

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165082	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2024
NAME OF PROVIDER OR SUPPLIER  Accura Healthcare of Lake City LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  1409 West Main Street Lake City, IA 51449	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49056</p> <p>Based on clinical record review, staff interviews, and facility record review, the facility failed to report an allegation of abuse to the Iowa Department of Inspections, Appeals and Licensing (DIAL) for 1 of 1 residents reviewed for abuse who reported a Certified Nursing Assistant (CNA) was being rough with (Resident #2). The facility reported a census of 39 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had diagnoses of hypertension (high blood pressure), heart failure, and urinary tract infection. The MDS documented the resident had a brief interview for mental status (BIMS) score of 15, which indicated no cognitive impairment.</p> <p>The Care Plan dated 3/21/24 revealed Resident #2 required assistance of one person with ambulation, bathing, bed mobility, dressing, grooming and toilet use.</p> <p>Interview on 4/2/24 at 3:00 PM with Resident #2 revealed Staff A, CNA entered the room, while I was in bed, Staff A started changing my brief. Staff A rolled me over and pushed real hard on my right leg thigh area and I yelled owe. Staff A then threw up her hands and said I am not dealing with this. Resident #2 revealed the dirty brief was still on when Staff A left the room. Resident #2 stated Staff A did not cover me up with anything, I laid there exposed. Staff A did not come back to finish changing me. Resident #2 revealed Staff A might have been too forceful when she pushed me over.</p> <p>On 3/23/24 at 11:10 AM, the Administrator, DON and Administrative Assistant revealed Resident #2 reported to the them, Staff A and Staff B came to get Resident #2 up that morning, they changed Resident #2 in bed and when Resident #2 was rolling, Staff A pushed Resident #2 's hip to assist and Resident #2 yelled out. Staff A threw up her arms and said she wasn ' t dealing with this and walked out of the room. Staff A did close the door as she left and Staff B was still in the room with Resident #2. Resident #2 stated I don ' t feel Staff A did anything on purpose Resident #2 stated she didn ' t feel like what the staff member was doing was intentionally trying to cause pain.</p> <p>On 3/23/24 the facility conducted an internal investigation and per the Administrator, DON, and Administrative Assistant, they reviewed all the information and since they didn ' t find any harm and Resident #2 was not hurt, they thought it was non reportable due to the fact Resident #2 didn' t feel like she was abused.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/2/24 at 3:42 PM per Director of Nursing (DON) there are no pending investigations sent to the Department of Inspection, Appeals and Licensing (DIAL).</p> <p>Per the facility policy titled Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy revealed all allegations of abuse and reported crimes must be coordinated through the facilities QAA Committee and communicated to QAPI to determine:</p> <p>a) If a thorough investigation is conducted;</p> <p>b) Whether the resident is protected;</p> <p>c) Whether an analysis was conducted as to why the situation occurred;</p> <p>d) Risk factors that contributed to the abuse (e.g., history of aggressive behaviors, environmental factors); and</p> <p>e) Where there is further need for systemic actions.</p> <p>Reporting: All allegations of Resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative.</p> <p>All allegations of Resident abuse shall be reported to the Iowa Department of Inspections and Appeals not later than two (2) hours after the allegation is made.</p> <p>All allegations of Resident neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation shall be reported to the Iowa Department of Inspections and Appeals, not later than two (2) hours after the allegation is made, if the events that cause the allegation result in serious bodily injury, or not later than twenty-four (24) hours if the events that cause the allegation involve neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation, but do not result in serious bodily injury. If there is a reasonable suspicion that the allegation of abuse also constitutes a crime committed against the resident by any person, whether or not the alleged perpetrator is employed by the facility, the Elder Justice Act requires the matter must also be reported to law enforcement. While the federal regulations require all abuse allegations be reported to DIA within 2 hours, the Elder Justice Act has a different time frame for reporting to the police/sheriff. If the allegation of abuse (that results from a crime) results in serious bodily injury to a resident, a report must be made to law enforcement not later than two (2) hours after the allegation is made. If the allegation of abuse does not result in serious bodily