

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165423	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2024
NAME OF PROVIDER OR SUPPLIER Accura Healthcare of Ames, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>44972</p> <p>Based on observation, interview, and clinical record review, the facility failed to maintain confidentiality of 2 of 5 residents reviewed (Residents #19 and #46) during the process of medication administration. The facility reported a census of 64 residents.</p> <p>Findings include:</p> <p>1. On 5/20/24 at 8:15 AM, witnessed Staff F, Certified Medication Aide (CMA), leave a glass of water containing Miralax (a laxative) at the dining table for Resident #19, failing to supervise her drinking the medication. Resident #19 and her husband sat at the table with numerous other residents in the area.</p> <p>2. On 5/20/24 at 7:53 AM, observed Staff G, Registered Nurse (RN), enter Resident #46's room to complete a blood glucose test and administer sliding scale insulin if needed. After administering the insulin, Staff G returned to the medication cart to document the administration of the insulin on the TAR. At this time, witnessed that she failed to close the screen, leaving Resident #46's information visible for others to see.</p> <p>In an interview on 5/21/24 at 3:40 PM, the Director of Nursing (DON) stated the facility didn't have a policy related to ensuring the securing of the computer screen with resident information when away from the computer. The DON stated they expected the staff to follow professional standards of care.</p> <p>In an interview on 5/21/24 at 3:40 PM, the DON stated they expected the staff to follow the 5 rights of medication administration unless a physician order directed otherwise. She added that she expected the staff to close the computer screen when away from or not in view of the computer.</p>

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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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44972</p> <p>Based on clinical record review and staff interview, the facility failed to refer one resident (Resident #57) with a Level I Preadmission Screening and Resident Review (PASARR) with a diagnosed serious mental disorder for evaluation of a Level II PASARR at the time the diagnosis was known to the facility for 1 of 1 resident reviewed for PASARR. The facility reported a census of 64.</p> <p>Findings include:</p> <p>Resident #57's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) of 10, indicating moderate cognitive impairment. The MDS included diagnoses of Type II diabetes mellitus, specific personality disorders, anxiety disorder, generalized anxiety disorder, personality disorder unspecified, vascular dementia, and post traumatic stress disorder (PTSD). The MDS reflected Resident #57 took antipsychotic and antidepressant medications.</p> <p>The Care Plan Focus revised 7/10/23 indicated Resident #57 had a history of trauma/life event resulting in PTSD and used high risk medications to treat mood disorders. Resident used antipsychotic medication and antidepressant medication to assist with negative behaviors.</p> <p>Resident #57's Level I PASARR completed 11/21/23 documented no Level II PASARR required as she had no serious mental impairment, intellectual disability, or other related conditions. The Level I PASARR included a diagnosis of an anxiety disorder. In addition, documented Resident #57 received Depakote for anxiety with Namenda and Risperdal for dementia. The screening listed no further PASARR screening required unless she had a significant change.</p> <p>Resident #57's clinical record lacked a PASARR following 11/21/23.</p> <p>Resident #57's Medical Diagnoses reflected the following diagnoses:</p> <p>a. Specific personality disorders added 2/2/24</p> <p>b. Personality disorder unspecified added 12/15/23.</p> <p>Resident #57's May 2024 Medication Administration Record included the following psychotropic medication orders:</p> <p>a. Mirtazapine oral tablet 3.75 milligrams (mg) one time a day for personality disorder with a start date of 2/5/24</p> <p>b. Sertraline HCL oral tablet 75 mg one time a day for personality disorder with a start date of 1/11/24.</p> <p>In an interview on 5/21/24 at 3:50 PM, the Administrator stated the facility didn't have a facility policy relating to PASARR's but the facility followed the federal mandated regulations for the completion of them.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 5/21/24 at 3:50 PM, the Administrator stated they expected the facility to audit the PASARR process regularly and update the PASARR's as required. He provided a copy of a Level I PASARR submitted for Resident #57 on the date of interview with the new diagnosis and medications.