STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165082	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Lake City LLC	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review and staff interviews, the facility failed to notify the family or responsible party when a resident had a change of condition for 2 of 15 residents reviewed (Residents #34 and #18). The facility reported a census of 41 residents. Findings include: 1. Resident #34's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS identified Resident #34 was independent with bed mobility, transfers and ambulation. Resident #34's MDS documented diagnoses of hypertension (high blood pressure), atrial fibrillation (irregular heart beat), and hypothyroidism. A Progress Note dated 1/17/25 at 7:17 PM documented Resident #34 reported to the nurse that she had a productive cough with white, thick mucus, runny nose and a sore throat. The note documented Resident #34 had abnormal lung sounds with crackles in the left lower lobe and diminished lung sounds to left upper lobe and right lobes diminishes. Resident #34's temperature was 102.4 degrees Fahrenheit and pulse oximeter (oxygen in the blood) measured 88-90% on room air. The note documented an appointment at the clinic was made for 3:30 PM. The note revealed the facility received a call that Resident #34 had pneumonia and was being admitted to the hospital. The Progress Note lacked documentation Resident #34's niece/POA was notified of the condition change and that she was being admitted to the hospital. A Progress Note dated 1/21/25 at 10:40 AM documented Resident #34's niece/POA called the Social Worker to report she was upset that she had not been notified of Resident #34 being taken to the emergency roiagnom on [DATE]. The note documented that the facility would educate staff moving forward as it was important families are notified of these situations. On 4/3/25 at 9:15 AM, the DON (Director of Nursing) reported it was the first time she was hearing about Resident #34's POA not being notified of the ER transfer/hospitalization . She reported there should have been a grievance form filled out. The DON reported she would expect the POA/responsible party to be notified regarding an ER transfer that resulted in a hospitalization . (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/3/25 at 9:37 AM, the Administrator provided an education form dated 1/21/25 that documented family notifications need to be completed and it was leadership responsibility to ensure they are done. These would be reviewed during morning clinical meetings. The form was signed by Social Services, ADON, Administrative Assistant, DON and Administrator on 1/22/25. On 4/3/25 at 10AM, the Administrator reported the charge nurses had been educated verbally regarding family notification but she did not have anything documented to prove the education was completed. On 4/3/25 at 10:40 AM, Resident #34 reported she wants her niece/POA to be notified of any condition changes including ER visit/hospitalization . Resident #34 reported that her niece/POA did not know she was hospitalized in January until she came to visit and she told the niece about it. A facility policy titled Notification of Change in Resident Health Status updated 2/8/23 documented the resident's legal representative would be notified of a change in resident status that included a significant change in the resident's physical, mental or psychosocial status for example, a deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complications. The facility would also notify the resident legal representative of a decision to transfer or discharge the resident from the nursing home. 49056 2. The MDS assessment dated [DATE] for Resident #18 documented diagnosis of non-traumatic brain dysfunction, non-Alzheimer ' s dementia, and hallucinations. The MDS showed the BIMS score of 15, indicating no cognitive impairment. Review of facility Progress Notes noted on 3/8/25 at 2:13 PM, Resident #18's family came to the facility for a visit, when family members arrived Resident #18 was sitting in the commons area. After a couple of hours the family took Resident #18 down to his room and noted there were precaution signs in the room and personal protective equipment outside of the room. Resident #18's family were informed at that time Resident #18 was positive for influenza A. Resident #18's wife was concerned that they had not been informed of the positive result and that if they had known they would not have come to visit him and wanted to know why he was out in the common area. Review of facility Progress Notes revealed on 3/8/25 at 2:23 AM revealed lab called and informed facility Resident #18 was positive for Influenza A. Review of electronic health records lacked documentation of notifying the family Resident #18 was positive for Influenza A. Interview on 4/3/25 at 9:23 AM with the DON revealed the expectation would be to notify families first thing in the morning.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review, observations, and staff interviews the facility failed to implement care plan interventions to reduce the risk for falls for 1 out of 4 residents (Resident #25) reviewed.The facility reported a census of 41 residents. Findings include: Resident #21's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS identified Resident #21 required partial/moderate assistance with bed mobility and all transfers. Resident #21's MDS documented diagnoses of hypertension (high blood pressure), Cerebrovascular Accident (CVA), non-Alzheimer's dementia, Parkinson's disease, seizure disorder and paroxysmal atrial fibrillation (irregular heart beat). The Care Plan with a target date of 7/8/25 documented Resident #21 was at risk for injury related to falls. The Care Plan and the CNA (certified nursing assistance) Kardex directed the following interventions: -Resident #21 to keep the door ajar so staff can keep a closer eye on him.-8/6/24 -Encourage Resident #21 to leave the room door open.-11/11/24 -Resident #21's bed to be in the lowest position when in bed.