

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER Accura Healthcare of Cherokee, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 921 Riverview Drive Cherokee, IA 51012	

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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474</p> <p>Based on clinical record review, staff interviews and facility policy review, the facility failed to ensure residents with impaired cognition were unable to exit the facility unattended for 1 of 4 residents reviewed for elopement (Resident # 1). This failure resulted in the resident leaving the facility without staff knowledge and therefore causing an Immediate Jeopardy to the health, safety, and security of the residents. The facility failed to ensure residents needing a mechanical lift were provided safe and appropriate transfers to prevent injuries for 4 of 4 residents reviewed (Resident # 2, #5, #6 & #7).</p> <p>The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of October 17, 2024 on December 17, 2024 at 9:17 a.m The Facility Staff removed the Immediate Jeopardy on October 17, 2024 through the following actions:</p> <ul style="list-style-type: none"> a. The facility floor nurse checked all facility windows and doors in the chronic confusion or dementing illness (CCDI) unit (memory care unit) and all were intact and working properly. b. Frequent checks were initiated on Resident #1. c. Administrator conducted a door alarm check, and all doors and alarms were working properly. d. Administrator reviewed elopement binder was current. e. Administrator completed education on the facility elopement policy. f. Administrator changed all facility door codes for exits and CCDI unit. g. Administrator initiated a sign off sheet for facility floor nurses to conduct door alarm checks at shift change. <p>The scope lowered from a J to D at the time of the survey after ensuring the facility implemented education and their policy and procedures.</p> <p>The facility identified a census of 36 residents.</p> <p>Findings Include:</p> <p>(continued on next page)</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 documented diagnoses of Alzheimer ' s Disease, psychotic disorder and Schizophrenia. The MDS showed a Brief Interview for Mental Status (BIMS) score of 99 indicating the resident was unable to complete the assessment.</p> <p>Review of progress notes revealed the following:</p> <p>a. 10/17/24 at 6:50 a.m., Staff member in the parking lot calls facility stating someone was coming around the south side of the building. Staff exits to assess the situation. Noted that this resident was outside. Staff times 2 assisted resident back into the building and back to the CCDI unit. No injuries noted. Frequent checks by staff initiated.</p> <p>b. 10/17/24 at 9:50 a.m., Reported patient was observed outside of the facility around 6:15 a.m Facility unsure exactly how she eloped and continuing to review the incident.</p> <p>c. 10/17/24 at 10:01 a.m., Nurse was notified Resident #1 was outside this morning just after shift change. Assessment completed. Head to toe assessment completed no redness or bruising noted, no open areas noted, no areas of concern at this time. Resident #1 was dressed appropriately for the cool weather with two pairs of pants, socks, tennis shoes, t-shirt, sweatshirt and winter coat. When asked if she was in any pain she responded no. When asked if she fell down she responded no. When asked how long she was outside she reported a little bit. When asked which door she went out she stared straight forward and would not respond each time she was asked. Frequent observation checks were initiated upon return to the facility. Proper authorities were notified and all involved staff were asked to provide statements. Hospice and primary care physician updated no new orders noted at this time power of attorney notified</p> <p>d. 10/18/24 at 1:43 p.m., Resident remains on frequent checks due to elopement that occurred on 10/17/24.</p> <p>Review of the MDS dated [DATE] revealed Resident #1 did not use a wander or elopement alarm.</p> <p>Review of elopement risk assessment dated [DATE] revealed Resident #1 high risk for elopement.</p> <p>Review of the care plan with a date initiated 7/24/24 revealed a focus area of resident is an elopement risk related to disorientation to place, wandering, confusion, Alzheimer ' s Disease, dementia, Schizophrenia, and psychosis. Resident #1 resides in the CCDI memory unit. She is orientated to self. She talks about wanting to go home. The CCDI unit has a locked door to the main nursing home side. Goals include the resident ' s safety will be maintained through the review date and the resident will not leave facility property unattended through the review date. Interventions and tasks include assess for fall risk, distract resident from wandering by offering , structured activities, food, conversation, television and books. identify patterns of wandering. Provide structured activities to include toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 12/16/24 at 10:20 a.m., with the Director of Nursing (DON) revealed she was informed at approximately 7:00 a.m., on 10/17/24 that Resident #1 had eloped from the facility. The DON explained the night shift staff had witnessed the resident outside as they left the building and notified the day shift. The DON arrived shortly after the incident and completed an assessment on Resident #1 with no injuries noted. Resident #1 was wearing 2 pairs of pants, a long sleeve shirt and sweatshirt over that. The DON revealed the resident may have been holding her winter coat while she was outside. The DON further revealed the staff working that night received disciplinary action as they had propped open the doors to the CCDI unit and now the doors are programmed to alarm if the door is open longer than 15 seconds.</p> <p>Review of written statement by Staff A, Licensed Practical Nurse (LPN) revealed the staff did have the door propped open a few times in the night, but this nurse could see up and down the hallway and into the living room at those times. No one was wandering but there were a lot of behaviors during the night.</p> <p>Interview on 12/16/24 at 11:30 a.m., with Staff A, LPN revealed she was working the night Resident #1 got out of the facility. Staff A revealed the staff had propped the door open but she was sitting where she could see what was going on in the CCDI unit the entire time. She revealed she never seen Resident #1 leave out of the CCDI unit. She is still unsure how Resident #1 got out of the facility that night. Staff A revealed the facility staff would prop the door open on the CCDI unit as the staff felt like they were confined in the CCDI unit and they didn't like that feeling. She further revealed she received disciplinary action for propping the doors open to the CCDI unit and the door alarms were changed so they can no longer prop the doors open.