

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165256	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Accura Healthcare of Onawa		STREET ADDRESS, CITY, STATE, ZIP CODE 222 North 15th Street Onawa, IA 51040	
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 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observations, resident, and staff interviews, the facility failed to display contact information for state and federal agencies in an accessible and prominent location in the facility for 4 out of 4 residents interviewed (Residents #14, #19, #29, #31, and #33). The facility reported a census of 40 residents. Findings include: Observation on 7/8/26 at 2:37 PM revealed a failure to post required contact information in a prominent and accessible location. The facility lacked an accessible displayed directory of pertinent state agencies and advocacy groups, including the state survey agency, licensure office, adult protective services, the State Long Term Care Ombudsman (SLTCO), and the Medicaid Fraud Control Unit, in a format understandable to residents and their representatives. During an interview on 7/8/26 at 3:10 PM, Resident #14 reported an understanding of the Ombudsman. The resident was unable to identify the location of information related to outside agencies. During an interview on 7/8/26 at 3:12 PM, Resident #29 reported she was unfamiliar with the definition of an Ombudsman. The resident reported she was unaware of where any information could be posted. During an interview on 7/8/26 at 3:15 PM, Resident #31 reported no understanding of the definition of the Ombudsman or where information could be posted. During an interview on 7/8/26 at 3:19 PM, Resident #33 stated that she was unfamiliar with the definition of an Ombudsman or where information could be posted. During an interview on 7/8/26 at 3:23 PM, Staff A, Certified Nursing Assistant (CNA), stated they thought Ombudsman information was posted in the copy machine room. Staff A noted that while residents generally do not access the copy room, staff are available to retrieve information upon request. During an interview on 7/8/26 at 3:19 PM, Resident #19 reported that she didn't know the definition of an Ombudsman. Resident #19 she was not aware of where information could be posted. During an interview on 7/8/26 at 3:29 AM, Staff B, Registered Nurse (RN), was asked to identify the location of information related to the Ombudsman. Staff B replied, I don't know what that is. During an interview on 7/8/26 at 3:49 PM, the Director of Nursing (DON) stated that Ombudsman forms were located at the front entrance vestibule. The Interim Administrator acknowledged that because the information was located behind a locked door, it was not accessible and not in a prominent location for residents to access.		

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, review of facility records, resident and staff interviews, and facility policy, the facility failed to ensure that residents and staff were adequately educated regarding the definition of a grievance, the grievance process, and the specific procedures for obtaining forms and filing grievances anonymously for 5 out of 5 residents interviewed (Residents #14, #19, #29, #31, and #33). The facility reported a census of 40 residents. Finding include: Observation on 7/8/26 at 2:37 PM, revealed that the facility failed to provide readily accessible grievance forms in a public area for residents. During an interview on 7/8/26 at 3:10 PM, Resident #14 reported an understanding of the definition of a grievance. The resident was unable to identify the location of grievance forms or the established procedure for their submission. During an interview on 7/8/26 at 3:12 PM, Resident #29 reported she was unfamiliar with the definition of a grievance, the grievance process, and the location of grievance forms. During an interview on 7/8/26 at 3:15 PM, Resident #31 reported an understanding of the definition and process of a grievance; however, the resident stated, I don't know where they keep the forms. I would have to ask. During an interview conducted on 7/8/26 at 3:19 PM, Resident #33 stated that she was unfamiliar with the definition of a grievance, the grievance process, and the location of grievance forms, specifically noting, I have no idea what that is. During an interview on 7/8/26 at 3:23 PM, Staff A, Certified Nursing Assistant (CNA), stated they thought the grievance forms were located in the copy machine room. Staff A noted that while residents generally do not access the copy room, staff are available to retrieve a form upon request. During an interview on 7/8/26 at 3:19 PM, Resident #19 reported that she didn't know the definition of a grievance or where a form could be found. During an interview on 7/8/26 at 3:29 AM, Staff B, Registered Nurse (RN), was asked to identify the location