STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165273	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of South Des Moines	4911 SW 19th Street Des Moines, IA 50315

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on clinical record review, staff interview, and policy review, the facility failed to initiate nursing assessments of a surgical amputation site in a timely manner for 1 of 1 residents reviewed for surgical sites (Resident #39). The facility reported a census of 74. Findings include: The admission Minimum Data Set (MDS) Assessment, completed on 7/14/25, revealed a Brief Interview for Mental Status score of 14, which indicated intact cognition for Resident #39. Diagnoses listed on the MDS include presence of an above the knee amputation and hypertension. Pain was assessed as moderate. The After Visit Summary from Resident #39's hospitalization from 6/26/25 -7/8/25 indicated an above the knee amputation occurred. Discharge instructions listed a follow-up appointment with Vascular Surgery on 8/12/25. The admission Skin Assessment completed on 7/8/25 noted a left leg amputation incision. No Physician Orders identified regarding cares to the surgical site. The Baseline Care Plan initiated on 7/8/25 listed an incision site to Resident's #39's left knee. The Comprehensive Care Plan obtained on 7/22/25 identified Resident #39 with the potential impairment to skin integrity related to fragile skin. Interventions included following facility protocol for treatment of injury. The Care Plan identified Resident #39 with an infection of the surgical amputation site. Interventions included administering antibiotic as ordered, following facility policy and procedures for line listing and summarizing/reporting infections and to monitor/document/report to MD signs/symptoms of a urinary tract infection. After the admission Skin Assessment was completed, no further Skin Assessments identified either by paper, which would be located in the Skin/Wound Book, or electronically in the medical record. Review of Progress Notes in the electronic medical record revealed the first documented evaluation of the left leg amputation site occurred on 7/19/25. This was due to the start of Clindamycin (antibiotic) on 7/15/25. The Progress Note dated 7/21/25 documented communication with the vascular surgeon's office. Orders obtained to monitor the incision and to keep clean and dry. The surgical site was then evaluated as clean, dry, and intact with sutures in place. During an interview on 7/24/25 at 9:25 AM the Assistant Director of Nursing (ADON) acknowledge the Resident #39's recent surgical left leg amputation, which occurred on 6/27/25. The ADON acknowledged the lack of nursing surgical site skin assessments during the first nine to thirteen days of admission. The ADON noted the facility's wound care provider does not treat surgical wounds.The policy Weekly Skin Assessment and Documentation Process, updated 1/20/23, outlined the following: Skin ulcers and non-ulcers will be assessed and documented weeklyTreatment orders for all skin ulcers or non-ulcers will be implemented per the facility/corporate Skin Management ProtocolThe Nurse Leader will communicate appropriate wound treatment order per the facility/corporate Skin Protocol to the physician for approvalThe Care Plan will be updated and reviewed to ensure that the skin/wound alteration and appropriate interventions have been identified on the Care Plan.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165273	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of South Des Moines	4911 SW 19th Street Des Moines, IA 50315

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, clinical record review, staff interview, and policy review the facility failed to flush an enteral gastrostomy tube (g-tube)(tube surgically inserted into the stomach to provide nutrition and medication) per the physician order prior to administering medication thru the gastrostomy tube for 1 of 1 resident (Resident #7) reviewed. The facility reported a census of 74 residents. Findings include: A Annual Minimum Data Set (MDS) for Resident #7 dated 7/3/25, included diagnoses of Non-Alzheimer's Dementia and hemiplegia (paralysis of one side of the body). The MDS revealed the resident had a g-tube. Observation on 7/22/25 at 9:50 AM, Staff A, Registered Nurse placed crushed medications and liquid medications into a cup and added 30 milliliters (ml.) of water to the medications. Staff A proceeded to administer the cup of medications mixed with water to Resident #7 thru her g-tube, and then administered 30 ml. of water into the g-tube. Clinical Physician Orders for Resident #7 documented an order with start date of 7/22/25 for 30 ml of water before medication administration and 30 ml water after medication administration for g-tube. The facility's Medication Administration via Enteral Tube Policy revised 1/31/24 revealed to flush enteral tube with at least 15 ml. of water prior to administering medications, dilute the solid or liquid medication as appropriate and administer, and flush the tube with a final flush of at least 15 ml of water to ensure drug delivery and clear the tube. Interview on 7/23/25 at 4:05 PM, the Director of Nursing stated her expectation when administering g-tube medications is to flush the g- tube per physician's order with water only, then add water to dilute the crushed and liquid medications and administer the diluted medications mixed with water, and follow with a flush of water only.