STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165311	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Le Mars	954 7th Avenue SE Le Mars, IA 51031

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44420 Based on clinical record review and staff interview, the facility failed to refer one resident with a negative Level I result for the PreAdmission Screening and Resident Review (PASRR), who was later identified with newly evident or possible serious mental disorder, intellectual disability, or other related condition, and received Mental Health Services to the appropriate state-designated authority for Level II PASRR evaluation and determination for 1 out of 1 resident reviewed for PASRR requirements, (Resident #19). The facility reported a census of 41 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #19 documented diagnosis of anxiety disorder, depression, psychotic disorder and hallucinations. Review of the clinical record revealed a Notice of Negative Level I Screen Outcome dated 3/29/21 revealed the PASRR level 1 screen remains valid for your stay at the nursing facility and should be transferred with you if you relocate. No further level 1 screening is required unless you are known to have or are suspected of having a major mental illness or an intellectual or developmental disability and exhibit a significant change in treatment needs. Further review revealed the following questions indicated the following: Mental health conditions diagnosed or suspected included: major depression, anxiety disorder. Has the individual received mental health services now or in the past? No. Review of the Care Plan last revised on 5/23/24 revealed Resident #19 used psychotropic medications (a drug that affects a person's mental state). Review of the Medical Diagnosis revealed Resident #19 with the following diagnosis: Delusion disorder, dated 3/11/21, Hallucinations, dated 3/24/23, Dementia, dated 3/31/23. Review of the Psychosocial Notes for Resident #19 revealed Telehealth services for medication management, behaviors, delusions, mood, sleeping patterns, confusion and appetite occurred on the following dates: 6/7/23, 6/26/23, 7/24/23, 8/14/23, 9/6/23, 11/13/23, 12/4/23, 3/11/24, 4/12/24. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Telehealth notes, the first dated 7/28/22 for Resident #19 showed an updated assessment and reason for referral that included dementia, major depressive disorder, delusional disorder, hallucination disorder, and anxiety disorder. Telehealth visits occurred periodically, the last visit occurred on 4/12/24. Review of Resident #19 ' s chart on 5/29/24 showed the facility lacked a follow-up and resubmission of a PASRR with the additional diagnosis of delusional disorder, hallucination disorder and dementia. In an interview on 5/29/24 at 9:31 AM, the Director of Nursing (DON) reported the facility lacked policies related to PASRR. The facility followed regulations and standard practices. The DON reported the Social Worker (SW) did not resubmit Resident #19 ' s PASRR because of the dementia diagnosis. The DON reported she didn ' t know if this met regulations. In an interview on 5/29/24 at 9:45 AM, the SW reported she failed to resubmit the PASRR because she thought a resident diagnosed with dementia did not require a resubmission no matter if a change occurred in mental health diagnoses or mental health services. The SW reported she has since resubmitted the PASRR after the DON spoke with her.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44474 Based on clinical record review and staff interview the facility failed to develop care plans to address usage of high risk medications and side effects to watch for 3 out of 14 sampled residents (Resident #8, #15 & #32) and failed to include dialyis information for 1 of 1 sampled resident (Resident #2) reviewed for comprehensive care plans. The facility reported a census of 41 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #8 documented diagnoses of diabetes mellitus, neurogenic bladder and hypertension. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. The MDS revealed Resident #8 had taken insulin injections the last 7 out of 7 days in the review period and is currently taking diuretic medication and opioid medication. Review of the Order Summary Report signed by the physician dated 3/13/24 revealed the following orders: a. Belbuca Buccal Film (opioid medication) twice a day with a start date of 2/13/24, b. Furosemide Tablet (diuretic medication) daily with a start date 7/21/22, c. Novolog (diabetic medication) sliding scale injection with a start date of 8/18/23, d. Novolog (diabetic medication) 3 times daily with a start date of 1/24/23, e. Tresiba Subcutaneous Solution (diabetic medication) daily with a start date of 5/13/24, f. Tramadol (opioid medication) daily as needed with a start date of 7/20/22, g. Tramadol (opioid medication) daily with a start date of 1/12/24. Review of the May Medication Administration Record (MAR) revealed the following orders: a. Furosemide Tablet daily with a start date 7/21/22, b. Tresiba Subcutaneous Solution daily with a start date of 5/13/24, c. Novolog sliding scale injection with a start date of 8/18/23, d. Novolog 3 times daily with a start date of 1/24/23, e. Belbuca Buccal Film twice a day with a start date of 2/13/24 and discontinue date of 5/21/24, f. Belbuca