STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165423	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Ames, LLC	3440 Grand Avenue Ames, IA 50010

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 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** 25858 Based on observation, clinical record review, staff interviews, facility self report and facility inservice record, the facility failed to ensure a resident was safe in the environment. Review revealed Resident #1 required assistance of one staff for personal hygiene and ambulation. On 7/4/24 at approximately 6:58 a.m., Staff A, Certified Nursing Assistant (CNA) assisted Resident #1 to the bathroom with a walker. Staff A proceeded to leave Resident #1 alone in the bathroom for which Resident #1 lost balance and fell to the bathroom floor and sustained a left hip fracture. Additionally on 8/27/24, Resident #2 was transported to an appointment with no staff assistance, fell while at the appointment, taken to the nearest emergency room and sustained a dental fracture to upper incisors. The facility reported a census of 65 residents. Findings include: 1. The Minimum Data Set (MDS) assessment with a reference date of 5/23/24 for Resident #1 documented a score of 8 on Brief Interview for Mental Status (BIMS) test which indicated moderately impaired cognitive impairment, was able to be understood and had the ability to understand others. The resident had diagnoses that included hypertension, diabetes mellitus, Non-Alzheimer's Dementia, anxiety and osteoarthrits and required substantial to maximal assistance with toileting, dressing and personal hygiene and supervision or touching assistance with oral hygiene and assistance with ambulation with walker. A Significant Change MDS assessment with a reference date of 7/18/24 for Resident #1 documented has the ability to be understood and ability to understand others. The resident had diagnosis that included hypertension, Non-Alzheimer Dementia and recent hip fracture, with recent fall with bone fracture and surgical wound. A Nursing Care Plan with a created date of 4/11/23, identified a problem of I have an Activity of Daily Living (ADL) self-care performance deficit related to weakness, deconditioning, impaired mobility and I am at risk for injury from falls due to impaired mobility and weakness, dementia and macular degeneration Interventions include: *(7/4/24), Non-skin strips placed on floor in bathroom. *Ambulate with me to the dining room and activities. (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 0689 Level of Harm - Actual harm Residents Affected - Few	*I use a front wheeled walker. *Please ensure my call light is in reach and remind me to use it for assistance. *Ambulation: Assist time 1 with front wheeled walker *Oral Cares: Assist times 1 *Toileting: Assist times 1 for toileting and peri cares. A Interdisciplinary Care Conference Worksheet dated 4/24/24, documented resident needs 1 assist with cares with front wheeled walker and has moderate cognitive impairment. A Fall Risk assessment dated [DATE], documented resident with no history of falls and is at moderate risk with shuffling steps and uses an assistive device, walker. The Progress Notes dated 5/23/24 at 9:23 a.m., documented Quarterly Nursing Assessment note: quarterly nursing assessment completed. Resident is disoriented to place and time. Wears glasses to aid in vision. Residents hearing is adequate. Has an upper extremity functional limitation in range of motion on one side of the body. No lower extremity limitations noted with range of motion. Resident transfers with supervision, one person physical assist. Is able to ambulate in corridor with supervision with setup help only. Resident uses a walker. Resident needs physical help with part of the bathing activity. Is able to dress self with limited staff assist. Completes personal hygiene with staff supervision. Resident is occasionally incontinent of urine. The Progress Notes dated 7/4/24 at 7:28 a.m., documented Health Status Note Text: Resident had a fall at 6:55 a.m. in resident's bathroom. Resident was found with head under the sink. Resident was using the walker at the time. Her slipper were off her feet. Resident was on her sides. Resident had loose stool in her brief. Resident states my left hip hurts very much. CNA, states I was in the room getting the husband. Then, I heard the noise from the bathroom and found her on the floor. No bleeding or bruises noted. No open injuries noted. Blood pressure inaudible with manual blood pressure cuff. 911 called at 7:00 a.m. and resident transferred to emergency room at 7:21 a.m. In an Unwitnessed Fall Report dated 7/4/24 at 6:58 a.m., documented CNA notified this nurse of fall of resident in bathroom at 6:56 a.m. At 6:58 a.m., Resident found on the floor of bathroom with head under the sink. Resident in right lateral posture lying on the floor and complaining pain to left hip. Resident then complained of pain to left leg. Resident husband waiting for her outside the room. Resident has small bowel movement in her brief, but due to nature of the fall and pain, no changes in position made to change the brief. Residents left leg was angled at knee and any movement to that limb aggravated pain. Pain level 10/10. No visible injuries or cut noted to head, limb or trunk at this time. Resident states I don't know what happened but my left leg hurts. Mobility status: Ambulatory with assistive device/with out assist at time of fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An investigation self-report amendment submitted to the Department by the facility on 7/4/24, included the following: Resident is assist time 1 staff, was brought into bathroom with walker to brush her teeth, left unattended and fell . Injury of Fracture of the Left Femoral Neck on the left leg. On Thursday July 4th 2024, at approximately 6:55 a.m., Resident #1 was assisted by Staff A in getting set up with oral cares at the bathroom sink. Staff A then left the bathroom to assist the roommate. While assisting the roommate, Staff A heard a noise from the bathroom. Staff A re-entered the bathroom to find Resident #1 on the floor of the bathroom lying on her left side. Staff B, RN, performed a head-to-toe assessment on Resident #1. Resident #1 stated that my left hip hurts very much. Staff B, RN, made the decision to send Resident #1 to the emergency room per nursing judgement related to head-to-toe assessment and positioning of leg. Corrective