STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Stanton	213 Halland Avenue Stanton, IA 51573

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on clinical record review, facility document review, and staff interview, the facility failed to report timely an allegation of possible abuse or injury of unknown origin for 1 of 1 resident (#21). The facility reported a census of 42 residents. Findings include: A facility self-report dated 7/05/24 revealed a resident sustained an injury of unknown origin and accused a staff member of making her fall on 6/26/24. The admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderately impaired cognition. It included diagnoses of cancer, Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and thoracogenic scoliosis (spinal curvature caused by disease or surgery). It revealed the resident was dependent with toileting hygiene and putting on and removing footwear, required supervision with eating and maximum assistance with all other activities of daily living (ADLs). The Electronic Health Record (EHR) included a progress note indicating the resident had an X-Ray in response to a left elbow injury. Facility Investigation notes dated 6/26/24 indicated the facility investigated the accused staff member and terminated her on 7/01/24 for other reasons. The investigation notes indicated the Director of Nursing (DON) contacted the facility's corporate office on 7/01/24 regarding reporting of the incident to the proper State Agency. The notes revealed the State Agency reporting process began on 7/03/24. On 7/19/24 at 5:35 PM, the DON stated she initially thought to report the incident to the state agency but was informed by her corporate administration that it was not a reportable event. She stated she later received direction to report the event to the state agency. On 7/22/24 at 8:35 AM, the Administrator stated the facility should follow the reporting requirements set by the State Agency.

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 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** 50471 Based on clinical record review, facility document review, staff interviews, family interview, and facility policy review, the facility failed to supervise and provide a secure environment for 1 of 1 residents reviewed for elopement (Resident #29). The facility reported a census of 42 residents. Finding include: The Minimum Data Sheet (MDS) assessment of Resident #29, dated 10/5/23, identified a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderate cognitive impairment. The MDS recorded the resident experienced mood symptoms of feeling down, depressed, or hopeless on 12 to 14 days of the previous 2-week look back period. The MDS did not reveal any wandering or exit seeking behavior. The MDS revealed the resident independent with bed mobility, personal care, transfers, toileting, eating, and dressing. The MDS documented diagnoses that included: type 2 diabetes mellitus, coronary artery disease, hypertension, renal insufficiency, and pancytopenia (low levels of red blood cells, white blood cells, and platelets). The MDS documented the resident received insulin injections on 7 out of 7 days of the assessment reference period. The Care Plan revised 10/3/23 identified the resident as an elopement risk. The care plan informed the staff to check the wander guard every shift, the resident's wander guard on shoelaces, history of removing wander guard, the resident will ask to leave the facility and walk around, and behaviors stating his is not in prison. The Wander Guard monitoring for the resident #29 revealed the Staff documented 10/24/23 to 7/17/24, current. The facility initiated, monitor the wander guard device every shift every day, started on 9/28/23. The staff did not complete documentation from 10/24/23 to 7/17/24, current. The Communication with Physician Progress Note dated 10/11/23 revealed Doctor started Donepezil 5 mg daily for dementia. New diagnosis of unspecified dementia, updated in the residents chart on 10/12/23. The Nurse Progress Note (PN) dated 10/20/23 revealed the resident left the building for unknown time, stated the resident exited the building between 4:30 PM and 5:00 PM. The staff unaware of the resident absence until the resident returned, approximately 5:45 PM. The resident brought to the facility whiskey and sandals. The PN revealed the resident wanted to drive the car to the facility, the resident unable to find the keys. Staff I, LPN stated she asked wife at dinner where the husband was, wife stated she did not know, she forgot. The resident revealed to Staff I that he attempted two other times, staff intervened, the resident waited and succeeded the last attempt. Staff I notified the Administrator, instructions placed wander guard on left ankle, 15 minute visual observations, head to toe assessment, and BIMS assessment. The sign in and sign out paper on 10/20/23 revealed the resident's daughter took the resident out of the facility at 3:15 PM and returned at 4:10 PM. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 15 minute visual observations for the resident #29 started 10/20/23 after the incident occurred, to 7/17/24, current. The facility did not provide documentation from 10/20/23 to 11/4/23. The staff did not provide any documentation for 12/1/23 to 12/31/23 and 5/1/24 to 5/31/24. The staff did not complete documentation from 1/1/24 to 4/30/24. The staff documented 6/1/24 to 7/17/24, current. The Elopement Drills are completed monthly. The staff provided documentation for every month with exception from 10/1/23 to 2/29/24, the staff was unable to provide documentation. The Elopement education is provided for staff at orientation and periodically at staff meetings. Observation on 7/18/24 revealed the resident's house is two and a half blocks north of the facility up a hill. Noted multiple houses, structures, and trees, unable to see the resident's house. South of the facility up the hill about half of a block is a active train track, south of the facility parking lot is an active walking trail. On 7/17/24 at 3:02 PM the Director of Nursing (DON) stated she was informed from the Regional [NAME] President of Operations via email about the elopement. The facility did a compliant review on the incident that occurred on 10/20/23 at 5:45 PM. Regional [NAME] President of Operations stated the resident #29 had higher