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, staff interviews and policy review, the facility failed to use appropriate infection control practices and Enhanced Barrier Practices (EBP) during urinary catheter care for 1 of 3 residents reviewed (Resident #66). The facility reported a census of 74residents. Findings Include:Resident #66's Quarterly Minimum Data Set (MDS) assessment, dated 5/29/25, reflected a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS listed Resident #66 had an indwelling urinary catheter. The MDS included diagnoses of other neurological conditions, benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms and retention of urine. The Care Plan with a target date of 9/3/25 included the following Focuses and Interventions:a. Resident #66 had an SP catheter (suprapubic) and a history of urinary tract infection (UTI). The intervention directed staff to change catheter bag twice a month and PRN, monitor output every shift.b. Resident is at risk of colonization at Multidrug-Resistant Organisms (MDRO). The intervention directed staff to use Enhanced Barrier Precautions (EBP). Review of the Electronic Health Record (EHR) for Resident #66 revealed an order from the Primary Care Physician (PCP) dated 3/3/25 for Enhanced Barrier Precautions and an order to change the catheter bag to a leg bag in the morning for UTI prevention, dated 7/18/25. Review of the Medication Administration Record (MAR) for Resident #66 for July 2025 revealed an administration of Cefdinir Oral Capsule (antibiotic), 300 mg, give 1 capsule by mouth two times a day for UTI until 7/23/25.During an observation 7/23/25 at 9:10 AM of catheter care for Resident #66, noted two staff in the resident's room. Staff B, Certified Nursing Assistant (CNA), walked out of the room without a gown or gloves on, she carried a room tray. Staff B handed the room tray to the Assistant Director of Nursing (ADON). Then, without sanitizing or washing her hands, Staff B donned a gown outside of the room and then placed gloves on her hands. Staff B retrieved a 2nd gown out of the cart and a 2nd pair of gloves and brought them in to the resident's room and handed them to another staff in the room, Staff C, CNA. Staff C placed the gown and gloves on the sink counter in the room as she was holding the resident's catheter bag, standing in front of the resident, she did not have a gown on, she did have on gloves. The resident was in a wheelchair, the leg bag was attached to his leg. Staff C handed the catheter bag to Staff B and then donned a gown and removed her gloves, she sanitized her hands and put on new gloves. A barrier was already placed on the ground with a container on the barrier. Staff B removed an alcohol swab from a wrapper and cleaned the port to the catheter bag, she emptied the urine into the container and then used a clean alcohol swab to clean the port. The container was emptied into the toilet and cleaned. During an interview 7/23/25 at 9:25 AM, Staff C acknowledged she and Staff B already started catheter care for Resident #66 before the observation. Staff C stated neither she nor Staff B had their gowns on when they removed the catheter bag and attached the leg bag. When the observation started, Staff C stated she had already removed the catheter bag and attached the leg bag, without wearing a gown. Staff C stated an understanding of EBP and stated she and Staff B should have worn gowns during the entirety of catheter care. During an interview 7/23/25 at 10:21 AM, the ADON stated an expectation staff wear gowns during the entirety of catheter care and an expectation staff sanitize their hands or wash their hands prior to placing gloves on their hands. The ADON stated she talked to all of her staff this morning about EBP and infection control practices when completing catheter care. Review of the facility policies for Catheter Care and Enhanced Barrier Precautions, dated 5/11/21 and 11/13/24 respectively, documented to wash hands or use hand sanitizer and apply gloves prior to cleansing the access port with an alcohol pad and an order for enhanced barrier precautions will be obtained for residents with urinary catheters, gowns and gloves will be readily accessible to staff to use when performing high-contact care activities, which includes device care or use; urinary catheters.