Buccal Film twice a day with a start date of 5/23/24, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g. Tramadol daily with a start date of 1/12/24, h. Tramadol daily as needed with a start date of 7/20/22. Review of the Care Plan with a revision date of 4/17/24 lacked information regarding usage of diuretic medication, insulin usage and opioid medication and signs and symptoms to watch for. 2. The MDS assessment dated [DATE] for Resident #15 documented diagnoses of diabetes mellitus, anemia and hypertension. The MDS showed the BIMS score of 13, indicating no cognitive impairment. The MDS revealed Resident #15 in the review period and is currently taking diuretic medication and opioid medication. Review of the Order Summary Report signed by the physician dated 3/13/24 revealed the following orders: a. Insulin Glargine with a start date of daily with a start date of 2/5/23, b. Hydrocodone-Acetaminophen daily as needed with a start date of 2/13/24. Review of the May Medication Administration Record (MAR) revealed the following orders: a. Insulin Glargine with a start date of daily with a start date of 5/14/24, b. Hydrocodone-Acetaminophen twice daily as needed with a start date of 5/15/24. Review of the Care Plan with a revision date of 2/6/24 lacked information regarding usage of diuretic medication, insulin usage and opioid medication and signs and symptoms to watch for. Interview on 5/29/24 at 2:43 p.m., with the Director of Nursing (DON) revealed she expected high risk medications and side effects to be on the care plan. 49056 3. The MDS assessment for Resident #32 dated 3/28/24 identified a BIMS score of 14, which indicated intact cognition. The MDS included diagnoses of atrial fibrillation, heart failure and hypertension. The MDS documented Resident #32 received the anticoagulation medication during the assessment period (last 7 days). Per the clinical Physician Order dated 5/18/24 directed staff to administer Warfarin (anticoagulant) 2 milligrams (MG), give 4 mg by mouth one time a day every Tuesday, Thursday, Saturday and Sunday for prevention of blood clot. Per the clinical Physician Order dated 5/17/24 directed staff to administer Warfarin 6 mg by mouth one time a day every Monday, Wednesday and Friday related to heart failure. Review of Resident #32 's Care Plan with an initiated date of 3/15/24 revealed the anticoagulant medication, potential side effects and what to monitor for while taking the high risk medication was not addressed on the comprehensive care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/30/24 at 8:45 AM, the DON stated the expectation would be to have the warfarin addressed on the care plan. The facility policy titled Comprehensive Care Plans dated 1/30/24 revealed it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes 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. 44420 4. The MDS assessment dated [DATE] for Resident #2 documented diagnoses of renal failure, arteriovenous fistula, stroke. The MDS showed the BIMS score of 13, which indicated no cognitive impairment. The Progress Note dated 3/15/24 at 10:24 PM revealed Resident #2 with a fistula in the left upper arm for dialysis with a dressing placed over the fistula. Review the Care Plan for Resident #2 failed to show the resident had a fistula for dialysis and lacked directions for assessments and fistula site care. In an interview on 5/29/24 at 1:27 PM, the Director of Nursing (DON) reported that the fistula should be on the care plan. The DON reported the resident returns to the facility with a dressing from dialysis but a dressing isn ' t needed, and the nurses know they have to assess the fistula. The DON stated, I do agree that the fistula should be on the care plan though.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 44420 Based on observations and diet orders the facility failed to update the care plan to reflect the current diet order of mechanical soft texture for 1 out of 14 residents (Resident #19). The facility reported a census of 41 residents. Findings Included: Observation of meal service on 5/29/24 starting at 11:55 PM, revealed Resident #19 ordered the scheduled therapeutic lunch for a mechanical soft diet which consisted of ground swiss steak, garlic mashed potatoes, waxed beans and bread with margarine. Staff G, Dietary [NAME] served the resident peas instead of waxed beans. The Physician's Order dated 4/22/24 for Resident #19 showed an order for mechanical soft diet texture. The Diet Type Report dated 5/29/24 showed Resident #19 as a mechanical soft diet. In an interview on 5/29/24 at 12:59 PM, the Dietitian reported peas could pose a choking hazard for Resident #19. The Dietitian reported that staff are required to follow the mechanical soft diet menu. Review of Resident #19 ' s chart on 5/29/24 at 1:32 PM showed no previous episodes of choking. Review of the Care Plan for Resident #19 on 5/29/24 at 12:52 PM showed the facility failed to update the resident ' s care plan to reflect the diet ordered on 4/22/24 of mechanical soft diet texture. The Comprehensive Care Plan policy last revised on 1/30/24 identified the care plan will be updated in a timely manner to ensure that services to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being. In an interview on 5/29/24 at 1:47 PM, the Director of Nursing reported the plan of care should reflect the current diet order.