injury, a report must be made to law enforcement not later than twenty-four (24) hours</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49056</p> <p>Based on observation, staff interviews, and facility record review, the facility failed to make sure the environment remained free from accident hazards as the door to laundry room was broke and 11 residents that are mobile had access to it and failed to provide adequate nursing supervision for 1 of 1 residents reviewed (Resident #7). The facility reported a total census of 39 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE] for Resident #7 documented diagnoses of hypertension (high blood pressure), dissociative and conversion disorder. The MDS showed the Brief Interview for Mental Status (BIMS) score was an 8 indicating moderate cognitive impairment. The MDS shows Resident #7 was independent with ambulation and transfers.</p> <p>Observation completed with the Director of Nursing (DON) on 4/2/24 at 12:05 PM of the laundry room door. The door to the laundry does have a key coded pad, but the DON just pushed the door open. The DON did not enter a code to unlock the door. Observed laundry door was behind another set of double doors that the facility does not keep locked.</p> <p>Interview on 4/2/24 at 12:05 PM with Staff H, Laundry Aide, stated the door lock had been broken for a couple of months, ever since our last maintenance guy left. The DON verbalized the facility is getting a new maintenance man next week. Staff H revealed that sometime last week Resident #7 was actively seeking the laundry room, she got past the double doors and another staff member caught her. Staff H revealed that there are chemicals in between the washing machines and under the folding table.</p> <p>Interview on 4/4/24 at 8:35 AM with Staff I, Housekeeping/Laundry - stated she was the one that found Resident #7 outside of the Laundry door. Staff I stated she was coming out of the Laundry room and found Resident #7, in the foyer-like area looking for the laundry room, she was looking for some clothing.</p> <p>Observations of chemicals between the washing machines that are open were Laundry Chlorine Destainer, Laundry Soft Sour and Laundry Emulsion Detergent. All three laundry detergents have the same hazardous warnings - harmful if swallowed, harmful with contact with skin, causes severe skin burns and eye damage and causes serious eye damage.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49056</p> <p>Based on resident, staff and record review, the facility failed to ensure staff answered resident call lights and responded to resident needs in a timely manner, within fifteen minutes, for 2 out of 2 residents interviewed (Residents #4 and #6). The facility reported a census of 39 residents.</p> <p>Finding included:</p> <p>1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #4 documented the Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS showed Resident #4 required extensive assistance from one person for transfers, bed mobility, dressing and toileting. The MDS diagnosis included hypertension, anxiety disorder, and dehydration.</p> <p>In an interview on 4/2/24 at 10:00 AM, Resident #4 reported she waited for her call light to be answered longer than 15 minutes at least two times. Resident #4 reported that she tracked the time by looking at her watch.</p> <p>Review of the facility call light report named Device Activity Report revealed on 3/31/24 at 8:14 PM it took staff 26 minutes to answer the call light for Resident #4.</p> <p>2. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #6 documented the Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS showed Resident #6 required extensive assistance of one person for bed mobility and extensive assistance of two persons for transfers. The MDS diagnosis included hypertension, heart failure and arthritis.</p> <p>In an interview on 4/2/24 at 1:00 PM, Resident #6 stated, I have waited longer than 15 minutes for the staff to answer the call light. When asked Resident #6, how she knows it 's been longer than 15 minutes, she stated that she can see the clock on the wall.</p> <p>Review of the facility call light report named Device Activity Report revealed on 4/1/24 at 8:28AM it took staff 18 minutes to answer the call light for Resident #6.</p> <p>In an interview on 4/2/24 at 2:44 PM, Staff E, Certified Nursing Assistant (CNA), stated she felt like they lack staff on the 2pm-10pm shift.</p> <p>In an interview on 4/2/24 at 3:49 PM, Staff F, CNA, stated they do not have sufficient staff to answer call lights. Staff F stated I feel like sometimes we do and we don' t, the 2pm to 10pm is the harder shift to fill.</p> <p>In an interview on 4/3/24 at 9:35 AM, Staff A, CNA, was asked if adequate staffing to answer call lights in a timely manner, Staff A stated, no the facility does not have sufficient staffing to answer call lights in a timely manner.</p> <p>On 4/4/24 at 10:42 AM Administrative assistant stated the facility does not have a call light policy they go by the state guidelines.</p>		