STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165324	A. BUILDING _____ B. WING _____	**10/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCURA HEALTHCARE OF PLEASANTVILLE, LLC	**909 NORTH STATE STREET PLEASANTVILLE, IA 50225**

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 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** Based on record review, staff interview, and facility policy and procedure that facility failed to provide adequate assessment and intervention for 1 of 3 sampled (Resident #1) when found on the floor. The facility failed to complete quarterly fall risk assessments in accordance with the plan of care. The facility reported a census of 48. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #1 had a Brief Interview for Mental Status score of 3, which indicated severe cognitive impairments. The MDS documented [DIAGNOSES REDACTED]. The MDS revealed that the resident required extensive assist of two staff for bed mobility, transfers, toilet use and personal hygiene. The MDS documented that the resident required assistance of staff for stabilization when moving from a seated position to standing, moving on and off the toilet, and surface-to-surface transfer. The MDS revealed no history of falls. The Care Plan directed staff to utilize a half side rail to reposition when in bed, staff to assist the resident with the side rail, and conduct quarterly fall risk assessments. During an interview on 9/30/20 at 2:27 p.m., Staff B (Nurse Aide) reported that she found the resident on the floor between the residents recliner and bed on 9/6/20 at about 6:30 a.m. Staff B reported that she left the resident after the resident reported being ok. Staff B went to the Nurse's Station and reported to Staff C (Registered Nurse) that the resident had fallen. Staff B reported that Staff A (Medication Aide) went down the hall, and helped pick up the resident. Staff B reported that the resident had been put in a wheelchair, then taken out to the main dining room. Staff B reported that she was not sure if staff could pick up a resident post fall without a nurse assessment. Staff B reported that the resident had a skin tear to the right elbow area. Staff B reported that she was not sure if Staff C completed an assessment on the resident. Staff B reported that there was good staffing numbers that day. During an interview on 9/30/20 at 11:15 a.m. Staff A (Medication Aide) reported she was at Nurses Station on 9/6/20 at 6:15 a.m. when Staff B reported that Resident #1 was on the floor. Staff B reported she entered the resident's room and visualized the resident rolled up in a blanket on the floor between the recliner and the bed. Staff A reported that Staff C (Registered Nurse) did not come to the resident's room to do an assessment. Staff A reported she helped Staff B put the resident in a wheelchair, and then the resident had been taken out to the dining room. Staff A reported that Staff C (Registered Nurse) had been aware that the resident fell when Staff B had asked for assistance at the Nurses Station. Staff A reported that the nurses are required to check out the residents when they fall. Staff A reported that the resident complain of pain in her right elbow. Staff A reported that she and Staff B did not want the resident to lay there for an hour, so that's why they picked the resident up. During an interview on 9/30/20 at 7:09 p.m. Staff D (Housekeeping Supervisor) reported on 9/6/20 that she had seen the resident sitting in the main dining room in her wheelchair with a skin tear on her right elbow. Staff D reported she asked the resident what happened, and the resident replied that she reached for something and fell out of her chair. Staff D reported that she saw Staff C, RN walking towards the resident. Staff D reported that she did see a dressing on the resident's right forearm later in the day. During an interview on 9/30/20 at 3:20 p.m. Staff C (Registered Nurse) reported that if a resident had fallen the nurse would do a fall assessment, ask about pain, assess how the fall happened, come up with an intervention to help prevent another fall, do documentation. Staff C reported that a doctor would be notified, documentation of incident in progress notes, and also use behavioral sheets. Staff C reported that she did not work when the resident had fallen. Upon review of the schedule Staff C corrected herself, then did confirmed that she did work 9/6/20 when the resident fell . Staff C reported the Nurse Aides did not notify her of the fall. During an interview on 9/30/20 at 6:15 p.m. Staff E (Registered Nurse) reported that she had been working on 9/6/20 in the closed unit, and had not been aware of a fall for Resident #1 until the next day. Staff E reported that nurses working together usually update each other if there had been a fall during the shift. Staff E reported she did remember on 9/6/20 that a Medication Aide entered the unit to get supplies to care for a skin tear. Staff E reported that if a resident falls the nurse will do a head to toe assessment, check resident's range of motion, and do vitals with neurological checks before the resident is moved, then call the doctor, and call the family. During an interview on 9/30/20 at 12:28 p.m. Staff F (Medication Aide) reported that if a resident is on the floor you first make sure the resident is ok, then call for help. Staff F reported that the nurses are to check the resident out, the nurse will direct Nurse Aides what to do. Staff F reported that Nurse Aides are not to move the resident unless directed by the nurse after a fall. Staff F reported the Medication Aides are not to do dressings on a skin tear, the nurse's deal with the skin tears. During an interview on 9/30/20 at 11:54 a.m. Staff G (Nurse Aide) reported that if a resident is on the floor the charge nurse is to be notified, and you do not move the resident until the nurse had checked the resident out. During an interview on 9/30/20 at 1:17 p.m. Staff H (Medication Aide) reported that on 9/6/20 the resident had fallen and two Nurse Aides brought the resident up to the table in the main dining room. Staff H noticed that the resident had a fifty cent piece skin tear on her right forearm. Staff H reported that Nurse Aides told her that the resident had fallen out of bed. Staff H reported that Staff C (Registered Nurse) was notified of the fall and the skin tear. Staff H reported that Staff C had been passing medications. Staff H reported that she herself took care of the skin tear put gauze and some medicated ointment on the skin tear. Staff H reported she had not been aware if Staff C had done an assessment on the resident. Staff H reported that if a resident is on the floor you don't leave them, you get the nurse, then the nurse does an assessment. Staff H reported you don't move the resident until you are told by the nurse. During an interview on 9/30/20 at 11:38 a.m. Staff I (Nurse Aide) reported that if a resident falls you check to see if they are ok, then go get the nurse to assess the resident. Staff I reported that you never move a resident after a fall until the nurse checks them out. During an interview on 10/01/20 at 10:02 a.m. Staff J (Registered Nurse) reported that a Nurse Aide on 9/07/20 not sure what time, told her that the resident had a fall out of bed on 9/6/20, and got a skin tear. Staff J reported she had not been working on the main floor where the resident in question lived, so she went to Staff K (Licensed Practical Nurse) and reported what the Nurse Aide told her. Staff J reported that they both then called the Director of Nursing. Staff J reported that the Director of Nursing directed them to fill out an incident report and skin sheet. Staff J reported that there was no information in report about the resident fall. Staff J reported that when a fall happens the Nurse Aides are not to move the resident until a nurse had completed an assessment, neurological checks are started, head to toe assessment, with vitals, and range of motion. Staff J reported the doctor and family would be notified. During an interview on 9/30/20 at 3:43 p.m. Staff K (Licensed Practical Nurse) reported during morning report on 9/7/20 there was no report of Resident #1 falling on 9/6/20. Staff K reported that Staff O (Nurse Aide) told her that Resident #1 had a fall on 9/6/20. Staff K reported that she then went to talk with Staff J (Registered Nurse) who was on duty the day of 9/7/20. Staff K reported that she had called Staff C (Registered Nurse) and asked about the residents fall, and Staff C refused to come in and chart about the residents fall. Staff K reported that post fall neurology checks, assessment, family, and doctor notification should have been done. During an interview on

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165324	A. BUILDING _____ B. WING _____	**10/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCURA HEALTHCARE OF PLEASANTVILLE, LLC	**909 NORTH STATE STREET PLEASANTVILLE, IA 50225**

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) 10/01/20 at 10:47 a.m. Staff L (Registered Nurse) reported that if a resident had fallen it should have been on the 24 hour report that's kept at the Nurse's Station. Staff L reported that if a resident had falls an assessment should be completed, in the documentation along with doctor and family notification. Staff L reported that residents should not be moved after a fall until the assessment is completed. During an interview on 10/01/20 at 12:17 p.m. Staff M (Director of Nursing at the time of the incident) reported that she had been aware that two Aides moved Resident#1 before the nurse had assessed the resident. Staff M reported she could not remember if the two Aides were disciplined for that. During an interview on 10/01/20 at 9:06 a.m. the Director of Nursing (DON) reported that if a resident had fallen the Nurse Aide should assure safety of the resident, stay with the resident and have another staff member get the nurse. Then the nurse would do a full assessment, and the nurse would direct the staff when the resident maybe moved. The DON reported an assessment would include a head to toe assessment, vitals, and range of motion assessment. The DON reported that the nurse would complete a risk management form (incident report), notify the doctor, on-call management, and notify the family. The DON reported further investigation as to the cause of the fall would be in the electronic health record. The DON reported a skin sheet would be