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F 0689 Level of Harm - 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** 44420 Based on clinical record review, observation, resident interview, staff interviews, and facility record review, the facility failed to provide adequate nursing supervision to prevent a fall that caused a distal femur fracture, need for hospitalization , pain control and decline in the resident ' s physical ability for 1 of 14 residents reviewed (Resident #29). The facility reported a total census of 41 residents. Past Noncompliance determined during the annual recertification survey of a facility incident that occurred on 1/22/24 regarding deficiency F689 with a scope and severity of a Level G. The facility provided evidence of education to the staff member directly involved in the facility incident that occurred on 1/23/24. The remainder of the nursing staff received education on 1/31/24. Findings included: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #29 documented diagnosis of hemiplegia, seizure disorder, traumatic brain injury (TBI). The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. The MDS identified Resident #29 with limitation in movement and impaired range of motion to one side of the body, upper extremity and lower extremity. The MDS also showed Resident #29 dependent on a helper for all effort, or the assistance of two or more helpers is required for toileting hygiene. The Care Plan dated 10/26/23 for Resident #29 identified stand-pivot transfers with assistance of two staff and a gait belt. Do not use his bathroom, use the bedside commode. The Fall Risk assessment dated [DATE] for Resident #29 identified the resident to be a moderate fall risk. The Incident Report dated 1/22/24 at 7:18 PM for Resident #29 identified staff called the nurse to the resident ' s room. The nurse observed the resident laying on his left side with legs outstretched. The nurse noted the resident ' s pants were down. The resident reported he tried to pull up his pants while turning then lost his balance. The resident informed the nurse that he thought his leg was broken. The Progress Note dated 1/22/24 at 7:25 PM for Resident #29 identified staff witnessed a fall then called 911 to assist the resident. Resident #29 transferred to the emergency room (ER) by Emergency Medical Technicians (EMT). The emergency room Discharge Plan dated 1/22/24 for Resident #29 revealed an x-ray diagnosis of a left distal femur T-shaped fracture. Resident #29 transferred to a hospital with a higher level of care for orthopedic services. The Hospital Records dated 1/22/22 at 1:57 AM showed Resident #29 admitted for a left distal femur fracture. The History of Present Illnesses explained Resident #29 lost his balance and fell while he attempted to transfer. Resident #29 reported dull pain in the left leg. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Orthopedic Consultation dated 1/23/24 at 6:40 AM identified Resident #29 sustained a left intra-articular distal femur fracture. Resident #29 reported pain around the left knee. The orthopedic surgeon recommended surgical management. The Operative Report dated 1/23/24 at 5:28 PM for Resident #29 confirmed the diagnosis of a left intra-articular distal femur fracture, closed, displaced. The post operative plan included non-weight bearing left lower extremity of likely 8 weeks, gentle range of motion for the left knee as pain allows. Post surgery the resident received intravenous (IV) antibiotics and pain medication. The surgeon also ordered apixaban 2.5 mg by mouth twice a day for 30 days to prevent blood clots. The Final Report dated 1/29/24 for Resident #29 identified the discharge orders included the following: Mechanical lift for transfers. Bedrest. Gentle range of motion to left knee as pain allows. No weight bearing to left left for likey 8 weeks. Physical Therapy and Occupational Therapy consults. Foley Catheter. Surgical dressing instructions. The Discharge Summary dated 1/29/24 for Resident #29 indicated Tylenol and hydrocodone ordered for pain, and apixaban ordered to prevent a blood clot. The Physician Orders for Resident #29 the following pain medication ordered upon readmission to the facility on [DATE]: Hydrocodone-Acetaminophen 7.5-325 milligrams (MG) 1 tablet every four hours as needed for moderate pain. Hydrocodone-Acetaminophen 7.5-325 milligrams (MG) 2 tablet every four hours as needed for severe pain. The January 2024 Medication Administration Record (MAR) revealed Resident #29 received hydrocodone for pain as follows: 1/29- 2 times for a total of 2 tablets, 1/30- 2 times for a total of 2 tablets, 1/31- 3 times for a total of 4 tablets. The February 2024 Medication