STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165423	A. BUILDING _____ B. WING _____	C 01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF AMES, LLC	3440 GRAND AVENUE AMES, IA 50010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date: 2/26/2023 The following deficiencies resulted from the facility's annual recertification survey with an investigation of intakes #103627-C and #104071-I, conducted January 23, 2022 to January 26, 2023. Complaint #103627-C was not substantiated. Facility reported incident #104071-I was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	**F000** Accura Healthcare of Ames 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 correction 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 and is in compliance with the requirements of participation, or that corrective action was necessary.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the	F 578	F578 In continuing compliance with F578, Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir, Accura Healthcare of Ames corrected the deficiency by updating Resident #35's IPOST, care plan, order in PCC and sticker to the outside of the door to reflect his desire to receive CPR. On 1/27/2023 and audit was completed to ensure Resident #35 and all like residents IPOST/Care Plans/Code Status orders in PCC/ and heart stickers on doors all match by the DON. To correct the deficiency and to ensure the problem does not recur, all facility Nurses and Facility Leadership team was educated on 1/27/2023 by the DON to ensure a new IPOST is obtained if a resident returns from the hospital with a different code status order and that IPOST, Code Status orders, Care Plans, and heart stickers on doors need to match the resident's wishes. The DON and/or designee will audit IPOST, Code Status orders, Care Plans, and heart stickers on doors for all residents 3x weekly for 4 weeks, 2x weekly for 4 weeks, and 1x weekly for 4 weeks, and PRN to ensure continued compliance. As part of Accura Healthcare of Ames ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	1/27/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Em Allan	Administrator	02/07/2023

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

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F 578	Continued From page 1	F 578		

facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on observations, clinical record reviews, and staff interviews the facility failed to have a consistent plan, policy, or procedure for advance directives for 1 of 25 residents reviewed (Resident #35). The facility reported a census of 64 residents.

Findings include:

The Iowa Physician Orders for Scope of Treatment (IPOST) signed 7/17/19 by the Resident ' s Responsible Party directed that Resident #35 requested a do not resuscitate (DNR) if he had no pulse and was not breathing. The Physician signed the order on 7/23/19.

The Order Audit Report included an order dated 12/17/20 to discontinue Resident #35 ' s DNR

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F 578	Continued From page 2	F 578		

order.

The Orders tab of the electronic health record (EHR) documented an order for cardiopulmonary resuscitation revised 11/27/22.

Resident #35 ' s Code Status in the EHR reviewed on 1/24/23 reflected a CPR status.

On 1/24/23 at 11:25 AM, an interview with Staff J, Certified Medication Aide (CMA)/Certified Nurse Aide (CNA), reported that in an emergent situation, the staff should look at the resident ' s door. If the resident had a heart on their door, it meant they requested CPR. Staff K, CMA, added that in an emergent situation, the staff looked to see if a resident ' s door had a heart on it, which meant they were a full code (CPR). After checking the door, the staff should check the EHR and hard chart (paper chart) to confirm.

On 1/24/23 at 11:29 AM, an observation of Resident #35's door revealed no heart symbol next to his name to indicate that he wished to have CPR.

On 1/24/23 at 11:42 AM, an interview with Staff L, Registered Nurse (RN), stated the resident ' s door would have a heart symbol on the outside of their door if they wished to be a full code. Following that the staff should verify in the EHR and their hard chart. Staff L added that management addressed the resident ' s code status at the time of the resident's admission to the facility.

On 1/26/23 at 2:35 PM, the Director of Nursing (DON) and the Administrator verbalized that the facility did not have a policy or procedure

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F 578	Continued From page 3 regarding Advance Directives.	F 578		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1,	F 584	F584 In continuing compliance with F584, Safe/Clean/Comfortable/Homelike Environment, Accura Healthcare of Ames corrected the deficiency by replacing Resident #3's wheelchair and cushion on 2/15/2023. The Executive Director will ensure that resident #3 and all like residents missing personal belongings are reported in a timely manner via the Accura Grievance Process and managed in a timely manner. To correct the deficiency and to ensure the problem does not recur, the Environmental Service Supervisor placed ID tags on all resident wheelchairs and walkers the week of 10/31/2022-11/4/2022 to ensure they don't get misplaced or assigned to the improper owner. The Executive Director reviewed the Accura Grievance Process and the importance of reporting missing items immediately during the Resident Council Meeting that took place on 2/6/2023. Facility Staff will be educated on the Facility's Grievance Process on 2/21/2023. The Executive Director and/or designee will audit all grievances and any resident council meeting minutes 3x weekly x 4 weeks, then 2x week x 4 weeks, then 1x weeks c 4 weeks, then PRN to ensure continued compliance. As part of Accura Healthcare of Ames ongoing commitment to quality assurance, the Environmental Service Supervisor and/or designee will report identified concerns through the community's QA Process.	2/15/2023

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F 584	Continued From page 4 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record reviews, facility policy review, resident, staff, and family interviews the facility did not exercise reasonable care for the protection of resident's property from loss or theft for 1 of 3 residents reviewed (Resident #3) The facility reported a census of 64 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #3 dated 12/02/22 documented a Brief Interview Mental Status of 15 indicating cognition intact. The MDS included diagnoses of hypertension and cerebral palsy. During an interview on 1/24/23 at 1:35 PM, Resident #3 said her manual chair was missing. Resident #3 described the chair as a dark purple manual chair with a turquoise, yellow and green Honeycomb cushion. Resident #3 asked for her chair from multiple staff but nobody found the wheelchair. Resident #3 stated that the facility staff knew about the lost wheelchair, including the Administrator and the Director of Nursing (DON). Resident #3 said she followed the staff into storage areas to look for her wheelchair. Resident #3 stated the facility used a storage unit west of town and she wondered if her wheelchair was sent there. Resident #3 believed she signed a form that listed her personal belongings brought with her upon admission. Resident #3 stated the	F 584		

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F 584	Continued From page 5 wheelchair was parked across the hall from her room and a few days later was moved. The facility document titled Inventory of Personal Effects dated 9/6/22 and signed by Resident #3 included a manual wheelchair. The facility document titled Grievance Process updated January 2023, stated: 1. The resident had the right to voice grievance to the facility or other agency or entity that hears grievances without discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their nursing facility stay. 2. The resident has the right to, and the facility would make prompt efforts to resolve grievances. The policy included that the facility should Ensure that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to the investigate grievance, a summary of the pertinent findings or conclusions regarding the resident's concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility because of the grievance, and the date the written decision was issued. During an interview on 1/24/23 at 2:03 PM, the Administrator stated he did not think the purple manual wheelchair came back during Resident #3's second stay at the facility on 8/26/22. The Administrator confirmed an inventory sheet was completed on 9/6/22 and included Resident #3's power wheelchair, however, the Administrator	F 584		

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F 584	Continued From page 6	F 584		

shared that there was another chair item listed but the writing was hard to read. The Administrator stated he did not work on 8/26/22 when Resident #3 moved into the facility. The Administrator reported he searched the entire building and the west storage unit, but could not locate Resident #3's manual wheelchair. The Administrator stated the process to report a missing item would be done by a resident completing a Grievance Form. The Administrator stated Resident #3 needed assistance to complete the Grievance Form, however, could sign her name. The Administrator stated neither Resident #3 nor the facility staff had completed a Grievance Form for the missing wheelchair.

