STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165382	A. Building B. Wing	02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Knoxville, LLC	606 North Seventh Street Knoxville, IA 50138

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35434 Based on clinical record review, policy review, and resident and staff interviews, the facility failed to ensure residents had the right to make choices about aspects of their lives which were significant to the resident by denying smoke breaks for 5 of 5 smokers reviewed (Residents #6, #7, #17, #27, and #30) and by not allowing a resident to lie down upon request for 1 of 6 residents reviewed for dignity (Resident #28). The facility reported a census of 50 residents. Findings include: 1. The Quarterly Minimum Data Set(MDS) assessment tool, dated 1/12/25, listed diagnoses for Resident #7 which included anxiety, depression, and unspecified intellectual disability. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition. A 4/7/22 Care Plan entry stated she loved to participate in smoking breaks. A 1/6/25 Smoking Evaluation stated the resident smoked mornings, evenings, and afternoons supervised. On 1/30/25 at 8:44 a.m., Resident #7 stated that whenever she had a disagreement with staff they took away her smoking break. She stated staff considered smoking a privilege and when this happened she felt belittled. 2. The Annual MDS assessment tool, dated 11/3/24, listed diagnoses for Resident #17 which included heart failure, hemiplegia(one-sided paralysis), and seizures. The MDS listed the resident's BIMS score as 15 out of 15, indicating intact cognition. The MDS documented that the resident that it was very important to do his favorite activities. A 3/14/24 8:37 a.m. Health Status Note stated the resident cursed at staff and called them names. The nurse decided the resident would not be able to smoke this morning. A 3/25/24 Care Plan entry stated the resident was a smoker and participated in routine smoke breaks supervised by staff. (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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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 12/17/24 Heath Status Note stated the resident had an outburst this morning directed at a Certified Nursing Assistant(CNA) for moving his leg. The resident called the CNA a name and yelled and swore at staff. The note stated the resident lost his 10:00 a.m. smoking break due to behaviors. A 1/22/25 Smoking Evaluation stated the resident smoked mornings, afternoons, and evenings with supervision. On 1/30/25 at 8:40 a.m., Resident #17 stated when he yelled, he was not allowed to go smoke. He stated his smoking breaks depended on if he was bad. He stated this made him feel kind of bad. 3. The Quarterly MDS assessment tool, dated 11/10/24, listed diagnoses for Resident #27 which included heart failure, coronary artery disease, and hemiplegia. The MDS listed his BIMS score as 15 out of 15, indicating intact cognition. An 8/7/24 Care Plan entry stated the resident utilized his vape pen during routine smoke breaks with staff supervision. A 1/27/25 Smoking Evaluation stated the resident smoked with supervision. On 1/30/25 at 8:29 a.m., Resident #27 stated staff took away his smoking break several times. He said this made him angry as he liked to go outside. A 2/2/25 Health Status Note stated the resident's son took him out to smoke and (staff) told him he was not allowed. The resident stated he would go no matter what. The resident had behaviors all day, refused to use the urinal, and alerted his call light every 5 minutes. 4. The Quarterly MDS assessment tool, dated 11/3/24, listed diagnoses for Resident #30 which included hemiplegia, anxiety, and depression. The MDS listed her BIMS score as 15 out of 15, indicating intact cognition. A 7/30/24 Care Plan entry stated the resident utilized a vape pen during routine smoke breaks with staff supervision. A 12/6/24 Health Status Note stated a staff member reminded the resident that the smoke break was not mandatory or required and the resident would not be going out to attend the morning smoke break due to her behaviors. A 1/22/25 Smoking Evaluation stated Resident #30 smoked in the mornings, afternoons, and evenings with supervision. On 1/30/25 at 8:32 a.m., Resident #30 stated if she talks back to the nurses, staff tell her she cannot to out to smoke. She stated this felt like punishment and she was not a little kid. 5. The MDS assessment tool, dated 11/10/24, listed diagnoses for Resident #28 which included Alzheimer's, non-Alzheimer's dementia, and age related physical debility. The MDS stated the resident required substantial/maximal assistance for chair to bed transfers and listed his BIMS score as 5 out of 15. