STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165535	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Aurelia, LLC	401 West Fifth Street Aurelia, IA 51005

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, interview and record review the facility failed to ensure that staff interacted with residents with dignity and respect for 1 of 13 residents reviewed, (Resident#9). The facility reported a census of 32 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #9 had a Brief Interview for Mental Status (BIMS) score of 14 (intact cognitive ability.) She was dependent on staff for toileting, showering and lower body dressing and required substantial assistance with toilet and sit to stand transferring. Diagnoses for Resident #9 included; anemia, hypertension, peripheral vascular disease, diabetes mellitus, osteoporosis, bipolar disorder, and fracture of the right pubis A Care Plan revised on 2/12/25, showed that Resident #9 was occasionally dependent on staff and others for meeting her emotional, intellectual, physical and social needs, and staff were to converse with the resident while providing care. Staff were to provide resident with cues, reorientation, reassurance and supervision as needed. The resident required assistance of one staff with a Wheeled [NAME] (FWW) and gait belt. (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/25 at 1:35 PM, Resident #9 was sitting in her recliner. When asked about an interaction with Staff I, Certified Nurse Aide (CNA) that morning, she became fidgety and teary eyed, and said I don't want to get anyone in trouble. Resident #9 said that it was about 4:00 AM that morning when she woke up with abdominal pressure and needed to use the bathroom. The resident turned on her call light and Staff I came into the room, and with a rough tone she snapped what do you want? The resident told the CNA that she needed to use the toilet and the CNA told her that the morning staff could do it later. Resident #9 told Staff I that she was having pressure and really needed to go, so the CNA helped her out of bed into the wheel chair. Resident #9 asked her if she was going to use the gait belt and she said that's not necessary. The resident told her that the other CNA always used it, and that therapy told her they needed to use it every time, but Staff I just responded but that ain't me and proceeded to transfer her to the wheel chair then onto the toilet. She said that she prayed she wouldn't fall. Resident #9 said that once she was on the toilet Staff I yelled at her push! you need to push harder! The resident told her she was trying but she was afraid that her catheter would come out. The CNA stayed in the room for about 10 minutes while the resident was on the toilet then checked on her and said you didn't do anything, I knew you wouldn't. Resident #9 said she felt that the CNA didn't want to help her at all and the resident apologized to the CNA several times. Resident #9 said that she felt afraid when this CNA came into her room because she felt that Staff I really didn't want to take care of her and she didn't feel safe with her. On 3/5/25 at 9:50 AM, Staff I, said that around 4:00 AM Resident #9 had her call light on so she went to check on her. The resident said she needed to go to bathroom so she transferred her to the bathroom with the use of the gait belt. She continued to complain of stomach pressure and Staff I said why don't you try pushing? The resident responded nothing comes out so she waited in the room for about 10 minutes. The resident did not have a bowel movement so she told her to make sure to tell the morning girls so they could try again. She said that she put the resident back to bed with no incident and reminded her to pull her call light if she needed anything else. Staff I said that the resident thanked her several times and they had gotten along great. Staff I maintained that she did everything the resident wanted, when she was on the toilet and said she was having trouble going, she suggested that she push harder. The resident had responded; I am, I'm trying. so Staff I said she didn't think she going to go so she wiped her and assisted her back to bed. Staff I said that she suggested that the resident make sure that the morning girls knew she hadn't had a bowel movement. Staff I maintained that she always used a gait belt with transfers, she suggested that told the resident try to push harder but did not yell at her. Staff I maintained that she treated the resident with respect On 3/5/25 at 2:31 PM, Staff E, Licensed Practical Nurse (LPN) said she administered medication to Resident #9 that morning and asked the resident how she was doing. The resident told her she was still upset about an interaction that happened with Staff I earlier that morning. The resident reported that she needed to use the bathroom and the CNA didn't use the belt when she transferred her and was rude and snapped you said you gotta go, now go! On 3/5/25 at 3:05 PM, Staff K, Activities Director, said that Resident #9 told her that she put on her call light that morning because her stomach was hurting she needed to use the bathroom. When the CNA came in, she told her that it could wait till morning but the resident told her again, that she needed to go to the bathroom so she assisted her to the toilet. The aide said to her Now go! and push! She had small results, and the aide told her she didn't go much, and brought her back into bed. Staff K said that the resident was visibly upset. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/25 at 12:39 PM, The Director of Nursing (DON) said that Staff I tended to have a loud voice and she could soften her tone around residents because some were more sensitive than others. Facility policy titled: Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy, mental abuse was the use of verbal or nonverbal conduct which causes or had the potential to cause the resident to experience humiliation, intimidation, fear, shame agitation or degradation.