Administration Record (MAR) revealed Resident #29 received hydrocodone for pain as follows: 2/1- 1 time for a total of 1 tablet, 2/2- 1 time for a total of 2 tablet, 2/3- 2 times for a total of 4 tablets, 2/4- 2 times for a total of 4 tablets, 2/5-2 times for a total of 4 tablets, 2/6- 3 times for a total of 6 tablets (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2/7- 4 times for a total of 8 tablets, 2/8- 1 time for a total of 2 tablet, 2/9- 3 times for a total of 6 tablets, 2/10-1 time for a total of 2 tablet, 2/11- 1 time for a total of 2 tablet, 2/12- 3 times for a total of 4 tablets, 2/13- 2 times for a total of 4 tablets, 2/14- 3 times for a total of 6 tablets, 2/15- 2 times for a total of 4 tablets, 2/16- 1 time for a total of 2 tablet. In an interview on 5/28/24 at 1:03 PM, Resident #29 stated, I was standing to use my urinal, one of my legs gave out from underneath me. Resident #29 reported that one Certified Nursing Assistant (CNA) hung onto him as he used the urinal. Resident #29 stated, I fell to the floor, had a dull pain that wasn ' t sharp. In an interview on 5/28/24 at 1:36 PM, Staff E, CNA reported she assisted Resident #29 to use the urinal while he stood at bedside. When Resident #29 finished urinating, Staff E assisted him to pull up one side of his pants. While Resident #29 attempted to pull up the other side of his pants, the resident leaned forward, causing him to fall in a forward direction. Staff E reported Resident #29 hit his head on the bedside commode and complained of left leg pain. Staff E reported to be the only CNA in the room at the time of the fall. When asked if there should have been two CNA ' s, Staff E replied, Yes, but my partner was on break and the nurse gets mad, so I didn ' t ask her. I usually ask for help. When asked if Staff E used a gait belt, she replied, No, he usually refuses, so I didn ' t ask. In an interview on 5/29/24 at 8:48 AM, Staff F, Licensed Practical Nurse (LPN) reported staff called her to Resident #29 ' s room. Staff F found Resident #29 lying on the floor, on his left side, in front of his nightstand. Resident #29 reported he tried to pull up his pants but fell and suffered from left leg pain. Staff F asked Staff E, CNA if she helped the resident. Staff E replied, Resident #29 insisted on pulling up his pants himself. Staff F reported Resident #29 lacked wearing a gait belt when she entered the room. Staff F then instructed Staff E to use the gait belt when getting the resident up. Staff F further stated, and I told Staff E to make sure she used it. When asked if Staff E assisted the resident to use the urinal alone, Staff F stated, yes. In an interview on 5/29/24 at 3:06 PM, the Director of Nursing (DON) reported the facility lacks policies related to gait belt usage and falls. The facility followed regulations and standard practices. In an interview on 5/30/24 at 8:10 AM, the DON reported Staff E failed to follow Resident# 29 ' s care plan by not waiting for another staff member before she provided Resident #29 with assistance for standing and using the urinal. The DON stated, Staff E was probably trying to help because the resident would have been in a hurry, and probably not wanting to wait for another staff member, but Staff E should have waited until someone was available. The DON reported that she planned to talk to the nurse about being more approachable, so that others can ask for help when needed. The DON also reported Staff E should have used a gait belt. The DON explained Resident #29 usually refused the gait belt because it was too tight. The DON has since ordered a larger gait belt and educated the resident regarding safety precautions. The DON stated, he ' s compliant now. The Comprehensive Care Plans policy last revised on 1/30/2024 identified The physician, other practitioner, or professional will inform the resident and/or resident representative of the risks and benefits of proposed care, of treatment, and treatment alternatives/options. The facility will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record, including discussions with the resident and/or resident representative.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review and staff interview the facility failed to address dementia care for 1 out of 1 residents reviewed (Resident #15). The facility reported a census of 41 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #15 documented diagnoses of diabetes mellitus, Non-Alzheimer ' s Dementia and hypertension. The MDS showed the Brief Interview for Mental Status (BIMS) score of 13, indicating no cognitive impairment. The MDS revealed an active diagnosis of Non-Alzheimer ' s Dementia. Review of Resident #15 ' s Active Diagnosis List revealed a diagnosis of Vascular Dementia, unspecified severity with mood disturbance with a created date of 1/19/24. Review of the Care Plan with a revision date of 2/6/24 lacked information regarding dementia care. Interview on 5/29/24 at 2:43 p.m., with the Director of Nursing revealed the facility should have addressed dementia on the care plan. She further revealed the dementia diagnosis was a fairly new diagnosis for Resident #18.