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An 8/31/22 Care Plan entry stated the resident required the assistance of 1 staff for transfers. On 1/27/25 at 2:27 p.m., Resident #28 sat in the hallway and yelled that he wanted to go to bed. Staff G Registered Nurse(RN) told him that he had to wait until after supper. On 1/29/25 at 1:04 p.m., Staff C CNA stated Staff G RN took away resident smoking breaks if they did such things as yell at staff or call them names. On 1/29/25 at 1:29 p.m., Staff D CNA stated they had one resident(Resident #17) who was rude and punched doors and when he did this, staff took away his smoking break. On 1/29/25 at 1:42 p.m., Staff E CNA stated there were times when Resident #17 swore at people and called them names. She stated times like that when he yelled and was disrespectful, staff took away his smoking break On 1/29/25 at 1:50 p.m., Staff F CNA stated sometimes staff took away Resident #17's smoking break because of the way he treated staff. She stated when he and his girlfriend started yelling and screaming and were disruptive, this would be a reason staff took the smoking break away. On 1/30/25 at 10:20 a.m., Staff G RN stated if residents broke the rules, staff would take their smoking break away. She stated staff could not turn them over their knee and spank them and this was the only thing they had. She stated if residents yelled, were very loud, used derogatory language to staff, or vaped in their rooms, she did not let them go out and smoke. She stated the behaviors could get serious if one didn't try to stop them now. Staff G stated the residents had rights but staff did also. She stated with regard to Resident #28, if it was pretty close to supper, they didn't have them lie down. She stated if they were going to lie down it was usually at 1:30 p.m. She stated they usually started to get residents to supper at 4:30 p.m. On 2/3/25 at 11:41 a.m., Staff H Nurse Specialist stated at times staff took away smoke breaks if residents bullied other residents or staff. She stated smoking was a privilege, not a right. She stated there was no reason that residents would not be able to lie down in the afternoon. On 2/3/25 at 1:26 p.m., the Administrator stated if there were instances where residents screamed, yelled, and called people names, staff may take their smoke breaks away. She stated it was a privilege to smoke and the facility had this system since she started 3 years ago. The facility policy Residents' [NAME] of Rights, dated November 2016, stated residents had the right to make choices about their activities and schedules, including sleeping and waking times). 42441 6. The Quarterly MDS dated [DATE] revealed Resident #6 had a BIMS of 14 indicating intact cognition. The MDS further documented the resident had diagnoses including anxiety disorder and depression. The Care Plan initiated 8/22/24 revealed Resident #6 was a smoker who smoked during routine smoke breaks with staff supervision. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #6's smoking assessments dated 8/22/24, 11/13/24 and 1/30/25 revealed the resident smoked 2-5 times a day, liked to smoke in the morning, afternoon and evenings, and was safe to smoke with supervision. Review of facility form titled, Resident Smoking Assessment, updated 4/21/22 revealed Administrative/Nursing Leadership and/or charge nurse may also deny residents the privilege to smoke for any safety concerns such as inclement weather. Resident #6 signed the facility form upon admission 8/22/24. Review of Progress Notes for Resident #6 revealed effective 1/6/25 at 7:00 PM, Staff A, Licensed Practical Nurse (LPN) approached the resident and stated, this is unacceptable behavior after the resident yelled in the hallway. Staff A documented she explained to the resident that she needed to return to her room and she would not be attending a smoke break with increased behaviors. During an interview 1/29/25 at 2:53 PM, Resident #6 confirmed that on 1/6/25 she was told by Staff A that she would not be allowed to go out on a smoke break as a result of increased behaviors. During an interview 1/30/25 at 8:55 AM, Resident #6 revealed when she was told by Staff A that she could not go outside for a smoke break on 1/6/25 it made her feel angry, dehumanized and punished like, I'm telling mommy on you. Review of facility policy titled, Resident Smoking Process, updated 4/21/22 revealed Administrative/Nursing Leadership and/or charge nurse may also deny residents the privilege to smoke for any safety concerns such as inclement weather.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35434 Based on clinical record review, policy review, and resident and staff interviews, the facility failed to ensure residents were free from mental abuse by denying smoke breaks based on resident behaviors for 5 of 5 smokers reviewed(Residents #6, #7, #17, #27, and #30). The facility reported a census of 50 residents. Findings include: 1. The Minimum Data Set(MDS) assessment tool, dated 1/12/25, listed diagnoses for Resident #7 which included anxiety, depression, and unspecified intellectual disability. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition. A 4/7/22 Care Plan entry stated she loved to participate in smoking breaks. A 1/6/25 Smoking Evaluation stated the resident smoked mornings, evenings, and afternoons supervised. On 1/30/25 at 8:44 a.m., Resident #7 stated that whenever she had a disagreement with staff they took away her smoking break. She stated staff considered smoking a privilege and when this happened she felt belittled. 