During and interview on 1/24/23 at 2:43 PM, Resident #3 reported she went to the storage room with the Administrator on 1/24/23 to look for her wheelchair and could not locate the wheelchair.

During an interview on 1/25/23 at 12:17 PM, Resident #3's family member stated she knew about her missing manual wheelchair. Resident #3's family member stated the resident had moved from another facility to the current facility via a van service. Resident #3's family member stated the resident rode in a power wheelchair during the trip and the van service folded the manual chair for transport in the van. Resident #3's family member stated she observed the manual wheelchair folded up in the hallway by Resident #3's room after her admission to the facility, however, the manual chair was gone after a few days. Resident #3's family member stated her wheelchair did not have a label.

During a joint interview on 1/25/23 at 3:11 PM the

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F 584	Continued From page 7 Administrator and Resident #3 discussed her manual wheelchair, the brand, and the size. The Administrator stated he planned to order a new chair for Resident #3 if the facility could not locate it. During an interview on 1/25/23 at 3:13 PM, the Administrator shared that he looked for the purple wheelchair over the past 4 months and Resident #3 informed him that the wheelchair was dark purple, almost black. The Administrator stated he spoke with Resident #3's family member who confirmed that Resident #3 had the manual chair at the facility on her admission to the facility on 8/26/22. The Administrator acknowledged that the hard to read handwritten item on the inventory checklist dated 9/6/22 appeared to be a manual wheelchair.	F 584		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns.	F 636	F636 In continuing compliance with F636, Comprehensive Assessments & Timing, Accura Healthcare of Ames corrected the deficiency by reviewing Resident #14 and all like residents to ensure MDS assessments were completed within 14 days of admission on 1/27/2023 by the Regional Reimbursement Specialist. To correct the deficiency and to ensure the problem does not recur, 1:1 education was provided to the MDS Coordinator on the requirement of having initial MDS assessments completed within 14 days of admission on 1/31/2023 by the Regional Reimbursement Specialist. The DON and/or designee will audit the timing of MDS assessments 1x weekly for 12 weeks and PRN to ensure continued compliance. As part of Accura Healthcare of Ames ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	1/31/2023

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F 636	Continued From page 8 (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization	F 636		

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F 636	Continued From page 9 or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and staff interviews the facility failed to complete 1 of 1 Minimum Data Set (MDS) assessment within 14 days of admission. The facility reported a census of 64 residents. Findings include: Resident #14 ' s Admission MDS assessment dated 9/1/22 documented an admission date to the facility as 8/23/22. The MDS assessment listed a completion date of 9/7/22. On 1/25/23 at 12:57 PM the MDS Coordinator explained that Resident #14 admitted to the facility on 8/23/22, based on that date, the Admission MDS should have been completed by 9/5/22 and not 9/7/22. On 1/25/23 at 3:50 PM, the Director of Nursing (DON) reported that the facility used the Resident Assessment Instrument (RAI) manual instructions when completing MDS assessments. The Long-Term Care Facility Resident Assessment Instrument 3.0 User ' s Manual dated October 2019 directed an MDS Admission Assessment should be completed no later than the 14th calendar day of the resident ' s admission (admission date plus 13 calendar days).	F 636		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		

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F 641	Continued From page 10 §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, staff interviews, and facility policy review, the facility failed to document a Preadmission Screening and Resident Review (PASRR) for 1 of 1 (Resident #14) residents reviewed on the Minimum Data Set (MDS) assessment. In addition the facility failed to accurately code an anticoagulant drug classification medication for 1 of 1 residents (Resident #8). The facility reported a census of 64 residents. Findings include: 1. Resident #14's MDS assessment dated 9/1/22 indicated that she did not have a Level II PASRR or a serious mental illness, intellectual disability, or a related condition. Resident #14 PASRR dated 8/11/22 identified that she did have a diagnosis of mental illness as defined by PASRR and needs specialized services. On 1/25/23 at 1:51 PM the Social Services Director verified that Resident #14's MDS dated 9/1/22 should have included that she did have a level II PASRR dated 8/11/22. 2. Resident #8's MDS assessment dated 10/20/22 indicated that she received an anticoagulant medication for seven out of seven days in the lookback period. The October 2022 Medication Administration	F 641	F641 In continuing compliance with F641, Accuracy of Assessments, Accura Healthcare of Ames corrected the deficiency by reviewing Resident #14, #8, and all like residents to ensure accurate PASRR coding and accurate medication coding on the current MDS assessment by 1/31/2023 by the Regional Reimbursement Specialist. To correct the deficiency and to ensure the problem does not recur, the MDS Coordinator received 1:1 education regarding Accurate MDS Coding on 1/31/2023 by the Regional Reimbursement Specialist. The DON and/or designee will audit MDS coding for accuracy on all MDS assessment section A1500 and medication class 1x weekly for 12 weeks and then PRN to ensure continued compliance. As part of Accura Healthcare of Ames ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	1/31/2023

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F 641	Continued From page 11 Record (MAR) the use of an anticoagulant medication. On 1/25/23 at 3:50 PM, the Director of Nursing (DON) explained that the facility used the Resident Assessment Instrument (RAI) manual instructions for completing MDS assessments.	F 641		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record reviews, and resident, and staff interviews, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 of 1 residents reviewed (Resident #4). The facility reported a census of 64 residents. Findings include: The Minimum Data Set (MDS) for Resident #4 dated 12/15/22 documented a Brief Interview Mental Status (BIMS) score of 15, indicating cognition intact. The MDS identified that Resident #4 had independence with bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS listed the following diagnoses of	F 684	F684 In continuing compliance with F684, Quality of Care, Accura Healthcare of Ames corrected the deficiency by completing a skin sheet and Risk Management Report for Resident #4 on 1/26/2023 by the ADON. Staff A, LPN was provided 1:1 education on 1/26/2023 by the DON that upon discovering a resident skin issue on resident #4 and all like residents, the need to follow the Facility Skin Protocol including how to complete a Risk Management Report and completing a skin sheet for continued monitoring until the area is resolved. To correct the deficiency and to ensure the problem does not recur, all licensed nurses were educated on the Facility Skin Protocol including how to complete a Risk Management Report and complete skin sheets until skin areas are resolved on 1/30/2023 by the DON. The DON and/or designee will audit to ensure all skin areas have a skin sheet and Risk Management Report with appropriate interventions in place 3x weekly for 4 weeks, then 2x weekly for 4 weeks, and then 1x weekly for 4 weeks and PRN to ensure continued compliance. As part of Accura Healthcare of Ames ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	1/31/2023

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F 684	Continued From page 12	F 684		

hypertension, diabetes, and Parkinson's disease.

