STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165529	A. Building B. Wing	09/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Shenandoah	1203 South Elm Street Shenandoah, IA 51601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on clinical record review, hospital record review, staff interviews, and facility provided document review the facility failed to follow facility guidance by transferring without a full body lift after a fall for 3 of 3 residents (Resident #1, Resident #2, Resident #3) reviewed. The facility reported a census of 42 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #1 dated 8/2/24 identified a Brief Interview for Mental Status (BIMS) score of 8 which indicated moderate cognitive impairment. The MDS documented diagnoses that included: anxiety disorder, depression, heart failure, atrial fibrillation (A-fib), dementia, osteoarthritis, and intervertebral disc degeneration. The resident was frequently incontinent of bladder. Resident #1's functional transfers, and sit to stands were dependent upon staff. The document revealed during the last 5 days of the assessment period the resident received scheduled pain medication and did not receive as needed (PRN) pain medication. The document further revealed that during the previous 7 days of the assessment period the resident received antianxiety, antidepressant, anticoagulant, and diuretic medications. The resident had no falls since the prior assessment. Resident #1's Care Plan printed on 9/14/24 revealed a focus area of risk for falls and had falls while in the facility. The Fall Risk assessment dated [DATE] identified Resident #1 at high risk for falls. The Incident Report dated 9/4/22 at 8:50 PM documented an aide passing by room and heard Resident #1 calling for help. Nurse to room and noted resident sitting on floor beside bed with back resting against bed and legs outstretched with left leg under right leg. Bed in low position and wearing socks. No obvious areas of concern noted, resident is complaining of left leg pain. Was able to move leg out from under other leg. No shortening or rotation noted to bilateral lower extremities. Neuro checks initiated. Assist up by two staff onto bed. No bruising or swelling noted. Resident states she was trying to get up to the bathroom and she was trying to get her phone. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nurse Note entered by Staff C, Licensed Practical Nurse (LPN) in Resident #1's electronic health record (EHR) dated 9/4/22 at 10:55 PM revealed the resident was found on the floor beside the bed with her back resting against the bed with her legs outstretched with the left leg under the right. The resident was assisted up by 2 staff onto the bed. On 9/5/24 at 2:01 AM Staff C, LPN, entered a Nurse Note indicating a change in condition form was completed and faxed to the physician. On 9/5/24 at 2:33 AM Staff C, LPN, documented in the Nurse's Note the resident was continuing to guard the left lower extremity, no bruising noted. On 9/5/24 at 4:50 AM Staff C, LPN, documented in the Nurse's Note the resident had complaints of left leg pain pointing to the knee and had stated I need an x-ray. The note stated no swelling or bruising, observed. On 9/5/24 at 6:30 AM Staff E, LPN, documented an assessment of Resident #1 found the resident with complaints of pain to the left thigh area and increased swelling. Staff E sent the resident to the hospital. The document hospital X-ray results dated 9/5/24 revealed a displaced oblique fracture of the distal femur of the left leg. On 9/14/24 at 3:44 PM Staff D, CNA, stated when coming in from a break during the evening shift, she heard Resident #1 call out nurse and observed the resident's feet in a weird way on the floor on top of the bedside table bottom brace. The staff notified Staff C, who came and completed vitals and assessment on the floor. Staff C provided a gait belt and instructed the CNA to assist her in getting the resident up. Staff D stated she asked Staff C if the resident should be sent to the hospital due to complaints of pain and the position the left leg was in. Staff D stated the resident complained of pain pointing/touching her left leg prior to getting up and when seated on the edge of the bed. On 9/14/24 at 3:58 PM Staff C stated she was contacted by Staff D indicating that Resident #1 was on the floor. The staff stated the resident was seated on the floor with the left leg under the right leg with no obvious rotation. Staff C stated neuro and vital assessments were completed, and then assisted Staff D with getting the resident off the floor and onto the bed. The staff acknowledged the resident rubbed the left leg and complained of pain. Staff C stated the resident was provided with PRN Tylenol due to complaints of pain. The staff stated neuro checks were completed throughout the night and the resident did appear to sleep at times, but did have complaints of pain. The staff stated she would have called the physician regarding the resident's fall if there had been an obvious injury. On 9/14/24 at 4:26 PM Staff E stated a mechanical dependent full body lift (Hoyer) should be used to get residents off of the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/14/24 at 4:33 PM Staff F, CNA, stated Resident #1 had utilized her call light earlier in the evening on 9/4/24 to ask for assistance regarding her cell phone. The staff provided reassurance to the resident on the location of the phone, and the resident settled down. Staff F stated she was at the nurse's station when she heard the resident had fallen. Staff F stated she heard the resident complain of pain in the left leg when checking on the staff to see if assistance was needed. The staff stated a Hoyer should be used for getting residents off of the floor. On 9/14/24 at 4:39 PM Staff G, CNA, stated she came on shift on 9/4/24 at 10:00 PM after Resident #1's fall. The staff stated the resident had called out in pain and she notified Staff C. Staff G stated Staff C provided the resident with Tylenol for pain. The staff stated the resident throughout the night shift complained of leg pain and wanted to go to the hospital. Staff G stated the roommate at one point attempted to get up and provide assistance to Resident #1. Staff G stated if a resident was found on the floor, she would follow the nurse's instructions and get the resident off the floor with assistance. 