2. The MDS assessment tool, dated 11/3/24, listed diagnoses for Resident #17 which included heart failure, hemiplegia(one-sided paralysis), and seizures. The MDS listed the resident's BIMS score as 15 out of 15, indicating intact cognition. A 3/14/24 8:37 a.m. Health Status Note stated the resident cursed at staff and called them names. The nurse decided the resident would not be able to smoke this morning. A 3/25/24 Care Plan entry stated the resident was a smoker and participated in routine smoke breaks supervised by staff. A 12/17/24 Heath Status Note stated the resident had an outburst this morning directed at a Certified Nursing Assistant(CNA) for moving his leg. The resident called the CNA a name and yelled and swore at staff. The note stated the resident lost his 10:00 a.m. smoking break due to behaviors. A 1/22/25 Smoking Evaluation stated the resident smoked mornings, afternoons, and evenings with supervision. On 1/30/25 at 8:40 a.m., Resident #17 stated when he yelled, he was not allowed to go smoke. He stated his smoking breaks depended on if he was bad. He stated this made him feel kind of bad. 3. The MDS assessment tool, dated 11/10/24, listed diagnoses for Resident #27 which included heart failure, coronary artery disease, and hemiplegia. The MDS listed his BIMS score as 15 out of 15, indicating intact cognition. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An 8/7/24 Care Plan entry stated the resident utilized his vape pen during routine smoke breaks with staff supervision. A 1/27/25 Smoking Evaluation stated the resident smoked with supervision. On 1/30/25 at 8:29 a.m., Resident #27 stated staff took away his smoking break several times. He said this made him angry as he liked to go outside. A 2/2/25 Health Status Note stated the resident's son took him out to smoke and (staff) told him he was not allowed. The resident stated he would go no matter what. The resident had behaviors all day, refused to use the urinal, and alerted his call light every 5 minutes. 4. The MDS assessment tool, dated 11/3/24, listed diagnoses for Resident #30 which included hemiplegia, anxiety, and depression. The MDS listed her BIMS score as 15 out of 15, indicating intact cognition. A 7/30/24 Care Plan entry stated the resident utilized a vape pen during routine smoke breaks with staff supervision. A 12/6/24 Health Status Note stated a staff member reminded the resident that the smoke break was not mandatory or required and the resident would not be going out to attend the morning smoke break due to her behaviors. A 1/22/25 Smoking Evaluation stated Resident #30 smoked in the mornings, afternoons, and evenings with supervision. On 1/30/25 at 8:32 a.m., Resident #30 stated if she talks back to the nurses, staff tell her she cannot to out to smoke. She stated this felt like punishment and she was not a little kid. On 1/29/25 at 1:04 p.m., Staff C CNA stated Staff G RN took away resident smoking breaks if they did such things as yell at staff or call them names. On 1/29/25 at 1:29 p.m., Staff D CNA stated they had one resident(Resident #17) who was rude and punched doors and when he did this, staff took away his smoking break. On 1/29/25 at 1:42 p.m., Staff E CNA stated there were times when Resident #17 swore at people and called them names. She stated times like that when he yelled and was disrespectful, staff took away his smoking break On 1/29/25 at 1:50 p.m., Staff F CNA stated sometimes staff took away Resident #17's smoking break because of the way he treated staff. She stated when he and his girlfriend started yelling and screaming and were disruptive, this would be a reason staff took the smoking break away. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/30/25 at 10:20 a.m., Staff G RN stated if residents broke the rules, staff would take their smoking break away. She stated staff could not turn them over their knee and spank them and this was the only thing they had. She stated if residents yelled, were very loud, used derogatory language to staff, or vaped in their rooms, she did not let them go out and smoke. She stated the behaviors could get serious if one didn't try to stop them now. Staff G stated the residents had rights but staff did also. She stated with regard to Resident #29, if it was pretty close to supper, they didn't have them lie down. She stated if they were going to lie down it was usually at 1:30 p.m. She stated they usually started to get residents to supper at 4:30 p.m. On 2/3/25 at 11:41 a.m., Staff H Nurse Specialist stated at times staff took away smoke breaks if residents bullied other residents or staff. She stated smoking was a privilege, not a right. She stated there was no reason that residents would not be able to lie down in the afternoon. On 2/3/25 at 1:26 p.m., the Administrator stated if there were instances where residents screamed, yelled, and called people names, staff may take their smoke breaks away. She stated it was a privilege to smoke and the facility had this system since she started 3 years ago. 42441 5. The MDS dated [DATE] revealed Resident #6 had a BIMS of 14 indicating intact cognition. The MDS further documented the resident had diagnoses including anxiety disorder and depression. The Care Plan initiated 8/22/24 revealed Resident #6 was a smoker who smoked during routine smoke breaks with staff supervision. Review of Resident #6's smoking assessments dated 8/22/24, 11/13/24 and 1/30/25 revealed the resident