STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165414	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Pomeroy, LLC	303 East 7th Street Pomeroy, IA 50575

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056 Based on clinical record review, staff interviews, and facility policy, the facility failed to notify the physician and family regarding a skin condition after a fall (Resident #1). The facility reported a census of 26 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 documented diagnosis of schizophrenia, depression, and orthostatic hypotension. The MDS showed the Brief Interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment. Review of facility Progress Notes on 4/30/25 at 10:25 a.m. revealed a nurse documented on 4/28/25 at 7:05 p.m. a fall follow up and revealed a skin condition, a bruise, was found on the back of Resident #1's right leg behind the knee, the bruise measured 2 centimeters (cm) x 4 cm, the bruise was described as yellow, green, purple in color. The Progress Note lacked information that the family and physician was notified. Review of facility skin sheets on 4/30/25 at 10:25 a.m. revealed the facility failed to fill out the skin sheet to monitor the bruise weekly. Review of the facility policy named Weekly Skin Assessment and Documentation Process dated 1/20/23 revealed skin ulcers and non-ulcer will be assessed and documented weekly by the facility wound nurse. Identifying a Skin Ulcer or Non-Ulcer Assessment: 1) The nurse who initially identifies the Skin Ulcer or Non-Ulcer Ulcer will complete the appropriate Skin Assessment (Non-Ulcer or Ulcer Assessment). 2) A separate Skin Assessment (Non-Ulcer or Ulcer Assessment) will be completed for each identified skin/wound alteration. (i.e., if two bruises are identified on one resident, two separate assessments will need to be completed, one for each area.) 3) The treatment orders for all Skin Ulcer or Non-Ulcer will be implemented per the Skin Management Protocol. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4) The Nurse Leader will fax the appropriate wound treatment order per the Skin/Wound Protocol for approval by the physician. 5) The care plan will be updated and reviewed to ensure that the skin/wound alteration and appropriate interventions have been identified on the Care Plan. 6) Notification to Physician 7) When the nurse on the floor observes a new skin/wound alteration they should utilize the fax forms to notify the physician/nurse practitioner or call and put the new order in the electronic health record. Interview on 5/1/25 at 9:30 a.m. with the Administrator stated the expectation would be to follow the facility policy and procedures.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056 Based on clinical record review and staff interview the facility failed to notify the Long Term Care (LTC) Ombudsman for 1 of 1 residents reviewed who transferred to the hospital (Resident #9). The facility reported a census of 26 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #9 documented diagnoses of quadriplegia, anxiety, depression and chronic pain. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. Review of Resident #9's Progress Notes revealed the following information: 8/13/24 at 4:45 p.m., Resident transferred to the emergency department and admitted to hospital. 8/22/24 at 12:55 p.m., Resident readmitted to facility from the hospital. 12/9/24 at 9:34 a.m., Resident transferred to the emergency department and admitted to hospital. 12/12/24 at 4:57 p.m., Resident readmitted to the facility from the hospital. 1/7/25 at 4:09 a.m., Resident admitted to hospital for surgical procedure. 1/10/25 at 4:00 p.m., Resident readmitted to the facility from the hospital. Review of Resident #9's Census tab revealed the following: 8/13/24- hospital unpaid leave 8/22/24- active 12/9/24 - hospital unpaid leave 12/12/24 - active 1/7/25 - hospital unpaid leave 1/10/25 - active Review of MDS listing revealed the following: 8/13/24 - discharge return anticipated 8/22/24 - Entry (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/9/24 - discharge return anticipated 12/12/25 - Entry 1/7/25 - discharge return anticipated 1/10/25 - Entry Review of the facility document titled Notice of Transfer Form to Long Term Care Ombudsman dated August 2024, December 2024 and January 2025 lacked Resident #9's name. Interview on 4/30/25 at 11:56 a.m., with the Nurse Consultant revealed the facility follows regulation with ombudsman notification. Interview on 4/30/25 at 12:35 p.m. with Administrator revealed she had pulled the same report from the electronic health record for the last couple of years and when she pulled it Resident #9's name is not showing up on the report. The Administrator stated she will have to get a hold of her supervisor to see what she needs to do to correct this report.