The Care Plan Focus dated 12/8/22 identified a potential for skin tears related to fragile skin. The Care Plan interventions dated 12/8/22 included:
1. Assist to keep skin clean and dry
2. Use lotion on dry skin areas
3. If skin tear obtained, treat per facility protocol

On 1/26/23 at 8:30 AM, observed Resident # 4 at the dining room table with a cut on her left arm, near the wrist with two sterile (steri) strips covering the injury.

Review of Resident #4's clinical record revealed no documentation, investigation or assessment of the skin tear.

The facility document titled Skin Management Protocol updated 1/20/23, instructed the following for skin tears:
a. Assess the area every 7 days until healed
b. Report to the physician if deterioration or signs of infection observed
b. Document dimensions weekly on the Skin Sheet - Non-Ulcer Assessment designated community wound nurse

On 1/26/23 at 9:16 AM, the Director of Nursing (DON) verified that she observed the skin tear on Resident #4 ' s left arm. The DON stated that neither she or the Assistant Director of Nursing (ADON) knew about the injury. The DON confirmed that Resident #4 ' s clinical record did not have documentation of the injury. The DON said she suspected that one of the nurses put the steri-strip on the injury. The DON stated she would do education with the nurses. The DON spoke to Resident #4 who told her she hit her arm

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F 684	Continued From page 13 on the juice cart. On 1/26/23 at 9:23 AM, the DON revealed that Staff A, Licensed Practical Nurse (LPN), had placed the steri-strips on Resident # 4's left arm. The DON stated that Staff A informed her that she worked as the medication aide at the time Resident #4 sustained the skin tear and that she had informed Staff B, Registered Nurse (RN). The DON stated that she expected the nurse to complete an injury report when Resident #4 sustained the skin tear to her left arm. The DON confirmed that Resident #4 ' s clinical record did not have documentation of an assessment and/or investigation of her skin tear. On 1/26/23 at 9:33 AM, Resident # 4 stated that she hit her left arm on the juice cart in the dining room on 1/24/22. Resident #4 denied knowing which facility staff put the steri-strips on the injury to her left arm. On 1/26/23 at 9:43 AM, Staff A revealed the injury to Resident #4's left arm occurred on 1/22/23, and that the resident had hit her arm on the juice cart that caused the skin tear. Staff A stated she applied two steri-strips and informed Staff B to complete the incident report. Staff A reported that she worked as the Certified Medication Aide (CMA) while Staff B worked as the nurse on duty that day.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 686		

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F 686	Continued From page 14 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations, and staff interview, the facility failed to ensure that residents did not develop avoidable pressure ulcers for 1 of 1 residents reviewed (Resident #8). The facility reported a census of 64. Findings include: The quarterly Minimum Data Set (MDS) dated 10/20/22 for Resident #8 identified a Brief Interview for Mental Status (BIMS) score of 11 indicating a moderate cognitive impairment. The MDS revealed the resident required extensive assistance of 1 staff member for bed mobility and personal hygiene, and extensive assistance of 2 staff members for transfers. The MDS further revealed the resident did not walk in her room or in the corridor. The MDS documented diagnoses that included diabetes, prior hip fracture, Parkinson's Disease, prior stroke, depression and traumatic brain injury. The comprehensive care plan revealed a focus area of Activity of Daily Living (ADL) deficit, revision date of 9/8/21. The care plan failed to direct staff to do any bed mobility or repositioning of the resident. The care plan additionally	F 686	F686 In continuing compliance with F686, Treatment/Svcs to Prevent/Heal Pressure Ulcers, Accura Healthcare of Ames reviewed Resident #8 and all like residents with pressure ulcers to ensure appropriate interventions were in place and care planned updated by 1/27/2023 by the DON. An audit of resident Braden assessments was conducted to ensure those who have a score under 12 have preventative interventions in place on their care plans to reduce the risk of pressure ulcers by 1/27/2023 by the DON. To correct the deficiency and to ensure the problem does not recur, the DON and ADON were provided 1:1 education to ensure all residents with pressure ulcers have preventative interventions including dietary interventions on 2/1/2023 by the Regional Nurse Consultant. The DON and/or designee will audit all residents with pressure ulcers 3x weekly for 4 weeks, then 2x weekly for 4 weeks, and then 1x weekly and PRN to ensure continued compliance. As part of Accura Healthcare of Ames ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	2/1/2023

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F 686	Continued From page 15 revealed a focused area of Impaired Skin Integrity related to decreased mobility, revision date of 12/6/22. This section of the care plan also failed to direct staff to do any bed mobility or repositioning of the resident. Record review of the current care plan revealed the facility failed to implement interventions related to the presence of a pressure ulcer that was identified on 12/15/22 until it was revised on 1/23/22. Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).	F 686		

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Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal

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separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

The Braden Scale for Predicting Pressure Sore Risk revealed documentation the resident scored a 15 indicating a low risk for the development of pressure ulcers. A score of 9 or less indicates a severe risk. A score of 10-12 indicates a moderate risk. A score of 13-14 indicates a mild risk. A score of 15-18 indicates a low risk. A score of 19 or higher indicates a resident is not considered at risk for pressure ulcer development.

The skin sheet, non-ulcer assessment dated 12/6/22 revealed the resident had blister to her right heel which had burst. The assessment documented the measurements were 7.0 cm x 3.0 cm x 0.1 cm.

The skin sheet, non-ulcer assessment dated 12/14/22 documented the blister to be resolved.

The skin sheet, ulcer assessment dated 12/15/22 documented the resident to have a Stage 2 pressure ulcer to her right heel. The assessment

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documented the pressure ulcer had measurements of 1.5 cm x 1.5 cm x 0.3 cm and further documented the pressure ulcer as facility acquired. Additional description included scant yellow drainage with no odor and the wound base having granulation tissue (pink or red tissue with a shiny, moist appearance).

The skin sheet, ulcer assessment dated 1/4/23 documented the pressure ulcer measurements had increased to 2.5 cm x 2.5 cm x 0.6 cm. Further description included scant yellow drainage with the wound base having pink or red tissue with a shiny, moist appearance. Further description included scant yellow and brown odorous drainage with the wound base having slough (yellow or white tissue that adheres to the ulcer bed in strings or clumps or is mucinous).

The skin sheet, ulcer assessment dated 1/11/23 documented the pressure ulcer had measurements of 2.2 cm x 2.2 cm x 0.2 cm. The ulcer was now noted to be a Stage 3 pressure ulcer. Further description included scant serosanguineous drainage (thin and watery fluid pink in color due to presence of small amount of red blood cells) with the wound base having pink or red tissue with a shiny, moist appearance. Further description included scant yellow and brown odorous drainage with the wound base having slough (yellow or white tissue that adheres to the ulcer bed in strings or clumps or is mucinous).