of grievance forms. Staff B replied, I don't know where. The Grievance Process last updated January 2023 identified the facility will notify residents individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official is available on the posted grievance process with whom a grievance can be filed, that includes, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality improvement Organization, State Survey Agency and State Long- Term Care ombudsman program or protection and advocacy system. During an interview on 7/8/26 at 3:49 PM with the Director of Nursing (DON) and the Interim Administrator, the DON stated that grievance forms were located at the front entrance. Upon being informed that forms were not accessible in that location and that no information regarding the grievance process was posted, the DON acknowledged that grievance forms must be readily available to residents. The Interim Administrator reported they would search for a facility policy.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and staff interview, the facility failed to ensure comprehensive care plans were updated to reflect current resident needs including restorative care, CPAP therapy, dietary orders, and fall interventions for 4 out of 12 residents reviewed (Residents #7, #8, #36, and #39). The facility reported a census of 40 residents. Findings include: 1. Resident #7's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 13/15 indicating normal cognition. The document revealed the resident had a limitation in movement of one leg. The facility's document, Restorative Nursing Program, revealed a start date of 6/25/26 with transfers 3-5 times/day for 5 days/week, ambulation greater than 50' 3 times/day, arm and leg exercises for 20 repetitions daily for 3 times/week with a 2# weight, and Nu-Step for 10-15 minutes. The clinical record's Point of Care documentation revealed data collection availability for arm and leg exercises, transfer practice and ambulation. Resident #7's Care Plan revised 5/9/26 did not include a focus area related to the resident's limitation in movement and the need for a Restorative Nursing Program to prevent regression of skills/strength. 2. The MDS assessment dated [DATE] for Resident #8 documented a BIMS score of 15, indicating no cognitive impairment. The MDS showed diagnoses of obstructive sleep apnea, congestive heart failure, and obesity. On 7/6/26 at 9:49 AM, observation of Resident #8's room confirmed the presence of a CPAP machine. In an interview on 7/9/36 at 8:32 AM, Resident #8 reported he uses the CPAP every night. The resident reported he is not sure if staff clean the CPAP tubing and mask. Review of clinical physician orders for Resident #8 dated 1/8/26 showed an order for nightly CPAP use. Review of Resident #8's care plan revealed that the facility failed to revise the comprehensive care plan to include the use, settings, and cleaning schedule for the CPAP machine. In an interview on 7/9/26 at 10:22 AM, Staff I, Registered Nurse (RN), reported that she added the CPAP information to the care plan on the second day of the survey. When asked if the CPAP information should be added to the care plan upon initiation of the device, Staff I confirmed that it should be. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #36's Significant Change MDS Assessment, related to initiation of hospice services, dated 5/13/26 revealed the resident was unable to complete a BIMS and required staff to answer questions regarding the resident's cognitive status. The document included the resident required a mechanically altered diet and had sustained 1 fall during the reporting period. Resident #36's Care Plan, revised 6/1/26, identified a nutritional focus area (revised 11/22/24) with a staff intervention for providing diet as ordered - general pureed diet with honey thick liquids (revised 11/6/24). The document disclosed the resident was a high risk for falls (revised 5/19/26) with staff interventions of the resident would crawl into and out of bed, and wheelchair (w/c) independently as she wishes (revised 11/6/24), the resident needed a safe environment with floor mat next to the bed at night (revised 11/6/24), and the resident needed a safe environment with the bed in the low position at night (revised 11/6/24). The clinical record's Clinical Physician Orders disclosed an order dated 5/15/26 for regular diet, mechanical soft texture and honey consistency. Observed on 7/6/26 at 11:00 AM Resident #36 seated on floor mats with bed in the lowest position with a family member present. Observed on 7/7/26 at 1:30 PM the resident seated on the floor mat with the bed in lowest position engaged in a card activity. Observed on 7/8/26 at 11:30 AM resident seated on the floor mat engaged in a card activity with the bed in the lowest position prior to Staff C, Certified Nurse Assistant (CNA) and Staff E, CNA, completing a transfer from the floor to the w/c. On 7/8/26 at 7:50 AM Staff E stated Resident #36's bed was always low and the mats were on the floor. On 7/8/26 at 11:35 AM Staff C stated the resident's bed was always in a low position and mats were on the floor as the resident will self transfer from her w/c to the floor to play with her cards. The facility failed to update the Care Plan to reflect a change in diet and fall interventions. 