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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 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** 41785 Based on observation, interview and record review the facility failed to ensure staff followed physicians' orders for 2 of 13 residents reviewed, (Resident #17 and #9). Resident #17 had an order for International Normalized Ratio (INR) blood test to be conducted on 2/13/25, staff failed to complete the blood draw. Staff were directed to report to the doctor if/when the Blood Glucose (BG) levels were out of parameters for Resident #9. The facility failed to follow through according to physician's orders. The facility reported a census of 32 residents. Findings include: 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #17 had a Brief Interview for Mental Status (BIMS) score of 15 (intact cognitive ability.) He required partial assistance with toileting hygiene, showering, dressing and transfers. Resident #17 was using anticoagulant medications and his diagnoses included: atrial fibrillation, heart failure, anxiety and depression. The Care Plan updated on 2/23/25, showed that Resident #17 was at risk for falls and staff were to have gait belt in place for all transfers and ensure the resident was wearing the appropriate footwear. He had limited physical mobility related to morbid obesity and was at risk for abnormal bleeding related to routine use of anticoagulants. On 3/3/25 at 1:01 PM, Resident #17 was sitting in a wheel chair in his room, he did not have any visible bruising on his arms or legs. The resident said that in February, he had a high INR (measures the clotting time of blood.) The resident said that he had been getting regular labs but they missed one and by the time they checked it, the INR was very high. He did not have any bleeding concerns. A review of the file revealed a Nursing Note dated 2/6/25 at 3:15 PM, for a verbal order to hold warfarin and restart 3 milligrams (mg) on Saturday, recheck INR on Thursday, 2/13/25. The chart lacked documentation that the order for a recheck of the INR had been entered into the electronic chart, or that the blood test had been taken on 2/13/25. According to the Lab Administration report dated 2/24/25 at 8:56 PM high value INR of 8.5 with reference range of 0.86 - 1.18. A document titled: PT/INR Tracking spreadsheet showed the last date that the testing had been documented was on 2/5/25 with no follow up dated for the next INR. On 3/5/25 at 7:30 AM Staff F, Licensed Practical Nurse (LPN) acknowledged that she was the nurse that entered the nursing note and had taken the verbal order on 2/13/25. She remembered the resident and his unstable INRs and they were drawing labs about once a week and were making many medication changes. Staff F had only worked at the facility a few times and did not remember the process for lab draws and if they were entering them directly to the Medication Administration Record (MAR) or if they were just passing on in report to the next shift. Staff F said that she works in many different facilities and they had different processes. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/25 at 12:30 PM, the Director of Nursing (DON) said that she did a chart audit and found that the INR lab for Resident #17 had been missed on 2/13/25. She said that the nurses didn't always use the INR tracking sheet and there maybe another way to keep closer tabs on the testing and next blood draw using the Electronic Health Record. 2) According to the MDS dated [DATE], Resident #9 had a BIMS score of 14 (intact cognitive ability.) She was dependent on staff for toileting, showering and lower body dressing and required substantial assistance with toilet and sit to stand transferring. Diagnoses for Resident #9 included; anemia, hypertension, peripheral vascular disease, diabetes mellitus, osteoporosis, bipolar disorder, and fracture of the right pubis. A Care Plan revised on 2/12/25, showed that Resident #9 had diabetes and staff were directed to follow doctors' parameters for low/high blood sugars and report as directed. The resident was occasionally dependent on staff and others for meeting her emotional, intellectual, physical and social needs, and staff were to converse with the resident while providing care. Provide resident with cues, reorientation, reassurance and supervision as needed. An Order Audit Report from the electronic chart showed an order on 2/5/25 at 12:24 PM, for Accu-Chek (measures blood glucose levels) to report to the physician if/when the BG levels were greater than 350 mg/dl (milligrams per deciliters) or lower than 70 mg/dl. A review of the electronic record showed that from 2/5/25 - 3/2/25, the BG levels were outside parameters and the chart lacked documentation that the doctor had been contacted on the following dates: a. 2/6/25 at 6:40 AM BG; 367 b. 2/6/25 at 11:23 AM BG: 366 c. 2/6/25 at 7:29 PM BG; 374 d. 2/7/25 at 8:37 AM BG; 386 e. 2/7/25 at 3:14 PM BG; 370 f. 2/8/25 at 7:34 PM BG; 436 g. 2/9/25 at 6:37 AM BG; 371 h. 2/12/25 at 7:26 PM BG; 353 i. 2/13/25 at 12:46 PM BG; 365 j. 2/14/25 at 6:20 AM BG; 358 k. 2/15/25 at 7:30 PM BG; 458 l. 2/16/25 at 4:37 PM BG; 352 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	m. 3/1/25 at 11:35 AM BG; 351 n. 3/2/25 at 7:35 PM BG; 359 On 3/6/25 at 12:39 PM, the Director of Nursing (DON) said that she was looking through the file for Resident #9 and did see that the high blood glucose levels were not being reported to the physician. She would expect the nurses to follow the doctors' orders on the parameters. The DON said that they did not have a specific policy on reporting blood glucose to the physician.