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>48886</p> <p>Based on observation, clinical record review, resident interview, staff interview and policy review, the facility failed to provide adequate supervision to 3 of 5 residents observed (Residents #19, #31 and #46) during medication administration. The facility reported a census of 64 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) for Resident #31, dated 2/15/24, documents a Brief Interview for Mental Status (BIMS) of 10, indicating mild impairment. The MDS included diagnoses of medically complex conditions, coronary artery disease, renal insufficiency, age related osteoporosis and depression.</p> <p>During an observation on 5/19/24 at 11:30 AM, Resident #31 had her tray table in front of her as she sat in a reclining chair in her room. On her tray table contained a small cup with 3 medications next to a glass of water. Resident #31 stated she didn't know what the pills were and said the nurse left them for her to take. Upon entry into Resident #31's room, observed no staff present in the room or outside of the room. Resident #31 didn't know how long the medication sat on the tray. Resident #31 shared a room with Resident #265, who was also present in the room.</p> <p>Resident #31's May 2024 Medication Administration Record (MAR) included the following orders:</p> <p>a. Gabapentin Capsule 100 MG, two capsules by mouth,</p> <p>- Noon dose administered by Staff E, Certified Medical Assistant (CMA), on 5/19/24.</p> <p>b. Tylenol 8-hour Arthritis pain tablet, extended release 650 MG, one tablet by mouth.</p> <p>- Noon dose administered by Staff E.</p> <p>The review of Resident #265's, Resident #31's roommate, clinical record identified a medical diagnosis of personal history of suicidal behavior.</p> <p>During an interview 5/20/24 at 11:29 AM, Staff E recalled going into Resident #31's room on 5/19/24 to give her, her noon medications. Staff E couldn't remember when she went in there, but believed it happened around 11:25 AM. Staff E stated when she went into Resident #31's room to give her the noon medications, which consisted of three pills, she was in the bathroom. Staff E stated said she called through the bathroom door to Resident #31, saying she had her noon medications and would leave them on her bedside tray. Staff E advised she left the medications on the bedside tray and left the room. Staff E recalled Resident #265 being in the room at the time. Staff E reported the facility policy and protocol is to watch residents take their medication, ensure they took their medication prior to leaving the room, and not to leave medication unattended in a resident's room. Staff E stated she should have taken the medication out of the room with her and gone back in the room when Resident #31 got out of the bathroom.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview 5/20/24 at 12:08 PM, the Director of Nursing (DON) reported that Staff E should have watched Resident #31 consume the medication, especially with her lower BIMs score. The DON stated Staff E shouldn't leave the medication in the room unattended.</p> <p>The undated Medication Administration Policy directed the facility to administer medications to residents in a safe manner.</p> <p>44972</p> <p>2. On 5/20/24 at 7:53 AM, observed Staff G, Registered Nurse (RN), enter Resident #46's room to complete a blood glucose test and administer sliding scale insulin if needed. After completing the glucose monitoring test Staff G went back to the computer on the medication cart to check the order for the amount of insulin to give Resident #46. When Staff G left, the container containing the blood glucose monitor, lancets, and 2 insulin pens on a tray table unattended in Resident #46 room, with her and her roommate present in the room. After administering the insulin, Staff G returned to the medication cart to document the administration of the insulin on the TAR. At this time, witnessed that she failed to close the screen, leaving Resident #46's information visible for others to see.</p> <p>3. On 5/20/24 at 8:15 AM, witnessed Staff F, Certified Medication Aide (CMA), leave a glass of water containing Miralax (a laxative) at the dining table for Resident #19, failing to supervise her drinking the medication. Resident #19 and her husband sat at the table with numerous other residents in the area.</p> <p>In an interview on 5/21/24 at 3:40 PM, the Director of Nursing (DON) stated the facility didn't have a policy related specifically to leaving medications unattended with a resident. The DON stated they expected the staff to follow professional standards of care.</p> <p>The undated Medication Administration Policy directed the facility to administer medications to residents in a safe manner.</p> <p>In an interview on 5/21/24 at 3:40 PM, the DON stated they expected the staff to follow the 5 rights of medication administration unless a physician order directed otherwise. She added that she expected the staff to close the computer screen when away from or not in view of the computer.