STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165082	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Lake City, LLC	1409 West Main Street Lake City, IA 51449

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, the facility failed to follow the physician's orders for oxygen for 1 resident (Resident #1), failed to ensure staff used professional standards during med pass, including observing the consumption of medication for 2 of 9 residents (Resident #3 and #4), and infection control practices for 1 of 9 residents reviewed (Resident #8), and failed to store meds properly. The facility reported a census of 41 residents.Findings include:1) According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 scored 6 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident's diagnoses included chronic obstructive pulmonary disease. The resident received oxygen.The Care Plan revised [DATE] identified Resident #1 had respiratory abnormalities and had Oxygen (O2) at 1.5 liters via nasal cannula.The Medication Administration Record for [DATE] showed Resident #1 had the order for O2 at 1.5 liters per nasal cannula with a start date of [DATE].The Weights and Vitals record documented the resident's O2 saturation on [DATE] at 6:35 a.m. at 97% on 2 liters/minute and [DATE] at 11:43 a.m. 96% at 2 liters/minute.The Progress Notes dated [DATE] at 4:08 a.m. and 6:30 a.m. documented the resident's O2 sat 96% and 97% on O2 at 2 liters.The Progress Notes dated [DATE] at 10:34 a.m. documented the resident's O2 sat 93% on O2 at 2 liters.The Progress Notes dated [DATE] at 2:58 a.m. documented the resident's O2 sat at 97% on O2 at 2 liters.On [DATE] at 9:15 a.m. Resident #1 laid in bed with the head of bed elevated. She had O2 per nasal cannula at 1.5 liters, via the concentrator.At 12:34 p.m. the resident sat in the dining room. She had O2 at 2 liters per nasal cannula via a portable O2 tank.At 1:05 p.m. the Assistant Director of Nursing (ADON) stated she did not think they could put O2 in the weights and vital record in 1/2's. She could not explain why 2 nurses put that in. She did not know who would have taken Resident #2 to the dining room with her O2 at 2 liters. She said they had a concentrator in the DR, they should hook her up to it while she was eating.At 4:40 p.m. the ADON stated an agency Certified Nursing Assistant (CNA) turned the O2 to 2 liters. She had educated the CNA and the nurse, and would educate the rest of the staff. 2) Medication Pass/storage: a. According to the MDS assessment dated [DATE], Resident #3 scored 15 on the BIMS indicating no cognitive impairment. The resident's diagnoses included diabetes, polyneuropathy, and dorsalgia (pain in the back).The Care Plan revised [DATE] identified the resident had actual pain. The interventions included giving medications as ordered.On [DATE] at 11:15 a.m. Staff F Certified Medication Aide (CMA) took an Ibuprofen 200 mg tab to Resident #3. Staff F walked away before Resident #3 swallowed the pill. b. According to the MDS assessment dated [DATE], Resident #4 scored 15 on the BIMS indicating no cognitive impairment. The resident's diagnoses included heart failure, chronic lung disease, and atrial fibrillation.The Care Plan revised [DATE] identified the resident on diuretic therapy. The interventions included administering diuretic medication as ordered.On [DATE] at 11:23 a.m. Staff F CMA took a Coenzyme Q10 and a Lasix (diuretic) 40 mg tab to Resident #4. Staff F walked out of the room before the resident swallowed the pills. c. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the MDS assessment dated [DATE], Resident #8 scored 15 on the BIMS indicating no cognitive impairment. The resident's diagnoses included atrial fibrillation.On [DATE] at 11:29 a.m. Staff F prepared medication for Resident #8. She took 2 round white tablets from a clear plastic cup, 1/2 full of the tablets, from the top drawer of the med cart. She picked them up with bare fingers and put them into a med cup. When asked what the pills were, she said Tylenol, and picked the cup up to show it had APAP 325 written on it.On [DATE] at 11:30 a.m. the DON, ADON and Administrator agreed staff should observe the residents swallow their medication, the medication should not be touched with bare hands, and medications should be stored in the containers the facility received them in, until ready to administer.The facility Medication Administration policy updated [DATE] documented medications were administered by licensed nurses, or other staff who were legally authorized to do so, as ordered by the physician and in accordance with professional standards of practice, and in a manner to prevent contamination or infection. The procedure included reviewing the Medication Administration Record (MAR) to identify medication to be administered, and compare to the medication source (bubble pack, vial, etc.). Identify the expiration date, and if expired, notify the nurse manager. When removing the medication from the source, taking care not to touch medication with bare hand. The procedure also included observing the resident's consumption of the medication.