STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165275	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Creston	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)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Record (EHR) review, resident interviews, staff interviews, and policy review the facility failed to provide restorative services to maintain or improve residents abilities for 6 of 19 residents reviewed (Resident #12, #18, #19, #3, #4, and #23). The facility reported a census of 19.Findings include:1. The Minimum Data Set (MDS) dated [DATE] for Resident #12 documented a Brief Interview for Mental Status (BIMS) of 11 indicating moderate cognitive impairment. The MDS also documented diagnoses of age-related physical debility, generalized muscle weakness, abnormalities of gait and mobility and a need for assistance with personal care.Review of the residents EHR documented no restorative documentation. On 6/22/26 at 3:35 PM Resident #12 stated he would like any therapy especially with the falls. Stated he does not receive restorative therapy, physical therapy or occupational therapy. On 6/24/26 at 4:24 PM Staff B, Physical Therapy Assistant (PTA) stated Resident #12 was not currently on her case load and did not know if he had a restorative program. Staff B stated there were residents at the facility that would benefit from a restorative program. 2. The MDS dated [DATE] documented Resident #18 had a BIMS of 14 indicating no cognitive impairment. The MDS further documented Resident #18 as dependent on lower body dressing, personal hygiene. The MDS documented Resident #18 required substantial to maximal assistance with upper body dressing and bathing for functional abilities.On 6/22/26 at 3:28 PM Resident #18 stated she had requested to be in a restorative program and had not received an answer from the facility staff on when she could start the program. She further explained she would like to be involved in a therapy program to be able to move better. 3. The MDS dated [DATE] documented Resident #19 had a BIMS of 15 indicating no cognitive impairment. The MDS further documented Resident #19's functional abilities as dependent with toileting hygiene with partial to moderate assistance with upper body dressing, lower body dressing and personal hygiene. On 6/22/26 at 10:23 AM Resident #19 stated he would like to do a restorative program to continue to gain strength as his goal was to return home. Resident #19 further explained he used to do Physical Therapy (PT) though was unaware of why it stopped and was afraid he would regress in the progress he had made previously.On 6/24/26 at 4:28 PM Staff B, Physical Therapist Assistant (PTA) stated Resident #19 was discharged from Physical Therapy in November of 2025 without a restorative program initiated. Staff B further explained Resident #19's ambulation assessment documented he was a stand-pivot with 1 assist for transfers. Staff B stated Resident #19 would benefit from a restorative program and that she was unaware of any residents currently on a restorative program. On 6/24/26 at 10:23 AM Staff C, Social Services Coordinator/Admissions and Discharge Coordinator stated the facility did not currently have a restorative program as the facility needed to hire for the position.On 6/24/26 at 5:00 PM the Administrator stated the facility does not currently have an active restorative program.4. Review of the Restorative Binder presented by the Administrator documented Resident #3, Resident #4, and Resident #23. On 6/24/26 at 2:43 PM Staff D, Certified Nurse Assistant (CNA) stated she had worked at the facility for a little over a year. Staff D explained when she first started at the facility there was some restorative being completed. Staff D stated in the last several months restorative has (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not been done with any of the residents. Staff D stated when residents were on restorative they would have to look at the care plan because it was not on a task in the computer or in a book to document. On 6/24/26 at 5:00 PM the Administrator stated the facility had the Director of Rehab for the facility develop restorative programs for 3 residents but have not started the programs for those residents as of this time. The Administrator acknowledged there was no place to document the restorative was being completed and the restorative had fallen off. The Administrator stated there was not currently a restorative program at the facility for any of the residents but they were working on getting one going.Review of an undated policy provided by the facility titled, Restorative Program Process documented the purpose was to ensure the residents achieved and maintained the highest level of function. The process was upon admission, quarterly, and with significant change the resident's level of function would be assessed by the licensed nurse or in collaboration with therapy. Based on the results of the assessment the licensed nurse would develop a care plan showing the resident's individual problem, determine approaches/interventions and set goals. The licensed nurse would develop a restorative nursing program with individualized interventions and goals which may include recommendations for strategy and adaptive equipment from therapy. Review of a facility provided policy titled, Restorative Program Process dated 10/26/21 documented its purpose to ensure the facility's residents achieve and maintain their highest level of function based upon admission, quarterly assessments, and with significant changes with the resident's level of function. The policy documented residents will be assessed by the licensed nurse or in collaboration with the therapy department. The policy further documented based on the results of the assessment the licensed nurse will develop a restorative nursing program with individualized interventions and goals which may include recommendations for strategy and adaptive equipment from therapy. The nurse will educate all direct staff assigned to the resident(s) on their restorative program, monitor staff to ensure compliance with the program, monitor daily restorative documentation, care plan the specifics goals and interventions, write a monthly restorative nursing summary for the resident(s) progress, make referrals to therapy as needed and develop a discharge plan when the restorative program is no longer needed.

