STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165528	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Spirit Lake	1912 Zenith Avenue Spirit Lake, IA 51360

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** 26527 Based on record review, staff and resident interview, the facility failed to notify the family of a change in condition for 1 of 3 residents reviewed (Resident #70). The facility reported a census of 70 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #70 scored 10 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident was independent with eating. The resident had diagnoses including heart failure, atrial fibrillation, and long term use of anticoagulant. The Care Plan revised 11/16/22 identified the resident needed assistance with all of her activities of daily living (ADL'S) except for eating. She had a potential for dehydration related to medication use. The interventions included the nurse to observe her for signs and symptoms of dehydration such as poor skin turgor, decreased urinary output, and dry mucous membranes, and notify the doctor of any changes. The Clinical Resident's Profile page showed the resident had a #1 and a #2 emergency contact listed. The Progress Notes dated 7/1/24 at 1:31 p.m. documented communication with the Dr. after the nurse assessed the resident with a pulse reading in the upper 30's and low 40's with repeated checks both manually with stethoscope and with pulse oximeter readings. The resident more drowsy in the morning and needed fed breakfast when normally independent with eating. Last administration time of Diltiazem (med to treat high blood pressure/chest pain) at 9:30 a.m. and pulse 100 at that time. New orders received to send to the emergency room (ER) for evaluation and treatment. Family member called with no answer and message left on situation. The Progress Notes dated 7/2/24 at 2:50 p.m. documented staff updated the family member on the resident going to the ER, what they did for the resident, and that she had returned. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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	The Progress Notes dated Sunday 7/7/24 at 10:51 a.m. documented a phone call placed to the resident's family member and gave an update on the resident's condition. The resident remained in bed with eyes closed and unresponsive at the time. The resident hadn't had much to eat or drink in the previous few days. The resident showed no signs/symptoms (S/S) of any pain, and rested with eyes closed. Vital signs (VS) within normal limits (WNL). Family said to keep the resident comfortable. At 10:57 a.m. the resident's family member called and after discussion with her family they would like the resident sent to the ER for evaluation. At 2:42 p.m. staff called the ER about the resident's status. The resident admitted for rapid ventricular response (RVR), A-Fib, and pneumonia. On 8/21/24 at 1:16 p.m. the resident's family member (contact #1) said she never received a call from the facility when the resident went to the hospital on 7/1/24. Someone called her on 7/2/24 and asked if she knew the resident went to the hospital the day before, what her condition was, and she had already returned. The family member said she didn't know. She said they called and told her on Friday evening the resident had some respiratory difficulty and they put her on oxygen. They did not call her on Saturday. On Sunday she received a call from the resident's friend asking if she knew the resident was unresponsive and hadn't been out of bed. She said the facility had not called her, and she had told them if they couldn't reach her to call another family member (contact #2). The resident's family member then called the facility. She didn't know what would have happened if she had not called the facility Sunday morning. At the hospital they determined the resident had a raging infection with a WBC of 19,000 (normal 4.500 to 11,000) and her heart rate 178 (normal 60-100) in the ER. On 8/22/24 at 12:34 p.m. the DON said if staff are unable to reach the 1st emergency contact they should call the next contact in the need to transfer a resident, or a change in condition requiring immediate attention. The facility policy Notification of Change of Resident's Health Status, updated 2/8/23 included the resident's physician the resident representative(s) would be notified of a change in status when there was a significant change in the resident's physical, mental, or psychosocial status for example a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications, a need to alter treatment significantly for example, a need to discontinue an existing form of treatment due to adverse consequences, or to start a new form of treatment, or a decision to transfer or discharge the resident from the nursing home.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review, facility record review, staff interviews and facility policy the facility failed to appropriately implement interventions to protect 1 out of 3 residents reviewed from physical abuse, (Resident #71). The facility reported a census of 67 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #71 documented diagnoses of Bipolar disorder, hypertension and diabetes mellitus. The MDS showed the Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. Review of the facility self report revealed the facility was made aware on 5/3/24 at 3:00 p.m., by Staff A, Restorative Aide and Staff B, Social worker Resident #71 reported Staff C, CNA was rough during a transfer. Interview on 8/21/24 at 12:05 p.m., with Staff D, Certified Nursing Assistant (CNA) revealed Resident #71 ' s husband had been pushing her down the hallway that morning and she was waving at her to come to her. Staff D could see Resident #71 had been crying and asked her what was wrong. Resident #71 stated don ' t let her come back and take care of me