smoked 2-5 times a day, liked to smoke in the morning, afternoon and evenings, and was safe to smoke with supervision. Review of facility form titled, Resident Smoking Assessment, updated 4/21/22 revealed Administrative/Nursing Leadership and/or charge nurse may also deny residents the privilege to smoke for any safety concerns such as inclement weather. Resident #6 signed the facility form upon admission 8/22/24. Review of Progress Notes for Resident #6 revealed effective 1/6/25 at 7:00 PM, Staff A, Licensed Practical Nurse (LPN) approached the resident and stated, this is unacceptable behavior after the resident yelled in the hallway. Staff A documented she explained to the resident that she needed to return to her room and she would not be attending a smoke break with increased behaviors. During an interview 1/29/25 at 2:53 PM, Resident #6 confirmed that on 1/6/25 she was told by Staff A that she would not be allowed to go out on a smoke break as a result of increased behaviors. During an interview 1/30/25 at 8:55 AM, Resident #6 revealed when she was told by Staff A that she could not go outside for a smoke break on 1/6/25 it made her feel angry, dehumanized and punished like, I'm telling mommy on you. Review of facility policy titled, Resident Smoking Process, updated 4/21/22 revealed Administrative/Nursing Leadership and/or charge nurse may also deny residents the privilege to smoke for any safety concerns such as inclement weather.

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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. 44972 Based on observation, clinical record review and staff interview the facility failed to ensure staff followed physician pre-op orders as directed prior to a resident procedure for 1 of 1 residents reviewed (Resident #43). Resident #43 did not receive a bath/shower the day of the procedure. The facility reported a census of 50 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #43 dated 1/12/25 included diagnoses of ulcerative colitis, Alzheimer's disease, anxiety disorder, and depression. The MDS identified a Brief Interview for Mental Status (BIMS) score of 3 indicating severely impaired cognition. The MDS documented the resident required extensive assistance with bathing, personal hygiene, and transfers and was dependent on staff assistance for toileting. Review of pre-op orders dated 1/20/25 in preparation for a colonoscopy to be completed on 1/24/25, stated the day of surgery, Resident #43 was to receive a shower or bath the morning of the procedure. Resident #43 was noted to have powder in her groins that was wet and clumpy when she arrived for the procedure. Review of documentation in Point Click Care (PCC) (the facility's electronic healthcare records), Resident #43 received a shower on 1/20/25 on day shift. Review of the facility provided bath sheets, Resident #43 received a shower on 1/23/25 between 2 and 6 PM and was noted to have excoriated groins and abdominal fold at that time. It was noted the treatment was completed to the area. There was no documentation of a shower or bath being completed on 1/24/25, the day of the colonoscopy procedure. In an interview on 1/30/25 at 2:51 PM, the Administrator stated it was the expectation staff provide a bath/shower to the resident per the physician order prior to the procedure to ensure the resident was clean and ready to go for the day. On 1/30/25 at 2:08 PM, the Administrator reported per email the facility did not have policies for bathing or following physician's orders and that it was the expectation they follow the Standards of Care practices.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 44972 Based on personnel file review, staff interview, and policy review, the facility failed to assure 1 of 5 staff reviewed met the requirements for Dependent Adult Abuse Mandatory Reporter Training (Staff B). The facility reported a census of 50 residents. Findings include: Staff B, Housekeeper, had a start date of 5/29/24. Record review revealed Staff B had not completed the 2 hour Dependent Adult Abuse Mandatory Reporter Training that was due 11/29/24. In an interview on 1/29/25 at 1:00 PM, the Administrator acknowledged Staff B had not yet completed the Dependent Adult Abuse Mandatory Reporter Training. She stated the employee was currently in the facility completing the training. She was aware new employees were to complete the training within 6 months. In an interview on 1/30/25 at 2:48 PM the Administrator stated it was the expectation the Business Office Manager use a spread sheet with all staff and the dates they are due to complete or renew their Dependent Adult Abuse Mandatory Reporter Training and the Business Office Manager was to let the Administrator know when the staff were coming due and get them completed as required. The facility provided Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy updated 10/19/22 stated within six months of hire each employee shall be required to complete an initial 2-hour training course provided by the Iowa Department of Human Services relating to the identification and reporting of dependent adult abuse. Each employee will take a 1-hour recertification training within 3 years of the initial training and every three years thereafter.