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to have sufficient staff to complete restorative as planned for 3 of 3 residents (Resident #4, #5, and #7), and ensure residents received at least 2 baths a week for 3 residents reviewed (Resident #1, #3, and #6). The facility reported a census of 41 residents.Findings include: Restorative: a. According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #4 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident's diagnoses included heart failure, atrial fibrillation, and asthma.The Care Plan revised 9/18/25 identified Resident #4 had limited physical mobility related to arthritis and advanced age. The goals included the resident would be able to perform exercises with staff, and ride the NuStep with staff. Interventions included to see under tasks.The Tasks Tab, POC Response History documented Resident #4's exercises included using the green or blue Thera band or up to 4# weight for bilateral upper extremities, shoulder flexion adduction/abduction, elbow flexion/extension, as tolerated, all planes, 1 time a day, 3-6 days a week. The history documented the restorative completed only 5 times the previous 30 days. b. According to the MDS assessment dated [DATE], Resident #5 scored 9 on the BIMS indicating moderate cognitive impairment. The resident depended on staff for transfers and did not ambulate. The resident's diagnoses included Multiple Sclerosis (MS).The Care Plan revised 6/11/25 identified Resident #5 had limited physical mobility related to disease process. The intervention to see under tasks.The POC Response History documented the resident to have Active Range of Motion, 10 repetitions, cervical extension-tilt head back gently, neck rotation-provide tactile assistance to position shoulder shrugs (scapular elevation), 2 sets times 10 repetitions providing cues and encouraging 5-10 second hold in rotation position. The history documented the restorative only completed 4 times the previous 30 days. c. According to the MDS assessment dated [DATE], Resident #7 scored 9 on the BIMS indicating moderate cognitive impairment. The resident had functional limitation in ROM on 1 side, both upper and lower extremities. The resident's diagnoses included hemiplegia (paralysis of 1 side of the body). The Care Plan revised 9/2/25 identified Resident #7 had limited physical mobility related to disease process. The intervention to see under tasks.The POC Response History documented the resident's exercises included:Active Range of Motion (AROM) upper body using table with cloth or towel. Place right upper extremity on towel. Scapular pro/retraction, horizontal add/abduction, forward/backward, side to side, 3 times 12-15 repetitions, 1 time a day, 3-6 days a week. The POC documented receiving restorative 1 time the weeks of 12/28/25 and 1/3/26, and 1/4/26 to 1/10/26.Passive ROM, circumduction, scapular pro/retraction, bicep flexion/extension, forearm pro/supination, wrist flex/extension, 3 times 12-15 repetitions, 1 time a day, 3-6 days a week. The POC documented receiving restorative 1 time the weeks of 12/28/25 to 1/3/26, and 1/4/26 to 1/10/26.Lower body AROM in all planes and PROM to the right lower extremity in all planes (easier to do so in bed) 10-15 repetitions, 1 time a day, 3-6 days a week. The POC documented receiving restorative 1 time the weeks of 12/28/25 to 1/3/26, and 1/4/26 to 1/10/26.On 1/14/25 at 10:43 a.m. Staff D Certified Nursing Assistant (CNA) stated she strove to get everything done when she worked, and when they were short that was no small task. She said she is the restorative aide and she had been getting pulled off of doing the restorative to work the floor.The facility Restorative Program Process updated 10/26/21 identified it's purpose to ensure their resident(s) achieved and maintained their highest level of function. The licensed nurse would monitor the daily restorative nursing program documentation and follow-up with staff as needed. Baths: a. According to the MDS assessment dated [DATE], Resident #1 scored 6 on the BIMS indicating severe cognitive impairment. The (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident required substantial/maximal assist with bathing. The resident's diagnoses included chronic obstructive pulmonary disease.The Care Plan revised 8/26/25 identified Resident #1 had an actual self-care deficit related to osteomyelitis and diabetes with diabetic neuropathy. The interventions included assist of 1-2 with bathing.The POC Response History documented Resident #1 was dependent for baths the past 30 days. The history showed 2 baths/week, with the exception of 1/4/25 to 1/10/25, having only 1 bath. b. According to the MDS assessment dated [DATE], Resident #3 scored 15 on the BIMS indicating no cognitive impairment. The resident required supervision/touching assistance with bathing. The resident's diagnoses included diabetes, muscle weakness, and other abnormalities of gait and mobility.The Care Plan revised 10/8/25 identified Resident #3 had an actual self care deficit related to polyneuropathy, diabetes, muscle weakness and abnormality of gait and mobility. The interventions included bathing assistance of 1.The POC Response History documented Resident #3 needed varying degrees of assistance for baths the past 30 days. The history showed 2 baths/week, with the exception of 12/21/25 to 12/27/25, having only 1 bath. c. According to the MDS assessment dated [DATE], Resident #6 scored 5 on the BIMS indicating severe cognitive impairment. The resident required partial/moderate assistance with bathing. The resident's diagnoses included non-Alzheimer's dementia.The Care Plan revised 5/9/25 identified Resident #6 had a self-care performance deficit related to dementia and limited mobility. The interventions included assist of 1 with bathing.The POC Response History documented Resident #6 needed varying degrees of assistance for baths the past 30 days. The history showed 2 baths/week, with the exception of 12/14/25 to 12/20/25, having only 1 bath.On 1/14/26 at 11:21 a.m. Staff E CNA said they had worked short lately, but she got her baths done. She said sometimes it got pretty hectic. She said most residents were scheduled for baths 2 times a week. She said since they had used more agency, she couldn't say if they were getting them done. On 1/15/26 11:30 a.m. the DON stated they had a staffing crisis and were working through it. Both the DON and Administrator stated they had admitted a new resident this week.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, review of menus, and staff interview, the facility failed to provide food and drink that was palatable, attractive, and at a safe and appetizing temperature. The facility reported a census of 41 residents.Findings include: a. A review of menus showed the menu starting 12/28/25 had apricot chicken on Wednesday 12/31/25. On 1/14/25 at 9:32 a.m. Staff A Licensed Practical Nurse (LPN) stated about a week and a half ago the residents received undercooked chicken. She said a resident complained about it so she cut the chicken and it was not fully cooked. At 9:36 a.m. the Assistant Director of Nursing (ADON) stated she and 2 other staff went to the kitchen and checked the chicken and it was cooked. She said there is that vein in the meat that can look like blood, and there was a sauce on the chicken also.Staff A reiterated the chicken was not cooked through, the meat inside was still pink/red. On 1/14/25 at 9:48 a.m. Staff B Certified Nursing Assistant (CNA) stated if they put the food in the breakroom for free she would eat it. She said sometimes food was undercooked. On 1/14/25 at 10:10 a.m. Staff C CNA stated in the past couple of weeks they had chicken that was not fully cooked. When you cut into it the meat was still pink/red. On 1/14/25 at 10:43 a.m. Staff D CNA stated the food was not visually appealing. One day the chicken was under cooked. Resident #8 said his was bleeding. Then she checked Resident #7's and it was not done, so she microwaved it. On 1/14/25 at 11:21 a.m. Staff E CNA stated the chicken thighs were raw. She said she was going to take the meat off the bone for a resident and discovered it. She said then they checked others an found the same. She said she microwaved each plate for about 1-1/2 minutes and up to about 185 degrees. She didn't know how many had been served before they caught it, but she knew a few residents said they got bloody chicken and didn't eat it. On 1/15/25 at 12:05 p.m. the Dietary Manager (DM) and Administrator identified the meal served on week 3 on a Wednesday at noon included Apricot Chicken. The Administrator stated they were told they had a concern about the chicken being undercooked. They went to the kitchen and checked the remaining chicken and found the chicken done, but had some veins they may have misinterpreted as blood. She and the DM determined they checked the chicken around 12:30 p.m. at tear down time. Meal service time started at 11:30 a.m. b. On 1/14/25 at 11:59 a.m. the residents in the dining room had been served the noon meal. Dietary staff and nursing staff filled trays to take to residents in their rooms. They used heated plate warmers. They had 2 carts. Staff D took the first cart, and when she reached Resident #10s room, she temped the food with the meat at 130.7 and potatoes 133 degrees. She delivered the tray. Soon after the DS had the 2nd cart and temped the meat at 126 degrees.The facility Policy & Procedure Manual for Food Temperatures documented the temperatures of all hot food items must be cooked to appropriate internal temperatures, held, and served at a temperature of at least 135 degrees.