4. Resident #39's MDS assessment dated [DATE] revealed a BIMS score of 15/15 indicating normal cognition. The document provided the resident had not had any falls during the reporting period. The document revealed the resident had a limitation in movement in both legs, The resident's Care Plan, revised 6/3/26, contained a focus area potential for falls initiated on 4/10/25 with staff interventions of an actual fall on 5/23/26 with low air loss mattress removed (initiated 6/3/26), bed to be in lowest position when resident is in it pressure reducing mattress in place (6/15/26), and lab urinary analysis with low bed position (5/23/26). The facility's document, Restorative Nursing Program, revealed a start date of 7/3/26 with arm and leg exercises 10-20 repetitions 1 time/day for 5 days/week and arm exercise with the use of the (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Omnicycle x15 minutes 2 times/week. The clinical record's Point of Care documentation revealed data collection availability for arm and leg exercises, and use of the Omnicycle. Observed on 7/6/26 at 11:14 AM the resident lying in bed with the bed at a normal height (not low to the floor) with the bedside table next to the bed and a fall mat on the other side of the bedside table - further into the room. Observed on 7/7/26 at 2:30 PM the resident in bed that was not lowered with the bedside table next to the bed, and the fall mat on the other side of the bedside table. On 7/8/26 at 11:30 AM Resident #39 stated the fall mat was put on the floor at the time of his fall. On 7/8/26 at 11:40 AM Staff C stated fall interventions for the resident included the use of a fall mat and a lowered bed. The facility failed to revise a Care Plan to include the resident's limitation in movement, the need for a Restorative Nursing Program to prevent regression of skills/strength and the use of fall mat as an intervention for the risk for falls. On 7/8/26 at 3:45 PM the Director of Nursing (DON) with the Regional Corporate Nurse and Interim Administrator present stated the Care Plans should reflect the resident's current needs, and could be updated by any member of the interdisciplinary team. The staff acknowledged the Care Plans should include all current fall interventions, diets, and the Restorative Nursing Program(s). The facility's Comprehensive Care Plans Policy, updated 12/3/25, revealed the care plan would be reviewed and revised by the interdisciplinary team, and updated in a timely manner to ensure that services provided assist the resident to attain or maintain the highest practicable level of physical, mental, and psychosocial well-being.		

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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** Based on clinical record review, observations, staff interviews, and policy review, the facility failed to protect residents from accidents and injuries for 2 of 3 residents (Residents #36, #39). The facility failed to follow fall interventions identified on the Care Plan. The facility reported a census of 40 residents. Findings include: 1. Resident #36's Annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 4/15 indicating severe cognitive impairment. The document coded the resident required dependent assistance for dressing, toilet hygiene, and partial/moderate assistance for transfers. The document disclosed the resident had 0 falls during the reporting period. Resident #36's Quarterly MDS assessment dated [DATE] revealed the resident was unable to complete the BIMS but staff interview provided the resident was able to recall the current season, location of her room, staff names/faces and that she was in a nursing facility. The document coded the resident required dependent assistance for dressing, toilet hygiene, and substantial/maximal assistance for transfers. The document disclosed the resident had 1 fall during the reporting period. The Care Plan revised 6/1/26 identified a focus area for self care performance deficit revised on 5/19/26 with staff interventions of pairs for cares for toileting (revised 8/11/25), pairs for cares for transfers (revised 8/27/25) and pairs for cares/staff participation for bathing (revised 8/11/25). The facility's documentation for a fall on 3/11/26 revealed the resident fell while in the shower room. The document indicated the resident did not sustain an injury. The facility's documentation for a fall on 5/9/26 revealed the resident