and said the aide that got her up was rough with her. Staff D revealed Resident #71 ' s husband said the aide threw the gait belt across the room. Staff D further revealed she reported the incident to Staff E, Licensed Practical Nurse (LPN). Interview on 8/21/24 at 2:03 p.m., with Staff E, LPN revealed it was around breakfast time when Staff D told her Resident #71 ' s husband was upset and Resident #71 was crying. Staff E explained to her Resident #71 told her the morning aide had been rough with her and she had been throwing things around in Resident #71 ' s room. Staff E explained Resident #71 had been tearful that morning when she saw her. Staff E stated she had told Staff F, Registered Nurse (RN), Assistant Director of Nursing (ADON) what was going on when she came in approximately between 8:00 a.m. and 9:00 a.m Interview on 8/21/24 at 8:52 a.m., with Staff B, Social Worker revealed Staff A, Restorative Aide said Resident #71 was visibly upset and could see she had been crying and was still crying. Resident #71 explained the morning aide had hit her leg on the wheelchair when she was assisting her. Resident #71 kept saying she didn ' t want anyone to get into trouble but it wasn ' t right on how she had been treated. Resident #71 cried throughout the interview. After talking with Resident #71 Staff A and Staff B reported it to the Administrator. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 8/21/24 at 10:57 a.m., with Staff A revealed she had seen Resident #71 at the breakfast table and could see she was crying at the table. Staff A revealed Resident #71 was talking to other people so she didn ' t want to interrupt at that time. Staff A revealed later in the day she heard staff members talking Resident #71 did not have a good day and had an altercation with an aide. Staff A asked Staff B to go and talk with Resident #71. Staff A explained Resident #71 was hesitant at first but explained to her there was an aide that came in her room in the morning and ripped her pajamas off of her and told her it was time to get up. Resident #71 further explained to her that she threw me into my wheelchair for breakfast and when we came back the aide stood her up and her foot got caught on her walker but she pushed her into her recliner. Resident #71 stated she didn ' t know what she did to make her mad but she didn ' t deserve to be treated like this. Staff A revealed she assured Resident #71 she was safe and reported it to the Administrator. Interview on 8/21/24 at 11:57 a.m., with Staff F revealed after she learned about the situation from the Administrator she went and talked to Resident #71. Resident #71 explained she felt the aide was rough and when she was transferring her into her wheelchair she felt like the aide had her over the wheelchair and just dropped her and was rough when she changed her sweatshirt. Staff F revealed she did an assessment and didn ' t find anything but didn ' t chart the assessment in the residents chart. Interview on 8/21/24 at 8:40 a.m., with the Administrator revealed he had been in the building and late that afternoon Staff A and Staff B came to him and stated Resident #71 was upset and after they talked to her it seemed like an allegation of abuse. The Administrator went and talked to Resident #71 and her husband. The Administrator further revealed Resident #71 revealed an aide pushed her walker away from her and she did a rough transfer. The Administrator further revealed he had the ADON talk with Staff C regarding what happened. The facility sent Staff C home pending an investigation. Review of Resident #71 ' s Progress Notes lacked documentation of the incident from the incident occurring on 5/3/24. Review of the facility provided policy titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy update on 10/19/22 revealed residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Interview on 8/21/24 at 3:41 p.m., with the Administrator revealed the facility seperated and reported the allegation of abuse as soon as they were aware of it.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review, facility record review, staff interviews and facility policy review the facility failed to report an allegation of abuse to the Iowa Department of Inspections & Appeals and Licensing (DIAL) within 2 hours of an allegation of abuse for 1 of 1 residents reviewed for abuse (Resident #71). The facility reported a census of 67 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #71 documented diagnoses of Bipolar disorder, hypertension and diabetes mellitus. The MDS showed the Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. Interview on 8/21/24 at 12:05 p.m., with Staff D, Certified Nursing Assistant (CNA) revealed Resident #71 ' s husband had been pushing her down the hallway that morning and she was waving at her to come to her. Staff D could see Resident #71 had been crying and asked her what was wrong. Resident #71 stated don ' t let her come back and take care of me and said the aide that got her up was rough with her. Staff D revealed Resident #71 ' s husband said the aide threw the gait belt across the room. Staff D further revealed she reported the incident to Staff E, Licensed Practical Nurse (LPN). Interview on 8/21/24 at 2:03 p.m., with Staff E, LPN revealed it was around breakfast time when Staff D told her Resident #71 ' s husband was upset and Resident #71 was crying. Staff E said Staff D explained to her Resident #71 told her the morning aide had been rough with her and she had been throwing things around in Resident #71 ' s room. Staff E explained Resident #71 had been tearful that morning when she saw her. Staff E stated she had told Staff F, Registered Nurse (RN), Assistant Director of Nursing (ADON) what was going on when she came in approximately between 8:00 a.m. and 9:00 a.m Interview on 8/21/24 at 2:28 p.m., with Staff F revealed she did not know about the situation prior to the Administrator notifying her of what was going on around 3:00 p.m Review of the facility self report revealed the facility was made aware on 5/3/24 at 3:00 p.m., by Staff A, Restorative Aide and Staff B, Social that Resident #71 reported Staff C, Certified CNA was rough during a transfer. Review of facility intake information the facility submitted a self report on 5/3/24 at 5:04 p.m. Review of the facility provided policy titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy update on 10/19/22 revealed the following information: a. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. All allegations of Resident abuse shall be reported to the Iowa Department of Inspections and Appeals not later than two (2) hours after the allegation is made. Interview on 8/21/24 at 3:41 p.m., with the Administrator revealed the facility reported the allegation as soon as they were aware of it.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review, staff interviews, and facility investigation record review, the facility failed to protect residents from further potential abuse after receiving an allegation of abuse alleging a CNA treated Resident #71 roughly and threw her into her wheelchair. Staff reported Resident #71 had feared the staff member would answer her call light on 5/3/24. The resident reported the concern to a staff member who reported it to the charge nurse who reported it to the Assistant Director of Nursing (ADON). The ADON denied being aware of the situation. The situation occurred before breakfast and the facility didn ' t start to investigate until after 3:00 PM. This failure resulted in residents living at the facility to be exposed to the potential of abuse therefore causing an Immediate Jeopardy to the health, safety, and security of the resident. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of March 3, 2024 on August 21, 2024. The facility staff removed the IJ on August 21, 2024 through the following actions: a. On 8/21/2024, staff member remains suspended and hasn ' t work since 5/3/24 b. On 8/21/2024, staff education was initiated to ensure all staff understand the facility abuse policy and reporting procedures. c. On 8/21/2024, All staff through the evening shift have been educated. Anyone not educated or not on the schedule will be educated on the vulnerable adult policy and reporting procedures prior to coming on shift. d. On 8/21/2024, All nursing leadership were educated by the Registered Nurse (RN) Nurse Specialist on their corporations investigation and allegation of abuse process and procedure. e. Any concerns will be reported to the Administrator immediately and addressed in facility Quality Assurance (QA). The scope lowered from a K to E at the time of the survey after ensuring the facility implemented education and their policy and procedures. The facility identified a census of 67 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #71 documented diagnoses of Bipolar disorder, hypertension and diabetes mellitus. The MDS showed the Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. Review of Resident #71 ' s Progress Notes lacked documentation of the incident from the incident occurring on 4/3/24. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 8/21/24 at 12:05 p.m., with Staff D, Certified Nursing Assistant (CNA) revealed Resident #71 ' s husband had been pushing her down the hallway that morning and she was waving at her to come to her. Staff D could see Resident #71 had been crying and asked her what was wrong. Resident #71 stated don ' t let her come back and take care of me and said the aide that got her up was rough with her. Staff D revealed Resident #71 ' s husband said the aide threw the gait belt across the room. Staff D further revealed she reported the incident to Staff E, Licensed Practical Nurse (LPN). Interview on 8/21/24 at 2:03 p.m., with Staff E, LPN revealed it was around breakfast time when Staff D told her Resident #71 ' s husband was upset and Resident #71 was crying. Staff E Staff explained to her Resident #71 told her the morning aide had been rough with her and she had been throwing things around in Resident #71 ' s room. Staff E explained Resident #71 had been tearful that morning when she saw her. Staff E stated she told Staff F, Registered Nurse (RN), Assistant Director of Nursing (ADON) what was going on when she came in approximately between 8:00 a.m. and 9:00 a.m Interview on 8/21/24 at 8:52 a.m., with Staff B, Social Worker revealed Staff A, Restorative Aide said Resident #71 was visibly upset and could see she had been crying and was still crying. Resident #71 explained the morning aide had hit her leg on the wheelchair when she was assisting her. Resident #71 kept saying she didn ' t want anyone to get into trouble but it wasn ' t right on how she had been treated. Resident #71 cried throughout the interview. After talking with Resident #71 Staff A and Staff B reported it to the Administrator. Interview on 8/21/24 at 10:57 a.m., with Staff A revealed she had seen Resident #71 at the breakfast table and could see she was crying at the table. Staff A revealed Resident #71 was talking to other people so she didn ' t want to interrupt at that time. Staff A revealed later in the day she heard staff members talking Resident #71 did not have a good day and had an altercation with an aide. Staff A asked Staff B to go and talk with Resident #71. Staff A explained Resident #71 was hesitant at first but explained to her there was an aide that came in her room in the morning and ripped her pajamas off of her and told her it was time to get up. Resident #71 further explained to her that she threw me into my wheelchair for breakfast and when we came back the aide stood her up and her foot got caught on her walker but she pushed her into her recliner. Resident #71 stated she didn ' t know what she did to make her mad but