BIMS upon return from the facility. The resident was educated about signing in & signing out when he wanted to leave the facility. Staff denied education about the code to the door, stated resident already knew the code. DON stated she does not know when staff stopped him from independently leaving at his will and when the wander guard was removed. On 7/18/24 at 8:06 AM Daughter and POA of the resident #29 recalled the elopement. Staff I updated her about the resident arriving back to facility about 5:45 PM. Staff I informed her the resident left and walked to his house, gathered sandals and whiskey, and walked back. He wanted to drive the car but could not find the keys. Daughter stated the resident is memory impaired, unable to make proper judgement decisions, resulted in placement at the facility. Daughter stated if the resident was able to find the keys to the car, he would have drove it back to the facility, the resident's wife resides at the facility. Stated earlier that day the Social Worker informed her that the resident was anxious, the resident stated to the staff he did not want to be there, his condition was better than others that live here. The daughter and social worker made arrangements for the daughter to come and take the resident(s) out for a walk. The daughter stated she took her parents out for a walk on the nearby trail after 3:00 PM and returned after 4:00 PM, stated she completed the sign in and sign out sheet, that would have the exact time. The daughter stated she arrived back to the facility checked parents back in, walked to the front entrance, the resident liked to walk her to the door, she punched the code in and said bye. The daughter stated he watched her punch in the code and he must have used that to get out. The resident stayed at door while she left. Stated she thought he was not anxious anymore and appeared to be okay. She thought he stole scissors or nail clippers to get the wander guard off. The resident was trying to prove a point, he wanted to show us that he can still do things on his own, that he does not need a nursing home. The daughter stated the resident is being monitored and treated by the telepsych Doctor, is involved in 1:1 activity, brother takes the resident to the farm with his dog, and on medications to help with his anxiety, he has been so much better. The daughter stated he has lived in [NAME] his entire life and knows the town and the way home. She feels like he was safe the day he got out. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/24 at 2:52 PM Staff J, CNA stated she worked the 2:00 pm to 10:00ppm shift on 10/20/23, she assisted another resident at the time of elopement. Staff J, seen the resident walking from the south nurses station to the north nurse station carrying a black garbage bag, as she was walking from the east wing to the west wing. Staff J denied hearing any alarms that shift. Staff J stated she was informed by other staff working that shift that the resident eloped that evening. Staff J denied hearing any pages for lost residents that shift. Staff J stated the resident will be sneaky when attempting to leave the facility, one attempt he wore a coat and sunglasses. Staff stated the education she received, frequent visual checks and redirect the resident when showing signs of increase exit seeking. Staff stated she is pretty sure, the resident is to always be supervised when outside. On 7/18/24 at 2:59 PM Staff K, CNA stated she worked the 2:00 pm to 10:00ppm shift on 10/20/23, Staff K aware the resident was out of the facility with his wife and daughter, unaware of the return time. Staff K denied any alarms sounding that shift and denied any pages for lost residents. Staff K updated about the elopement late that shift. Revealed she seen the Nurse laughing about it, shocked that the Nurse did not appeared to be taking the incident serious. The education that was provided redirect the resident when exit seeking, notify the nurse, and supervise the resident when outside. On 7/18/24 at 3:15 PM Staff I, LPN confirmed she was the nurse supervising the resident on 10/20/23 during the elopement. Staff I stated lots of visitors coming in and going out of the facility that evening. Staff I informed that the resident having increase anxiety, Social Worker spoke with daughter, daughter took wife and the resident out of facility in attempt to decrease anxiety. Staff I stated she seen them arrive back, and seen the daughter, the resident, and a third person walk to the front door (south entrance), she did not stand there to see them walk out the door. Staff I assumed the resident left with daughter. Staff I stated the daughter does not always tell the staff when she is taking the resident out of the building. Staff I denied reviewing the sign in and sign out sheet or calling the daughter to verify. Staff I revealed continued doing her tasks. Staff I stated when she assisted the wife at supper she asked the whereabouts of the resident, the wife stated she forgot. Staff I continued to assume the resident was out with the daughter. Staff I was informed by the south nurse that the resident walked back into building holding a sack of items. Staff I asked the resident where he came from, the resident replied I left and went home to take care of a few things. The resident had whiskey and sandals. Staff I stated the resident was approximately gone from 4:30 PM to 5:45 PM. The resident is to have a wander guard on, the resident had different shoes on therefore the wander guard alarm did not sound. The resident revealed to staff I that he waited until he got the chance and then followed someone out. Other residents and their families outside of the facility. The resident ignored the questions asked by the families and kept walking to his house. Staff I stated you can see his house from the window in his room. Staff I revealed the resident wore a long sleeve flannel plaid shirt and jeans. Staff I stated resident appeared to be proud of himself. Staff I reported she called the administrator, the daughter, and the primary care physician. Staff I was instructed to start 15 minute checks, head to toe assessment, and BIMS. Staff I stated the resident recently admitted and did not have a routine yet, nor showed a certain time of day to be more anxious. The facility policy titled Missing Resident/Elopement Process updated 7/12/21 directed staff: Care Plan will be modified as needed based on risk assessment. An alarm bracelet may be placed on the resident to audibly alert the staff of attempts by the resident to exit the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's care plan shall address behaviors using resident specific goals and/or approaches as assessed by the IDT. Staff will encourage activities which the resident enjoys in order to occupy/distract the resident.