STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Stanton	213 Halland Avenue Stanton, IA 51573

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 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** Based on clinical record review, PASRR document review and staff interview, the facility failed to refer 1 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 or other related condition, to the appropriate state-designated authority for Level II PASRR evaluation and determination for 1 out of 1 residents (Resident #35) reviewed for PASRR requirements. The facility reported a census of 38 residents. Finding include: The Minimum Data Set (MDS) dated [DATE] for Resident #35 documented a Brief Interview for Mental Status (BIMS) score of 13 indicating no cognitive impairment. Review of Resident #35's Electronic Health Record (EHR) titled, Diagnosis revealed diagnoses of anorexia on 5/2/25 and unspecified psychosis on 10/2/25. Review of Resident #35's EHR titled, Notice of PASRR level 1 Screen Outcome dated October 1, 2024 documented under mental health diagnoses major depression and anxiety disorder. Document did not include the diagnosis of anorexia or psychosis. On 6/18/25 at 8:57 AM the Director Of Nursing (DON) stated October was the time when the previous MDS Coordinator went on maternity leave and Staff D, Licensed Practical Nurse (LPN) took over doing MDS and that was when the facility realized the previous MDS Coordinator was not completing what should have been completed. The DON stated she had not thought of anorexia as something that should be resubmitted to PASRR. The DON acknowledged that the diagnosis of psychosis was a diagnosis that should have been sent to PASRR for another evaluation. The DON stated as soon as the facility received the order for anorexia and psychosis the PASRR should have been updated. The DON acknowledged that she dropped the ball on that. The DON stated she was the staff that was in charge of completing the PASRR submissions at that time. Review of undated document titled, Status Change PASRR documented a resident required a new PASRR referral when an additional diagnosis of a mental health disorder was identified. On 6/19/25 the Administrator stated the facility did not have a policy for PASRR submissions. The Administrator stated the facility follow requirements for change in status per PASRR.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, hospital record review, and staff interviews, the facility failed to provide adequate and timely assessment and intervention for 1 of 13 residents (Resident #38) reviewed. Resident #38 experienced nausea with vomiting for 4 days and the chart lacked vital signs or bowel assessments throughout that time period. The resident was sent to the hospital and was found to have a bowel obstruction with perforation. The facility reported a census of 38 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #38 had a Brief Interview for Mental Status (BIMS) score of 15 (intact cognitive ability). The resident required partial assistance with hygiene, dressing and toileting. He was occasionally incontinent of urine and bowel and had occasional constipation. Diagnoses for Resident #38 included anemia, atrial fibrillation, heart failure, Benign Prostatic Hyperplasia (BPH) and urgency incontinence. The Care Plan initiated on 4/16/25, showed that Resident #38 had the potential for bowel and bladder incontinence related to BPH, a history of malignant neoplasm of the prostate and constipation. Staff were to assess bowel sounds and abdomen and to report abnormalities to the primary care physician. Staff were to follow bowel protocols and to give as needed medication for constipation. The following was found in the Nursing Progress Notes: a. On 5/7/25 at 9:18 AM, Resident #38 complained of nausea/vomiting and refused food and medications. A fax was sent to the provider. b. On 5/7/25 at 11:34 AM, the resident requested to see the doctor related to vomiting and back pain. An appointment was made to see the doctor at 2:00 PM that day c. On 5/7/25 at 7:08 PM, the resident came back from clinic. The doctor suspected complicated urinary tract infection. He was given an antibiotic in the clinic and a follow up prescription for Zofran for nausea. The resident was added to the hot list. The Doctor Clinic Note dated 5/7/25, indicated that Resident #38 presented with left sided back pain and vomiting and was uncomfortable going to the bathroom. The doctor noted that the resident had some trouble with his prostate in the past, and his overall functional status had declined since he was admitted to the nursing home. His bowel sounds were not assessed in the clinic and a urine culture was initiated. The resident was given a gram of antibiotic; Rocephin and Toradol for pain. Continued Nursing Progress Notes: d. On 5/8/25 at 8:08 AM, Zofran was given for nausea after vomiting 3 times. e. On 5/8/25 at 11:17 AM, unable to keep pills down this morning. f. On 5/8/25 at 11:38 AM, Cefdinir 300 mg antibiotic prescribed for UTI (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g. On 5/8/25 at 6:11 PM, the resident was still nauseous, given Zofran. h. On 5/9/25 at 8:48 AM, Zofran given for nausea i. On 5/10/25 at 7:19 AM Zofran needed for nausea j. On 5/10/25 at 9:25 AM, came out for breakfast but didn't eat much k. On 5/10/25 at 12:46 PM, the resident stated he vomited after breakfast. The housekeeper reported dark colored vomit. Contacted Director of Nursing (DON) and asked if he should be sent to the ED l. On 5/10/25 at 1:10 PM, call received from doctor and order was received to send to the Emergency Department (ED) due to possible dehydration. m. On 5/10/25 at 6:01 PM, the resident was being transferred to a different hospital for a small bowel obstruction, acute kidney injury, pneumoperitoneal. A review of the Vitals and Progress Notes showed that from 5/8 through 5/10/25, the chart lacked completed vital signs or bowel assessments. The ED report dated 5/10/25 at 1:42 PM, showed that Resident #38 presented with abdominal pain, nausea, vomiting, a heart rate of 105 Beats Per Minute (BPM), and Blood Pressure (BP) of 95/56. The abdomen was soft, mildly distended, tenderness to palpation with significant tenderness in right lower extremity, positive guarding, no rebound tenderness. Vital signs show that he was tachycardic and hypotensive. Fluids and pain medication started. After fluids the BP was 86/63. Radiology findings were suggestive of a small