STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Carlisle	680 Cole Street Carlisle, IA 50047

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 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. Based on document review, electronic health record review (EHR), staff interviews, and policy review the facility failed to report a resident's allegation of sexual abuse (Resident #4) to the State Agency within the required timeframe for 1 of 3 residents reviewed for abuse and dignity. The facility reported a census of 72. Findings include: The Quarterly Minimum Data Set (MDS) Assessment completed on 12/4/25 revealed Resident #4 with a Brief Interview for Mental Status score of 4, indicating severe cognitive impairment. The MDS documented that Resident #4 was dependent on staff for completion of personal cares and transfers and wheelchair use. The Incident Investigative Report showed the facility submitted on online report of sexual abuse involving Resident #4 on 1/22/26 at 8:13 AM to the Iowa Department of Inspections, Appeals, and Licensing. During an interview on 1/26/26 at 1:55 PM, Staff C, Certified Nursing Assistant (CNA), stated Resident #4 reported the morning of 1/22/26 that the guy from last night needs to be fired as he raped me. Staff F, CNA, who was also present when the comment was made, mentioned to Staff C that Resident #4 made the same type of statement the morning of 1/21/26. During an interview on 1/27/26 at 8:35 AM, Staff F, CNA confirmed Resident #4 reported the morning of 1/22/6 that they were raped. Staff F stated Resident #4 said the same thing the morning of 1/21/26 while they assisted completing personal cares on the resident. Staff F explained they were under the impression another staff member reported it to the nurse working on 1/21/26 but was not sure. During an interview on 1/27/26 at 935 AM, Staff G, CNA, explained Resident #4 reported the morning of 1/21/26 that the black guy raped me while completing personal cares. Staff G thought they had notified the Director of Nursing (DON) of the statement on 1/21/26. If they didn't the tell the DON, then they may have told the nurse working that day. Staff G unable to recall the name of the nurse working. During an interview on 1/28/26 at 10:00 AM, Staff H, CNA, explained Resident #4 reported to them on morning of 1/21/26 that a black man raped me and the black girl. Resident #4 said this man was the one who comes in and turns the light on. After completing personal cares, Staff H stated they went to inform Staff I, Registered Nurse, of the statements Resident #4 had made. Staff I acknowledged and told Staff H they would take care of it. Staff H's written statement dated 1/22/26, as noted in the facility's incident investigative file, documented on 1/21/26 they were getting Resident #4 ready for breakfast when the resident voiced the dark black man raped me. The statement further noted Staff H informed Staff I at approximately 8:00 AM of the allegation. During an interview on 1/28/26 at 2:00 PM, Staff I acknowledged Staff H approached them the morning of 1/21/26 to report Resident #4's rape allegation. Staff I explained they then called the DON at approximately 7:30-8:00 AM that morning to report. During an interview on 1/28/26 at 10:20 AM, the DON explained Staff I did not contact them on 1/21/26 regarding Resident #4's rape allegations. They were first made aware of Resident #4's rape allegation the morning of 1/22/26 by Staff D, Licensed Practical Nurse, via phone. With any allegations of abuse, the DON stated staff should immediately notify the charge nurse but also themselves and/or the facility administrator to ensure reporting and (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigating timeframes are met. The policy Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy, updated 10/19/22, noted the following: Allegations of resident abuse shall be reported to the Iowa Department of Inspections, Appeals, & Licensing no later than 2 hours after the allegations is made.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on facility document review, staff interviews, and policy review the facility failed protect residents from further potential abuse once an allegation of sexual abuse was reported to staff, for 1 of 2 abuse allegations reviewed. An employee meeting the general description of the alleged perpetrator worked and had access to residents after the allegation was were made. The facility reported a census of 72. Findings include: During an interview on 1/28/26 at 10:00 AM, Staff H, Certified Nursing Assistant (CNA), explained Resident #4 reported to them on the morning of 1/21/26 that a black man raped me and the black girl when they asked the resident how they slept during the night. Resident #4 said this man was the one who comes in and turns the light on. After completing personal cares, Staff H stated they went to inform Staff I, Registered Nurse (RN), of the statements Resident #4 had made. During an interview on 1/28/26 at 2:00 PM, Staff I, RN acknowledged Staff H, CNA approached them the morning of 1/21/26 to report Resident #4's rape allegation. Staff I explained she then called the Director of Nursing (DON) at approximately 7:30 AM that morning to report. During an interview on 1/28/26 at 10:20 AM, the DON explained Staff I did not contact them on 1/21/26 regarding Resident #4's rape allegations. They were first made aware of the allegation the morning of 1/22/26. After reviewing schedules from the previous day, Staff J, CNA, was suspended, per protocol, as they matched the general description Resident #4 provided. The DON acknowledge Staff J had worked the night shift on 1/21/26. Staff J was informed of the work suspension on 1/22/26. The facility's staffing schedules reflected Staff J worked the night shift of 1/20/26 and 1/21/26. The policy Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy, updated 10/19/22, noted the following: 1.Upon receiving a report of an allegation of resident abuse, neglect, exploitation or mistreatment, the facility shall immediately implement measures to prevent further potential abuse of residents from occurring while the facility investigation is in process. 