2. The MDS for Resident #2 dated 7/2/24 identified a BIMS score of 2 which indicated severe cognitive impairment. The MDS documented diagnoses that included: depression, wedge compression fracture unspecified lumbar vertebra, adjustment disorder with mixed anxiety and depressed mood, and spinal stenosis. Resident #2's functional transfers, and sit to stands were partial/moderate assistance upon staff. The document revealed during the last 5 days of the assessment period the resident received scheduled pain medication and did not receive PRN pain medication. The document further revealed that during the previous 7 days of the assessment period the resident received antidepressant medication. The resident had no falls since the prior assessment. The resident had occasional bladder incontinence. Resident #2's Care Plan printed on 9/14/24 revealed a focus area of risk for injury for falls and had falls while in the facility. The interventions for staff to follow prior to 8/24/24 included: non-skid socks or shoes when ambulating, call light within reach, fall risk assessment completed quarterly and with any falls, and having his walker within reach. The Fall Risk assessment dated [DATE] identified Resident #2 at moderate risk for falls. On 8/24/24 at 10:38 PM the Nurse Note revealed the resident had an unwitnessed fall. Following an assessment, the resident was assisted off the floor and ambulated with 2 assist and his walker to the bathroom. The resident had a 1 cm round abrasion to the right elbow and 4 cm round, raised knot on the middle back of his head. On 8/25/24 at 12:10 AM the Nurse Note revealed a change of condition and the resident was sent to the hospital for evaluation. On 8/25/24 at 2:56 AM the Nurse Note revealed the resident returned with no acute injury. The entry further revealed facility fall protocol was resumed with neuro checks and routine monitoring. On 9/14/24 at 1:58 PM observed Staff K assisting Resident #2 from the dining room to his room. The staff utilized a gait belt and front wheeled walker. Resident #2 had a stutter step gait. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The MDS for Resident #3 dated 6/11/24 identified a BIMS score of 12 which indicated moderate cognitive impairment. The MDS documented diagnoses that included: peripheral vascular disease, diabetes, cerebrovascular accident, non-Alzheimer's dementia, Parkinson's, depression, systemic Lupus erythematosus, unspecified, and polyneuropathy. The resident was occasionally incontinent of bladder and bowel. Resident #2's completed transfers, ambulation with a walker, dressing and toileting skills with independence. The document revealed during the last 5 days of the assessment period the resident received scheduled pain medication and did not receive PRN pain medication. The document further revealed that during the previous 7 days of the assessment period the resident received antidepressant, diuretic, antiplatelet, and hypoglycemic medications. The resident had no falls since the prior assessment. Resident's Care Plan printed 9/15/24 revealed a focus area addressing moderate risk for falls with interventions for staff to follow prior to 8/23/24 included: education to resident to be backed up to the bed before sitting, fall assessment quarterly and with any falls, and staff were to follow the facility fall protocol. The Fall Risk assessment dated [DATE] revealed a moderate fall risk for falls. The Nurse Note in the EHR dated 8/23/24 at 2:54 PM revealed the resident was found on the floor and was assisted up from the floor by 2 staff. An assessment and fax were sent to the primary care provider. The Nurse Note on 8/30/24 at 5:02 AM revealed the resident had turned on the call light after falling to the floor and sustaining an injury. The resident had a laceration to the left forearm and was taken to the hospital by emergency medical services. The resident required sutures and steri-strips. The Nurse Note on 9/6/24 at 12:03 AM revealed the resident was on the floor with legs in front of her. The resident was assisted up off of the floor by 2 staff. The assessment revealed the resident was slightly out of breath. Neuro checks were initiated and the resident was assisted to bed following the assessment. On 9/15/24 at 10:30 AM observed Resident #3 ambulating without assistance in her room, using furniture as supports as she ambulated. On 9/15/24 at 11:00 AM the Administrator stated the facility did not have specific policies related to falls. The Administrator acknowledged the Education Forms for Staff D dated 9/10/24 and Staff C dated 9/10/24 indicated a policy regarding falls and staff not lifting residents from the floor manually but with a mechanical full body (Hoyer lift). The Administrator stated there was not a policy but the facility had a document titled Safe Resident Handling and Movement Quick Talks that the facility followed that was provided by the facility's workman's compensation provider. The Administrator stated the facility followed standards of practice, and Center for Medicare and Medicaid Services (CMS) guidelines. On 9/15/24 at 11:45 AM Staff I, LPN, MDS Coordinator, concurred the facility did not have a Facility Fall Protocol as referenced in Resident #3's care plan. Staff I stated the CNA's knew not to get residents up from the floor prior to nurse assessments, and the nursing staff knew that Hoyer lifts were required to get residents up from the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided document, Safe Resident Handling and Movement Quick Talks, dated 8/18, revealed a caregiver should never lift a resident. The document further revealed that if a resident cannot be coached on getting up from the floor, the staff should use a mechanical lift or call 911.