STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165568	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Cascade LLC	701 North Johnson Street NW Cascade, IA 52033

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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and facility document review the facility failed to train staff regarding the full body lift sizing guidelines for 2 out of 2 resident reviewed. The facility reported a census of 46 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #6 dated 6/11/25, listed diagnoses of stroke, and Alzheimer's Disease. The MDS revealed the Brief Interview for Mental Status (BIMS) score of 10 (moderate cognitive impairment). The MDS reflected Resident #6 dependent with chair to bed and bed to chair transfers. The Care Plan for Resident #6 dated 4/23/24, identified her as dependent upon 2 staff for all transfers utilizing the full body lift. The Care Plan directed no beige sling (slippery). The Care Plan failed to identify what size of lift sling to use. On 7/2/25 at 9:37 AM, A Certified Nurses Aid (CNA) took Resident #6 to her room. Staff C, reported she's a new CNA to this facility. Her partner CNA went to get the Director Of Nursing (DON). The CNA explained to Resident #6 she's going to bed. The Business Office Manager (BOM)/CNA entered the room to assist Resident #6 into the bed with the full body lift. The staff directed Resident #6 to hug herself as they lifted her. Staff used a cloth blue full body sling to lift Resident #6. Raised the resident, legs of the lift wide bed lowered lifted feet lower the other CNA unhook sling after lowered to the bed. On 7/2/26 at 4:40 PM, Staff D, Licensed Practical Nurse (LPN) reported the staff all have a personal preference on the full body slings they pick to use for the residents. On 7/3/25 at 11:20 AM, the Assistant Director of Nursing (ADON) confirmed several of the full body lift sling tags appeared illegible. The ADON confirmed the tags needed to show the size of the full body lift sling. The ADON reported the facility failed to know the tags were illegible and they failed to know the staff were using the slings according to their own personal preference. On 7/3/25 at 1:57 PM, the DON reported it's unacceptable for the staff to use any sling they like with the lifts. They are expected to know the size for each of the residents. (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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/3/25 at 2:16 the DON revealed the facility lacked a system in place for distinguishing sling sizes. On 7/3/25 at 2:20 PM, the Administrator confirmed the facility lacked a system for the lift sizing for residents. 2. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 scored a 0 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per this assessment the resident is completely dependent on staff requiring a 2 person assist and a Hoyer lift. Review of Resident #4's Care Plan dated 10/2/2024 revealed, the resident is dependent on staff due to impaired mobility. The resident is dependent on staff for meeting all needs including emotional, intellectual, physical, and social needs due to cognitive deficits and physical limitations. On 6/27/25 at approximately 7:35 pm Resident #4 had a fall from a Hoyer lift as he was being transferred into bed by two seasoned staff Certified Nursing Assistants (CNA's). Facility nursing staff immediately commenced assessment of the resident's injuries and provided first aid. Facility staff notified the on-call physician and the on-call hospice worker. Hospice advised they would notify the family to allow facility staff to care for the resident. Hospice advised that unless bleeding can not be stopped the resident does not need to be transported to the hospital at this time. On 7/2/25 at 12:20 pm Staff B, Certified Nursing Assistant, (CNA) was queried regarding the incident. Staff B advised she and another staff CNA were transferring the resident back to bed when the incident occurred. She shared that both she and the other CNA were right there with the resident but the fall happened so fast they were unable to prevent the fall. Staff B advised she had her hand on the resident's upper leg but was unable to stop him when he lunged forward. The resident had stiffened up and straightened his legs and then reached up and grabbed the Hoyer straps which caused the front sling to shift downward causing the resident to propel forward sliding out of the sling. The resident fell forward and his face and mouth landed on the leg of the Hoyer. It is believed when the resident fell forward he hit his forehead on the guide bar near the top front of the lift. The resident was talking the entire time and did not lose consciousness. Towels were used to apply pressure to his forehead to stop the bleeding. A blanket was placed over the resident to keep him warm. Nursing staff including the Director of Nursing, (DON) assessed the resident and initiated the facility fall protocol. The resident's physician was contacted as well as Hospice. Staff B who worked as a CNA for 17 years and has been employed at this facility for five years has no knowledge of this resident or any other resident having a fall from a Hoyer. CNA's have Hoyer training in their certification process. Upon hire all CNA's have to demonstrate they are competent using the mechanical Hoyers. Staff in-service trainings conducted yearly provide refresher training. Random staff audits are conducted to assess staff competency. Prior to use, Hoyer slings are checked for integrity. Staff B advised they have various Hoyer slings that are used interchangeably with the Hoyers. The particular sling used during the transfer was the nylon dark blue with bright pink trim. These particular slings are not staff favorites as they tend to be somewhat slick if the resident is moving around. Staff B advised, staff typically use the sling that is already in use with the resident for that day. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/2/2025 at approximately 1:40 pm Staff A was interviewed regarding this incident. Staff A advised she was assisting staff B with Resident #4 when the incident occurred. Resident #4 has a habit of grabbing onto the Hoyer straps when being transferred. On this day, he had a hold of the top straps on the Hoyer sling. He was asked to hug his body as this is often done to keep the resident's arms and hands away from any Hoyer movement. We have always told the residents they should cross their arms and hug themselves and hold on. As we went to pull the wheelchair back and turn him towards the bed he grabbed a hold of the top of the straps again and this tilted the sling downward. As he did this he also stiffened up at the same time and this propelled him forward. Although we had a hand on his leg this did not prevent him from propelling forward, falling out and hitting his face on the leg of the Hoyer. Staff A advised they do not always use the same sling or Hoyer it just depends on what is available. Staff A advised it is a hit or miss as to what sling they use with the white Hoyer which is typically kept in this resident's hallway. Staff A advised the particular sling they were using during that transfer is not a favorite as it tends to be a little slippery depending on what type of material the resident's clothes are made of. Staff A advised nursing has been made aware of staff 's concern with the material of those particular slings. Staff A described this sling as dark blue with bright trim on the outside. Staff A was not sure what size these slings would be. Staff A advised she has been a CNA for many years and has never had a resident fall out of a Hoyer. Hoyer audits and yearly training are required at the facility. On 7/3/25 at 10:30 am Staff E Licensed Practical Nurse, (LPN) was queried regarding the Hoyer lift process and slings. Staff E advised as a nurse she frequently assists with Hoyer transfers. Staff E was asked how staff determine what sling they use with the residents. Staff E shared sizing is determined based on resident size as there are different size slings. Previously the slings were not marked for size but they are now. The slings are stored in a closet and they were not sorted or kept in any particular order. Staff E advised she does not care for the dark blue sling with the magenta border as it is too slippery. When asked, Staff E advised she had been told by CNA's they had expressed this concern to management but she herself had not. When asked for clarification Staff E advised she has never seen a staff member use the Hoyer inappropriately or not follow procedures and protocol when conducting a Hoyer transfer. Although she was not present at the time of the incident she advised both CNA's involved are very experienced with transfers and she feels this was an unfortunate accident and not an error on the part of the staff members. The mechanical full body lift owners guide undated, directed always ensure the sling is the correct size and capacity for the patient being transferred.