Action: Staff A was provided 1-1 education on the need to stay with residents who are coded as needing assistance of 1 or more staff members at all times during personal care tasks. All facility staff members were educated on the need to stay with residents who are coded as needing assistance of 1 or more staff members at all times during personal cares tasks by the Director of Nursing on 7/5/24. The Hospital Consultative Note dated 7/4/24 at 10:53 a.m., documented, Resident #1 is an [AGE] year-old female, whom I was asked to see in consultation for a left displaced femoral neck fracture. She fell in the bathroom this morning. She walks with a walker. She complains of left hip pain. Diagnostic Data: X-rays of left hip reveal a displaced femoral neck fracture without preexisting arthritis. Assessment: Left displaced femoral neck fracture in an ambulator. Observation on 9/17/24 at 8:45 a.m., Staff C, Certified Nursing Assistant (CNA) and Staff D, CNA, transferred Resident #1 with the use of a gait belt and front wheeled walker from the wheelchair to a recliner. Resident had a slow steady gait and complained of left hip pain during the transfer. Interview on 9/16/24 at 2:30 p.m., Staff A, CNA stated that they went into Resident #1 room to assist the resident to the bathroom on 7/4/24 approximately 6:55 a.m. Staff A stated that as Resident #1 was in the bathroom the roommate attempted to open the door to the bathroom so Staff A, left Resident #1 alone in the bathroom as they assisted the roommate back to the recliner. Staff A then heard a noise come from the bathroom. Staff A stated that when they went back into the bathroom, Resident #1 was on the floor. Staff A stated that the expectation of the staff is to stay with a resident that needs assist of 1 for cares, including personal/oral hygiene and that Staff A got education on the need to stay with any resident that required staff assistance. Interview on 9/17/24 at 10:00 a.m., Staff B, Registered Nurse (RN) stated they worked on 7/4/24 when Resident #1 fell in the bathroom. Staff B, confirmed and verified that Resident #1 needed assistance of 1 staff for cares and that it is the expectation of the staff to stay with any resident that requires assistance and that the facility did education about the expectation of staying with a resident that requires assist. Interview on 9/17/24 at 1:50 p.m., The Director of Nursing confirmed and verified that the expectation of staff are to stay with any resident that requires cueing, supervision or assistance with cares. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An Inservice Record dated 7/5/24, documented that Residents who are coded as needing assistance of one or more staff members for ADL's should not be left alone while they are completing a personal task (brushing teeth). They [NAME] be supervised throughout the completion of the task. 2. The MDS assessment with a reference date of 6/13/24 for Resident #2 documented a score of 6 on BIMS test which indicated severely impaired cognitive impairment, unclear speech, sometimes is understood and usually understands others. The resident had diagnoses that included hypertension, Alzheimer's Disease, Non-Alzheimer's Dementia, depression and Schizophrenia and is independent with ambulation with a walker and had a recent fall with 2 or more injuries. The Plan of Care with an initiated date of 9/10/20, had a focus area of I have impaired cognitive function or impaired thought processes related to cognitive communication disorder. Interventions include: *RESIDENT WILL HAVE STAFF PERSON OR FAMILY MEMBER GO TO APPOINTMENTS WITH HIM *Verbal communication can be difficult to understand at times. Sometimes I will write notes to staff to communicate or make my needs known. The Progress Notes dated 8/27/24 at 9:55 p.m., documented Health Status Note Text: Resident had gone to for a Dental appointment in the morning. In the afternoon after his consultation he had a fall there and was sent to Hospital ER. The Progress Notes dated 8/28/24 at 5:00 a.m., Comprehensive Encounter Date of Service: Chief Complaint: Post ER visit History of Present Illness: Patient is a [AGE] year old male with chronic health conditions. Schizoaffective disorder, insomnia, dyslipidemia, cognitive communication deficit, essential hypertension, regional lumbar radiculopathy, osteoarthritis, spinal stenosis, and Alzheimer's. Today he is seen in his room via telehealth, he is at baseline. He was at a dentist clinic visit yesterday and had a fall with injury to his mouth. He was sent to ER for evaluation. Noted open spot in top front gums from extraction and two small teeth have chips next to open spot, no bruising or bleeding. He is calm, pleasant, disorganized thought process. The Progress Notes dated 8/28/24 at 2:19 a.m., documented Health Status Note Text: Resident returned from ER at 11:15 p.m., accompanied/transported by the facility Administrator. Resident is alert, aware of surroundings. Told this Nurse he lost balance and fell at the dentist office earlier. Only injury is chipped tooth. Resident states only pain is to neck and back, but doesn't need anything for pain at present time. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Medical Center Emergency Department dated 8/27/24, documented, reason for visit is a fall, patient presents via Emergency Medical Services with complaint of being found on the bathroom floor of the dentist office. Patient was apparently dropped off at the dentist for a tooth extraction, but no one from the facility remained with the patient at the appointment. History of Alzheimer's dementia and schizophrenia. C-collar in place upon arrival. Description=fall , initial encounter with broken teeth. Patient presents with fall. History of dementia. Found on floor at dentist office with dental fractures. Dental fracture to upper incisors. Dental cement applied to fractured tooth. Patient brought to the Emergency Department by EMS after being found on the floor of the bathroom at the dentists office. Patient did not have any attendants at his visit. History taking is extremely limited from patient as is not oriented to person, place situation. Speaks in short sentences, difficult to understand. Appears to have multiple dental fractures, one tooth site oozing blood. Dried blood in mouth. Interview on 9/17/24 at 11:25 a.m., the facility administrator confirmed and verified that residents are to have staff accompany them to appointments if families are not able to.