-12/31/24 Review of the Care Plan revealed duplicate interventions to keep the door open on 8/6/24 and 11/11/24. Review of the Clinical Record revealed Resident #21 had 7 falls from 11/1/24 to 3/1/25. On 3/31/25 at 1:21 PM observed Resident #21's door to room closed. Upon entering the room, observed Resident #21 lying in bed and bed was not in a low position per the care plan. Resident #21 reported he had had a few falls in the past and had hit his head. On 4/1/25 at 9:35 AM, observed Resident #21's door to room closed. Upon entering the room, observed Resident #21 lying in bed and bed was not in a low position per the care plan. On 4/2/25 at 4:53 PM, the DON (Director of Nursing) reported she expected staff to follow the care plan/kardex. She reported the facility was going to do education as some CNAs do not know what the kardex is. She reported she wanted to get back to the staff carrying a pocket care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Comprehensive Care Plan dated 1/30/24 documented it was the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The policy further documented that the qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on observations, clinical record review, staff interviews, and policy review, the facility failed to provide care and services according to accepted standards of clinical practice for 2 of 15 residents reviewed (Residents #21 and #23). The facility reported a census of 41 residents. Findings include: 1. Resident #21's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS identified Resident #21 required partial/moderate assistance with bed mobility and all transfers. Resident #21's MDS documented diagnoses of hypertension (high blood pressure), Cerebrovascular Accident (CVA), non-Alzheimer's dementia, Parkinson's disease, seizure disorder and paroxysmal atrial fibrillation (irregular heartbeat). The Care Plan with a target date of 7/8/25 documented Resident #21 was noncompliant with cares/activities of daily living (ADLs) and would get up on his own. The care plan directed staff to increase supervision as needed. In addition, the care plan identified Resident #21 was at risk for injuries related to falls and had Parkinson's disease. The care plan directed staff to contact wife for any falls with known or possible head injuries to see if Resident #21 would like to be seen in the emergency room (ER). The care plan directed staff to administer medications and the diet as ordered by the Physician. A Physician Order dated 4/19/24 directed staff to give Eliquis (anticoagulant) 5 mg (milligrams) twice a day for atrial fibrillation (irregular heartbeat). A Progress Note dated 11/6/24 at 10:15 PM documented Resident #21 was found lying on the floor on his right side between the recliner and the bed. The note documented Resident #21 had an abrasion to the middle of his forehead that measured 5 cm (centimeters) x 4 cm with no active bleeding. A Progress Note dated 11/7/24 at 2:59 PM documented Resident #21 went out to a Dr's appointment and returned without any incident. New orders were received to start APAP (Tylenol) 1000 mg (milligrams) three times a day, oxycodone (opioid pain medication) 5 mg q 6 hours as needed and apply mupirocin ointment to the abrasion to forehead x 7 days. A Progress Note dated 11/8/24 at 5:28 PM documented the radiology department called and insurance approved Resident #21 to have a head CT (computed tomography) scan scheduled for 11/11 at 8 AM. A Progress Note dated 11/11/24 at 5:30 AM documented Resident #21 got up unassisted and fell landing on his right side. Neurological assessment initiated. A Progress Note dated 11/11/24 documented Resident #21 went out of the facility for a CT scan at 7:30 AM and returned to the facility at 8:15 AM. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Progress Note dated 11/11/24 at 11:23 AM documented Resident #21's CT scan results showed a subdural hematoma (pool of blood between the brain and its outermost covering). The note documented Resident #21 had a Dr's appointment at 1 PM and if he had a change in condition prior to the appointment to send him to ER. A Progress Note dated 11/11/24 at 12:50 PM documented Resident #21 went to Dr's appointment regarding the CT scan results. A Progress Note dated 11/11/24 at 3:37 PM documented Resident #21 was admitted to the hospital for observation. A Hospital Progress noted dated 11/11/24 documented Resident #21 had fallen on 11/6/24 and sustained an abrasion to his forehead. The noted revealed Resident #21 was on Eliquis (blood thinner) for anticoagulation due to atrial fibrillation. The CT scan showed a small (0.5 cm) mixed density right subdural hematoma and a small (0.5 cm) subacute left sudural hematoma. The progress note directed to hold the Eliquis medication at this time until follow up CT in 2 weeks. A Progress Note date 11/12/24 at 2:37 PM documented Resident #21 returned to the facility. A facility Physician fax form dated 11/13/24 directed to hold Resident #21's Eliquis anticoagulant medication at least until CT scan was repeated and Resident #21 saw a neurosurgeon as those outcomes would guide further recommendations. Review of the Clinical Record revealed the Eliquis medication was discontinued on 11/12/24. An Incident Report titled unwitnessed fall dated 11/18/24 at 3:57 PM documented Resident #21 was observed lying on the floor between the bed and heating unit on his right side with his right arm under his head and left arm back. The incident report documented Resident #21 had an abrasion to his right forehead. A facility form titled Hawk- Change in Condition dated 11/18/24 documented Resident #21 fell when getting up to close the window that was not open. The condition change form that was faxed to the Physician lacked information that Resident #21 had hit his head during the fall. The form was signed by the Physician on 11/20/24. A Clinic note titled Telephone dated 11/19/24 at 9:22 AM documented the clinic nurse called and spoke to a facility nursing staff member who reported Resident #21 did have an unwitnessed fall hitting his head along with his arm and had some abrasions. The facility staff member reported the facility offered to take Resident #21 to the ER but staff reported that the wife agreed to have nursing staff monitor him closely at the nursing home instead. The facility staff reported Resident #21 was neurologically intact and vitals have been normal. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Clinic note titled Telephone dated 11/19/24 at 11:21 AM documented Resident #21 PCP (Primary Care Physician) medical recommendations continued to be an ER evaluation for any head injury with Resident #21. The Physician documented the last time Resident #21 had a head injury, vitals were fine and neurological assessment intact he had a subdural hematoma. The note documented with the current subdural hematoma, this may have expanded with the recent falll. In addition the note documented if Resident #21 or his wife refused for him to go to the ER, that was one thing but they do need to be clearly aware that was the medical recommendation. Review of the Progress Notes revealed the fall that occurred on 11/18/24 was not documented in the progress notes until 11/19/24 at 1:26 PM. The progress notes lacked documentation the wife or resident offered and refused to go to ER. A facility form titled Education dated 11/21/24 documented if Resident #21 had a fall with head injury or if unknown head injury the facility must call his wife and verify if she would like him to be seen in ER every time. The education form documented if the wife does not want Resident #21 to be seen in ER then a good progress note needs to be completed on the refusal. The education form included nurse signatures and dates acknowledging the education. A Progress Note titled Care Conference note on 11/26/24 at 2:10 PM documented Resident #21 PCP was firm that her medical recommendation was that Resident #21 be seen in ER for a follow up head CT scan for any fall that he does hit his head with. Resident #21's wife was in agreement and would like to be notified when he does have a fall. A facility form titled VAMC SLUMS Examination (screening tool used to assess cognitive function) dated 11/27/24 documented Resident #21 scored a 16. A score 1-20 indicated dementia. A Progress Note dated 12/2/24 documented Resident #21 had a head CT scan completed. A Progress Note dated 12/4/24 documented Resident #21 went and returned from Dr's appointment. The note documented the head CT scan results being forwarded to neurosurgeon for further recommendations. A Clinic Telephone Encounter Note dated 12/5/24 documented Resident #21 had a history of subdural hematoma and the family canceled consulting/management with the neurosurgeon due to difficulty with transportation. The note documented on 12/4/24 the CT scan was faxed to the neurosurgeon's office to see if he could give an opinion on this patient for further management. The neurosurgeon' office reported that they are unable to give an opinion without an office visit/consultation. A facility MD/Nursing Communication form dated 12/4/25 revealed Resident #21 PCP documented a diagnosis of moderate dementia without behavioral or mood disturbance. Review of the Clinical Record after 12/5/25 revealed there was no further follow up on the Eliquis anticoagulant medication on whether to continue to hold the medication, discontinue the medication or restart the medication. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An IR titled unwitnessed fall dated 12/31/25 at 4:30 AM revealed staff found Resident #21 lying on his stomach on the floor right next to his bed. Resident #21 denied hitting his head. Review of the Progress Note lacked documentation Resident #21's wife was offered or refused an ER visit due to an unwitnessed fall. An IR titled unwitnessed fall dated 2/3/25 at 6:05 AM revealed staff observed Resident #21 lying on his right side with head facing the wall by his dresser. The note documented Resident #21 had a rug burn to his right temple area and neurological assessment initiated. Review of the Progress Note lacked documentation Resident #21's wife was offered or refused an ER visit due to an unwitnessed fall with head injury. An IR titled unwitnessed fall dated 2/27/25 at 4:40 AM documented staff walked by Resident #21 room and observed him on the floor by his recliner sitting on his bottom with his knees bent up, facing the TV and his arms wrapped around the arm of the chair holding himself upright. His bed was raised almost all the way up. Resident #21 reported he sat up, put his shoes on and started to walk towards his recliner, lost his balance and fell to the floor. The IR documented there were no injuries. The IR lacked documentation on whether Resident #21 was asked if he hit his head or not during the fall. Review of the Progress Note lacked documentation Resident #21's wife was offered or refused an ER visit due to an unwitnessed fall with unknown head injury. A Progress Note dated 3/24/25 at 12:39 PM revealed Resident #21 had been having increased coughing episodes during meal times and when drinking water. The note documented a fax was sent to Resident #21's PCP requesting an order for speech therapy (ST) evaluation and treatment. A Progress Note dated 3/24/25 at 5:07 PM documented a fax was received with a new order for ST evaluation and treatment for diet appropriateness. A Progress Note dated 3/27/25 at 2:01 PM documented ST evaluation completed with recommendations for Resident #21 to have a general diet with thin liquids, no straws. Mechanical soft solids cut into bite sized and ground meat added with moisture. Speech therapy recommended large pills to be cut in half if able and given in pudding/applesauce. A Progress Note dated 3/27/25 at 5:27 PM documented ST recommendations faxed and received back signed by PCP. A facility form titled Rehab Communication for Resident #21 dated 3/27/25 documented ST recommended PO (by mouth) diet of thin liquids with no straws along with mechanical soft solids cut into bit sizes and ground meat with added moisture. ST recommended large pills cut in half if able and given in chocolate pudding. The form had the word yes documented on it and signed by DNP (Doctor of Nursing Practice) on 3/27/25. On 3/31/25 at 1:27 PM, Resident #21 reported his diet changed a couple of days ago because of coughing. He reported the coughing had gotten better with the diet change. Observed a water pitcher with a straw in the pitcher sitting on the bed side table next to the bed. When asked if he could have straws, he said no but that lasted about a day before the straws were given back. Review of the Care Plan with a target date of 7/8/25 and the CNA (certified nursing assistant) Kardex did not address Resident #21 was not to have straws. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/1/25 at 7:50 AM, observed Resident #21 sitting at the dining room table eating cereal. The Speech Therapist and a speech therapy student were at the table observing Resident #21 eating. The speech therapist student explained the recommendation for Resident #21 not to have straws. She said when you drink with a straw it requires sucking causing the liquid to shoot back of the throat and could potentially go down the wrong pipe. The speech therapist student reported they had observed Resident #21 would cough when using a straw. Observed Staff A, LPN (Licensed Practice Nurse) bring over a cup of medication in whole forms without applesauce or pudding and a cup of thin liquid with a straw in it. The Speech Therapist told the nurse there was a recommendation for no straws. The Speech Therapist directed the nurse to try giving the pills whole and use the straw to give liquids. Observed Resident #21 take a few pills given on a spoon by the nurse and then take a drink with the straw. Resident #21 had a hard time swallowing the