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46873 Based on clinical record review, resident interview, family interview and staff interviews, the facility failed to provide appropriate pain management for 2 of 2 residents reviewed (Res #16 and Res #21). The facility reported a census of 42 residents. Findings include: The Minimum Data Set (MDS) assessment of Resident #16 dated 5/21/24 identified a Brief Interview of Mental Status (BIMS) score of 13 which indicated cognition intact. The Care Plan of Resident #16 documented a Focus Area of Pain initiated 12/11/23. The Care Plan directed staff to administer as needed pain medication as directed by physician and notify the nurse of any signs of pain. On 7/16/24 at 10:52 am, Resident #16 stated she had taken a fall which resulted in a broken tailbone prior to moving to the facility. She stated she still had a lot of pain and although the facility administered pain medication, it was not effective enough. She stated that at that moment, she could hardly stand to sit in the chair due to pain. The Treatment Administration Record (TAR) of Resident #16 for the months of May, June and July of 2024 were reviewed. The TAR revealed the resident had an order for a lidocaine patch, 4% for lower back pain. It was not signed off as being utilized at all for the months reviewed. The Medication Administration Record (MAR) for Resident #16 for July of 2024 indicated Acetaminophen, extended release, 650 mg had been given three times a day scheduled since 4/22/24. Neither the MAR or the TAR for any of the months reviewed revealed any staff had documented a pain level for the resident at any time. The Weights & Vitals portion of the Electronic Health Record revealed a numerical pain assessment had last been documented on 4/7/24. The Progress Notes indicated the following: 5/20/24: Pain: Indicators of Pain: None 5/25/24: Resident denies shoulder pain and no bruising noted to left deltoid from B12 injection. No other progress notes were found indicating a pain assessment since 5/25/24. On 7/18/24 at 10:24 am, Staff O, Certified Nurse Aide (CNA) stated the resident complained of back pain earlier that morning during cares. She stated the resident complains of pain every day, sometimes more than once a day. She stated she notifies the nurse to see if the resident has anything available for pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/24 at 10:26 am, Staff P, Registered Nurse (RN) stated Resident #16 has chronic pain. She said her pain level ranges day to day anywhere from stating her pain is 0 as high as a 7 or 8 on a 1-10 pain scale. She explained pain should be monitored three times a day with the scheduled acetaminophen and she would update the order to add pain monitoring into the MAR. She stated she knows the resident has increased pain when she is in her chair. She said the family is looking at hospice care and she hoped the resident could obtain better pain management once she enrolled in hospice care. She also stated some days the resident refuses to get out of bed due to her pain being so high. She said she is not aware if the physician had ever been notified of the resident's pain not being appropriately managed. On 7/18/24 at 10:37 am the Director of Nursing (DON) stated pain management documentation is individualized for the resident. She stated if a resident who generally does not have pain and has no scheduled pain medication, it should be monitored at minimum once a month along with monthly vital signs. She stated for any resident who is on any scheduled pain medication, it should be documented with each administration of the medication. All residents receive a quarterly pain assessment as part of the MDS as well. On 7/19/24 at 12:19 pm, the DON stated if staff is noting a resident to have increased pain, especially to the point of not being able to get out of bed, she would expect the nurse to notify the physician so the pain medication regimen could be evaluated by the physician. 47079 2. On 7/16/24 at 1:20 PM, Resident #21's relative confirmed the resident was under hospice care and had not had her morning pain medication. The Pain Interview dated 6/15/24 revealed the resident reported she had almost constant pain within the preceding five (5) days. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderately impaired cognition. It included diagnoses of cancer, Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and thoracogenic scoliosis (spinal curvature caused by disease or surgery). It revealed the resident was dependent with toileting hygiene and putting on and removing footwear, required supervision with eating and maximum assistance with all other Activities of Daily Living (ADLs). The Electronic Health Record (EHR) included a physician order dated 6/13/24 and reordered on 6/26/24 for Hydrocodone-Acetaminophen Oral tablet 10-325 mg and directed staff to give 2 tablets by mouth three times a day for pain and give 1 tablet by mouth every 24 hours as needed for pain. The Medication Administration Record (MAR) indicated the resident's Hydrocodone-Acetaminophen order was to be administered at breakfast, mid AM, and at bedtime. The Medication Administration Audit Report revealed the resident's Hydrocodone-Acetaminophen was administered late 41 times out of 105 doses when following the standard administration schedule or 19 times out of 105 doses when following the custom administration schedule (3-hour time range for each ordered dose). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Pain Scale rating review indicated the resident had an average pain rating of 4.8 out of 10. The Care Plan dated 6/13/24 included pain due to arthritis and scoliosis and directed staff to administer pain medication as directed by the physician. On 7/19/24 at 12:57 PM, the Director of Nursing stated the facility did not have a policy directly addressing pain management. She stated the facility followed regulations.