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, interviews and record review the facility failed to develop a comprehensive care plan for 1 of 13 residents reviewed. Staff utilized a seat buckle in the wheel chair for Resident #15 and the care plan lacked a focus area or interventions for monitoring. Staff failed to include the details related to seat buckle use and did not define interventions to be used during the use of seat buckle. The facility reported a census of 26 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #15 was absence of spoken words, rarely/never understood and did not understand others. She was unable to participate with a Brief Interview for Mental Status cognitive skills severely limited. She had upper extremity (shoulder, elbow, wrist and hand) and lower extremity impairment on both sides and was totally dependent on staff for toileting, dressing, hygiene, and transfers and used a wheel chair. Her diagnoses included: diabetes mellitus, aphasia, seizure disorder, malnutrition, Rett's Syndrome (neurological disorder that causes severe muscle movement disability condition leads to loss of motor skills, language abilities loss of purposeful hand skills.) The MDS showed that she did not use a physical trunk restraint. The Care Plan last updated on 4/8/25, showed that the resident had artificial nutrition per gastrostomy tube. If the resident was in the wheelchair, she was to remain upright for one hour following the administration of feeding and fluids. Resident #15 was completely dependent with care, and required a Hoyer mechanical lift for transfers. She had the potential for injury from falls/seizures related to Rett's Syndrome, Aphasia, Epilepsy, Scoliosis, and spasticity, The resident used a small tilt-in-space wheelchair for locomotion, and bilateral 1/2 side rails in bed to allow for boundary identification. On 4/28/25 at 11:18 AM, Resident #15 was sitting in a wheel chair in the dayroom in front of the television sleeping. The wheelchair was slightly tipped back, and she had a waist buckle around her lower abdomen. Her arms were on her chest and her hands were contractures. At 11:43 AM, the resident was still in the dayroom, there were no other residents or staff nearby. On 4/30/25 at 2:23 PM, Staff D, [NAME] Clinical Specialist agreed that the resident did not attempt to access her body, because she did not move her arms or hands on her own. Staff D agreed that the lap strap should be added to the care plan. According to a facility policy titled: Comprehensive Care Plans dated April 2/25, the facility would develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights that included measurable objective and timeframe to meet a resident medical nursing and mental and psychosocial needs and all services that were identified int eh resident comprehensive assessment and meet professional standards of quality. The comprehensive care plan would be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on record, policy, and chart review, the facility failed to follow through with physician's orders for 1 of 13 residents reviewed. Staff were monitoring the blood glucose levels for Resident #23 four times a day and the physician directed them to contact him/her according to the established parameters. In a 3-month timeframe, the blood glucose levels were outside those parameters 8 times, and staff failed to contact the doctor. The facility reported a census of 26 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #23 was admitted to the facility on [DATE], and had a Brief Interview for Mental Status (BIMS) score of 15 (intact cognitive ability.) The resident was independent with hygiene, dressing, transfers and walking. Her diagnoses included: hypertension, diabetes mellitus, arthritis, obesity, developmental disorder, edema and long-term use of insulin. The Care Plan for Resident #23, updated on 4/9/25, showed the resident had altered cognition related to a diagnosis of developmental disorder. She was at risk for alteration in blood glucose levels, staff were to report abnormal blood glucose levels to the physician. An order entered on 1/31/25 at 10:12 AM, showed that staff were to monitor the blood sugar levels for Resident #23 four times a day, and notify the provider if blood sugar was more than 400 Milligrams per deciliter (mg/dL) or less than 60 mg/dL. The Blood Sugar Summary (BSS) document in the electronic chart showed the following documentation. On each occasion, the chart lacked information regarding a doctor notification. a. 4/27/25 at 11:22 AM, 56 mg/dL b. 4/10/25 at 3:00 PM, 471 mg/dL c. 3/26/25 at 6:08 PM, 400 mg/dL d. 3/8/25 at 10:25 AM, 429 mg/dL e. 2/15/25 at 3:31 PM, 481 mg/dL f. 2/14/25 at 10:55 AM, 43 mg/dL g. 2/4/25 at 3:52 PM, 406 mg/dL h. 2/1/25 at 7:50 PM, 53 mg/dL The BSS showed that 4 times, Staff C, Licensed Practical Nurse (LPN) administered the glucose test and failed to follow through with a call to the doctor. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/25 at 2:42 PM, Staff C, said that she was aware of times that Resident #23 had high blood glucose readings but she hadn't ever had to contact the doctor. She didn't remember what the parameters were, but the resident would often eat her roommates cookies and that would cause the high glucose levels. On 4/30/25 at 2:29 PM, Staff D, Regional Clinical Specialist said that if/when there were doctor-ordered parameters, staff were expected to follow through with a call to the doctor. A facility policy dated 2/8/23, titled: Notification of Change in Resident Health Status, the resident's physician would be notified of a change in resident status when there was a significant change in the resident physical, mental or psychosocial status; for example a deterioration in health or clinical complications, or a need to alter treatment significantly such as discontinue an existing form of treatment due to adverse consequences or to begin a new form of treatment.