</p> <p>Review of written statement by Staff B, Certified Nursing Assistant (CNA) revealed the door was propped open throughout the night here and there but the nurse was aware and could see the hallway, living room and dining area in the CCDI unit. Stated there had been several behaviors occurring that night. Staff B verified she has checked on Resident #1 was approximately 5:50 a.m., and Resident #1 was in her room.</p> <p>Review of written statement dated 10/18/24 at 1:30 p.m., by Staff C, CNA revealed Staff C began to explain that they were confused as to how Resident #1 had left the unit. Staff C asked Staff B if the secured door to the CCDI unit was propped open at all. Staff B responded yeah, but just while she took the trash out. Staff C informed the charge nurse of the door being propped open for a short time and that Staff C was initiated frequent checks on Resident #1.</p> <p>Review of facility provided policy titled Missing Resident Elopement Process updated 7/12/2021 revealed the following information:</p> <ol style="list-style-type: none"> a. If for any reason, door alarms are turned off, the staff will continually visually monitor the door or doors. b. When a resident is located, the following procedures will be followed: <ol style="list-style-type: none"> i. An incident report will be reviewed at monthly safety committee meetings and each quarter with the Quality Assurance Committee. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Observation on 12/16/24 at 11:51AM revealed Staff D, Certified Nurse ' s Aide (CNA), and Staff E, CNA used a EZ Way Mechanical lift to transfer Resident #5 from the bed to the wheelchair. Staff D locked one wheel of the mechanical lift before she used the mechanical lift controller to raise the resident out of the bed. Staff also failed to lock the wheelchair brakes before lowering the resident down into the wheelchair from the mechanical lift. Failure to lock the brakes caused the wheelchair to roll back as the lift lowered the resident into the wheelchair. Staff E attempted to steady the wheelchair by placing her body against the wheelchair.</p> <p>4. The MDS assessment dated [DATE] for Resident #6 documented diagnoses of a stroke, dementia and unsteadiness on feet. The MDS showed a BIMS score of 6, which indicated severe cognitive impairment. The MDS also showed Resident #6 dependent on a helper for all efforts when repositioning and for transfers.</p> <p>The Care Plan for Resident #6 showed on 8/15/23 the facility initiated use of a mechanical lift with assistance of two persons for transferring the resident between surfaces. On 12/4/24 the facility initiated use of a mechanical lift with assistance of two persons for toileting.</p> <p>Observation on 12/16/24 at 12:19 PM revealed Staff D, Certified Nurse ' s Aide (CNA), and Staff E, CNA used a EZ Way Mechanical lift to transfer Resident #6 from the bed to the wheelchair. Staff D locked two wheels of the mechanical lift before she used the mechanical lift controller to raise the resident out of the bed. Staff E also locked two brakes of the mechanical lift before she lowered the resident into the wheelchair.</p> <p>5. The MDS assessment dated ,d+[DATE] for Resident #7 documented diagnoses of difficulty in walking, dementia, and disorientation. The MDS showed Resident #7 unable to complete a cognitive assessment. The MDS also showed Resident #7 dependent on a helper for all efforts when repositioning and for transfers.</p> <p>The Care Plan for Resident #7 showed on 8/18/23 the facility initiated use of a mechanical lift with assistance of two persons for transferring the resident between surfaces.</p> <p>Observation on 12/16/24 at 12:42 PM revealed Staff D, Certified Nurse ' s Aide (CNA), and Staff E, CNA used a EZ Way Mechanical lift to transfer Resident #7 from the bed to the wheelchair, and weighed the resident using the lift scale. While Staff D and Staff E placed a sling beneath the resident, Staff D stated, I know the sling is way too big. Staff placed the mechanical lift, attached the straps, and locked two wheels then used the controller to raise the resident out of bed. When lifted off the bed observation showed the beginning of the crossed webbing of the sling exceeded the top of the resident ' s head. Staff noted the scale indicated the resident weighed 164.4 pounds (lbs). When the resident ' s placement reached over the center of the wheelchair, Staff E locked two brakes of the mechanical lift then lowered the resident. The extra material of the sling caused the resident to be positioned improperly within the sling which required staff to manipulate the resident ' s position in order to sit properly within the wheelchair. When asked how staff knew what size sling to use, the CNA ' s indicated the sling size would need to be looked up. Visual observation of the EZ Way sling tag indicated the sling as an extra large. When asked if Resident #7 required an extra large sling, both CNA ' s reported they did not know. When asked about Staff D ' s comment of the sling being too big, Staff E stated it was the only one left. When asked if sling sizes were often an issue, Staff E stated, yes we don ' t have enough sizes especially after the laundry staff leave.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/16/24 at 2:23 PM, the Administrator reported staff could look up the proper size sling by reviewing the lift binder.</p> <p>The EZ Way Smart Lift Operator ' s Instructions last revised on 10/24/24 indicated:</p> <ol style="list-style-type: none"> a. The wheels of the lift should never be locked when lifting or lowering a resident. b. When lowering a resident into a wheelchair, the wheels of the wheelchair should be locked. c. A medium size sling is required for residents weighing between 90 and 220 lbs. d. An extra large sling is required for residents weighing between 280 and 450 lbs. e. The start of crossed webbing of the sling is positioned at the nape of the neck. <p>In an interview on 12/16/24 at 3:32 PM, Staff F, Registered Nurse stated, I was always taught mechanical lift wheels should be locked when lifting and lowering a resident. The Administrator reported staff recently received education related to mechanical lifts due to a mechanical lift incident involving a resident. The Administrator revealed the education failed to include information about mechanical lift and wheelchair locks during transfers. The Administrator reported the facility used lifts from different manufacturers and expected staff to follow the lift operator ' s instructions for the brand of lift used. The Administrator also reported that she planned to purchase additional slings, attach sling weight information for sizing directly to the lifts, and educate staff on sling size and wheel lock information.</p>