bowel obstruction with possible transition point in the right hemiabdomen, suggestive of perforation. The patent and family agreed to have him transferred for possible surgical intervention. The hospital report dated 5/10/25 at 7:51 PM, showed that the admitting diagnosis was septic shock. The BP was 76/53, HR 121 BPM, respiration 50 breaths per minute. The active problems included; septic shock, bowel perforation and congestive heart failure. On 5/10/25 at 10:43 PM, the postoperative diagnosis included perforated small bowel, small bowel obstruction internal hernia causing small bowel volvulus (twisting of intestine cutting off blood.) Nursing Progress Notes showed: a. On 5/16/25 at 2:17 PM, the resident was admitted back to facility b. On 6/1/25 at 2:25 AM, the resident passed away. On 6/18/25 at 9:56 AM Staff C Licensed Practical Nurse (LPN) remember calling the doctor on 5/10/25 to get an appointment in the clinic that day. She said that she found out the next day, that he still had stomach issues and pain in his back. She did not remember having listened to his bowel sounds or taking any vitals. The resident had been on antibiotics for a couple days, he was lethargic, didn't want to come out of his room. She called the doctor on 5/10 because he was not getting any better and he looked septic. Staff C said he was pail, lethargic, isolating, and just laying there in bed. Staff C acknowledged the symptoms of sepsis included a high temperature, low BP, and high pulse. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/25 at 10:29 AM Staff E, Certified Nurse Aide (CNA) stated that Resident #38 was very nauseous, and was up half the night vomiting. She got him to try some broth, and crackers, but he ended up getting sick and much weaker. When he was first admitted he was able to get himself to the bathroom but then he became weaker and had several falls because he was trying to take himself to the bathroom. On 6/18/25 at 10:39 AM, Staff B, Registered Nurse (RN) worked with him one day before he was hospitalized . He had been complaining of stomach hurting, and it was passed on in report that he had a UTI. That morning he threw up the pills that she had given him so she contacted the doctor to see if he wanted her to re-administer the antibiotic. She gave him some Zofran, he said he felt better, and tried to eat a little breakfast and she gave him another dose of antibiotic. He had vomited in the trash can, she said it was a watery orange, and it looked like bile. Staff B said that they complete hot charting when a resident was on an antibiotic. What they were expected to do was to check a temperature and any adverse effect of antibiotic. She thought that she had assessed his bowel sounds and they were quiet, but he didn't have pain in the abdomen, it was more generalized back pain. She said that he didn't complain of burning with urination. On 6/18/25 at 7:14 AM, the Director of Nursing (DON) said that if a resident was on hot charting that meant that they would keep a running list at the nurse's station of the residents that were on an antibiotic and they were expected to chart on that resident daily. When asked if that meant to include vital signs, she said that it depends on the situation. On 6/18/25 at 1:18 PM, the DON said that that nurses should have put something in the notes about pain, should have done daily vitals as the Resident #38 was not getting better. On 6/19/25 at 7:08 AM, the DON said that they did not have a policy on resident change in status, and they would follow standard of care. The facility did not provide the resource for the standard of care for resident assessments that they teach the staff.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and clinical record review the facility failed to ensure that a resident was provided supplemental oxygen for 1 of 1 resident reviewed. In two separate observations in the dining room, it was discovered that the oxygen tank for Resident #89 was empty. The facility reported a census of 38 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #89 had a Brief Interview for Mental Status (BIMS) of 15 (intact cognitive ability). She required minimal assistance with hygiene, dressing, personal hygiene and was on continuous oxygen therapy. Her diagnoses included atrial fibrillation, heart failure, renal insufficiency, diabetes mellitus, presence of cardiac pacemaker. The Care Plan dated 6/12/25, showed that the resident had the potential for actual respiratory abnormalities related to Congestive Heart Failure (CHF), shortness of breath and the use of supplemental oxygen. Staff were to assist with the tank/concentrator as needed. The Orders tab in the electronic charts showed an order dated 6/5/25 at 3:49 PM, for continuous oxygen, 3 liters, via nasal cannula. On 6/16/25 at 11:57 AM, Resident #89 was sitting at the lunch table in her Wheel Chair (WC) with an oxygen tank on the back of the WC. The gauge on the top of the tank showed the needle in the red zone that indicated it was empty. The Nasal Cannula (NC) was hanging on the tank and attached to the resident's nostrils. At 12:36 PM, the resident propelled herself back to her room and the oxygen tank was still on empty. On 6/17/25 at 11:43 AM, Resident #89 was at the lunch table in her WC with an oxygen tank on the back. The needle was in the red zone. The Director of Nursing (DON) then went over to the resident and checked the tank. She told the resident that the tank was making a ticking sound and wheeled her out of the dining room area. They came back a short time later with a different oxygen tank and the needle showed there was oxygen in that tank. On 6/17/25 at 12:03 PM, Staff D Licensed Practical Nurse (LPN) said that she had pushed Resident #89 out to the dining room but she hadn't looked at the oxygen tank. She said that they keep the tank on the back when the WC was in the resident's room. Staff D said that some of the tanks will have a ticking sound if/when it was getting low or empty. She said that the Certified Nurse Aides (CNA) will usually will tell them if/when the oxygen tank was empty. On 6/19/25 at 7:05 AM, the DON said that at 3 liters, the tank would get empty pretty quickly. She acknowledged that the staff should have been checking it more closely. The DON said that they did not have a policy for supplemental oxygen use but to follow the standards of care. The facility did not provide the resource used to educate staff on the standards of care for oxygen use.