she didn ' t deserve to be treated like this. Staff A revealed she assured Resident #71 she was safe and reported it to the Administrator. Interview on 8/21/24 at 11:57 a.m., with Staff F revealed after she learned about the situation from the Administrator she went and talked to Resident #71. Resident #71 explained she felt the aide was rough and when she was transferring her into her wheelchair she felt like the aide had her over the wheelchair and just dropped her and was rough when she changed her sweatshirt. Staff F revealed she did an assessment and didn ' t find anything but didn ' t chart the assessment in the residents chart. Interview on 8/21/24 at 8:40 a.m., with the Administrator revealed he had been in the building and late that afternoon Staff A and Staff B came to him and stated Resident #71 was upset and after they talked to her it seemed like an allegation of abuse. The Administrator went and talked to Resident #71 and her husband. The Administrator further revealed Resident #71 revealed an aide pushed her walker away from her and she did a rough transfer. The Administrator further revealed he had the ADON talk with Staff C regarding what happened. The facility sent Staff C home pending an investigation. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility provided policy titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy update on 10/19/22 revealed the following information: a. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. b. All allegations of Resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative. c. Upon receiving a report of an allegation of resident abuse, neglect, exploitation or mistreatment, the facility shall immediately implement measures to prevent further potential abuse of residents from occurring while the facility investigation is in process. If this involves an allegation of abuse by an employee, this will be accomplished by separating the employee accused of abuse from all residents through the following or a combination of the following, if practicable: (1) suspending the employee; (2) segregating the employee by moving the employee to an area of the facility where there will be no contact with any residents of the facility; and in rare instances (3) separating the employee accused of abuse from the resident alleged to have been abused, but allowing the employee to care for and have contact with other residents, only if there is a second employee who remains with and accompanies the employee accused of abuse at all times to supervise all contacts and interactions with the residents. Interview on 8/21/24 at 3:41 p.m., with the Administrator revealed the facility separated Staff C from all residents and sent her home and reported the allegation as soon as they were aware of it.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review and staff interview, the facility failed to refer 1 resident with a negative Level I result for the PreAdmission Screening and Resident Review (PASRR), who was later identified with newly evident or possible serious mental disorder, intellectual disability, or other related condition, to the appropriate state-designated authority for Level II PASRR evaluation and determination for 1 out of 1 resident reviewed for PASRR requirements, (Resident #57). The facility reported a census of 67 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #57 documented diagnoses anxiety disorder, psychotic disorder and delusional disorders. The MDS included a Brief Interview for Mental Status (BIMS) score of 7 indicating severe cognitive impairment. The MDS revealed diagnoses of anxiety disorder, psychotic disorder and delusional disorder. Review of the active diagnosis list in the clinical record revealed the following diagnoses; a. Delusional disorders with an active date of 2/12/24 b. Anxiety disorder with an active date of 4/3/24. The Care Plan with revision date of 5/10/24 revealed the resident has dementia with behaviors, delusional disorder and anxiety. The clinical record lacked an updated PASRR to include updated diagnosis. The facility does not have policy on PASRR and follows the PASRR guidelines. Interview on 8/20/24 at 10:15 a.m., with the Social Services Director revealed the PASRR should have been redone with the updated diagnosis.

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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** 26527 Based on record review, staff and family interview, the facility failed to provide adequate assessment and timely intervention for 1 of 3 resident's reviewed with a change of condition (Resident #70). The facility reported a census of 67 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #70 scored 10 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident was independent with eating. The resident had diagnoses including heart failure, atrial fibrillation, and long term use of anticoagulant. The Care Plan revised 11/16/22 identified the resident needed assistance with all of her activities of daily living (ADL'S) except for eating. She had a potential for dehydration related to medication use. The interventions included the nurse to observe her for signs and symptoms of dehydration such as poor skin turgor, decreased urinary output, and dry mucous membranes, and notify the doctor of any changes. The Clinical Resident's Profile page showed the resident had a #1 and a #2 emergency contact listed. The Progress Notes included the following documentation: a. On 7/1/24 at 1:31 p.m. communicated with the Dr. after the nurse assessed the resident with a pulse reading in the upper 30's and low 40's with repeated checks both manually with stethoscope and with pulse oximeter readings. The resident more drowsy in the morning and needed fed breakfast when normally independent with eating. Last administration time of Diltiazem (med to treat high blood pressure/chest pain) at 9:30 a.m. and