Weekly weight and skin review notes dated 12/7/22, 12/15/22 and 12/29/22 lacked documentation of Resident #8 being discussed during the any of these weekly meetings. On 1/25/23 at 3:50 pm, the Director of Nursing

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(DON) stated there were only 3 meetings in December due to the holidays.

Review of document titled Dietitian fax to Physician revealed the resident was seen by a Registered Dietitian on 10/28/22.

Review of document titled Consultant Dietitian Report revealed the resident was seen by a Registered Dietitian on 1/16/23.

The facility was unable to provide documentation of a Registered Dietitian performing any other visits in between those two dates.

A progress note dated 1/4/23 at 4:34 pm by Staff A, Licensed Practical Nurse (LPN) documented a noted decline to the wound and physician notification was made.

A progress note dated 1/9/23 at 10:48 am by the Assistant Director of Nursing stated a new order for an antibiotic was received for possible cellulitis to the right foot.

A progress note dated 1/12/23 at 9:20 am by Staff D, facility Registered Dietitian stated a recommendation of LiquaCel (a liquid collagen liquid protein) to promote skin healing of the stage 2 pressure ulcer.

A progress note dated 1/23/23 at 4:03 pm by the ADON stated a referral had been received to send the resident to a wound clinic.

A visit note dated 12/19/22 by Staff H, Nurse Practitioner revealed documentation of a Stage II pressure ulcer to the right heel containing 60% slough.

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A visit note dated 1/23/23 by Staff H, Nurse Practitioner revealed documentation of a Stage III pressure ulcer of the right heel that was black and appeared necrotic (dead skin).

Observation on 1/23/23 at 10:55 am revealed the resident to be in her wheelchair wearing heel protectors on both feet.

Observation on 1/24/23 at 9:41 revealed the resident to be in her recliner wearing heel protectors on both feet.

Observation on 1/25/23 at 10:42 am revealed the resident to be lying in bed with heel protectors on both feet.

Observation on 1/26/23 at 9:13 am revealed the resident to be sitting in her wheelchair wearing a sock on her left foot and a slipper on her right foot. No heel protectors were in place.

On 1/24/23 at 12:34 PM, Staff I, Licensed Practical Nurse (LPN), MDS Coordinator stated she is new to the role of MDS Coordinator in the facility. She voiced she is currently going through the care plans of all of the residents and updating them as she felt they were not accurate at the time she began the position.

On 1/25/23 at 10:08 am, the ADON stated she is the primary person who manages wounds in the facility. She stated she has received no specialty wound training. She further stated the facility used to have a wound Nurse Practitioner for the facility but those visits stopped perhaps last summer. She stated in the beginning of December a blister was found and it slowly

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declined. She felt it was going back and forth in wound healing. She stated she talking to the Registered Dietitian a couple of weeks earlier about a dietary supplement and that the resident is diabetic. She stated the facility Nurse Practitioner assessed the wound on 12/19/22 and 1/23/23. She voiced the protocol for wounds are that she assesses them once a week unless she is informed of a decline in the wound. She stated her expectation is that a resident who needs assistance to be repositioned should be assisted every 2-3 hours.

On 1/25/23 at 1:31 pm, the Director of Nursing (DON) stated that prior to the resident's wound being discovered, interventions for prevention of development of a pressure ulcer would include whatever was on her care plan. She stated she had a pressure reducing cushion on her recliner. She stated the resident does not have a specialty mattress on her bed but all of the mattresses in the facility are considered pressure reducing mattresses. She stated when the resident was in her wheelchair for meals she would be transferred to her bed or recliner after meals. She voiced her expectation is residents should be assisted to reposition every 2-3 hours if they are unable to reposition themselves.

On 1/25/23 at 3:47 pm, the Regional Nurse Specialist for the facility stated the facility does not have a policy for Registered Dietitian reviewing residents. She stated it would be considered a standard of care to have the Registered Dietitian involved in residents with wounds.

On 1/25/23 at 3:50 pm, the DON stated updating care plans is an interdisciplinary approach. She

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F 686	Continued From page 22 stated her expectation is that care plans should be updated quarterly and with significant changes. She stated they follow the Resident Assessment Instrument (RAI) process for care plan reviews. She further stated the ADON is the person who typically updates the care plans for any skin issues or any incidents filed in Risk Management (a portion of the Electronic Health Record for incident reports such as falls, skin injuries, etc.).	F 686		
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 observations, clinical record review, facility policy review, resident interview, and staff interview the facility failed to store residents smoking materials in a secure location, outside of the resident's room, and failed to complete an assessment for safety related to smoking for 1 of 1 resident reviewed (Resident #25). The facility also failed to identify, develop, and implement a comprehensive care plan to include smoking. The facility reported a census of 64 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #25 dated 11/2/22, for Resident #25, identified a Brief Interview of Mental Status	F 689	F689 In continuing compliance with F689, Free of Accidents/Supervision/Devices, Accura Healthcare of Ames corrected the deficiency by completing a Smoking Assessment for Resident #25 on 1/24/2023 and audited all like residents to ensure all residents that smoke have a current smoking assessment and a smoking care plan in place. This was completed on 1/25/2023 by MDS Coordinator. To correct the deficiency and ensure the problem does not recur, the MDS Coordinator was provided 1:1 education on completing smoking assessments and care plans timely on 1/24/2023 by the Regional Nurse Consultant. The DON and/or designee will audit smoking assessments 3x weekly for 4 weeks, then 2x weekly for 4 weeks, and then 1x weekly for 4 weeks and PRN to ensure continued compliance. As part of Accura Healthcare of Ames commitment to quality assurance, the Facility Director of Nursing and/or designee will report any identified concerns through the community's QA Process.	1/25/2023

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(BIMS) score of 14, which indicated no cognitive impairment. The MDS documented diagnosis that included: hypertension & end stage renal disease.

The Care Plan for Resident #25 date initiated 4/17/20, failed to identify a focus area, goal, &/or the interventions related to smoking.

On 1/23/23 at 12:18 PM, during initial tour of the facility, Resident #25 stated he was allowed to go outside to vape with staff supervision. Resident #25 stated the facility had a rule that the residents could not go outside and smoke independently. Resident #25 provided a note attached to his personal refrigerator with smoking times listed as 9 AM, 11 AM, 1 PM, 4 PM, and 7 PM. Resident #25 stated he was allowed to keep his vape in his room, however, not allowed to vape in his room. Resident #25 stated he switched to a vape instead of a cigarette so he would not have to wear a smoking apron.

Review of Resident #25's clinical record review revealed no Smoking Evaluation &/or assessment.

