practices will be utilized to minimize the risk of exposing residents and team members to the legionella bacteria. On 7/22/24 at 8:35 AM, the Administrator stated the Legionella assessment and prevention policy and procedure should be followed and the checks should be completed.	F 880		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0544	A. BUILDING: _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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) COMPLETE DATE
L 964	58.43(9) Resident abuse prohibited 481-58.43(135C) Resident abuse prohibited. Each resident shall receive kind and considerate care at all times and shall be free from mental and physical abuse. Each resident shall be free from chemical and physical restraints except as follows: when authorized in writing by a physician for a specified period of time; when necessary in an emergency to protect the resident from injury to the resident or to others, in which case restraints may be authorized by designated professional personnel who promptly report the action taken to the physician; and in the case of a mentally retarded individual when ordered in writing by a physician and authorized by a designated qualified mental retardation professional for use during behavior modification sessions. Mechanical supports used in normative situations to achieve proper body position and balance shall not be considered to be a restraint. (II) 58.43(9) Upon a claim of dependent adult abuse of a resident being reported, the administrator of the facility shall separate the victim and accused abuser immediately and maintain that separation until the abuse investigation is completed. (I, II) This Statute is not met as evidenced by: Based on clinical record review, facility document review, and staff interview, the facility failed to report timely an allegation of possible abuse or injury of unknown origin for 1 of 1 resident (#21). The facility reported a census of 42 residents. Findings include: A facility self-report dated 7/05/24 revealed a resident sustained an injury of unknown origin and accused a staff member of making her fall on	L 964		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0544	A. BUILDING: _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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) COMPLETE DATE
L 964	Continued From page 1	L 964		

6/26/24.

The admission Minimum Data Set (MDS) dated 6/20/24 revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderately impaired cognition. It included diagnoses of cancer, Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and thoracogenic scoliosis (spinal curvature caused by disease or surgery). It revealed the resident was dependent with toileting hygiene and putting on and removing footwear, required supervision with eating and maximum assistance with all other activities of daily living (ADLs).

The Electronic Health Record (EHR) included a progress note indicating the resident had an X-Ray in response to a left elbow injury.

Facility Investigation notes dated 6/26/24 indicated the facility investigated the accused staff member and terminated her on 7/01/24 for other reasons.

The investigation notes indicated the Director of Nursing (DON) contacted the facility's corporate office on 7/01/24 regarding reporting of the incident to the proper State Agency. The notes revealed the State Agency reporting process began on 7/03/24.

On 7/19/24 at 5:35 PM, the DON stated she initially thought to report the incident to the state agency but was informed by her corporate administration that it was not a reportable event. She stated she later received direction to report the event to the state agency.

On 7/22/24 at 8:35 AM, the Administrator stated

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0544	A. BUILDING: _____ B. WING _____	C 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF STANTON	213 HALLAND AVENUE STANTON, IA 51573

(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) COMPLETE DATE
L 964	Continued From page 2 the facility should follow the reporting requirements set by the State Agency.	L 964		