pulse 100 at that time. New orders received: Send to emergency room (ER) for evaluation and treatment. Family member called with no answer and message left on situation. b. On 7/1/24 at 2:05 p.m. the Director of Nursing (DON) assessed the resident with a low pulse and the DON was in contact with the doctor. Staff called for the ambulance around 1:25 p.m. and the ambulance left with the resident around 1:40 p.m. c. On 7/1/24 at 6:12 p.m. the resident returned, no new medications. The ER Nurse called to give report. The resident on Telemetry the entire ER visit with no changes in sinus rhythm. A computed tomography (CT) of the head performed with negative findings or abnormalities. A B-type natriuretic peptide (BNP, test to monitor heart failure) elevated, and 20 mg of Lasix intravenous (IV) given in the ER. Her physician would see her on Wednesday rounds. d. On 7/1/24 at 11:14 p.m. the resident took a pudding cup, was weak, tired, and had a cough present. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. On 7/2/24 at 2:50 p.m. updated family on the resident going to the ER, what they did for the resident, and she had returned. Vitals were good thus far but she had nausea, decreased energy, decreased eating, and crackles in the upper lungs. Notified the DON of the information and she stated the resident would be seen the following day on rounds and family notified. f. On 7/3/24 at 5:36 p.m. the Dr. assessed the resident on rounds. No new orders. g. On Friday 7/5/24 at 8:55 p.m. the nurse assessed the resident's oxygen at 86% on room air. The resident's head of the bed (HOB) elevated, and lung sounds diminished. After discussion with another nurse, noted the resident had an as needed (PRN) order for an albuterol inhaler, but did not have one in facility at the time. A call placed to the on call Dr. at 8:55 p.m. and he suggested Albuterol Nebs 2.5 mg/3 ml every 4 hours PRN, and oxygen to maintain saturation >90%. The resident's family member updated at 9:01 p.m. on the new order. The clinical record lacked follow up assessment of the resident's lung sounds. The Progress Notes dated Sunday 7/7/24 at 10:51 a.m. documented a phone call placed to the resident's family member and gave an update on the resident's condition. The resident remained in bed with eyes closed and unresponsive at the time. The resident hadn't had much to eat or drink in the previous few days. The resident showed no signs/symptoms (S/S) of any pain, and rested with eyes closed. Vital signs (VS) within normal limits (WNL). Family said to keep the resident comfortable. At 10:57 a.m. the resident's family member called and after discussion with her family they would like the resident sent to the ER for evaluation. At 2:42 p.m. staff called the ER about the resident's status. The resident admitted for rapid ventricular response (RVR), A-Fib, and pneumonia. The O2 Sats Summary showed the resident's O2 sat on 7/5/24 at 9:18 p.m. at 86%. The last recorded O2 sat documented on 7/6/24 at 5 a.m. at 94%. The Blood Pressure Summary showed the last recorded blood pressure on 7/3/24 at 10:51 a.m. The Respiration Summary showed the last recorded respirations on 7/3/24 at 10:50 a.m. The Temperature Summary showed the last recorded temperature on 7/3/24 at 10:50 a.m. The Nutrition - Fluids and Percentage eaten records showed the resident had no food or fluids since lunchtime on 7/5/24. A Transfer/Discharge Report dated 7/7/24 documented the last vital signs were from 7/3/24 and 7/6/24. The resident was not eating or drinking fluids, and started oxygen on 7/5/24, not normal for her, and that day non-responsive. A Prehospital Care (ambulance) Report dated 7/7/24 at 11:15 a.m. documented paged for a female unresponsive with a low heart rate. The resident laid pale and clammy in bed. The resident did not respond. The resident breathing around 40 per minute (normal 12-20). The resident connected to a monitor showing atrial fibrillation with (heart) rates 150- 210 (normal 60 to 100) but mostly on the 170 side. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A History and Physical dated 7/7/24 documented the resident's assessment included pneumonia, atrial fibrillation with rapid ventricular response, sepsis (a life threatening response to an infection), congestive heart failure, acute kidney injury, and acute hypoxic respiratory failure. The resident presented with significant tachycardia (rapid pulse), hypoxia, elevated white blood count (WBC) at 19,000, and a chest x-ray concerning for pneumonia. On 8/21/24 at 10:10 a.m. Staff F Certified Nursing Assistant (CNA) stated they left the resident in bed on Saturday, she was tired not eating or drinking. On Sunday she again stayed in bed and she thought she may be opened her eyes. They took her meal trays to her room but she didn't think she ate or drank. The resident had been going downhill and they were concerned about her. They did notify the nurse. On 8/21/24 at 10:45 a.m. Staff G Registered Nurse (RN) stated the resident had not been feeling well for a few days. She had a cough, and not eating or drinking. She thought they had something going around at the time. She said she did try to call the family and could not reach them. They called her back later and she updated them on her condition. At the time they called she was unresponsive. The resident had visitors that morning and they also voiced their concerns with her condition. On 8/21/24 at 10:54 a.m. Staff H CNA stated the resident wouldn't eat or drink and they could tell she was going downhill. She talked with the nurse about her condition. On 8/21/24 at 12:35 p.m. Staff I CNA stated she had worked the days leading up to the resident's hospitalization . She said the resident had been going down hill. She said the CNA's talked to the nurses about it. On 8/21/24 at 1:16 p.m. the resident's family member (contact #1) said she never received a call from