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, interviews and record review the facility failed to monitor and treat skin breakdown to prevent worsening of ulcers for 2 of 3 resident reviewed, (Resident #3 and #21). Resident #3 had an ulcer on his toe, staff failed to contact the doctor when treatment was ineffective. The toe was eventually amputated. Resident #21 had chronic pressure areas on her bottom and found to not have treatment in place. The facility reported a census of 32 residents. Findings include: The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound bed. 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #3 had a Brief Interview for Mental Status (BIMS) score of 13 (moderate cognitive deficit.) The resident had 1, unhealed, Stage 2 pressure ulcer. The MDS dated [DATE], showed that the resident had a diabetic foot ulcer. He was totally dependent on staff for transfers, toileting and hygiene, Diagnosis included type II diabetes mellitus, dysphagia following cerebrovascular disease, hemiplegia or hemiparesis, cerebrovascular accident. The Care Plan for Resident #3, revised on 1/27/25, showed that he was non-ambulatory and non-weight bearing status and required the assist of 2 for mobility. The resident was at risk for skin impairment with a history of pressure to buttock, right toe, plantar aspect of the 5th toe. Staff were directed to follow the skin treatments as ordered by provider, check all of the body for breaks in skin and treat promptly as ordered by doctor. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an observation on 3/4/25 at 6:44 AM, Staff A Certified Nurse Aide (CNA) and Staff B, CNA prepared to transfer Resident #3 from the wheel chair to the shower chair for a shower. The resident was wearing a shirt and brief. They transferred him to the bed with the use of the Hoyer Mechanical Lift. Once he was in bed, they removed the protective boots that covered his feet up to his knees. The resident had a callous on his right foot where the great toe had been. His right shin had three scabbed areas along the top of the bone. When asked about the scrapes, the CNA's said they didn't know if that was being documented or how long he had the skin breakdown. The chart lacked documentation of the scrapes on his shin. On 3/5/25 at 10:43 AM, Staff D, Registered Nurse (RN) acknowledged that she was responsible for documenting weekly skin issues. She said that she was not aware of any skin breakdown on the right shin for Resident #3. She went into the room and looked at the area and asked the resident what happened. He said that it was from crossing his feet in bed. Staff D said that she would start a skin sheet for him and a risk management because it is scabbed. She said she hadn't been told about it, the girls hadn't told her about those spots and that should have been documented. A review of the chart revealed that on 5/6/24 at 11:50 AM, resident had been readmitted to the facility after a hospitalization with three new areas of skin breakdown. The Readmission Assessment included: Right foot big toe pressure area 0.3 centimeters (cm) x 0.3 cm open area. Right foot little toe pressure area 0.8 cm x 0.5 cm. Right foot second toe scattered scabs. The following documentation was found in the Nursing Notes (NN) and on the paper documentation titled: Non-Ulcer Skin Assessment (SA) leading up to the amputation of the right great toe: a. (NN) 5/8/24, Encounter note by NP; resident post hospitalization for pneumonia and returned to facility with antibiotic therapy. had scabs on left toes and dressing on right great toe, continue orders paint scabs on toes with betadine daily and right great toe remove old dressing, cleanse with saline, apply povidone-iodine to area, skin prep to surround kin and cover with polymen and meplex tape every 2 days, monitor for worsening signs/symptoms. b. (SA) 6/4/24, 0.3 cm x 0.6 cm, wound bed is scabbed, surrounding skin color pink, surrounding tissue wound edges intact. Progress improved continue treatment plan. c. (NN) 6/5/24 Encounter note by NP; skin on toes improved. d. (SA) 6/11/24 size 0.3 cm x 0.6 cm scabbed, red and pink surrounding. improved e. (SA) 6/18/24 size 0.5 cm x 1 cm. improved treatment continued. f. (SA) 6/25/24 size 0.5 cm x 1 cm. improved treatment continued. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	g. (SA) 7/2/24 0.8 cm x 1 cm. wound bed scab, pink surrounding skin intact wound edges. deteriorated. (chart lacked documentation of physician contact with change). h. (SA) 7/9/24 0.6 cm x 1 cm scab, pink intact and improved i. (SA) 7/16/24 0.5 cm x 1 cm wound bed yellow, surrounding skin pink surrounding tissue fragile progress is improved j. (SA) 7/23/24 0.5 cm x 0.5 cm. surrounding tissue blanchable progress improved slough (dead tissue) yellow or white. k. (NN) Encounter note from the NP, signed on 7/25/24 at 5:02 PM, did not address foot ulcers. l. (SA) 7/30/24, 0.5 cm x 0.5 cm. yellow wound bed surrounding tissue fragile not changed m. (SA) 8/6/24 0.5 cm x 0.5 cm slough 10%, improved n. (NN) 8/13/24 at 10:59, the doctor was in the facility and antibiotic started related to cellulitis (bacterial skin infection) to right great toe. o. (SA) 8/13/24 0.5 cm x 0.5 cm. yellow wound bed, pink surrounding skin, deteriorated, started on antibiotic. A Physician Progress Note dated 8/13/24, showed that the visit diagnosis included; cellulitis and abscess (collection of pus surrounded by inflamed tissue) of toe of right foot. A breakdown to right big toe, area was wet, purulent (containing pus) with redness spreading up the foot. The patient was placed on antibiotic for 10 days. If no improvement, given his severe debility this likely could result in amputation. He had undergone amputation of previous toes due to similar circumstances. Next visit on 9/10/24 will follow closely p. (NN) 8/18/24 at 10:09 AM, Encounter note by NP, follow up to cellulitis of right toe, erythema top of right foot. q. (NN) 8/19/24 at 2:24 PM, less redness and swelling noted to right toe r. (SA) 8/20/24 not changed granulation 90%, 80% red tissue. s. (NN) 8/21/24 at 2:59 PM, no redness swelling odor or signs of infection. (According to the Medication Administration Record, the last day of antibiotic was given on 8/22/24) t. (NN) 8/23/24 at 5:49 PM, foot is slightly pink and warm, resident stated pain in ankle not foot. u. (SA) 8/24/24 0.5 cm x 0.5 cm condition not changed continue with treatment v. (SA) 9/3/24 size unchanged, wound bed white surrounding tissue pink 80% granulation, and white Progress improved (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	w. (SA) 9/10/24, size unchanged, progress was left blank, continue treatment. x. (SA) 9/17/24, size same, progress not changed treatment continue y. (NN) 9/19/24 Encounter by the NP indicated no acute concerns expressed from nursing the documentation lacked any reference to the foot ulcers. z. (NN) 9/24/24 at 9:32 AM, call out to the Nurse Practitioner (NP) with update regards to right foot. Increased redness and drainage. May we have referral to wound nurse. aa. (SA) 9/24/24 measured 0.5 cm x 0.5 cm yellow discharge, 100% slough. Progress deteriorated. Hand written note to be seen by wound care. bb. (NN) 9/24/24 at 9:54 AM, orders for x-ray and referral to bone and joint surgeon. cc. (NN) 9/26/24 at 2:45 PM, out of facility for appointment dd. (NN) 9/26/24 at 4:17 PM resident admitted to hospital to amputate toe. A note from the NP signed on 9/24/24, showed that she spoke with the nurse about concerns that the wound on the right great toe knuckle, had drainage and redness. The resident was unable to feel his toe when it was touched. Initiated orders for a wound culture, antibiotic, x-ray and referral to wound clinic and bone specialist. According to the notes from the Bone, Joint and Sports Surgeons dated 9/26/24 at 4:32 PM, the X-rays of the right foot of Resident #3 showed erosive changes of the distal aspect of the medial proximal phalanx and proximal aspect (bone located on the bottom row) of the distal phalanx (bone at the end of toe) concerning for osteomyelitis. Sensation is diminished to the great toe, open ulceration noted to the dorsal medial aspect of right great toe at interphalangeal joint (joint between the phalanges of toe) It is covered in fibrotic slough, (yellow, tan or white, dead tissue) serous drainage (clear to yellow) present, full-thickness down to the bone measured 1.5 cm x 1.5 cm and there was visible and palpable bone (able to touch) within the wound bed. The toe was erythematous and edematous (red and swollen). Soupy, serous drainage present coming form the wound. Recommended admit to hospital tonight for Intravenous antibiotics, vascular workup and toe amputation within the next few days as long as vascular status was okay. Discussed risks with the patient, biggest risk included delayed wound healing, continued infections, possible need for further surgery and further loss of foot or limb. According to the hospital History and Physical, dated 9/26/24 at 5:33 PM, the principal presenting problem included acute hematogenous osteomyelitis (inflammation of the bone due to infection) of right foot. Presented as an open ulceration to dorsal medial aspect of the right great toe at the interphalangeal joint of the hallux, covered with fibrotic slough, as well as healthy granular tissue. Some serous drainage present. It was full-thickness down to palpable and visible bone. Measured 1.5 cm x 1.5 cm the surrounding erythema to the right great toe. Soupy, serous drainage present. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 3/5/25 at 10:26 AM, Staff D, Registered Nurse (RN) said that she was conducting skin assessments in May of 2024 and when Resident #3 came back from a hospitalization with pneumonia, he had scabs and other pressure injuries to his feet and legs. She said that they suspected that it had been caused by the foot devices that they were using at the hospital. She said that the doctors didn't ever change the treatments and the scabs kept getting moist. Staff D said that Resident #3 was always having some skin breakdown related to his diagnosis of diabetes. Staff D said that they would try a different treatment if the color, pain or discharge changed. The doctors and NP would visit monthly and they were always looking at the resident's feet but they didn't ever see a need to change the treatments. On 3/5/25 at 11:30 AM, Staff D said that Resident #3 didn't get to the wound clinic on 9/24/24 because he was sent right to the bone specialist and then onto the hospital. Staff D reviewed the skin sheets and said that there hadn't been any changes in the toe that would have alerted them to call the doctor. Even if someone had seen a change, the doctor came in once a month and he or she would have looked at the resident's skin. On 3/5/25 at 2:36 PM, Staff E, Licensed Practical Nurse (LPN) remembered when she called the NP on 9/24/24 with her concerns about Resident #3. She said that she thought it was getting worse and they hadn't changed treatment orders. It was about a week prior to the amputation that she noticed changes. She had been directed to report to the Director of Nursing, which she said she did. She said that as an LPN, she was told she was to report to an RN with skin issues. There were times when she would provide treatment and the residents dressing was not in place, or it was soiled and looked as if it hadn't been changed for a while. On 3/5/25 at 12:10 PM, the NP said she remembered the ulcer on the toe of Resident #3 and that she contacted the primary care physician for culture and a wound care referral. She acknowledged that she saw the resident on 8/15/24 for a follow up after the primary care doctor had seen the resident on 8/13 and started an antibiotic for cellulitis on the right foot. The next visit she had with him was on 9/19 but did not make reference to the foot. When asked if she had looked at the foot on the 9/19 visit, she said that whatever she had in her notes was what she provided. The NP said that when she made monthly visits, she would consult with nursing before and after the visit about concerns and stated I can only address what I'm notified of. She stated that everything that she addressed was in her notes and could not say for sure if nursing should have contacted her sooner with changes in condition or what they may have seen leading up to the amputation that could have helped catch the deterioration sooner. On 3/6/25 at 12:35 PM, the DON said that she was not working at the facility in August of 2024 but she did look at the record on the progression of the toe wound for Resident #3 and acknowledged that it was concerning the nurses hadn't noticed the deterioration sooner. The DON read the report from the bone specialist and said that there would have been some warning signs before the wound was down to the bone. She would have directed the nurses to address and reassess the treatments if there wasn't improvement in healing after two weeks of a treatment. The DON said that they have two different skin sheets, one for non-ulcer and one for when an ulcer had developed. The form to be used after ulcer development, had more detailed documentation to include odor, coloring, size etc. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165535	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Aurelia, LLC	401 West Fifth Street Aurelia, IA 51005

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F 0686 Level of Harm - Actual harm Residents Affected - Few	2) The MDS dated [DATE], showed that Resident #21 had a BIMS score of 14 (intact cognitive ability). She required partial assistance with toileting hygiene, dressing and toilet transfers. Resident #21 was at risk for pressure ulcer, and treatments included application of nonsurgical dressing. Her diagnoses included malnutrition, depression, weakness and pressure ulcer of sacral region, Stage 2. On 3/4/25 at 10:04 AM, Staff L, CNA assisted Resident #21 in the bathroom. When asked if she had any skin breakdown, Staff L said that she didn't know of any. The resident said she did, and when she got up from the toilet the CNA acknowledged that she had some protective cream on her buttocks. Staff L wiped her bottom with a