whole pills and did cough when he used the straw. The Speech Therapist directed the nurse to try giving the whole meds without using the straw. Observed Resident #21 take whole pills on a spoon from the nurse, take a drink from the cup without the straw and he was able to swallow the pills without difficulty and did not cough. The Speech therapist and the nurse both told Resident #21 that he does better without the straw. The Speech therapist told Resident #21 that she knew he had a preference for straws but the straw was causing him to cough. On 4/1/25 at 7:59 AM observed straw in the water pitcher in Resident #21's room. On 4/1/25 at 9:35 AM, observed Resident #21 lying in bed with a water pitcher on the bed side table with straw in it. Resident #21 reported the water pitcher was delivered that way with a straw in it. When asked if he was using the straw he said yes. On 4/1/15 at 10:04 AM, the DON (Director of Nursing) reported she had talked to Resident #21's wife regarding his diet change and she did not want to do a shared negotiated risk. She reported Resident #21 had been educated about the types of food he was able to eat but was not sure if he had been educated regarding not using a straw. The DON was informed Resident #21 had a straw yesterday and today in his water pitcher. The DON acknowledged the concern and reported she would follow up. A Speech Therapy Encounter Note dated 4/1/25 at 11:03 AM documented Resident #21 was seen in the dining room to complete dysphagia therapy. The note documented nursing came to administer medication, where straw was present in thin liquid. Nursing then administered three pills at a time via spoon, where Resident #21 tried thin liquids via straw. Moderate oral holding of about 20 seconds noted before initiation of the swallow. Resident #21 then took three more pills with thin liquids via cup rim with no oral holding noted and immediate initiation of the swallow. Speech therapy will continue to recommend intake of medications with pureed consistencies, however will continue trial with thin liquids via cup rim and no straws. On 4/1/25 at 2:08 PM, the Nurse Consultant reported the facility completed immediate education with the staff regarding straw usage so it should not happen again. On 4/1/25 at 3:04 PM, the Nurse Consultant reported she would expect staff to follow therapy recommendations and physician orders. 4/1/15 at 2:00 PM, the Nurse Consultant verified she could not locate any additional documentation or follow up regarding the Eliquis after 12/5/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/25 at 10:45 AM, the Nurse Consultant reported her expectation after a fall with a head injury or suspected head injury and the resident was taking anticoagulant was to complete neurological assessments according to the Risk Management Policy and if there was a deviation from the neurological assessments to follow up with the Physician for further direction. The Nurse Consultant reported Resident #21's Physician would be rounding on 4/2/25 to address the Eliquis medication. She reported she did not think the Pharmacist reviewed the Eliquis medication during pharmacy reviews as the Eliquis was discontinued and was not put on hold so the Eliquis was not on Resident #21's medication list. The Nurse Consultant reported she would expect staff to follow physician orders and that the facility follows the regulations/standards of care. On 4/2/25 at 12:00 PM, the Nurse Consultant reported falls on 12/31/24, 2/3/25 and 2/27/25 were unwitnessed falls and required neurological assessments. She acknowledged the clinical record lacked documentation that the facility contacted wife regarding an evaluation in the emergency room and that the facility did not follow the care plan or Physician recommendations. On 4/2/25 at 12:37 PM, the Nurse Consultant acknowledged the condition change form from 11/18/24 did not address Resident #21 had hit his head. On 4/2/25 at 12:42 PM, the Administrator reported the facility does not have a policy that addresses anticoagulant medications. The Administrator reported the facility follows regulations and standards of care related to following Physician orders. A facility policy titled Notification of Change in Resident Health status updated 2/8/23 documented the resident's physician and resident's legal representative will be notified of a change in resident status when an accident involving the resident results in injury and has the potential for requiring physician intervention. 2. Resident #23's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. The MDS identified Resident #23 required supervision/touching assistance with bed mobility and transfers. Resident #23's MDS documented diagnoses of hypertension (high blood pressure), anemia, heart failure, diabetes mellitus, and arthritis. The Care Plan with target date 7/29/25 revealed Resident #23 had bladder incontinence and directed staff to monitor/document for signs and symptoms of a urinary tract infection (UTI). A Progress Note titled Transfer to Hospital Summary dated 2/28/25 at 2:25 AM documented Resident #23 was being admitted to the hospital for a UTI and IV (intravenous) antibiotics. A Progress Note titled Admission Summary dated 3/2/25 at 1:20 PM documented Resident #23 returned to the facility. The March 2025 Medication Administration Record (MAR) for Resident #23 directed staff to administer Cefdinir 300 mg (milligrams) 1 capsule two times a day for 5 days for acute cystitis with hematuria (bladder infection). A Physician fax form dated 3/11/25 directed staff to obtain a UA (urinalysis) with C&S (culture and sensitivity) related to fatigue and status post UTI. A Progress Note dated 3/12/25 documented the UA was collected and sent with labs. