Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165434	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Ogden, LLC	625 East Oak Street Ogden, IA 50212

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 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** 40905 Based on observations, clinical record review, and staff interviews, the facility failed to notify the Physician for a resident with a 10-pound weight loss in 10 days for 1 (Resident #86) of 1 resident reviewed for weight loss. The facility reported a census of 36 residents. Findings include: The Minimum Data Set summary for Resident #86, dated 10/23/24, documented the resident was admitted [DATE]. Observation on 10/21/24 at 12:10 PM, Resident #86 did not eat any of her lunch and propelled herself out of the dining room. The weights and vitals form for Resident #86, documented the following dates and weights: a. 10/10/24 - 132.4 pounds b. 10/20/24- 121.4 pounds, with a weight loss of 10 pounds in 10 days. A 10 pound weight loss triggers for greater than 7.5 percent loss which is significant. Interview on 10/24/24 at 12:31 PM, the Director of Nursing confirmed the Physician was not notified of the resident's weight loss and expectation the Physician should have been notified.

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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident’s assessment is updated at least once every 3 months. 50500 Based on clinical record review and staff interview, the facility failed to complete a comprehensive assessment no less than once every three months for 1 of 13 residents reviewed (Residents #18). The facility reported a census of 36 residents. Findings include: Review of the Resident #18's clinical record revealed the last Minimal Data Set (MDS) assessment was completed on 6/14/24. The next scheduled quarterly comprehensive assessment was due 9/14/24 and as of 10/23/24, the assessment had not been completed and is greater than 25 days overdue. During an interview on 10/24/24 at 10:30 AM, Staff A, MDS coordinator, acknowledged the overdue comprehensive assessment for Resident #18. Staff A unable to provide rationale for the missed assessment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 40905 Based on observations, clinical record review, and staff interviews, the facility failed to revise and update the resident's care plan for 2 residents (Resident #14 and #22) on a diuretic (medication to help the body get rid of excess fluid) and a resident (Resident #26) placed on hospice of 12 residents reviewed. The facility reported a census of 36 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #14, dated 9/21/24, included diagnoses of diabetes and renal (kidney) failure. The MDS further documented the resident was receiving a diuretic medication. Resident #14's Care Plan, revised 10/1/24, lacked an update with a focus and interventions for the diuretic medication and monitoring. 2. The MDS for Resident #22, dated 8/2/24, included diagnoses of heart failure and diabetes. The MDS further documented the resident was receiving a diuretic medication. Resident #22's Care Plan, revised 8/9/24, lacked an update with a focus and interventions for the diuretic medication and monitoring. 3. The MDS for Resident #26, dated 8/14/24, included diagnoses of diabetes and stroke. The MDS further documented the resident was receiving a diuretic medication. The Clinical Census for Resident #26 documented the resident was placed on hospice services 10/15/24. Resident #26's Care Plan, revised 10/19/24, lacked an update with a focus and interventions for hospice care. Interview on 10/24/24 at 1:26 PM, the MDS Coordinator stated expectation for diuretic medication and hospice services to be included on care plan and expectation for care plans to updated. Interview on 10/24/24 at 2:15 PM, the Administrator stated the facility did not have a policy for updating care plans, they follow the standard of practice.

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Centers for Medicare & Medicaid Services