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 44420 Based on review of the planned menu, observation and staff interviews facility staff failed to follow the planned menu for 1 out of 41 residents observed (Resident #5). The facility identified a census of 41 residents. Findings included: The facility's Week 1 menu identified the following items as part of the planned menu for the pureed lunch meal on 5/29/24: Pureed swiss steak Mashed potatoes Pureed peas Pureed bread with margarine Pureed candy bar Milk Observation on 5/29/24 at 12:25 PM revealed Staff G, Dietary [NAME] failed to puree bread and margarine. Staff G plated the meal then handed the plate to staff to serve without pureed bread and margarine to Resident #5. The Food and Nutrition Services in Healthcare Facilities policy date 2021 identified food will be placed in bowls or on platters and delivered to the dining tables just prior to service. The food will: a. Be at the appropriate temperature for service and be covered if necessary. b. Have the appropriate serving size or serving utensil according to the planned menu In an interview on 5/29/24 at 12:59 PM, the Dietitian reported that she expected the pureed diets to be served per the menu.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 44420 Based on observations and diet orders the facility failed to assure the food served met the resident's needs according to their assessment and diet orders. Observations determined that 1 out of 41 residents did not get the food in their ordered texture (Resident #19). The facility reported a census of 41 residents. Findings Included: 1. Observation of meal service on 5/29/24 starting at 11:55 AM, revealed Resident #19 ordered the scheduled therapeutic lunch for a mechanical soft diet which consisted of ground swiss steak, garlic mashed potatoes, waxed beans and bread with margarine. Staff G, Dietary [NAME] served the resident peas instead of waxed beans. The Physician's Order dated 4/22/24 for Resident #19 showed an order for mechanical soft diet texture. The Diet Type Report dated 5/29/24 showed Resident #19 as a mechanical soft diet. Review of the Care Plan for Resident #19 on 5/29/24 at 12:52 PM showed the facility failed to update the resident ' s care plan to reflect the diet ordered on 4/22/24 of mechanical soft diet texture. In an interview on 5/29/24 at 12:59 PM, the Dietitian reported peas could pose a choking hazard for Resident #19. The Dietitian reported that staff are required to follow the mechanical soft diet menu. Review of Resident #19 ' s chart on 5/29/24 at 1:32 PM showed no previous episodes of choking. The Food and Nutrition Services in Healthcare Facilities policy date 2021 identified food will be at the proper temperature, texture and/or consistency to meet each individual ' s needs and desires. In an interview on 5/29/24 at 1:47 PM, the Director of Nursing reported that dietary staff should serve the therapeutic diet as per the menu.

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	165311	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Le Mars	954 7th Avenue SE Le Mars, IA 51031

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44420 Based on observations, staff interviews, and facility policy review the facility failed to ensure sanitary conditions where staff prepared and stored food. The facility identified a census of 41 residents. Findings included: The initial kitchen tour on 5/28/24 at 10:32 AM revealed the following: The bottom of refrigerators, and freezers contained an accumulation of food debris and dried liquid. The floor in the kitchen and dishwashing area contained a variety of scattered food debris and dried liquid. Open shelving beneath preparation tables contained food debris and dried liquid. The snack cart and vegetable storage bin contained a variety of scattered food debris. Handles on the snack cart with grime. Milk freezer with a thick layer of ice buildup. The Cleaning Schedules for May 2024 showed staff failed to complete cleaning tasks all the days of May except 5/3/24. Additional cleaning schedules for May 2024 showed the milk cooler cleaning task signed off by staff as completed. The Food and Nutrition Services in Healthcare Facilities policy date 2021 identified cleaning and sanitizing refrigerators on a regular