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Progress Note dated 3/13/25 documented a fax was received regarding UA and waiting for final C&S results prior to treatment. Review of the final culture results dated 3/16/25 documented >100,00 CFU (colony forming unit) per ml (milliter) of yeast sensitivity. The form documented the culture results were faxed to the facility on [DATE]. A new physician order for Macrobid (antibiotic) 100 mg twice a day for 5 days was documented on the form and signed by the DNP and dated 3/19/25. Review of the form revealed a note was written on the bottom of the form to the pharmacy to start the Macrobid on 3/20/25 at supper. The results and physician order for Macrobid were double noted by two facility nurses on 3/19/25. Review of the Progress Notes lacked documentation the facility received the final culture results or that the results were faxed to the Physician for review. The Progress Notes lacked any documentation regarding follow up or phone calls to the Physician regarding the results or need for treatment. The March 2025 MAR revealed the Macrobid medication was not started until the evening of 3/20/25. On 4/3/25 at 9:00 AM, the DON (Director of Nursing) reported the laboratory fax the results to the facility and then the nurses fax the results to the Physician. She reported she would expect documentation in the progress notes to reflect when the facility received the culture results and notified the Physician of the results. The DON verified the facility received the culture results on 3/17/24 by the timestamp on the fax. She reported she would expect the nurses to follow up with the Physician if there had not been a response and document the follow up in the progress notes. She reported she was working with the nurses regarding timely responses and documentation with the faxes. She reported she would expect the antibiotic to be started the day the antibiotic was ordered. She said if the fax was received the afternoon of the 19th she would expect the order to be started that evening. She reported the facility had an E-kit (emergency kit) so if the pharmacy was not able to deliver the medication the nurses could take the medication from there. She acknowledged the order for Macrobid was BID and was not started until the evening the following day after the order was received. On 4/3/25 at 10:00 AM, the DON verified Macrobid medication was available in the Ekit. A facility policy titled Notifying Clinicians of Lab Results updated 10/19/22 documented the facility must promptly notify the ordering physician and/or designee results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the order physician ' s orders. The policy further documented labs or diagnostic results that are outside the normal range, the facility to do the following: a. Notify the physician via phone or fax of the abnormal lab results. b. If the physician had not responded by the next day a phone is made to the physician office for response. c. If the physician still has not answered the DON is notified to attempt to get a response or notify the Medical Director for a response.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review, staff interview and policy review the facility failed to provide bathing assistance for 2 of 2 residents reviewed for bathing (Residents #1 and #13). The facility reported a census of 41 residents. Findings include: 1. Resident #1's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS did not document or code how much assistance Resident #1 required for bathing. Resident #1's MDS included diagnoses of peripheral vascular disease, diabetes mellitus, non-alzheimer's dementia, and an unstageable pressure ulcer to buttocks. The Care Plan with a target date of 8/12/25 documented Resident #1 required assistance of one staff member with bathing or showering. The facility form titled Bath Schedule documented Resident #1 was scheduled for a bath on Monday and Wednesday. The facility electronic from titled Shower/Bath Self for the last 30 days documented Resident #1 received a bath/shower on 3/12, 3/17, 3/24, 3/26 and 3/31. The form documented the response not applicable on 3/5 and 3/10. The form lacked documentation Resident #1 had refused any baths or showers. According to the documentation Resident #1 did not receive a bath/shower from 3/1 through 3/11. The Clinical Record lacked documentation of any other attempts to offer or encourage Resident #1 to shower or bathe. On 3/31/25 at 3:34 PM, Resident #1 reported she only gets one bath per week and she was supposed to have two baths a week. She reported the facility does not have enough staff at times so she does not get her bath. On 4/2/25 at 2:49 PM, the Corporate Nurse acknowledged the lack of documentation regarding bathing for Resident #1. She reported she could not locate any other documentation that baths/showers were completed in the last 30 days. 2. Resident #13's MDS dated [DATE] assessment identified a BIMS score of 15, indicating intact cognition. The MDS documented Resident #13 required substantial/maximal assistance for bathing and was dependent on staff for tub/shower transfer. Resident #13's MDS included diagnoses of diabetes mellitus, cerebrovascular accident (stroke), Psychotic disorder, anxiety and depression. The Care Plan with a target date of 8/5/25 documented Resident #13 required assistance of two staff members with bathing. The care plan directed staff to give a whirlpool bath on Wednesday and Saturdays and if Resident #13 refused the bath to tell him his sister wanted him to get in the bath. The care plan documented Resident #13 frequently refused his baths. The care plan directed staff to encourage Resident #13 to take baths. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility form titled Bath Schedule documented Resident #13 was scheduled for a bath on Monday and Wednesday. The facility electronic from titled Shower/Bath Self for the last 30 days documented Resident #13 received a bath on 3/10, 3/17, 3/24, 3/31. The form documented Resident #13 refused a bath on 3/12 and the response not applicable was documented on 3/5 and 3/26. According to the documentation Resident #13 did not receive a bath from 3/1 through 3/9 and had only received 4 baths in the last 30 days. The Clinical Record lacked documentation of any other attempts to offer or encourage Resident #13 to bathe or attempts to reapproach when Resident #13 refused to bathe. On 3/31/25 at 1:57 PM, Resident #13 reported he has only been getting baths once a week. When asked if this was his preference he said no. He reported he has told the staff about not getting his baths but nothing has changed. On 4/2/25 at 2:49 PM, the Corporate Nurse acknowledged the lack of documentation regarding bathing for Resident #13. She reported she could not locate any other documentation that baths were completed in the last 30 days. She reported she could not locate any documentation in the progress notes regarding refusals. She reported she would expect staff to offer baths according to resident preference. She reported the facility does not have a bathing policy. She reported the facility follows the regulations and standard of practice. On 4/2/25 at 3:24 PM, the Administrator reported Resident #13 refused care and bathing often and the care plan reflected this. The Administrator acknowledged the concern with bathing, will educate staff and start the plan of correction. On 4/3/25 at 3:30 PM, the DON (Director of Nursing) reported she did not know what non applicable meant when it was documented on the bathing forms. She said it could mean that there was a mix up between the facility bath list/schedule and what was documented in the electronic medical record.