The facility document titled Resident Smoking Agreement for Resident #25, signed by the resident on 11/1/22, stated:

1. The policy applied to cigarettes, cigars, pipes, or any other materials that require fire. Also included electronic or vapor cigarettes and chewing tobacco.

2. All tobacco products included smoking tobacco, lighters, chewing tobacco, or other smoking paraphernalia would be kept by family members, or maintained by the facility staff stored in a secure location. Residents may not store smoking materials or supplies on person, in their

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belongings, or in their room, the resident would be re-evaluated and may not be allowed to continue smoking privileges if deemed unsafe.

3. A Smoking Evaluation with Care Plan interventions addressing safety issues must be completed upon admission, quarterly, annually, and for change in condition assessments.

4. The resident &/or the resident representative must sign the resident smoking agreement upon admission, and as needed, which confirmed the understanding of the smoking policy and the schedule.

5. Following the completion of the Smoking Evaluation & Acknowledgment of the policy, residents allowed to smoke in the designated smoking area with the supervision of a family member, resident representative, or facility employee. No residents were authorized to smoke independently, must be supervised. When the facility staff provided supervision, smoking would only occur at times designated by the facility.

The facility document titled Facility Smoking Process updated 4/21/22, stated:

1. The policy applied to cigarettes, cigars, pipes, or any other materials that require fire. Also included electronic or vapor cigarettes and chewing tobacco.

2. All tobacco products included smoking tobacco, lighters, chewing tobacco, or other smoking paraphernalia would be kept by family members, or maintained by the facility staff stored in a secure location. Residents may not store smoking materials or supplies on person, in their belongings, or in their room, the resident would be re-evaluated and may not be allowed to continue smoking privileges if deemed unsafe.

3. A Smoking Evaluation with Care Plan

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F 689	Continued From page 25 interventions addressing safety issues must be completed upon admission, quarterly, annually, and for change in condition assessments. 4. The resident &/or the resident representative must sign the resident smoking agreement upon admission, and as needed, which confirmed the understanding of the smoking policy and the schedule. 5. Following the completion of the Smoking Evaluation & Acknowledgment of the policy, residents allowed to smoke in the designated smoking area with the supervision of a family member, resident representative, or facility employee. No residents were authorized to smoke independently, must be supervised. When the facility staff provided supervision, smoking would only occur at times designated by the facility. On 1/24/23 at 12:14 PM, the Nurse Consultant (NC) stated if residents smoked a Smoking Assessment would be located in the residents Electronic Health Record (EHR) under the Assessments tab. Jointly reviewed Resident #25's assessments in the EHR with the NC and the NC confirmed the resident did not have any smoking assessments. Jointly reviewed Resident #25's care plan with the NC and the NC confirmed the resident did not have smoking included on his care plan. On 1/25/23 at 2:45 PM, the Director of Nursing (DON) stated expected smoking to be on Resident #25's care plan. On 1/25/23 at 2:45 PM, the Director of Nursing (DON) stated the facility policy stated no vapes, cigarettes or lighters were to be kept in the resident's rooms. The DON stated some residents were noncompliant and the	F 689		

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F 689	Continued From page 26 Administrator had spoken individually with the noncompliant residents and the Resident #25 continued to adamantly refuse to give up the vape. The DON stated she expected the Smoking Assessments to be completed on admission, quarterly & with a significant change in status. The DON stated Resident #25 was not a chronic smoker upon admission to the facility, however, once another resident went out to smoke regularly then Resident #25 started smoking. The DON stated Resident #25 did not go out to smoke due to the cold weather. The DON stated expected smoking to be on Resident #25's care plan.	F 689		
F 728 SS=D	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the	F 728	F728 In continuing compliance with F728, Facility Hiring and Use of Nurse Aide, Accura Healthcare of Ames removed Staff M, Unlicensed Aide from the nursing schedule on 1/26/2023. To correct the deficiency and to ensure the problem does not recur, the facility will not allow individuals hired to be Certified Nursing Assistants to work in that capacity for a period of longer than 4 months unless those individuals are actively participating in a State-approved training and competency evaluation program, or are scheduled to take written competency or skills examinations within 4 months of the start of employment. In the event those individuals fail to pass their examinations within that 4-month timeframe, they will be removed from the nursing schedule until they obtain their official certification. The Executive Director and/or designee will audit 1x weekly for 12 weeks and then PRN to ensure continued compliance. As part of Accura Healthcare of Ames ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	1/26/2023

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F 728	Continued From page 27 requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff interviews, and facility policy review, the facility failed to ensure certification of a Nurse Aide after 4 months of employment for one of five employee records reviewed (Staff M, Nurse Aide). The facility reported a census of 64 residents. Findings include: The Annual Employee Performance Evaluation for Staff M listed her job title as Unlicensed Nurses Aide with a hire date of 5/5/20. The Evaluation signed by Staff M on 5/4/22 included a goal to become certified. An interview with the Director of Nursing (DON) and the Administrator on 1/26/23 at 10:04 AM revealed Staff M unsuccessfully attempted to get her certification by taking the competency evaluation on 3 occasions between 5/5/20 and 1/24/23. The DON indicated they did not move Staff M out the Nurse Aide role and responsibility	F 728		

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F 728	Continued From page 28 due to an individual Centers for Medicare and Medicaid Services (CMS) waiver received on 10/7/22. The Update to COVID-19 Emergency Declaration Blanket Waivers for Specific Providers revised 8/29/22 directed that all nurse aides, including those hired under the above blanket waiver at 42 CFR §483.35(d), must complete a state approved Nurse Aide Competency Evaluation Program (NATCEP) to become a certified nurse aide. Additionally, the requirements at 42 CFR §483.154(b)(i) and (ii) require these nurse aides to pass a written or oral exam, and demonstrate skills learned. CMS did not waive the requirement that the individual employed as a nurse aide be competent to provide nursing and nursing related services at 42 CFR §483.35(d)(1)(i), and that requirement must continue to be met. We are aware that there may be instances where the volume of aides that must complete a state approved NATCEP exceed the available capacity for enrollees in a training program or taking the exam. This may cause delays in nurse aides becoming certified. If a facility or nurse aide has documentation that demonstrates their attempts to complete their training and testing (e.g., timely contacts to state officials, multiple attempts to enroll in a program or test), a waiver of these requirements (42 CFR §483.35(d)) is still available and the aide may continue to work in the facility while continuing to attempt to become certified as soon as possible. However, for all other situations, this waiver is terminated.	F 728		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs.	F 758		

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F 758	Continued From page 29 §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and	F 758	F758 In continuing compliance with F758, Free from Unnec Psychotropic Meds/PRN Use, Accura Healthcare of Ames reviewed Resident #60 and all like residents to ensure appropriate rationale on GDR's were present on 1/30/2023 by the DON. To correct the deficiency and to ensure the problem does not recur, the DON was educated on reviewing rationale provided by physicians on GDRs to ensure they are appropriate, and if the rationale is not appropriate to contact the physician to obtain an appropriate rationale by the Regional Nurse Consultant. The DON and/or designee will audit GDRs to ensure they have appropriate rationale monthly x 3 months and then PRN to ensure continued compliance. As part of Accura Healthcare of Ames ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	1/30/2023