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interviews, staff interviews, Electronic Health Record (EHR) reviews and policy review the facility failed to provide residents with dignity, respect and interact with residents in a kind and considerate manner during cares for 2 of 2 residents reviewed (Resident #2 and Resident #19). The facility reported a census of 19 residents. Findings Include: 1. The Minimum Data Set (MDS) dated [DATE] documented Resident #2 had a Brief Mental Interview for Mental Status (BIMS) of 1 indicating severe cognitive impairment. On 6/25/26 at 3:58 PM Staff J, Certified Nurse Assistant (CNA) stated she had witnessed Staff E, Register Nurse (RN) yelling at Resident #2 to act her age and comments to Resident #2 telling her to shut up on multiple occasions. Staff J stated she reported the incidents to Staff F, previous Director of Nursing (DON). 2. The MDS dated [DATE] documented Resident #19 had a BIMS of 15 indicating no cognitive impairment On 6/24/26 at 12:38 PM Resident #19 stated he had witnessed on multiple occasions Staff E yell at Resident #2 to shut the hell up and make belittling comments to her frequently. Resident #19 stated Staff E made him feel very uncomfortable, uneasy and that he was not able to ask for assistance when needed from Staff E. Review of document titled, Employee Termination Worksheet documented Staff E had a termination date of 4/8/26 for misconduct. On 6/24/26 at 2:43 PM Staff D, CNA stated she had witnessed staff yell at a resident. Staff D stated she reported the incident and the Director of Nursing (DON) came in and asked him to leave. Staff D explained the nurse was Staff E, Registered Nurse (RN) and he was terminated. Staff D stated she witnessed the incident. Staff D explained it was Resident #2 that Staff E yelled at. Staff D said Resident #2 was yelling and was confused. Staff D explained Staff E told the resident she was in a nursing home and where else would she be at her age. Staff D explained Staff F, Previous DON and Staff E were really close and Staff F would also talk down to Resident #2. Staff D stated she had called the DON because she felt it was verbal abuse. On 6/24/26 at 10:00 AM Staff G, CNA stated she did not hear Staff E yell at Resident #2 but her co-worker Staff D told her that Staff E had yelled at Resident #2. Staff G explained that Staff D told her that she wrote a report about the incident and Staff F came in and walked Staff E out. Staff G explained that Staff E had an attitude with everyone, all the residents and all the staff. On 6/24/26 at 9:09 AM Staff H, CNA stated Staff E was fired because he yelled at Resident #2. Staff H stated Staff E told Resident #2 to shut up and stop crying. Staff H explained she had heard about it the next day from Staff D. On 6/24/26 at 9:09 AM Staff I, CNA stated Staff E was fired because he yelled at Resident #2. Staff I stated Staff E told Resident #2 to shut up and stop crying. Staff I explained she had heard about it the next day from Staff D. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/24/26 at 12:24 PM the Administrator stated Staff E was terminated for yelling at a resident. The Administrator stated the incident was turned into the state office as a result and was determined to be a do not investigate incident. The Administrator stated his termination document explained the investigations. The Administrator stated human resources completed an investigation. The Administrator stated the incident occurred 4/1/26. Review of a policy provided by the facility dated 1/30/24 titled, Promoting and Maintaining Resident Dignity documented it was the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. Speak respectfully to residents; avoid discussions about residents that may be overheard.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, Electronic Health Record review (EHR) and policy review the facility failed to provide a clean and homelike environment. The facility failed to remove black fuzzy substance from window air conditioning units, surrounding window trim and walls to 2 of 2 resident rooms reviewed (Resident #18 and #19). The facility reported a census of 19. Findings Include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #18 had a Brief Mental Interview for Mental Status (BIMS) of 14 indicating no cognitive impairment. On 6/22/26 at 3:11 PM an observation revealed a black and fuzzy substance inside of window air conditioning unit in Resident #18's window. On 6/22/26 at 3:13 PM Resident #18 stated she believed mold was inside her window air conditioning unit. She explained she reported it to the facility and was told it would be replaced in April. Resident #18 further explained that her room was musty and smelled because of it. 2. The MDS dated [DATE] documented Resident #19 had a BIMS of 15 indicating no cognitive impairment. On 6/22/26 at 3:52 PM observation revealed a black and fuzzy substance inside of Resident #19's window air conditioning unit, surrounding window trim and down the wall in his room. On 6/22/26 at 3:52 PM Resident #19 stated he was unsure why the window air conditioning unit was still in his window because it was not being used. Resident #19 further explained that he had a new wall unit he utilized for air conditioning. On 6/23/26 at 1:36 PM Staff A, Maintenance Director acknowledged a black and fuzzy substance in Resident #18's window air conditioning unit and in Resident 19's window air conditioning unit, the surrounding window trim and down the wall. Staff A stated he did not believe the substance was mold because it was impossible for it to grow in a window air conditioning unit. Staff A further explained he had been cleaning the area with bleach.On 6/25/26 at 1:39 PM the Administrator stated she would expect the window air conditioning units to be replaced.The facility was unable to provide a policy related to a clean / homelike environment for the residents at the facility.