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056 Based on record review, staff interviews and facility policy the facility failed to put proper interventions in place to prevent a stage 2 pressure ulcer to the right heel consistent with professional standards of practice for 1 of 1 residents reviewed (Resident #38). The facility reported a census of 41 residents. Findings include: The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound bed. Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and 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 Minimum Data Set (MDS) assessment dated [DATE], for Resident #38 documented diagnoses that included hip fracture, peripheral vascular disease, and renal insufficiency. The MDS showed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS identified the resident as at risk for pressure ulcers and also identified the facility had placed a pressure reducing device for the bed. The MDS indicated Resident #38 needed substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with sit to lye, lye to sitting on side of bed, sit to stand, chair/bed to chair transfers and toilet transfers. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #38's baseline Care Plan dated 9/20/24 revealed Resident #38 needed assistance from 1 staff member with repositioning and bed mobility. The baseline Care Plan failed to identify any interventions in place to prevent pressure ulcers. Review of facility provided skin sheet dated 10/5/25 revealed Resident #38 with an area to his right heel measuring 2.5 centimeters(cm) x 2.5cm indicated a Stage 2 pressure ulcer. The facility policy named Pressure Injury Prevention Guidelines dated 2024 revealed to prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure injury present. Individualized interventions will address specific factors identified in the resident's risk assessment, skin assessment, and any pressure injury assessment(moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). The goal and preferences of the resident and/or authorized representative will be included in the plan of care. Interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used and, for tasks, the frequency for performing them. In the absence of prevention orders, the licensed nurse will utilize nursing judgement in accordance with pressure injury prevention guidelines to provide care, and will notify physician to obtain orders. Prevention devices will be utilized in accordance with manufacturer recommendations(heel flotation devices, cushions, mattresses). Guidelines for prevention may be utilized in obtaining physician orders. The facility may use facility specific guidelines or see Pressure Injury Prevention Guidelines below. Interventions will be documented in the care plan and communicated to all relevant staff. Compliance with interventions will be documented in the medical record The effectiveness of interventions will be monitored through ongoing assessments of the resident and/or wound. Interview with the DON on 4/3/25 at 1:10 PM stated there were no indications to put interventions in place, Resident #38 had a low braden score and was working with therapy. The DON stated Resident #38 did have a pressure reducing mattress to his bed. The DON stated there was no risk management or incident completed on this area and could not find a root cause analysis, the facility thought this area happened from his shoe. Interview with the DON on 4/3/25 at 3:30 PM revealed the expectation is to review the resident's information during the admission's process and put interventions in place based on that information.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056 Based on clinical record reviews, staff interviews and policy review, the facility failed to put effective interventions in place and provide adequate nursing supervision to prevent accident and injuries from falls for 1 of 1 residents reviewed (Resident #18). Resident #18 had a risk for falls with a history of repeated falls. Resident #18 had his thirteenth fall on 3/5/25 in a three-month period of time. On 1/9/25 Resident #18 had an unwitnessed fall in his room, resulting in a fracture to his left hand. Findings include: Resident #18's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. The MDS listed Resident #18 as independent with rolling left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed to chair transfers. The MDS listed Resident #18 as supervision for toileting. The MDS described Resident #18 as frequently incontinent of urine. Resident #18's MDS included diagnoses of non-traumatic brain dysfunction, non-Alzheimer's dementia, and hallucinations. The Facility Incident Reports (IR) documented from 12/26/25 to 3/5/25 revealed Resident #18 fell on [DATE], 12/30/24, 1/7/25, 1/9/25 x2, 1/26/25, 2/4/25, 2/6/25, 2/10/25, 2/18/25 x 2, 3/5/25 x 2. The Care Plan with a target date of 1/6/25 revealed Resident #18 had a risk for falls related to encephalopathy. Resident #18 tends to place himself on the floor when looking for objects or tinkering with items. Resident #18 also tends to walk without a walker. The interventions directed the following: 12/26/25 Medication reviewed and changes made. 1/7/25 Gripper socks on at bedtime as resident allows. 1/9/25 Has had recent medication changes, will have primary care physician review medications. 1/10/25 Re-eval with physical therapy. 1/26/25 Encourage Resident #18 to wear proper footwear at all times. 2/6/25 Staff to encourage Resident #18 to utilize a walker when appearing unsteady. 2/10/25 Medication review by primary care physician for possible insomnia. 2/18/25 Recliner replaced with straight back chair in resident's room. 3/5/25 All regular socks removed from room and only gripper socks added to room. 3/5/25 Assessment and treatment for acute illness. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Progress Notes on 12/30/24 at 11:07 AM revealed Resident #18 was found on the floor in the dining room, with his walker on the floor with him. Intervention to put a sign on the walker directing Resident #18 to utilize the walker. The facility failed to complete an Incident Report and a Root Cause Analysis to identify the reason for the fall. An IR dated 12/30/25 at 9:30 PM identified an unwitness fall in his room. The IR indicated Resident #18 was found lying on his right side in front of closet, Resident #18 had a drawer at the bottom of the closet open and taking out the items. Resident #18 denied falling and put himself down on the floor, Resident #18 reported he was fixing the drawer with nails. The IR for 12/30/25 stated assessment not needed as care plan updated that Resident #18 placed himself on the floor. An IR dated 1/7/25 3:30 AM identified an unwitnessed fall in his room. The IR indicated staff heard a noise coming from Resident #18's room, staff found Resident #18 on his knees leaning against the recliner. Resident #18 stated I think I fell right here. Intervention to have gripper socks on at bedtime as Resident #18 will allow. An IR dated 1/9/25 at 3:00 AM identified an unwitnessed fall in his room. The IR indicated staff went to check on Resident #18 due to on 15 minute safety checks, Resident #18 was found lying flat on his back on the floor next to bed. Resident #18 did receive a bruising to the palm and back of his left hand and his left wrist. Intervention is a medication review. The facility failed to put any additional interventions in place until the medication review was completed. Review of facility Progress Notes revealed the facility updated the primary care physician on the swelling and bruising to the left hand/wrist, and continued complaints of right shoulder pain. Appointment scheduled for 1/9/25 at 2:00 PM. Review of the x ray results of the left wrist and hand dated 1/9/25 at 2:27 PM revealed Resident #18 had a minimally displaced oblique fracture(bone is broken at an angle and the broken ends are slightly out of alignment) of the third metacarpal (middle finder that connects the palm to the hand) mid/proximal diaphysis (the area of the shaft of a long bone that is near the proximal end). An IR dated 1/9/25 at 11:15 PM identified an unwitnessed fall in his room. The IR indicated staff entered room to find Resident #18 laying on his left side facing dresser, left arm under his head, right arm at side, legs partly bent. When nurse entered room, Resident #18 was on his knees leaning on the bed. The certified nursing assistant (CNA) stated he wouldn't wait to be assessed. Resident #18 continued to have a splint on left hand, lower arm in place. RCA: Medication changes taking time to get out of the system. Intervention: physical therapy to re-evaluate need for walker. The facility failed to put any additional interventions in place until physical therapy could see Resident #18. Information provided by the Administrator on 4/3/25 revealed physical therapy saw Resident #18 on 1/13/25. An IR dated 1/26/25 at 2:10 PM identified an unwitnessed fall in the hallway. The IR indicated Resident #18 was found on the floor with a rug burn noted to the right knee. Resident #18 unsure of how it happened. Intervention: Encourage Resident #18 to wear proper footwear at all times. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An IR dated 2/4/25 at 10:58 AM identified an unwitnessed fall in his room. The IR indicated Resident #18 was found laying on the floor and yelling for help. Upon entering room, Resident #18 was laying on left hip with legs extended and propping himself up with arms. Resident #18 stated he slid out of his recliner. Intervention: dycem applied between cushion and chair. An IR dated 2/6/25 at 6:50 PM indicated Resident #18 had a witnessed fall in his room. The IR indicated staff was assisting Resident #18 to get ready for bed. Staff asked Resident #18 to sit down into his chair so his legs can rest, when the CNA turned around, Resident #18 stepped towards the door to leave his room and tripped over his feet and fell to the floor. Intervention: Encourage Resident #18 to use a walker when appearing unsteady. An IR dated 2/10/25 at 7:35 AM indicated Resident #18 had an unwitnessed fall in his room. The IR indicated Resident #18 was found on the floor between his dresser and the wall with his head in the corner, lying on his left side. Resident #18 fully dressed with gripper socks on and brief is dry. Resident #18 stated I was trying to get that worm as he pointed to a piece of yarn on the floor. Resident #18 noted to have skin tear to left forearm and some bruising to his left elbow and left ear. Intervention: Facility will have Resident #18 seen by primary care physician for medication review due to reported by night nurses that Resident #18 is not sleeping at night. The facility failed to put any additional interventions in place until the medication review could be completed. An IR dated 2/18/25 at 4:35 AM indicated Resident #18 had an unwitnessed fall in his room. The IR indicated Resident #18 was yelling for help, when staff entered the room he was lying on the ground in front of the recliner. Resident #18 stated I slipped off the damn thing. Intervention: Dycem placed underneath the recliner to prevent from sliding backwards. An IR dated 2/18/25 at 1:45 PM indicated Resident #18 had an unwitnessed fall in his room. The IR indicated Resident #18 was found next to the recliner between the wall and recliner and feet out toward the center of the floor facing toward the west wall. When Resident #18 was asked what he was doing, he was not able to answer stating he doesn't know what's going on and said he is waiting for some woman. Intervention: Recliner removed from room and replaced with straight back chair. Resident #18 sent to the emergency room per primary care physician due to his decline with respiratory status and increased confusion. An IR dated 3/5/25 at 00:00 AM indicated Resident #18 had an unwitnessed fall in his bathroom. The IR indicated that Resident #18 was found on the floor of his bathroom in front of toilet sitting on buttocks. Resident #18 had bottom pants off and was sitting on the floor. Resident #18 had regular socks on no gripper socks. Intervention: to make sure Resident #18 had gripper socks on at all times. All regular socks removed from the room; only gripper socks in room. An IR dated 3/5/25 at 3:05 AM indicated Resident #18 had an unwitnessed fall in his room. The IR indicated staff checked on Resident #18 on the floor laying on his left side next to bed. Resident #18 stated I don't know how I got myself in this predicament. Resident #18 had taken non-skid socks off so a new pair applied. Intervention: Assessment and treatment for acute illness. The facility failed to put any additional interventions in place until acute illness resides. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 4/3/25 at 3:30 PM revealed the expectation regarding falls/interventions for the nursing staff is to fill out the risk management and put interventions in place immediately. DON stated that she is going to implement Risk Management binders at the nurse's station to help with implementations of interventions and to notify her if they need help with an intervention. Review of facility Progress Notes dated 1/1/25 at 00:35 AM revealed Resident #18 was found in bed with a female resident in her room. Resident #18 was found naked from the waist down and his pants and brief were on the floor by the bed. Staff assisted Resident #18 out of the bed and back to his room. Intervention at this time to initiate one on one. The facility failed to fill out an Incident Report and root cause analysis with this incident. Interview on 4/1/25 at 12:54 pm interview with Staff C, Licensed Practical Nurse (LPN) revealed Resident #18 hadn't been in his room and they were looking for him and found him in another room, in the resident's bed with no clothes on from waist down. Staff C stated she got him out of bed and dressed him. Staff C stated Resident #18 told her he was going to bed. Staff C stated the other resident was asleep. Staff C stated she didn't know if the other resident knew he was there, the resident wasn't awake and she still had her clothes on. When Staff C was asked about frequent check, Staff C stated that we just checked on him frequently, Resident #18 was always going in another resident's room. Staff C stated if she documented frequent checks she doesn't remember or if they had implemented the fifteen minute visual checks. Staff C stated we just did frequent ones because he was a wanderer and we would do them every so often, we didn't have a formal place to document the frequent checks. Interview on 4/1/25 at 4:00 PM with Staff B, Certified Nursing Assistant (CNA), revealed that it is day by day with what Resident #18 wears to bed, sometimes he just wears a brief and sometimes he wears sweatpants. Staff B stated that she had never known him to sleep naked. Review of facility Progress Notes dated on 1/22/25 at 10:40 AM revealed Resident #18 was found sitting at the end of the bed with no pants/brief on, his pants were at his ankles and the other Resident (whose room this was) was in bed with eyes closed and did not appear to be aware that this Resident was even in there. Staff assisted Resident #18 pulled his pants up and walked him out of the room. Per Administrator on 4/3/25 stated they tried to identify patterns of wandering, stating he was typically looking for the bathroom, so a sign was placed on the bathroom door. The facility failed to fill out an Incident Report and root cause analysis with this incident. Review of the facility's policy named Risk Management dated 9/27/24 revealed all accidents/incidents involving residents will be reported, investigated and reviewed through the facilities Quality Assurance and Performance Improvement (QAPI) Process to ensure residents receive the highest quality of care. The nurse identifying an incident (see all incident types below) will be responsible for completing the incident report in the electronic health record. Incident Reports: a) All incident reports are located under the clinical tab under the dropdown box under care management and choose risk management and click on active. Under active click on the new button tab. This will open a new incident report window and enter resident specifics and location. b) Select the appropriate type of Incident: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165082	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Lake City LLC	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1) Witness or Unwitnessed Fall 2) New Skin Issue 3) Elopement 4) Medication Error 5) Resident to Resident incident 6) Abuse 7) Unusual event 8) Smoking injury, Burns Completion of Incident Reports: a) Fill out completely all tabs of incident report, be very specific. b) Details: 1) incident description 2) resident ' s description 3) immediate action taken, assessment at time of incident and intervention initiated (care plan intervention). c) Injuries: 1) Injuries, select from drop down type and location 2) Level of pain 3) Level of Consciousness, Mobility, and Mental Status 4) Note section: any supporting note (increased confusion, increased pain or new pain, refusal of pain medication, gait disturbance new or unusual, etc). d) Factors: 1) Predisposing Environmental factors, select all that apply. 2) Predisposing Physiological factors, select all that apply. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) Predisposing Situation, select all that apply. 4) Other information, additional information as needed (resident has a urinary tract infection (UTI) and is more confused,things that may have contributed to the incident). e) Witnesses 1) Only list first and last name of those staff that actually witnessed the incident. f) Actions: 1) Agencies/People notified (emergency department, director of nursing, physician, family and law enforcement as appropriate). 2) Progress Notes, this note will populate to the resident ' s chart. 3) Triggered user-defined assessments (UDA) will prepopulate as required and appropriate and complete before moving to next step. g) Notes: close out the incident by charting about your interdisciplinary team (IDT) reviewing the incident report, what the root cause was, and all interventions related to this incident. h) Signature, sign when completed. Witness statements: a) These will be completed on facility ' s investigation statement form by the witness, only document name of witness in risk management. b) Sign incident as completed by the end of shift. c) All investigation assessments are located under the resident ' s chart and are due by the end of the nurses shift that incident occurred. Neurological Assessment: a) Must be completed with every unwitnessed fall or a fall with possible head injury. b) Neuro checks must be completed in the following time frames: 1) Every 15 minutes x 4 2) Every 30 minutes x 2 3) Every hour x 2 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165082	A. Building B. Wing	04/03/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4) Every 4 hours x 3 5) Every shift x 3 All Incidents Reports and investigations will be completed by the end of your shift. DON, MDS and ED will review risk management Monday through Friday to identify new incidents. a) Incident dashboard indicates incidents occurred in the last 7 days. b) Incident analysis located on dashboard. c) Review all active incident reports daily. d) Huddle/Stand-up review all new incidents. e) Monitor UDA portal for any UDA ' s were not initiated or completed (under in progress), in both Clinical and Admin. f) Ensure intervention is appropriate and care planned. g) Once reviewed, report will be signed by the DON, ED and MDS within 48 hours. h) Review all residents who have had 2 or more incidents in 30 days for trending and need for further interventions to prevent incidents.