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>44972</p> <p>Based on observation and staff interviews, the facility failed to maintain a safe environment by leaving a medication cart unlocked and unsupervised. The facility reported a census of 64 residents</p> <p>Findings include:</p> <p>In an observation on 5/20/24 at 9:12 AM, Staff F, Certified Medication Aide (CMA), left the medication cart unlocked and unattended when she walked into Resident #1's room to administer their medications. The medication cart sat against the wall outside of Resident #1's room out of sight from the room.</p> <p>In an interview on 5/21/24 at 3:40 PM, the Director of Nursing (DON) stated they didn't have a facility policy related to ensuring staff locked the medication carts when not in sight. She expected the facility staff to follow the professional standards of care. In addition, she expected the staff to have the medication cart be locked at all times when away from the cart or when unable to see the cart.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>47079</p> <p>Based on observation, menu review, staff interview, and policy review, the facility failed to serve the correct serving size of protein for 3 of 5 residents who received pureed diets. The facility reported a census of 64 residents.</p> <p>Findings include:</p> <p>On 5/21/24 at 11:12 AM, Staff A, [NAME] stated the facility had five (5) residents who required pureed diets. She placed five (5) portions of pork casserole, two (2) cups of pineapple sauce, and five (5) slices of bread into a blender and pureed the contents.</p> <p>She measured the pureed mixture and noted five (5) cups of pureed contents. She referred to the pureed portion conversion chart and verbalized the required serving as two #8 serving scoops. The #8 serving scoop equaled 4 ounces which indicated the serving should measure a total of 8 ounces.</p> <p>Between 12:05 PM and 12:25 PM, Staff A prepared 3 pureed diet plates with one #8 scoop of protein, half of the required portion size.</p> <p>An observation at the end of meal service revealed the pureed protein had more than half remaining.</p> <p>On 5/22/24 at 9:25 AM, the Administrator stated the staff member should follow the pureed conversion chart during meal service.</p> <p>The undated document labeled Puree Process directed staff to find the correct scoop size that corresponds to the portion size.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>47079</p> <p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, staff interview, and policy review, the facility failed to serve food to maintain a safe and appetizing temperature. The facility reported a census of 64.</p> <p>Findings include:</p> <p>On 5/21/24 at 11:38 AM, Staff A, Cook, checked the temperature of 13 menu items on the steam table for lunch. All 13 items revealed a temperature above 135 Fahrenheit (F).</p> <p>At 12:17 AM, Staff A placed a resident's plate on a serving tray and the Dietary Manager (DM) placed a cup of milk on the tray then placed the tray on the top shelf of the delivery cart.</p> <p>At 12:25 PM, Staff A, placed a resident's plate of food on the last tray on the delivery cart. Staff B, Cook, confirmed the commitment to deliver the food.</p> <p>When asked to check the temperature of the items on the first tray placed on the delivery cart, the DM received a temperature for the broccoli of 99.0 F; the tater tots 127.9 F; and the milk's 44.7 F.</p> <p>At 12:50 PM, Staff A checked the temperature of the remaining food on the steam table. The chicken soup's temperature measured 117.2 and the tomato soup's measured 130.1 F.</p> <p>On 5/22/24 at 9:14 AM, the Administrator stated they should have discarded the food and prepared a new plate of food for the resident.</p> <p>The Food Temperatures policy dated 2021 instructed to cook all hot food items to appropriate internal temperatures, held, and served at a temperature of at least 135 F. It also indicated cold foods stay below 41 F during the holding, plating process, and until food leaves the service area.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47079</p> <p>Based on observations, staff interviews, and facility policy review, the facility failed to maintain sanitary practices by improperly storing and serving food. In addition, the dietary staff failed to wear hairnets while in the food service area. The facility reported a census of 64 residents.</p> <p>Findings include:</p> <p>On 5/19/24 at 9:10 AM, a kitchen observation identified the following findings:</p> <p>A Traulsen refrigerator contained:</p> <ol style="list-style-type: none"> 1) An undated Jarritas orange drink. 2) Two unlabeled blue pitchers that contained clear liquid. 3) An undated small tub of beef paste. <p>A Whirlpool refrigerator contained:</p> <ol style="list-style-type: none"> 1) An uncovered, unlabeled, and undated aluminum pan of red items resembling strawberries. 