filled out, immediate intervention documented by the nurse, and doctor notification. The DON reported that in regards to the fall for Resident#1, the nurse should have documented the fall. The DON reported that she had been aware that the previous Director of Nursing did talk to the nurse involved. During an interview on 10/01/20 at 12:31 p.m. the DON had not been aware of any education given to Staff B (Nurse Aide) or Staff A (Medication Aide) about moving a resident after a fall, and before nurse assessment had been completed. The DON agreed that the Aides could have asked the other nurse on duty, called the on-call person, or called the Assisted Director of Nursing for help. During an interview on 10/01/20 at 9:00 a.m. Resident #1 reported that she had been sitting in her chair and she reached for her book and fell out of her chair. Resident #1 reported that the girls found me and picked me, then took me out to eat, then later one of the girls patched up my arm. During an observation on 10/01/20 at 9:00 a.m. Resident #1 had a small 2 centimeter reddish purple bruise on her right forearm close to the elbow. Employee record review for Staff A (Medication Aide) and Staff B (Nurse Aide) lacked education or disciplinary action for moving a resident post fall without permission from the Nurse. Clinical record review lacked documentation of a fall for Resident #1 on the date of 9/6/20. The 24 Hour Report Sheet dated 9/6/20 with time of 6:00 a.m. to 6:00 p.m. documented ok next to Resident #1. A Health Status Note dated 9/7/20 at 10:38 a.m., Staff J (Registered Nurse) documented Resident #1 reported I rolled out of bed yesterday. The staff noted a skin tear to right elbow measuring 3 centimeters by 2 centimeters, surrounding skin intact, no drainage, and no signs of infection. Resident #1 winced with palpation. The staff notified Resident #1's responsible party, obtained vitals, current assessment, and notified hospice who reported a new bed will be delivered this afternoon. Nurse Practitioner notified. Will continue to monitor. The Schedule Sheet dated 9/6/20 revealed that Staff C (Registered Nurse) assigned to Resident #1. A document titled Unwitnessed dated 9/7/20 with time of 11:11 a.m. contained the following documentation; Nursing Description: Resident reported to this nurse that she fell out of bed yesterday morning. Resident Description: I fell out of bed yesterday morning. Injury right elbow 3 centimeter by 2 centimeter skin tear to right elbow noted. Physician and family notified at 12:20 p.m. Hawk-Fall Risk assessment dated [DATE] documented the resident to be at moderate risk for falls. Hawk-Fall Risk assessment dated [DATE] documented the resident to be at high risk for falls. Clinical record revealed that the facility failed to complete quarterly fall risk assessments, as directed by the care plan. Non-Pressure Skin Condition Report documented by Staff K (Licensed Practical Nurse) revealed that the right elbow skin tear had been first observed on 9/6/20, but assessed first on 9/7/20. The Employee Corrective Action Form, signed by Staff C on 9/11/20, documented the following incident/infraction; on 9/6/20 Nurse Aide reported to you that resident had a skin tear. No investigation was done: Resident reported she had fallen: no investigation was done: It is facility policy and protocol that incidents are investigated and followed up on-Assessment of resident, risk management completed, skin sheets completed, doctor and family notified. Expectations Moving Forward; follow facility protocol. The undated Accidents/ Incidents Investigation and Reporting Policy and Procedure documented the Standard as follows: Accidents and Incidents must be investigated and reported to the Director of Nurses for Quality Assurance Review. The Process directed staff as follows: Regardless of how minor an accident or incident may be, including injuries of unknown origin, it must be reported and an incident report form must be completed on the shift that it occurred. Employees witnessing an accident/ incident involving a resident, employee or visitor must report it as soon as possible. Do no leave the person unattended unless it is absolutely necessary to summon assistance. The charge nurse must be informed of all accidents/ incidents so medical attention can be provided. Do not move the person until he/she has been examined for possible injuries. The charge nurse must initiate an investigation of the accident/ incident including an Incident Report. Follow-up assessment and documentation of a resident's accident/incident must be completed every shift for 72 hours. Skin condition report form must be used if skin tear, bruises or sutures are present. The undated Falls Management document directed staff for Standard Process as follows: Resident will have a head to toe assessment completed after a fall, with documented resident's response to fall every shift for 24-72 hours. The updated Job Description for Registered Nurse with dated 2/2016 directed essential functions and responsibilities to include the following; completes proper charting accurately and completely; performs other administrative duties related to resident care in an efficient and timely manner. Staff C signed the document on 10/23/19.