2.If this involves an allegation of abuse by an employee, this will be accomplished by separating the employee accused of abuse from all residents through the following or a combination of the following, if practicable: a. Suspending the employee b. Segregating the employee by moving the employee to an area of the facility where there will be no contact with any residents of the facility; and in rare instances c. Separating the employee accused of abuse from the resident alleged to have been abused, but allowing the employee to care for and have contact with other residents, only if there is a second employee who remains with and accompanies the employee accused of abuse at all times to supervise all contacts and interactions with the residents.The Incident Investigative Report showed the facility submitted on online report of sexual abuse involving Resident #4 on 1/22/26 at 8:13 AM to the Iowa Department of Inspections, Appeals, and Licensing

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, observation, document review and facility policy review the facility failed to maintain an effective pest control program so that the facility was free from any infestation of any kind of vermin in the facility. The facility reported a census of 72 residents. Finding include:In an interview with Staff D, Licensed Practical Nurse (LPN) on 1/26/26 at 3:00 pm, she revealed there was a mice problem at the facility and in the staff break room. She further stated mice ate her snack that was in her personal locker inside the breakroom. This occurred about a week ago and the facility added mice traps and boxes at that time and the exterminator came out to the facility. The facility provided a document titled Work Orders for dates December 29, 2025 - January 29, 2026 and an entry log mouse in room [ROOM NUMBER] was documented as closed work order.During an observation of room [ROOM NUMBER] on 1/27/26 at 9:00 am, the 6-drawer clothing dresser revealed mice droppings in 4 out of 6 drawers. Drawers contained resident's clothing articles such as socks, jeans and personal items. During an observation of a vacant room [ROOM NUMBER] on 1/27/26 at 9:10 am mice droppings were noted in a corner of the room near the heat register. During an interview with Staff E, Maintenance Director on 1/27/26 at 10:45 am he reported the facility had an ongoing mice problem and the exterminator had made extra visits to the facility this month. He stated whenever there are sightings of mice they tackle the problem by calling for additional visits from the pest control company. He also added that staff told him they caught live mice a day prior in their work area but he was not in the building at that time. In an interview with Staff A, Housekeeping Aide on 1/27/26 at 11:45 am she revealed the mice problem was so bad that they had to throw away multiple items from the Activity Room storage closets. Staff were going through Christmas decorations items in the storage closet and while pulling out boxes, they discovered many items were torn and chewed up by mice and they seen a live mouse jumping out of one of the boxes. Staff A further revealed one of the resident's rooms, a recliner's cushion was pulled out revealed a bunch of mice poop in there and they threw away a few of her soft toys. In an interview with the Administrator on 1/27/26 at 12:05 pm she stated mice droppings were first noted at the beginning of January (2026) and pest control routinely serviced the building monthly but they made additional visits since then. She provided a facility wide education about proper food storage and to avoid bringing any candy or snack foods that could be attracting mice. The Administrator confirmed that the recliner that had mice droppings was replaced and they had an exterminator coming to the facility again this week. During an observation of the Activity Room on 1/28/26 at 9:55 am revealed 3 Residents were present in the room. Multiple mice droppings were noted around the room near the edges by the entrance door and near a nightstand located in the corner of the room on the right side of the entrance door. Some droppings were black and some were green. Behind the nightstand there was a white square box with debris all around it. In an interview with the Administrator on 1/28/26 at 11:00 am she stated the debris behind the nightstand in the Activity Room has been cleaned up and the mice droppings too. She further revealed a hole in the floorboard of the corner will be patched up. The facility provided policy titled Pest Control Program dated 12/3/25 documented the facility will maintain an effective pest control program for common household pests and rodents.