

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER Accura Healthcare of Creston		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 East Howard Creston, IA 50801	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on clinical record review, resident and staff interviews, and policy review, the facility failed to follow the physician's orders for 1 of 3 residents (#1). The facility reported a census of 21 residents. Findings include: The Minimum Data Set (MDS) for Resident #1 dated 8/06/25 revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated moderately impaired cognition. It included diagnoses of chronic obstructive pulmonary disease (COPD), anxiety, depression, cerebrovascular accident (stroke) with right side hemiplegia (paralysis), aphasia (inability to speak), and dysphagia (difficulty swallowing). It indicated the resident required setup assistance with eating, moderate assistance with oral hygiene, maximal assistance with toileting hygiene, upper body dressing, and personal hygiene and all mobility, and was dependent with bathing, lower body dressing, and footwear. It also indicated the resident had a feeding tube and more than 50% of his total caloric intake was provided by tube feeding but the resident did not experience coughing or choking when swallowing medications. The Electronic Health Record (EHR) included a physician's order dated 5/13/25 which indicated staff may crush medications and slurry/cocktail meds if appropriate and administer every shift for medication administration. The Care Plan revised 11/26/24 directed staff to administer the resident's medications as ordered. The October Medication Administration Record (MAR) confirmed the resident did not receive his scheduled evening medications on 10/24/25 and directed the reader to see Progress Notes. The Progress Notes dated 10/24/25 indicated seven (7) of the resident's scheduled evening medications were not done because the nurse could not access the G-tube (PEG tube <Percutaneous Endoscopic Gastrostomy> - a feeding tube surgically inserted directly into the stomach). On 10/30/25 at 5:35 am, Staff A, Registered Nurse (RN) stated he could not give Resident #1 his medications because he could not access Resident's #1's G-tube. He also stated he charted against them because he did not feel Resident #1 would miss any nighttime medications that would be detrimental. On 10/30/25 at 9:00 am, Resident #1 indicated he didn't receive his nighttime medications on 10/24/25. On 10/30/25 at 11:18 am, the Director of Nursing (DON) stated staff should have contacted the on-call nurse and escalated the situation higher if needed. On 10/30/25 at 12:21 pm, the Administrator indicated the facility did not have a policy regarding following physician's orders.</p>

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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NAME OF PROVIDER OR SUPPLIER Accura Healthcare of Creston		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 East Howard Creston, IA 50801	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>(continued on next page)</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on clinic record review, resident and staff interviews, and policy review, the facility failed to maintain competent staff by failing to access a G-tube (a feeding tube surgically inserted directly into the stomach) to provide medications and failing to stop feeding a resident through a G-tube when the resident complained of pain for 1 of 3 residents reviewed (#1). The facility reported a census of 21 residents. Findings include: The Minimum Data Set (MDS) for Resident #1 dated 8/06/25 revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated moderately impaired cognition. It included diagnoses of chronic obstructive pulmonary disease (COPD), anxiety, depression, cerebrovascular accident (stroke) with right side hemiplegia (paralysis), aphasia (inability to speak), and dysphagia (difficulty swallowing). It indicated the resident required setup assistance with eating, moderate assistance with oral hygiene, maximal assistance with toileting hygiene, upper body dressing, and personal hygiene and all mobility, and was dependent with bathing, lower body dressing, and footwear. It also indicated the resident had a feeding tube and more than 50% of his total caloric intake was provided by tube feeding. The Electronic Health Record (EHR) included physician's orders dated 8/08/23, 8/09/23, 6/11/25, and 9/13/25 for medications to be administered through the PEG tube. It also included a physician's order dated 8/01/25 that directed staff to give 360 milliliters (mLs) of Nutren 1.5 Enteral liquid (nutritional supplement) via PEG-tube 4 times a day related to dysphagia, oropharyngeal phase and flush with 60 mLs H2O (water) before and after feeding. The Care Plan revised 11/26/24 directed staff to administer the resident's medications as ordered. It also directed staff to provide Resident #1 with tube feeding as ordered and monitor for tolerance. The October Medication Administration Record (MAR) confirmed the resident did not receive his scheduled evening medications on 10/24/25 and directed the reader to see Progress Notes. It also indicated the resident received his AM nutritional supplement on 10/25/25. The Progress Notes dated 10/24/25 indicated seven (7) of the resident's scheduled evening medications were not done because Staff A, Registered Nurse (RN) could not access the G-tube. On 10/30/25 at 5:35 am, Staff A, Registered Nurse (RN) stated he could not give Resident #1 his scheduled medications because he could not access Resident's #1's G-tube and he charted against them. He also stated when he returned to work on 10/24/25, the resident had a new feeding tube with a different access port and he could not find the specific feeding syringe designed for the resident's new tube. He further stated he still had access to piston syringes (feeding syringe with a long, narrowing tip used to access feeding tubes) but indicated they were not the specific syringe for the resident's new feeding tube. He admitted he did not contact the on-call nurse and waited to report it to Staff B the following morning because he did not feel Resident #1 would miss any nighttime medications that would be detrimental. He mentioned when Staff A arrived for the morning shift, she confirmed the piston syringe was not the syringe specifically designed for the resident's feeding tube, and she contacted the Director of Nursing (DON). Staff A revealed the DON instructed Staff B on how to obtain the office keys to access the syringes specifically designed for the resident's feeding tube. The Progress Notes dated 10/25/25 revealed Staff B, RN, documented the resident's abdomen was non-distended and he did not have pain prior to the 10/25/25 morning tube feeding. It further revealed that when Staff B began pouring the nutritional supplement in the resident's tube, the resident got really jerky and made it difficult to finish. Staff B documented the resident started complaining of pain higher than 10 on a 0-10 pain scale and that she finished feeding the resident, flushed the tube, and assessed his abdomen which was described as distended and painful upon light pressure. On 10/30/25 at 9:00 am, Resident #1 confirmed he didn't receive his nighttime medications on 10/24/25. He also confirmed he notified Staff B of his pain when she began feeding him through his tube on 10/25/25. On 10/30/25 at 9:37 am, Staff B stated she continued feeding the resident after his complaints of pain because she thought he had not eaten enough during previous shifts and his pain was potentially due to hunger. She said she had no idea what his squirmy reaction was for but she knew patients were sometimes tender after surgeries. She stated based on his reaction, she didn't know whether to stop or finish because she didn't know if it was pain or hunger. On 10/30/25 at 10:20 am, the DON stated the piston syringes would have fit the resident's feeding tube. An observation of the accessible piston syringes and the resident's feeding tube revealed the syringes would have functioned in administering the resident's medications. On 10/30/25 at 11:18 am, the DON stated Staff A should have called the on-call nurse regarding the inability to access the resident's feeding tube and escalated it as needed. She also stated Staff B should have stopped the action and contacted the DON. An undated policy titled Care and Treatment of Feeding Tubes indicated the facility policy is to utilize feeding</p>		