the facility when the resident went to the hospital on 7/1/24. Someone called her on 7/2/24 and asked if she knew the resident went to the hospital the day before, what her condition was, and she had already returned. The contact #1 said she didn't know. She said they called and told her on Friday evening the resident had some respiratory difficulty and they put her on oxygen. They did not call her on Saturday. On Sunday she received a call from the residents friend asking if she knew the resident was unresponsive and hadn't been out of bed. She said the facility had not called her, and she had told them if they couldn't reach her to call another family member (contact #2). Contact #1 then called the facility. She didn't know what would have happened if she had not called the facility Sunday morning. At the hospital they determined the resident had a raging infection with a WBC of 19,000 and her heart rate 178 in the ER. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/24 at 2:03 p.m. the friend of the resident stated they went out to see the resident every Sunday. She was always up in her recliner or her wheelchair. That last Sunday when they went to visit, the room was dark and she was in bed. She had a wet washcloth over her forehead. They went to the nurses station and asked what was wrong with her. Some staff members stated she was not feeling well. And the friend said she could see that and asked how long she had been that way. The staff members said since Friday. She asked if they had called contact #1 and they said they had tried but could not get a hold of her. The resident's friend stated she thought it strange they couldn't get a hold of her but she knew contact #1 had told them they could call contact #2 if they couldn't get a hold of her. The resident's friend called contact #1 and asked if she knew the resident's condition. Contact #1 said no and she had not received any calls from the nursing facility. The friend was very upset that they were leaving her lay like that and not doing something for her, or notifying some one. On 8/21/24 at 3:02 p.m. the DON stated the resident had been declining. She said if a resident continued to show declines nursing staff should assess their condition and report to the resident's physician and family regarding the declines. On 8/22/24 at 11:40 a.m. the Regional Nurse Consultant stated they had no policy on assessment, they went by the regulations and standards of practice.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 50500 Based on observations, staff interview, and policy review, the facility failed to provide food that is nourishing and palatable. The facility reported a census of 67. Findings include: 1.Breakfast test tray obtained on 8/21/24 at 8:30 AM. Temperature of the scrambled eggs recorded at 123 . The French toast edges were tough and dried out. 2.Kitchen lunch observation completed on 8/21/24 at 11:30 AM. The meatloaf on the steam table was seen with burned edges all around the pan. Staff observed having difficulty cutting the entree into individual pieces. 3.Resident meal round completed on 8/21/24 at 12:00 PM in the East Dining Room. Several residents voiced the meat loaf was burnt and unable to cut thru. Resident plates observed with hard, burnt, inedible meatloaf crust. 4.Lunch test tray obtained on 8/21/24 at 12:35 PM. The meatloaf received was burnt along the edges and crunchy when consumed. On 8/21/24 at 12:30 PM the Staff J, Certified Dietary Manager, interviewed and acknowledged the meatloaf was dried out. Staff J was not aware of the French toast quality nor the below standard temperature of the scrambled eggs. The undated policy Food Temperatures revealed that foods sent to the unit for distribution will be transported and delivered to maintain temperatures at or above 135 .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 50500 Based on observations and staff interviews, the facility failed to provide food prepared by methods that conserve nutritive value and flavor. The facility reported a census of 67. Findings include: On 8/21/24 at 11:00 AM, Staff I, cook, observed preparing four serving of puree meatloaf and carrots. Hot water utilized to thin out the items to achieve the correct puree consistency. When asked, Staff I reported water is mainly use when pureeing foods. During an interview on 8/21/24 at 12:30 PM with Staff J, Certified Dietary Manager, acknowledged that water is not the most appropriate liquid to use. Industry standards recommend liquids that add additional flavor, calories, or protein when pureeing to conserve nutritive value and flavor.

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are assessed for appropriateness for a feeding assistant program, receive services as per their plan of care, and feeding assistants are trained and supervised. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500 Based on clinical chart review, observations, staff interviews, and policy review, the facility failed to accurately care plan the use of Paid Nutritional Aides (PNAs), assess the appropriateness of PNA, and used a PNA for feeding assistance on a resident with swallowing difficulties for 1 of 2 residents who utilize a PNA at meals (Resident #27). The facility reported a census of 67. Findings include: The Minimum Data Set (MDS) dated [DATE] documented Resident #27 had a Brief Interview for Mental Status (BIMS) of 15 indicating an intact cognitive status. The MDS documented the resident had diagnoses including aphasia, depression, dyskinesia of esophagus, osteoarthritis (left and right hand), essential tremor, and dysphagia (pharyngoesophageal phase). The MDS reported Resident #27 complained of difficulty or pain with swallowing, coughs/chokes during meals or when swallowing medication, and loses liquids/solids from mouth when eating/drinking. Clinical record review revealed Resident #27 ordered a puree