had a loss of balance and fell while in the bathroom, and sustained a laceration. The clinical record's Progress Notes revealed the following entries: On 3/11/26 at 2:00 PM the resident sustained a fall, steri strips were applied to the superficial area by the nurse practitioner who was in the facility. The resident requested to be seen in the emergency room. Per the nurse practitioner a scan was completed and was negative. On 3/12/26 at 11:55 AM new order for Bacitracin daily to the area on the left part of the resident's head. On 5/9/26 at 8:02 PM Certified Nursing Assistant (CNA) in bathroom with resident when the resident leaned forward and fell sustaining a 2 cm gash, .5 wide that stopped bleeding with a cool compress. On 7/8/26 at 7:50 AM Staff E, CNA, stated the resident required 2 staff assistance for self care tasks and transfers. Staff E stated staff should not leave her while completing toileting. The staff stated the resident required assistance for standing but could not walk. On 7/8/26 at 11:35 AM Staff C, CNA, stated the resident was always a 2 staff assistance for transfers, toileting, and dressing. On 7/8/26 at 1:50 PM Staff F, CNA/Bath Aide, stated the resident required 2 staff assistance for transfers to and from the modified shower chair, and 1 staff for bathing. On 7/9/26 at 7:00 AM reviewed the Care Plan, revised 6/1/26, with the Director of Nursing (DON) for the self care deficit with staff interventions for the resident requiring 2 staff assistance for transfers, toileting and bathing. The DON acknowledged pairs for cares indicated 2 staff and the resident had required 2 staff for transfers, toileting, and bathing since 8/25. The DON concurred the resident should have had 2 staff present during each of the falls that occurred in 3/25 and 5/25 based on the interventions stated in the self care deficit. The DON indicated she thought changing to 2 staff was a new intervention since 5/25 (most recent fall) due to the resident's decreased stability rather than the resident's size. Reviewed the 3/11/26 fall report and documentation of no injury and no hospitalization with the DON, and the DON stated that was incorrect as the resident did sustain a head injury, did go to the hospital and had a CT scan completed which was negative. The DON stated the staff should be referring to the (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care Plan and following the interventions for residents. The facility failed to follow Care Plan interventions for the prevention of 2 falls. 2. The MDS assessment dated [DATE] revealed a BIMS score of 15/15 indicating normal cognition. The document provided the resident had not had any falls during the reporting period. Resident #39's Care Plan revised 6/3/26 contained a focus area for potential for falls initiated on 4/10/25 with staff interventions of an actual fall on 5/23/26 with low air loss mattress removed (initiated 6/3/26), bed to be in lowest position when resident is in it pressure reducing mattress in place (6/15/26), and lab urinary analysis with low bed position (5/23/26). Observed on 7/6/26 at 11:14 AM the resident lying in bed with the bed at a normal height (not low to the floor) with the bedside table next to the bed and a fall mat on the other side of the bedside table - further into the room. Observed on 7/7/26 at 2:30 PM the resident in bed that was not lowered with the bedside table next to the bed, and the fall mat on the other side of the bedside table. Observed on 7/8/26 at 11:30 AM the resident lying in bed with the bed not in a low position and the fall mat folded, leaning against the wall at the foot of the bed. Observed on 7/8/26 at 1:20 PM the resident lying in a bed, not lowered, with the fall mat folded and leaning against the wall. On 7/6/26 at 1:44 PM Resident #39 stated he had fallen from bed while dreaming. On 7/8/26 at 11:30 AM the resident stated the fall mat was put down at the time of his fall. The resident stated he did not like the fall mat as it prohibited the bedside table from being near him. Resident #39 stated the staff put the fall mat down on the floor at night. On 7/8/26 at 11:40 AM Staff C stated fall interventions for the resident included the use of a fall mat and a lowered bed. The staff stated the resident's fall occurred when the resident was confused. On 7/9/26 at 8:15 AM Staff G, CNA, stated staff referred to the Care Plan for information on resident assistance needs. On 7/8/26 at 3:50 PM the Director of Nursing (DON) with the Regional Nurse Consultant and Interim Administrator present expected staff to follow the fall interventions that were put into place and on the Care Plan. The facility's Comprehensive Care Plans Policy, updated 12/3/25, revealed staff would be notified of their roles and responsibilities for carrying out the interventions in the Care Plans initially and when changes occurred.		