STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165425	A. BUILDING _____ B. WING _____	**07/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCURA HEALTHCARE OF CHEROKEE, LLC	**921 RIVERVIEW DRIVE CHEROKEE, IA 51012**

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** Based on record review and staff interview, the facility failed to notify the residents family of changes in residents condition and new orders for 1 of 4 active residents reviewed, (Resident #2). The facility reported a census of 39 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment, dated 5/13/20, Resident #2 had [DIAGNOSES REDACTED]. The MDS documented Resident #2 scored 12 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility, dressing, and toilet use, transfers and personal hygiene. The Care Plan dated 5/16/20 with a goal target date of 7/28/20, identified Resident #2 with impaired cognitive function/forgetfulness at times. Resident voices needs, feelings, concerns as desires, as able and as health allows. Goal was resident will be able to communicate basic needs as health allows through the review date. Interventions included: a. Communicate with the resident/family/caregivers regarding residents capabilities and needs as needed. b. Ask yes/no question in order to determine the residents needs as needed. c. Encourage resident to voice needs as chooses and as able to. d. Observe resident for verbal and nonverbal expressions/communication. e. Present just one thought, idea, question or command at a time as needed. The Progress Notes dated 6/23/20 at 10:45 a.m., documented the resident had a possible vasovagal episode at the end of shower when staff raised the hoyer lift. Resident became weak and nonresponsive to staff. When resident began to come around and have verbalizations and awareness after about 3 minutes resident urgently thought needed a bowel movement and was passing significant gas. Once on the bed pan was not able to have bowel movement. Resident blood pressure is very quiet however and heart rate chronic irregular with [MEDICAL CONDITION]. Feet were purple and cool but was cold from shower as well. Resident embarrassed by episode and reassurance provided. Resident stated she had never experienced that before. The Progress Notes dated 7/3/20 at 10:24 a.m., documented resident up with assistance with hoyer for shower this a.m. vagal episode noted prior to repositioning back to bed. Episode passed quickly and resident dressed and assisted into wheelchair to visit with family on phone at window. No further episodes noted. The Progress Notes dated 7/4/20 at 2:32 p.m., documented resident repositioned. Resident #2 opened her eyes but did not respond. Breathing is slow and steady. No signs or symptoms of pain or discomfort. Resting in bed at this time. The Progress Notes dated 7/5/20 at 9:14 a.m., documented resident is lethargic this morning, able to answer yes/no questions but speech is garbled with attempts to say more. Resident refused morning scheduled medications. The Progress Notes dated 7/5/20 at 1:43 p.m., documented a verbal order for Tylenol 650 milligrams suppository rectally every 6 hours as needed for pain/fever ordered. The Progress Notes dated 7/5/20 at 8:50 p.m., documented held resident medications this evening because resident was not making sense with words and showed signs of not being able to swallow very good. The Progress Notes dated 7/6/20 at 1:51 a.m., documented resident was having a hard time breathing, her oxygen level was 86% on room air. Resident still unable to make words that she wants to say and gets frustrated when unable. The Progress Notes dated 7/21/20 at 2:57 p.m., documented received new orders for [MEDICATION NAME] 1,000 milligrams three times a day oral (2 tablets of 500 milligram) for continued pain, resident is aware. The Progress Notes lacked any documentation regarding the family notification of any of the mentioned new orders or changes in condition. During an interview on 7/29/20 at 4:10 p.m. the Director of Nursing confirmed and verified the clinical record lacked any documentation that the family was notified of the new orders or changes in the residents condition and it was the expectation of the nurses to notify the family of changes or new orders.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.