diet with regular consistency liquids. Quarterly Nursing Assessment Progress Note dated 8/1/24 indicated Resident #27 needs extensive staff assistance at meals and is dysphagic. Resident #27's Care Plan with a target date of 11/1/24 documented a focus area related to an alteration in nutrition due to chewing/swallowing difficulties related to dyskinesia of esophagus, dysphasia, and missing teeth. Intervention included resident will eat meals in the [NAME] dining room with staff assistance. The Care Plan did not address the specific use of PNAs with meal assistance. Further clinical record review lacked formal assessments addressing the use of PNAs for feeding assistance and whether or not a PNA is appropriate given Resident #27's dysphagia diagnosis. Lunch observation on 8/21/24 at 11:30 AM showed a PNA feeding Resident #27 a puree diet. Breakfast observation on 8/22/24 showed a PNA feeding Resident #27 a puree diet. Director of Nursing (DON) reported, on 8/22/24 at 10:15 AM, no regularly scheduled formal assessments completed on the continued use of PNAs. The DON stated if a resident coughing more than usual or having a bad day the PNA would be notified and not allowed to feed the resident. The facility does not allow PNAs to assist residents who receive thickened liquids. DON reported no further restrictions in place on PNA use. The facility's Speech and Language Pathologist (SLP) interviewed on 8/22/24 at 10:30 AM. The SLP reported Resident #27 is higher than normal aspiration risk given the medical diagnoses. SLP states they were not involved in the decision process of utilizing a PNA for Resident #27. (continued on next page)

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The undated policy Paid Feeding Assistants (Nursing Facilities) outlined paid feeding assistants are not permitted to assist resident who have complicated eating problems such as difficulty swallowing. Nurses or nurse aides must continue to assist resident who require staff with more specialized training. Per policy, resident selection for PNA use must be based on the charge nurse current assessment of the resident's condition and the resident's latest comprehensive assessment and plan of care.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50500 Based on temperature log review, observations, policy review, and staff interview, the facility failed to ensure food is stored, prepared, and served in a sanitary manner as well ensuring dishes and utensils cleaned in a sanitary manner to prevent foodborne illness. The facility reported a census of 67. Findings include: 1.Initial kitchen tour completed on 8/19/24 at 11:15 AM. The dry storage room had a container of oil sitting on the floor next to a storage rack. An unlabeled/dated container of what appeared to be sunflower seeds found on a storage rack. The walk-in cooler revealed the following: a.Two squeeze bottles, which appeared to be salad dressing, were not labeled nor dated; b.Outdated containers of food found (pork roast dated 8/9, potato salad dated 8/7, and fruit cocktail dated 8/6); c. A container of pickles, with torn aluminum foil as a cover, dated 8/6; d.A zip-loc bag with a used bag of shredded lettuce was not labeled nor dated; e.An unsealed zip-loc bag with an open bag of Heath candy pieces. 2.Follow-up kitchen tour completed on 8/21/24 at 8:10am. The walk-in freezer had an open bag of frozen browned chicken as well as an unlabeled/dated zip-loc bag of what appeared to be diced potatoes or meat. A container of pea salad, dated 8/13, found in the walk-in cooler. 3.Lunch service observation completed on 8/21/24 from 11:00 AM to 12:30 PM. Hand hygiene was not observed by Staff I, cook, during the continuous observation. Staff I observed wiping hands on her pants, rubbing her nose, and touching various kitchen equipment/handles with bare hands. Staff I observed spreading ice around a bin, with bare hands, which contained prefilled glasses of milk/juice for resident use. Staff I donned gloves prior to start of lunch service with no hand hygiene performed. During service, Staff I observed touching kitchen equipment/handles, food containers, and tray tickets with gloved hands as well as spreading ice around the bin holding prefilled glasses of milk/juice for resident use. With the same pair of gloves, Staff I seen deboning chicken for resident lunch plates. 4.Food temperature logs reviewed showed 8 meal temperatures were not recorded in August out of 62 meals, 33 meal temperature were not recorded for July out of 93 meals, 22 meal temperatures were not recorded for June out of 90 meals and 27 meal temperatures were not recorded in May out of a total of 93 meals. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5.Dish machine temperature logs reviewed showed 52 final rinse temperature readings were not recorded in August out of 62. No final rinse temperatures recorded for the month of July. Eighty seven final rinse temperatures were not recorded for the month June out of 90. No log located for the month of May. On 8/21/24 at 8:30 AM, Staff K, dining services personnel, reported not knowing which temperature gauge (out of 3 gauges) to look at to ensure the proper final rinse temperature reached. On 8/21/24 at 12:30 PM the Staff J, Certified Dietary Manager, interviewed. Staff J stated meal temperatures and dish machine final rinse temperatures are expected to be documented for each meal/three times per day. Hand hygiene and glove change should have been completed at key times during meal preparation/service. The undated policy Food Storage revealed: 1.Dry storage food items will be stored on shelves and all containers much be legible and accurately labeled and dated. 2.Refrigerated leftover food is stored in covered containers or wrapped carefully/securely and used within 3 days or discarded. 3.Frozen foods should be covered, labeled, and dated. 