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F 758	Continued From page 30 indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff interviews, and facility policy review, the facility failed to follow-up on the provided order for an adequate rationale to continue the use of an as needed psychotropic medication no later than fourteen days of use for 1 of 1 resident sampled (Resident #60). The facility reported a census of 64. Findings included Resident #60's Minimum Data Set (MDS) assessment dated 9/19/22 documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of anxiety and depression. The Note to Attending Physician/Prescriber signed by the provider on 9/22/22 directed to continue the use of clonazepam for six months due to chronic use. The order lacked an appropriate rationale to continue use of clonazepam. The November 2022 Consultant Pharmacist's Medication Regimen Review Recommendation Pending a Final Response dated 12/1/22 determined the prescriber gave a six month stop date but Resident #60's electronic health record (EHR) had not been updated.	F 758		

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F 758	Continued From page 31 The December 2022 Consultant Pharmacist's Medication Regimen Review Recommendation Pending a Final Response dated 12/27/22 determined the prescriber gave a six month stop date but Resident #60's electronic health record (EHR) had not been updated. Resident #60's January 2023 Medication Administration Record included an order for clonazepam tablet 1 milligrams (MG) dated 9/14/22 with no end date. The order directed to give one tablet by mouth every 12 hours as needed for anxiety related to other specified anxiety disorders. On 1/25/23 at 9:35 AM, the facility Medical Director revealed they had no other documentation available to clarify the rationale for the continued use of the as needed clonazepam. On 1/25/23 at 10:29 AM, an interview with the Assistant Director of Nursing (ADON) indicated no policy regarding medication administration of as needed (PRN) medications. She stated that she expected the nursing staff to follow standard practices. A documentation demonstration revealed supplementary space for narcotic documentation but not for psychotropic medications. She stated that some nurses documented behavior rationales for PRN antianxiety medications in the progress notes but the practice was not consistent across all nursing staff. On 1/26/23 at 4:30 PM the ADON indicated the PRN order had been discontinued.	F 758		
F 760 SS=G	Residents are Free of Significant Med Errors	F 760		

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F 760	Continued From page 32 CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, facility policy review, staff, Pharmacist, and Advance Registered Nurse Practitioner (ARNP) interviews, the facility failed to provide 3 of 5 residents (Resident #19, #34, and #50) with medications as ordered. On 4/13/22 Resident #19 received another resident's medications. Resident #19 required an overnight hospitalization due to chest pain experienced after receiving the medication. In addition, the facility gave a medication not as ordered to Resident #34 on 1/26/22 during an observation. This resulted in an excess of an anticonvulsant medication given. The facility also failed to administer Resident #50 hypertensive extended release (ER) medication as directed by crushing the medication, thus changing the release time of the medication. The facility reported a census of 64 residents. Findings include: 1. Resident #19's quarterly Minimum Data Set (MDS) assessment dated 4/7/22 documented a Brief Interview of Mental Status (BIMS) score of 14, indicating no cognitive impairment. The MDS revealed she is independent with bed mobility, transfers, walking, and eating. The MDS documented a diagnosis of schizophrenia. The MDS indicated that Resident #19 use an antipsychotic medication for seven out of seven days in the lookback period.	F 760	F760 In continuing compliance with F760, Residents are Free of Significant Med Errors, Accura Healthcare of Ames terminated the employment of Staff H, LPN on 4/13/2022. Accura Healthcare of Ames provided 1:1 education to Staff C, CMA on administering Extended Release medications and that those medications should not be crushed on 1/26/2023 by the DON. Accura Healthcare of Ames provided 1:1 education to Staff C, CMA on the correct way of administering liquid medications on 2/1/2023 by the DON. To correct the deficiency and to ensure the problem does not recur, all licensed nurses and CMA's were educated on the correct way to administer liquid medications and to ensure medications that cannot be crushed when administering them are not crushed on 2/1/2023 by the DON. An audit was completed on all residents with orders to crush medications to ensure they are not on medications that cannot be crushed and/or medications that cannot be crushed will be added to additional directions to MAR to alert Nursing Staff to not crush those medications on 1/30/2023 by the DON. The DON and/or designee will audit medication pass 3x weekly for 4 weeks, 2x weekly for 4 weeks, and then 1x weekly for 4 weeks and then PRN to ensure continued compliance. As part of Accura Healthcare of Ames ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	2/1/2023

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Resident #19's Clinical Census identified that on 4/13/22 she went to the hospital and returned on 4/14/22 to the facility.

The facility document titled, Self-Report, dated 1/24/23 for Resident #19 documented on 4/13/22 that at approximately 7:58 AM, Resident #19 received medications not prescribed for her at approximately 7:15 AM. The form listed that while Staff H, Licensed Practical Nurse (LPN), did her morning medication pass, she mistakenly administered the following medications to Resident #19.
a. Fetzima 120 milligrams (mg) (antidepressant medication)
b. Jardiance 25 mg (diabetic medication)
c. Metformin XR 1,000 mg (diabetic medication)
d. Zyprexa 2.5 mg (antipsychotic medication)
e. Perphenazine 24 mg (antipsychotic medication)
The document instructed the facility notified Resident #19 family, psychiatric nurse, Nurse Practitioner, and Poison Control. Poison Control recommended that Resident #19 went to the emergency room, but she refused. At approximately 10:40 AM, while onsite at the facility, Staff F, Advanced Registered Nurse Practitioner (ARNP), gave an order to send Resident #19 to the Emergency Department (ED) for chest pain. Resident #19 got admitted to the local hospital from the ED for nursing observation.