cleaning schedule, and as needed. The kitchen will be thoroughly cleaned, and food preparation surfaces sanitized prior to closing each day. The director of food and nutrition services will assure that instructions for the food and nutrition services department are properly carried out, and that all local, state, and federal food, food safety and sanitation regulatory requirements are met. In an interview on 5/28/24 at 10:56 AM, the Dietary Manager (DM) reviewed the cleaning schedule. The DM stated, My staff obviously signed off that they cleaned the milk cooler but didn ' t defrost it. I' ll address it with that person. When asked if she expected all the cleaning tasks to be completed and signed by staff, the DM replied, yes. The DM explained that she recently had time off work and hasn ' t been able to follow up with staff.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on record review and staff interviews the facility failed to provide accurate resident records for 1 of 14 residents (Residents #8). The facility reported a census of 41 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #8 documented diagnoses of diabetes mellitus, neurogenic bladder and hypertension. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Interview on 5/28/24 at 11:34 a.m., with Resident #8 revealed her bed rail had been loose and when she was being assisted the side rail broke off of the bed and she fell off of the side of the bed. Review of Resident #8 ' s Progress Notes revealed the following: a. On 12/26/23, Resident #8 being seen after going to the emergency room (ER) on 12/23/23 for left shoulder pain and returning to the facility on the same day. While in the ER an x-ray was obtained of the left shoulder which showed advanced degenerative change. Nursing staff also express resident fell out of bed yesterday. b. On 12/27/23 at 10:51 p.m., Resident #8 reports pain to the left shoulder and arm. As needed, tramadol has been effective. Resident #8 is lying in her new bed and it is in the lowest position. c. On 12/28/23 at 11:03 a.m., Resident #8 returns from doctor appointment with order for non-weight bearing to left shoulder. Follow-up with CT scan of left shoulder. d. On 1/17/24 at 1:11 p.m., CT results received impression: Acute intra-articular fracture of the anterior aspect of the glenoid with maximum distraction of fracture fragments in the order of 3 mm. e. On 3/28/24 at 10:54 a.m., Resident #8 returns after seeing the doctor with the following noted healed fracture no restrictions. Review of facility provided Incident Report dated 12/25/23 revealed while resident was being repositioned in bed, the side rail became disengaged and resident rolled off side of bed. Resident #8 states while trying to help them change me, I grabbed ahold of the rail as I was turning and I started falling. Review of the facility provided document titled Timeline of Incident revealed on 12/25/23 at 2:05 p.m., Resident #8 was lying in bed while she was being assisted by staff. Staff went to reposition her to her left side, Resident #8 went to grab her bed rail to hold on to and the bed rail broke apart from the bed frame causing Resident #8 to fall out of bed onto her left side. Staff brought in a replacement bed with functioning bed rails.On 1/17/24 the facility was notified by the physician Resident #8 had an acute fracture. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/29/24 at 9:53 a.m., with Staff A, Licensed Practical Nurse (LPN) was just coming onto shift when the staff called her down to Resident #8 ' s room. When Staff A entered the room Resident #8 was laying on the floor face down with the bed rail broke off of the bed. Resident #8 was assessed and assisted back into bed with the hoyer lift. Interview on 5/29/24 at 10:29 a.m., with Staff B, Certified Nursing Assistant (CNA) revealed she had assisted Staff C, CNA with Resident #8 into bed to change her brief. Staff B revealed when Resident #8 rolled onto her left side she grabbed the bed rail and the rail broke and Resident #8 fell to the floor. Staff B further revealed she had noticed the bed rail was a little loose but it had been that way for awhile and she didn ' t think it would break. Interview on 5/29/24 at 12:20 p.m., with Staff C, CNA revealed she had been assisting Staff B, CNA with Resident #8. Staff C revealed Resident #8 rolled onto her left side and the side rail on the bed broke and Resident #8 fell out of the bed onto the floor. Review of Resident #8 ' s electronic health record lacked documentation regarding information on the incident that occurred on 12/25/24. Interview on 5/30/24 at 8:40 a.m., with the Director of Nursing revealed the staff should have charted the incident in the Progress Notes.