4.After engaging in other activities that contaminate hands. The undated policy Hand Washing revealed hands should be washed: 1.After touching bare human body parts other than clean hands and clean, exposed portions of the arm. 2.After handling soiled equipment or utensils. 3.During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks. 4.Before donning gloves for working with food. The undated policy Food Temperatures revealed temperatures will be taken and properly recorded for each meal to ensure hot food is cooked to the appropriate internal temperature and cold food maintained and served at the appropriate temperature. The undated policy Dish Machine Temperature Log revealed: 1.Staff will monitor and record temperature to assure proper sanitizing of dishes. 2.Staff will be trained to record dish machine temperatures for the wash and rinse cycles at each meal.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on record review, staff interviews and facility policy review the facility failed to provide accurate resident records for 1 of 19 residents (Residents #71). The facility reported a census of 67 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #71 documented diagnoses of Bipolar disorder, hypertension and diabetes mellitus. The MDS showed the Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. Interview on 8/21/24 at 12:05 p.m., with Staff D, Certified Nursing Assistant (CNA) revealed Resident #71 ' s husband had been pushing her down the hallway that morning and she was waving at her to come to her. Staff D could see Resident #71 had been crying and asked her what was wrong. Resident #71 stated don ' t let her come back and take care of me and said the aide that got her up was rough with her. Staff D revealed Resident #71 ' s husband said the aide threw the gait belt across the room. Staff D further revealed she reported the incident to Staff E, Licensed Practical Nurse (LPN). Interview on 8/21/24 at 2:03 p.m., with Staff E, LPN revealed it was around breakfast time when Staff D told her Resident #71 ' s husband was upset and Resident #71 was crying. Staff E Staff D explained to her Resident #71 told her the morning aide had been rough with her and she had been throwing things around in Resident #71 ' s room. Staff E explained Resident #71 had been tearful that morning when she saw her. Staff E stated she told Staff F, Registered Nurse (RN), Assistant Director of Nursing (ADON) what was going on when she came in approximately between 8:00 a.m. and 9:00 a.m Review of the facility self report revealed the facility was made aware on 5/3/24 at 3:00 p.m., by Staff A, Restorative Aide and Staff B, Social worker Resident #71 reported Staff C, Certified CNA was rough during a transfer. Review of Resident #71 ' s Progress Notes lacked documentation of the incident from the incident occurring on 5/3/24. Review of facility provided policy titled Risk Management updated 10/25/2021 revealed all accidents/incidents involving residents will be reported, investigated and reviewed through the facilities QAPI Process to ensure residents receive the highest quality of care. Interview on 8/21/24 at 11:52 a.m., with the Director of Nursing (DON) revealed she was not sure if the incident should be documented in the resident's chart.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50500 Based on observation and staff interview, the facility failed to provide infection control practices with the lack of enhanced barrier protection used during wound care treatment for 1 of 1 resident observed (Resident #53) and lack of hand hygiene when assisting residents to eat. The facility reported a census of 67. Findings include: 1.On 8/20/24 at 2:00 PM, Staff M, Licensed Practical Nurse (LPN) and Staff N, LPN, completed wound care to Resident 53's left lower calf. Upon room entry, no signage observed indicating resident placed in enhanced barrier protection (EBP). Staff M and Staff N performed hand hygiene and donned gloves prior to initiating treatment, which was completed as ordered. During interview with Staff N on 8/20/24 at 3:00 PM, it was reported EBP was not indicated for Resident #53 as the wound was not considered chronic. EBP would be initiated when classified as chronic, which is defined as greater than 30 days. The Enhanced Barrier Precautions policy updated 5/6/24, reported on order for EBP obtained for wounds (e. g. chronic wounds, such as pressure ulcer .) and/or indwelling medical devices. The Center for Disease Control (CDC) indicated EBP should be utilized with high-contact resident care activities such as wound cares whereas a wound is defined as any skin opening requiring a dressing (www.cdc. gov/hai/containment/PPE-Nursing-Homes.html). 2.During breakfast on 8/20/24 at 7:45 AM, Staff A, Restorative Aide (RA) observed assisting two residents at the same time to eat. On multiple occasions, Staff A seen rubbing the resident's arm and back to encourage them to eat (resident sitting on Staff A's left). Staff A then picked up eating utensils and/or drinking glasses to assist the other resident., who was sitting on Staff A's right. No hand hygiene was observed throughout. During the same meal period, Staff O, Certified Nursing Assistant (CNA), observed assisting two residents at the same time to eat. On two separate occasions, Staff O seen wiping a resident's mouth and nose with the clothing protector with no hand hygiene completed after the task. Staff O proceed to pick up eating utensils and or drinking glass to assist the other resident. The DON interviewed on 8/20/24 at 9:30 AM and reported there is no specific policy or procedure in place regarding hand hygiene for staff during meal assistance. The Hand Hygiene policy updated 5/6/24, indicated an alcohol-based hand sanitizer to be used: 1. After touching a resident or the resident's immediate environment. 2. After contact with blood, bodily fluids or contaminated surfaces.