The History and Physical (H&P) from the local hospital dated 4/13/22 documented Resident #19 got evaluated at the local ED and is doing well, but she did have palpitations (feelings of having a fast-beating, fluttering, or pounding heart) and some left-sided chest discomfort with some

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F 760	Continued From page 34 nausea, but no vomiting. On 1/26/23 at 12:32 PM Staff G, Pharmacist, explained that the medications Resident #19 received in error on 4/13/22, Zyprexa and Perphenazine, may cause some drowsiness. He reported that he could speculate other side effects that could have happened, but he believed that medication error could cause those side effects. On 1/26/23 at 12:36 PM Staff F revealed that the error happened due to Resident #19 having the same first name as another resident. She added that Resident #19 also has a psychiatric doctor that she consulted and decided to keep her at the facility unless symptoms occur. She explained that when she arrived onsite on 4/13/22, Resident #19 was expressing symptoms of chest pain. At that time, they decided to send her to the local ED. Staff F revealed that Resident #19 likely had chest pain due to her anxiety. On 1/26/23 at 12:39 PM Staff H verified that she administered Resident #19 the wrong medications on 4/13/22. She reported Resident #19 as the first person she gave medications to that morning and the medications were right next to another resident in the cart with the same first name. She expressed that she immediately called the ARNP and checked Resident #19's vitals when she realized that she made the error. She expressed that she also called the nurse manager on call and informed Resident #19. After Resident #19 started having a complaint of chest pain, Staff F arrived to the facility and sent Resident #19 to the local hospital. She revealed she received education on the situation and that the facility fired her later that day.	F 760		

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F 760	Continued From page 35 The facility's undated policy titled, Medication Administration Procedures, instructed staff to identify the resident before administering medications. 2. On 1/26/23 beginning at 8:06 am observed Staff C, Certified Medication Aide (CMA), prepare the medications for Resident #34. Staff C poured liquid, levetiracetam 100 mg/ml, into a plastic medication cup as she held it up in the air. The medication cup appeared to hold 10 milliliters (ml) of medication, equaling 1000 mg. Resident #34's January 2023 Medication Administration Record (MAR) listed an order for levetiracetam 750 mg by mouth two times a day. 3. During this continuous observation on 1/26/23 watched Staff C prepare Resident #50 ' s medications, including metoprolol 25 mg, extended release (a blood pressure medication). After Staff C prepared all of Resident #50 ' s medications, she poured his medications into a pouch, including the metoprolol, and crushed the medications using a pill crusher. Then she mixed the crushed medications with pudding. Staff C reported that she crushed all of the medications. The Care Plan Problem dated 11/10/22 indicated that Resident #50 had a risk for adverse side effects (ASE) from high risk medications. The included Intervention dated 11/10/22 instructed the staff that Resident #50 takes anti-hypertensive medications. Please administer them to him as ordered. The document labeled which tablets should never be crushed updated 11/10/21 included a section regarding Controlled release medications. The	F 760		

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F 760	Continued From page 36 section directed that these medications are designed to release medicine over an extended period to allow less frequent administration. Crushing may mean a fatal dose is released. Some slow-release tablets are scored and can be divided or halved, but not crushed. Examples include Toprol XL (metoprolol succinate) and Sinemet CR (carbidopa and levodopa). On 1/26/23 at 9:38 am, the Pharmacist Consultant stated the Metoprolol extended release should not be crushed. On 1/26/23 at 12:03 pm, Staff C explained that she knew that metoprolol should not be crushed and that she did it by mistake. She stated her procedure for liquid medications is to look at the lines on the medication cup and measure it. An undated document titled Medication Administration Procedures directed the staff regarding general procedures to follow for all medications: a. Note any allergies or contraindications the resident may have prior to drug administration b. Oral medication administration: - If the medication is liquid, pour the correct amount directly into a graduated medication cup or measuring device provided with the liquid.	F 760		
F 803 SS=D	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.;	F 803		

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F 803	Continued From page 37 §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; §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 observations, facility menu review, clinical record review, and staff interviews, the facility failed to serve portions as directed by the facility menu for 3 of 4 residents reviewed (Residents #10, #32, and #50) for pureed diets. The facility reported a census of 64 residents. Findings include: 1. The facility's Week 2 menu for Wednesday ' s lunch identified the following items to be served as part of the planned pureed textured diet for the lunch meal on 1/25/23. Bratwurst on a bun Sweet and Sour Sauerkraut Fried potatoes (no skin) Cranberry dessert	F 803	F803 In continuing compliance with F803, Menus Meet Resident Nds/Prep in Adv/Followed, Accura Healthcare of Ames corrected the deficiency by providing 1:1 education to Staff O, Cook on the correct pureed diet preparation process on 2/20/2023 by Facility Dietitian. To correct the deficiency and to ensure the problem does not recur, facility staff who cook were educated on the correct pureed diet preparation process on 2/20/2023 by Facility Dietitian. The Facility Food Service Supervisor and/or designee will audit pureed diet preparation and meal service to ensure accurate portions are served 3x weekly for 4 weeks, 2x weekly for 4 weeks, then 1x weekly for 4 weeks and then PRN to ensure continued compliance. As part of Accura Healthcare of Ames ongoing commitment to quality assurance, the Facility Food Service Supervisor and/or designee will report identified concerns through the community's QA Process.	2/20/2023

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During an observation on 1/25/23 at 11:07 AM, Staff O, Cook, reported that the facility had four residents on a pureed diet. Staff O reported that she planned to puree four servings of each entrée on the menu. Staff O identified the serving ladles as:
- Blue handle scoop - mechanical soft diet - 4 ounces (oz)
- Filtering ladles- 2 oz
- Tan filtering ladle - 3 oz
- Gray ladle - regular diet - 4 oz
- #10 tan scoopers for pureed
- #12 green scooper for pureed
- #8 gray scooper for dessert

Staff O placed three 4 oz ladles of gravy into a Robot Coupe (commercial food processor) container, added three bratwursts and blended the contents together. Staff O poured the contents into a measuring cup and reported a total of 24 oz. Staff O reported each resident would receive two 4 oz scoops of bratwurst for 8 oz total. Staff O poured the pureed contents into a metal pan, covered the pan with foil, and placed it on the steam table.

At 10:12 AM, Staff O placed four 4 oz ladles of Sauerkraut and one 4-oz ladle of gravy in the Robot Coupe container and blended the contents together. Staff O poured the contents into a measuring cup and reported a total of 20 oz. Staff O reported each resident would receive two 4-oz. servings when served. Staff O poured the contents into a metal pan, covered the pan with foil, and placed the pan on the steam table.

At 10:17 AM, Staff O placed four hotdog buns into the Robot Coupe container and added three 4 oz ladles of gravy into the container and blended the

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contents together. Staff O reported a total of 18 oz. Staff O reported each resident to receive two 4-oz servings. Staff O poured the contents into a metal pan, covered it with foil, and placed the pan on the steam table. Staff O stated that she was complete with the pureeing process.

At 12:13 PM, two residents (Resident #10 and #32) received pureed diet and one resident (Resident #50) received pureed meat only and one resident did not eat.

In an interview at 2:26 PM, Staff O stated that she could not identify any errors in the preparation process. When asked, Staff O how she determined which ladle to use to obtain an ordered serving amount to each resident. Staff O stated that she always made four servings and divided it by 2 scoops of a 4-oz (#10) ladle per person. Staff O did not mention nor reference the conversion chart.

During an interview 1/25/23 at 2:54 PM, the Dietary Manager (DM) stated they expected the pureed diet preparation process required the conversion chart reference to accurately determine the serving ladle to be used.