cloth and noted some redness and a small slit near the coccyx. The resident said that it did hurt and she asked the CNA for a patch. Staff L said that she could not do that, that would have to be done by the nurse, so the resident asked for a lot of cream. A review of the Orders tab in the electronic chart revealed an order dated 2/5/25 at 2:58 PM, for Mepilex (foam dressing for acute and chronic wounds) to coccyx to be changed every 3 days and as needed (PRN) until healed. A Nursing Note dated 2/3/25 at 1:33 PM, showed that the resident had an area on the inner buttocks below coccyx measured 2 cm x 0.5 cm. Review of the skin sheets found a new sheet titled: Non-ulcer Skin Assessment, started on 2/3/25, that documented an open area to inner buttock, left. The document lacked any follow up measurements or descriptions of the ulcer. On 3/5/25 at 2:48 PM, Staff E said that she applied the dressing for Resident #21 and at times, the dressing has not been on as ordered. On 3/6/25 at 12:33 PM, the DON said that at times, the wound nurse would get pulled to the floor and it may be difficult for her to get all of the assessments completed. She did not know why there wouldn't have been a follow up to measurements or documentation and staff are directed to complete treatments as ordered. On 3/6/25 at 11:11 AM, the Administrator said that they did not have a specific policy for skin assessments, but staff were directed to refer to the DIMES protocol for skin issues. Debridement Infection, Moisture Balance, Edge and Supportive Products. (DIMES) The Wound Care Guidelines included description of wounds and supportive products, but lacked information on when nursing should contact the doctor and recognize the current treatment regimen consider changing.

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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** 41785 Based on observation, interview and record review the facility failed to ensure safe transfer techniques with the use of a Gait Belt (GB) for 1 of 3 residents reviewed, (Resident #17). The facility reported a census of 32 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #17 had a Brief Interview for Mental Status (BIMS) score of 15 (intake cognitive ability). He required partial assistance with toileting hygiene, showering, dressing and transfers. Resident #17 had diagnoses that included: atrial fibrillation, heart failure, anxiety and depression. The Care Plan updated on 2/23/25 showed that Resident #17 was at risk for falls and staff were to have the Gait Belt in place for all transfers and to ensure the resident was wearing the appropriate footwear. Limited physical mobility related to morbid obesity. On 3/3/25 at 1:01 PM, Resident #17 was sitting in a wheel chair that did not fit well and he seemed to be sliding down. The resident said that he could stand and pivot with transfers, but he needed assistance with walking. He said that he had a fall in the shower room when he slipped to the floor. Resident #17 said that he didn't want to get the staff in trouble, but the Certified Nurse Aide (CNA) that was transferring him from the shower chair to the wheel chair hadn't used a GB. A Nursing Note dated 2/21/2025 at 11:23 PM, showed that at approximately 6:55 PM that evening, the nurse was alerted to the shower room by a CNA after Resident #17 fell after his shower. The CNA reported to the nurse that Resident #17 had been sitting on the shower chair when he went to stand up onto a dry towel in front of him, he slid out of the chair onto the floor. Upon entering shower room, the nurse noted that the resident was naked, on the floor with his legs extended in front of him. He did not have a GB around him. The intervention initiated at the time of the fall was for the CNA staff to use gait belt with all transfers. On 3/5/25 at 11:03 AM, Staff G, Registered Nurse (RN) said that she remembered when Resident #17 had the fall in the shower and that he did not have a GB applied. She said it was the expectation that staff would always use gait belt with assisted transfers. On 3/6/25 at 12:31 PM, the Director of Nursing (DON) said that the CNA should have dried the upper part of body of the resident after his shower, then put on his shirt before applying the GB. She thought that agency staff were required to complete a competency checklist before working on the floor independently. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A checklist form titled: Competency for Ambulation with a Gait Belt updated on 5/11/21, showed that staff were expected to apply GB over clothing and not on bare skin and tighten so it was snug. Stand facing resident, grasp belt on each side brace knees against the resident knees, block resident feet with your feet, assist to standing position. Stand at resident's side while they gain balance and do not let go of the GB. If the learning did not meet the requirements for the competency, training must be given and competency repeated within 14 days.