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy review, the facility failed to accurately complete a comprehensive Minimum Data Set (MDS) assessment for 3 of 15 residents (#5, #7, #8). The facility reported a census of 19 residents.Findings include: 1. Resident #5's quarterly MDS dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of orthostatic hypotension (drop in blood pressure upon standing), morbid obesity, and emphysema. It indicated the resident received tracheostomy care while a resident at the facility. The Electronic Health Record (EHR) did not include physician's orders for tracheostomy care. The Progress Notes did not include entries regarding tracheostomy care. The Care Plan revised 4/12/26 did not include tracheostomy care. On 6/22/26 at 12:46 PM, Resident #5 stated she never had a tracheostomy. On 6/24/26 at 12:21 PM, the Director of Nursing (DON) stated the tracheostomy was entered in the MDS in error. 2. The MDS dated [DATE] for Resident #7 documented a BIMS of 13 indicating no cognitive impairment. The MDS also documented a diagnosis of essential (primary) hypertension. Review of Resident #7's EHR titled, Orders since Resident #7's admission documented no use of anticoagulant therapy Review of Resident #7's MDS indicated use of anticoagulant therapy. Review of Resident #7's EHR titled, Care Plan documented no focus, goal, or interventions related to anticoagulant therapy. On 6/24/26 at 2:20 PM the Director of Nursing (DON) stated she would expect the MDS would have an accurate assessment of Resident #7. The DON stated Resident #7 was on aspirin and that was incorrectly identified as an anticoagulant. 3. Resident #8's annual MDS dated [DATE] identified a BIMS score of 06 out of 15 which indicated severely impaired cognition. It included diagnoses of blood clots in the lungs, irregular heartbeat, and difficulty walking. It also indicated the resident was taking an anticoagulant medication (blood thinner) in the 7-day look-back period. The EHR did not include a physician's order for a blood thinner. The Progress Notes indicated the resident received a blood thinner in the 7-day look-back period preceding 1/27/25. The Care Plan revised 4/11/26 did not indicate the resident took a blood thinner. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/24/26 at 12:21 PM, the DON stated the anticoagulant was entered in the MDS in error. Review of a policy updated 4/25 provided by the facility titled, Conducting an Accurate Resident Assessment documented The appropriate, qualified health professional will correctly document the resident's medical, functional, and psychosocial problems and identifies resident strengths to maintain or improve medical status, functional abilities, and psychosocial status. A registered nurse will coordinate the RAI completion process with the appropriate participation of health professionals. The registered nurse is responsible for certifying that the assessment has been completed.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Record (EHR) review, staff interview, and policy review, the facility failed to refer a resident with a negative Level I result for the Preadmission Screening and Resident Review (PASRR), who had an identified mental disorder, intellectual disability or other related condition that was not addressed on the PASRR completed prior to admission to the facility, to the appropriate state-designated authority for Level II PASRR evaluation and determination for Resident #3. The facility failed to refer Resident #3 to the PASRR appropriate state-designated authority for Level II PASSR evaluation and review for determination when a new antidepressant medication was started. The facility failed to re-submit a Level II PASRR with a 180 day time limited approval to the appropriate state-designated authority for Level II PASRR evaluation and determination for Resident #14. The facility reported a census of 19 residents.Findings Include: 1. The Minimum Data Set (MDS) dated [DATE] documented Resident #3 had a Brief Mental Interview for Mental Status (BIMS) of 14 indicating no cognitive impairment. The MDS further documented Resident #3 had a diagnosis of Post Traumatic Stress Disorder (PTSD) on admission with an admission date of 12/4/25. Review of document dated 12/2/25 titled, Preadmission Screening and Resident Review Screening Notice (PASRR) documented no diagnosis of PTSD under the diagnosis of mental health diagnoses portion of the screening. Review of document titled, Orders documented medication Mirtazapine oral tablet with drug classification antidepressant started on 5/18/26. Interview on 6/24/26 at 10:38 AM the Administrator stated they did not currently have any one in the facility assigned to do PASRR review or submission. She acknowledged the PTSD diagnosis and antidepressant medication would need to be on the PASRR or a new PASRR needed to be submitted with the information for review. 2. Resident #14's quarterly MDS dated [DATE] identified a BIMS score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of depression and bipolar disorder. It revealed she required setup assistance with eating and oral hygiene, maximal assistance with bathing and upper body dressing, and was dependent with all other Activities of Daily Living (ADLs) and mobility. It revealed the resident admitted to the facility on [DATE]. The Care Plan dated 11/05/25 included the resident's Level II PASRR and documented the 180-day approval. A document titled Notice of PASRR Level II Outcome dated 10/31/25 revealed the resident was approved for a 180-day time limit. The Electronic Health Record (EHR) Miscellaneous tab document list did not include an updated Level I PASRR determination after the 180-day time limited approval ended on 4/29/26. On 6/23/26 at 9:43 AM, the Administrator stated she identified on 5/01/26 resident PASRRs were not up-to-date. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/26 at 1:30 PM, the Regional Clinical Specialist stated the facility did not have a policy specific to PASRR submission and follows regulatory PASRR requirements.