The Job Summary document dated 5/10/22 for a Cook indicated they ' re responsible for preparing food in accordance with current applicable federal, state, local standards, guidelines, and regulations, the facility ' s established policies and procedures, and as may be directed by the Dietary Supervisor, to ensure that quality food service is provided at all times. The Essential Job Functions section listed
- Prepare, serve food, and meals in accordance with planned menus, diet plans, recipes, portions,

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F 803	Continued From page 40 and temperature control procedures while keeping the work area clean, sanitized and uncluttered during preparation and service of food. - As well as review and process diet changes and ensure menus are maintained and followed in accordance with established procedures. On 1/26/23 at 2:40 PM, review of a policy titled Policy and Procedure Manual: Select Menus and dated 2021 stated that Therapeutic menus should be checked for accuracy and completement using the individuals' records and the diet/nutrition care manual if needed.	F 803		
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:	F 812	F812 In continued compliance with F812, Food Procurement Store/Prepare/Serve-Sanitary, Accura Healthcare of Ames corrected the deficiency by placing a thermometer in the GE freezer in the kitchen and removed all unlabeled and undated items from all refrigerators and freezers by 1/27/2023 by Facility Food Service Supervisor. To correct the deficiency and to ensure the problem does not recur, the facility has obtained ServSafe Certification packets and all Food Service staff members will become ServSafe Certified by 2/27/2023. ServSafe Certification is a widely recognized, all-encompassing education program for all food-handlers to educate them on Food Safety, Personal Hygiene, Controlling Time & Temperature, Preventing Cross-Contamination, and Cleaning and Sanitizing. The Facility Food Service Supervisor and/or designee will audit food preparation, meal service, and sanitation processes 3x weekly for 4 weeks, 2x weekly for 4 weeks, and then 1x weekly for 4 weeks and PRN to ensure continued compliance. As part of Accura Healthcare of Ames ongoing commitment to quality assurance, the Facility Food Service Supervisor and/or designee will report identified concerns through the community's QA Process.	2/26/2023

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F 812	Continued From page 41 Based on observations, staff interviews, and facility policy review, the facility failed to maintain sanitary practices by improperly storing, preparing, and serving food. The facility reported a census of 64 residents. Findings include: During an initial kitchen observation on 1/23/23 at 10:26 AM, the following findings were identified. The GE freezer located in the kitchen did not have a thermometer to confirm proper temperature. The freezer contained loose ground meat in the bottom left basket directly under an unlabeled, undated, partially opened bag of ground meat. An undated, opened tub of resident's ice cream. The McCall refrigerator contained an undated, opened half gallon of whipping cream. The Beverage-Air milk cooler contained an opened, undated gallon of milk. The dry storage room freezer contained an opened, undated bag of breaded food, as well as pillsbury puff pastry sheets with a use by date of 10/21/22. The dry storage room had two uncovered boxes of potatoes with no opened date present. The dry storage room shelf had a shelf stock of beef base marked keep refrigerated for best quality. The dry storage room had an analog thermometer indicating a room temperature of 88 degrees Fahrenheit. On 1/23/23 at 2:29 PM, observed opened and undated three bags of mixed vegetables, one bag of peas, and one bag of precooked folded omelets in the Frigidaire freezer. The Frigidaire deep freezer had an opened and undated bag of	F 812		

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F 812	Continued From page 42 pizza. An observation of the pureed process on 1/25/23 at 11:07 AM, revealed Staff O picked up a dry washcloth from an unsanitized kitchen cart and dried off the inside and outside of the robot-coupe container then adding 4 hotdog buns without changing gloves or performing hand hygiene. On 1/25/23 at 11:43 AM, discovered three beef pot roast packs in standing water in the kitchen sink. The Assistant Dietary Manager (DM) revealed they placed the three items in hot water at 10:00 AM. During an observation on 1/25/23 at 12:13 PM of Staff O, Cook, serving food, revealed that her apron touched the top of the food preparation area adjacent to the steam table when she leaned forward to scoop the food. In addition, Staff O separated the residents ' menus with the same gloved hands and returned to plating the residents ' lunch. Staff O grabbed hotdog buns with tongs but then grabbed the bun with the same gloved hand used to temperature check the food. Staff O left the food serving area, returned with a chef salad obtained from the refrigerator, and continued serving resident food without changing gloves. Staff O placed a resident's sandwich on the preparation area in front of her to cut the sandwich with no sanitizing of the prep area from contact with the apron. Staff O removed the gloves, without hand hygiene, she picked up other menus, grabbed the tray delivery cart, rolled it closer to the steam table, donned new gloves, thumbed through resident menus, and continued plating resident food. During food plating, Staff O placed Resident #24's plate on top of the pureed sauerkraut and bread serving	F 812		

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F 812	Continued From page 43 bins then placed the plate on a new tray for a different resident. Staff O grabbed a pack of hamburger buns off of the top shelf of the steam table serving platform and pulled a bun out with her gloved hand, reached into a compartment under the steam table, and pulled out packaged crackers, placed them on a resident's plate then continued plating food. On 1/25/23 at 12:45 PM, observed Staff O pulling cellophane from a roll, without sanitizing the counter, she laid it on the counter to tear off the needed portion, then covered hotdog buns with the same side that came in contact with the counter surface. A subsequent observation in the kitchen on 1/25/23 at 2:26 PM revealed the same three beef pot roasts in the same sink but emptied of water with the faucet dripping but not on the pot roasts. During an interview on 1/25/23 at 2:54 PM the DM stated they expected that gloves should be worn while preparing and serving food. The DM continued explaining that changing gloves should occur when gloves are visibly soiled or have touched anything not directly related to food, and that hand washing should occur between glove changes. The DM stated that Staff O is responsible for managing food storage including monitoring for opened or expired products, properly labeling opened food with the date opened and the expiration date. On 1/26/23 at 11:13 AM, witnessed the assistant DM wearing a hairnet only around her hair bun with other hair exposed. On 1/25/23 at 4:00 PM, observed Staff P without	F 812		

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a hairnet or other hair-containing device in use. In an immediate interview with Staff P, he stated that he should be wearing a hairnet while in the kitchen.

On 1/25/23 at 4:10 PM the DM reported that they required all kitchen staff to wear hairnets at all times.

The Job Summary document labeled Cook, dated 5/10/22 indicated essential job functions as labeling, dating, and storing food properly according to established policies.

The Policy and Procedure Manual: Food Storage dated 2021 indicated a storage room temperature should be 50-70 degrees and that all freezer foods should be covered, labeled, and dated.

The Food Safety and Sanitation dated 2021 stated that hair restraints are required and should cover all hair on the head. It also included that all employees will wash their hands just before they start to work in the kitchen and after smoking, sneezing, using the restroom, handling poisonous compounds, dirty dishes, touching their face, hair, other people, surfaces, or items with potential for contamination.

The General Food Preparation and Handling policy dated 2021 directed that thawing of meat should occur in the sink, submerging the item under cold water (less than 70 degrees) that is running fast enough to agitate and float off loose ice particles.