2) An opened, undated plastic container of strawberries. 3) An undated, previously opened carton of Lactaid. 4) An unlabeled bag of shredded, orange item resembling cheese. <p>A Whirlpool freezer contained:</p> <ol style="list-style-type: none"> 1) An unlabeled, undated bag of breaded items. 2) An unlabeled, undated plastic bag of flat, yellow items. <p>A General Electric (GE) freezer contained:</p> <ol style="list-style-type: none"> 1) An unlabeled, undated bag of flat, yellow items. <p>An Amana and three (3) Frigidaire freezers contained undated, unlabeled, previously opened food items.</p> <p>The Scotsman ice machine scoop was lying on top of the ice machine without a barrier.</p> <p>On 5/19/24 at 4:10 PM, observed Staff C, Dietary Aide (DA), in the food preparation area wearing a white ball cap without a hairnet covering the exposed hair nor the beard.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/21/24 at 11:18 AM, Staff D, Maintenance Assistant, walked through the food service area without wearing a hairnet nor beard covering.</p> <p>On 5/21/24 at 11:50 AM, Staff A, Cook, removed a pan of bread off the resident menus on the top shelf of the steam table and place it on the rear stack of plates within the steam table serving area. Between 11:55 AM and 12:10 PM, noted the pan of bread on three (3) resident's plates used to serve lunch.</p> <p>On 5/21/24 at 1:05 PM, during a follow up kitchen observation reflected all concerns corrected from the initial tour on 5/19/24 except the Whirlpool freezer still contained an unlabeled, undated bag of breaded items.</p> <p>On 5/22/24 at 9:14 AM, the Administrator stated the maintenance staff shouldn't be in the kitchen area unless repairing equipment. All staff in the kitchen should cover all of their facial and head hair with a hairnet. He added the staff should label, date, and cover all food prior to putting in storage.</p> <p>The Food Storage policy dated 2021 directed to cover, label, and date all refrigerated and frozen foods.</p> <p>The General Food Preparation and Handling policy dated 2021 instructed to thoroughly clean and sanitize any utensil or serving dish prior to use.</p> <p>The Food Safety and Sanitation dated 2021 indicated the facility required hair restraints that should cover all hair on the head. In addition, the facility required beard nets with visible facial hair.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44972</p> <p>Based on observation, staff interview, and policy review, the facility failed to maintain proper infection control practices to protect against potential cross contamination for 2 of 16 residents observed (Resident #2 and #41). As a Certified Medication Aide (CMA) prepare Resident #2's medication, they failed to perform hand hygiene after coughing and blowing their nose. In addition, the facility failed to keep a resident's blanket clean after placing in a shared sink before putting it back on a resident (Resident #41). The facility reported a census of 64.</p> <p>Findings include:</p> <p>1. On 5/20/24 at 7:45 AM witnessed Staff H, Certified Medication Aide (CMA), prepare Resident #1's medications. Staff H began to cough into her hands and blow her nose. She failed to perform hand hygiene after and continued to prepare Resident #2's medication, then administer it to them.</p> <p>In an interview on 5/21/24 at 3:40 PM, the Director of Nursing (DON) stated she expected staff to complete hand hygiene before and after each medication pass. If the staff coughed or blew their nose, they needed to perform hand hygiene before continuing the medication pass.</p> <p>47079</p> <p>2. On 5/19/24 at 12:11 PM when Staff B, Cook, delivered Resident #41, their lunch tray, they removed the blanket from his legs and placed it in a shared sink with another resident.</p> <p>Resident #41's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Resident #41 required set up assistance with eating and oral hygiene, the needed maximum assistance with personal hygiene. The MDS included diagnoses of severely impaired vision, retrolental fibroplasia (a disease that causes blindness) and cerebral vascular accident (stroke).</p> <p>The Care Plan Focus dated 4/9/24 indicated Resident #41 had impaired visual function. The Interventions directed the staff to arrange Resident #41's personal belongings on his right side to promote independence.</p> <p>On 5/19/24 at 4:10 PM, observed Resident #41's blanket back over his legs.</p> <p>On 5/20/24 at 9:24 AM, witnessed Resident #41's blanket lying on the floor to the left of his recliner as he slept.</p> <p>On 5/22/24 at 9:09 AM, the DON stated the staff member should have placed the blanket on his wheelchair and not in the sink.</p> <p>The General Guidelines policy dated 10/5/23 directed staff to maintain a sanitary environment for the staff, residents, visitors, and the general public.</p>		