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F 0909 Level of Harm - Actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review and staff interview the facility failed to appropriately inspect bed rails in the facility for 1 of 1 resident reviewed (Resident #8). The facility reported a census of 41 residents. Past Noncompliance determined during the annual recertification survey of a facility incident that occurred on 12/25/23 regarding deficiency F909 with a scope and severity of a Level G. The facility provided evidence of the bed being changed out with safe bed rails. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #8 documented diagnoses of diabetes mellitus, neurogenic bladder and hypertension. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Interview on 5/28/24 at 11:34 a.m., with Resident #8 revealed her bed rail had been loose and when she was being assisted the side rail broke off of the bed and she fell off of the side of the bed. Review of Resident #8 ' s Progress Notes revealed the following: a. On 12/26/23, Resident #8 being seen after going to the emergency room (ER) on 12/23/23 for left shoulder pain and returning to the facility on the same day. While in the ER an x-ray was obtained of the left shoulder which showed advanced degenerative change. Nursing staff also express resident fell out of bed yesterday. b. On 12/27/23 at 10:51 p.m., Resident #8 reports pain to the left shoulder and arm. As needed, tramadol has been effective. Resident #8 is lying in her new bed and it is in the lowest position. c. On 12/28/23 at 11:03 a.m., Resident #8 returns from doctor appointment with order for non-weight bearing to left shoulder. Follow-up with CT scan of left shoulder. d. On 1/17/24 at 1:11 p.m., CT results received impression: Acute intra-articular fracture of the anterior aspect of the glenoid with maximum distraction of fracture fragments in the order of 3 mm. e. On 3/28/24 at 10:54 a.m., Resident #8 returns after seeing the doctor with the following noted healed fracture no restrictions. Review of facility provided Incident Report dated 12/25/23 revealed while resident was being repositioned in bed, the side rail became disengaged and resident rolled off side of bed. Resident #8 states while trying to help them change me, I grabbed ahold of the rail as I was turning and I started falling. (continued on next page)

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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 0909 Level of Harm - Actual harm Residents Affected - Few	Review of the facility provided document titled Timeline of Incident revealed on 12/25/23 at 2:05 p.m., Resident #8 was lying in bed while she was being assisted by staff. Staff went to reposition her to her left side, Resident #8 went to grab her bed rail to hold on to and the bed rail broke apart from the bed frame causing Resident #8 to fall out of bed onto her left side. Staff brought in a replacement bed with functioning bed rails.On 1/17/24 the facility was notified by the physician Resident #8 had an acute fracture. Review of the CT shoulder imaging dated 1/8/24 revealed in the findings there is an acute appearing intra-articular fracture of the anterior aspect of the glenoid with maximum distraction of fracture fragments in the order of 3 mm. Interview on 5/29/24 at 9:53 a.m., with Staff A, Licensed Practical Nurse (LPN) was just coming onto shift when the staff called her down to Resident #8 ' s room. When Staff A entered the room Resident #8 was laying on the floor face down with the bed rail broke off of the bed. Resident #8 was assessed and assisted back into bed with the hoyer lift. Interview on 5/29/24 at 10:29 a.m., with Staff B, Certified Nursing Assistant (CNA) revealed she had assisted Staff C, CNA with Resident #8 into bed to change her brief. Staff B revealed when Resident #8 rolled onto her left side she grabbed the bed rail and the rail broke and Resident #8 fell to the floor. Staff B further revealed she had noticed the bed rail was a little loose but it had been that way for awhile and she didn ' t think it would break. Interview on 5/29/24 at 12:20 p.m., with Staff C, CNA revealed she had been assisting Staff B, CNA with Resident #8. Staff C revealed Resident #8 rolled onto her left side and the side rail on the bed broke and Resident #8 fell out of the bed onto the floor. Interview on 5/29/24 at 12:41 p.m., with Staff D, Maintenance Director revealed the beds have a tab on the rail that holds them in place and a pin that keeps them locked. The side rail was bad on both sides from what appears to have been bent from a bigger person pulling on the side rails on each side. The tab was bent so much that the pin that keeps the rail in place wasn ' t able to hold it any longer. Review of facility provided document titled Work History Report with created date of 5/29/24 revealed preventative maintenance with a due date of 11/30/24 and 12/31/24 under task completion revealed no action recorded. Review of the facility provided instructions titled Beds- Electric: Inspect Bed Rails dated 5/29/24 at 2:57 p.m., revealed items identified as poor condition should be removed from service. Maintenance check included ensuring that the rails engage and lock as specified and tighten, adjust or replace any parts such as end caps, knobs, bolts, screws, ect. that are loose, show signs of wear or are missing. Interview on 5/29/24 at 3:19 p.m., with the Administrator revealed the previous maintenance guy had been doing the bed checks and he retired at the beginning of November and the facility was without a full-time maintenance person. The bed rail inspections did not get done in November or December. After the incident happened, the facility realized the bed rail inspections were not being. The Administor further revealed he trained the new maintenance guy on how to do the bed rail inspections and they are now being completed.