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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** 50500 Based on clinical record review and staff interview the facility failed to obtain follow-up laboratory (lab) blood work in the time frame as ordered by the Primary Care Provider (PCP) for use of Coumadin, an anticoagulant, for Resident #7. The facility reported a census of 36 residents. Findings include: The Minimal Data Set (MDS) assessment dated [DATE] revealed Resident #7 with a Brief Interview for Status score of 13 indicating intact cognition. Diagnoses on the MDS include atrial fibrillation/other dysrhythmias, heart failure, hypertension, and renal insufficiency/renal failure/or end stage renal disease. Anticoagulant use indicated on the MDS. Admission lab blood work for Resident #7 obtained on 8/30/24 revealed a Prothrombin Time (PT) level of 16. 5 seconds (reference range 9.9-13.1 seconds) and International Normalized Ratio (INR) result of 1.4 (reference range 0.9-1.2). The PCP ordered follow-up PT and INR to be completed in one week, with a date of 9/6/24. Lab results on 9/6/24 revealed a PT level of 38.0 seconds and an INR of 3.3 both indicated as high levels. The PCP ordered follow-up PT and INR to be completed on Monday, 9/9/24. Lab work was not completed on the date as specified by the PCP, which was 9/9/24. There is no indication in the clinical record that staff notified the PCP of the delayed lab work. Lab results on 9/10/24 revealed a PT level of 60.6 seconds and an INR of 8.3 both indicated as high levels. PCP ordered follow-up PT and INR to be completed on Thursday, 9/12/24. Lab results on 9/12/24 revealed a PT level of 32.4 seconds and an INR of 2.8. PCP ordered follow-up PT and INR to be completed in 7-10 days, with dates of 9/19/24 - 9/22/24. Lab results on 9/18/24 revealed a PT level of 35.3 seconds and an INR of 3.0. PCP ordered follow-up PT and INR to be completed in 2 weeks, with a date of 10/2/24. Lab work was not completed on the date as specified by the PCP, which was 10/2/24. There is no indication in the clinical record that staff notified the PCP of the delayed lab work. Lab results on 10/4/24 revealed a PT level of 53.7 seconds and an INR of 4.7. PCP ordered follow-up PT and INR to be completed on Thursday, 10/10/24 or Friday 10/11/24. Lab work was not completed on the dates as specific by the PCP, which was 10/10/24- 10/11/24. There is no indication in the clinical record that staff notified the PCP of the delayed lab work. Lab results on 10/15/24 revealed at PT level of 30.3 seconds and an INR of 3.6. PCP ordered follow-up PT and INR to be completed in one week, with a date of 10/23/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/24 at 4:15 PM, the Director of Nursing (DON) reported routine labs obtained on Wednesdays. Given the urgency of PT and INR monitoring, these labs are typically obtained as outlined by the PCP. The DON voiced an expectation for staff to document in the clinical record if a lab draw missed or unsuccessful. The DON stated staff should also notify the PCP. During a follow-up interview on 10/24/24 at 9:00 AM, the DON explained ordered lab draws are hand-written in the lab calendar, which all staff have access to. The night shift staff reviews the calendar daily and will prepare a lab face sheet for the upcoming labs for the next day. Night shift staff will also note the upcoming lab draw on the 24-hour nursing report sheet. In addition, PT/INR results and next lab draw dates are tracked on a separate form titled PT/INR Tracking. Review of the lab calendar with the DON showed staff wrote for a PT and INR on Resident #7 to be obtained on 10/2/24 as well as 10/11/24. The PT/INR Tracking form also noted follow-up labs to be obtained on 10/2/24 and 10/11/24. The DON acknowledged the delay in lab work and unable to provide a rationale for the oversight. The lab draw ordered for 9/9/24 was obtained on 9/10/24. Both the lab calendar and PT/INR Tracking form noted a draw date of 9/10/24.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40905 Based on observation, policy review, and staff interview, staff failed to serve food under sanitary conditions, in order to reduce the risk of contamination and foodborne illness. The facility reported a census of 36 residents. Findings include: On 10/23/24 from 11:40 AM - 12:50 PM, during continuous observation of the lunch service, Staff B, [NAME] was preparing food items for the residents' plates and Staff C, [NAME] was preparing drinks. Throughout the meal service, Staff C spilled milk on the floor, put on a glove and cleaned up the milk with a paper towel, removed the glove, did not complete hand hygiene and proceeded to fill the glasses and place the glasses on the residents' trays. Staff C applied a glove and with the same gloved hand opened the refrigerator door, picked up a slice of cheese and placed the slice of cheese on a hamburger that was served to a resident. Staff B washed her hands, applied gloves, and with the gloved hand touched the outside of the butter container, removed the lid and with the same gloved hand touched a slice of bread. Facility policy, Bare Hand Contact with Food and Use of Plastic Gloves dated 2021, documented gloves are just like hands, anytime a contaminated surface is touched, the gloves must be changed, and hands must be washed. If used, single use gloves shall be used for only one task and discarded when interruptions occur in the operation, and hands are to be washed after removing single use gloves. Interview on 10/23/24 at 2:00 PM, the Dietary Manager stated expectation when using gloves to touch any food items, to not touch other items prior to touching the food item. The 2013 Food Code, published by the Food and Drug Administration and considered a standard of practice for the food service industry, includes the following requirements: 1) Single-use gloves are to be used for only one task, such as working with ready-to-eat food and for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation, 2) prohibits food employees from bare hand contact with ready-to-eat food (unless washing fruits and vegetables) and requires food employees to wash their hands immediately before engaging in food preparation, including before donning gloves for working with food, in order to prevent cross contamination when changing tasks.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 40905 Based on observations, staff interview, and policy review the facility failed to maintain the kitchen, food preparation and service area free of insects. The facility reported a census of 36 residents. Findings include: Observation on 10/21/24 at 10:18 AM, the door to the kitchen from the hallway has a sign posted on the door, for the door to remain closed, and the door was open: several flies observed throughout the kitchen area. The Dietary Manager (DM) acknowledged the flies and stated the door across from the open kitchen door goes to the outside and is used frequently. Continuous observation on 10/23/24 from 11:40 AM - 12:50 PM, the door to the outside of the building, across from the kitchen door, propped open, with staff coming in and out thru the kitchen door, as unloading truck. Meal service conducted and several flies observed throughout the kitchen, landing on plates, bread/butter, food on the plates for residents, utensils being used for service, and also flying around and landing on both dietary aides. Facility policy Pest Control dated 2021, documented appropriate action will be taken to eliminate any reported pest situation in the department. Interview on 10/23/23 at 2:00 PM, the DM stated the kitchen had not been treated for the flies and expectation for flies to not be in the kitchen and not on food and service items.