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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** 41785 Based on observation, interview and record review the facility failed to follow through with an intervention for edema management for 1 of 1 resident reviewed. Resident #23 had chronic edema and staff were directed to apply edema wear to her lower extremities in the morning and to remove it at night. The resident was observed to be without the compression stockings all day and staff documented that the task had been completed. The facility reported a census of 26 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #23 was admitted to the facility on [DATE], and had a Brief Interview for Mental Status (BIMS) score of 15 (intact cognitive ability.) The resident was independent with hygiene, dressing, transfers and walking. Her diagnoses included: hypertension, diabetes mellitus, arthritis, obesity, developmental disorder, edema and long-term use of insulin. The resident was taking a diuretic medication. The Care Plan for Resident #23, updated on 4/9/25, showed that she had altered cardiovascular status related to edema and hyperlipidemia, staff were to monitor edema and report changes. The resident had altered cognition related to a diagnosis of developmental disorder. The Orders tab in the electronic chart showed an order dated 2/14/25 at 6:00 AM, to apply edema wear in the morning and remove at night. On 4/28/25 at 12:52 PM, Resident #23 was sitting in her chair in room with feet on the floor. She was wearing gripper socks and her feet were swollen. When asked if she had some compression hose, she pointed to the bathroom where a pair of hose were hanging on the towel rack. She said she needed help to put them on, and they were still wet because they had been washed. The Medication Administration Record/Treatment Administration Record (MAR/TAR) for April, printed on 4/28/25 at 1:43 PM, showed that the nurse had documented that the resident was wearing the edema wear. On 4/28/25 at 4:04 PM, Resident #23 was sitting in a chair near the nurses' station. She was wearing the gripper socks, and did not have her compression hose on. She said that they were still hanging in the bathroom and said they are still wet, I'll get them on tomorrow. The MAR TAR for April, printed on 4/29/25 at 6:47 AM, showed that staff documented that the edema wear had been removed on the night of 4/28/25. On 4/30/25 at 11:56 AM, Staff D, Regional Clinical Specialist, indicated that the facility did not have policies on edema management but that staff were expected to follow the physicians orders.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 41785 Based on the Center for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report for Quarter 1, 2025 review, facility staffing reports review, and staff interviews, the facility failed to submit accurate staff reports for the PBJ Staffing Data Report. The facility reported a census of 26 residents. Findings include: The PBJ Staffing Data Report with a run date of 4/23/25, for the 1st quarter of the fiscal year 2025; (October 1 - December 31), triggered for a failure to have licensed nursing coverage 24 Hours/Day. Infraction dates included: 10/19, 10/20, 11/28, 12/2, 12/3, 12/4, 12/5, 12/6, 12/8, 12/9, 12/10, 12/11, 12/13, 12/16, 12/17, 12/18, 12/19, 12/20, 12/22, 12/23, 12/24, 12/25, 12/26, 12/27, 12/30 and 12/31. A review of the nursing schedules and timesheets revealed that nurses were on duty on the above dates. On 4/29/25 at 3:30 PM, the Administrator said that the PBJ report was being submitted by a third-party entity. She said that the process had been unorganized and confusing and the facility had identified and arranged for a different company to provide the service in the future. The Administrator said that the report had been showing an overstaffing of nurses on one day, then the following day, showed no nurses at all. She acknowledged that it was not submitted correctly. According to the facility policy dated 2/23/25 titled: Nursing Services and Sufficient Staff, the facility was responsible for submitting timely and accurate staffing data through the CMS Payroll-Based Journal system.