

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: 165311	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Accura Healthcare of Le Mars		STREET ADDRESS, CITY, STATE, ZIP CODE 954 7th Avenue SE Le Mars, IA 51031	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and policies reviewed the facility failed to prepare, serve and distribute food in accordance with food service safety for general practices of mealtime service. The facility reported a census of 40 residents. Findings include: Observed on 7/13/26 at 10:05 during the initial kitchen walk through Staff B, Cook, and Staff C, Cook, with visible facial hair without beard nets, and the vent above the preparation table with dust fluff hanging from it. Continuous observation on 7/14/26 at 11:30 AM revealed the following: A. Staff B, Staff C, and Staff D, Cook, with visible facial hair without beard nets. B. Staff E, Cook, donned gloves without hand hygiene, opened a bag of lettuces, used the gloved right hand to reach in and put the lettuce on the plate. The staff closed the bag and placed it in a resealable plastic bag. C. During meal preparation and serving the serving utensils were placed on counters and the preparation table without barriers. D. Staff C donned gloves without hand hygiene and prepared room trays and served to the dining room with the use of serving utensils for the steam table foods. E. Staff C touched the bread packaging and removed sliced bread using the gloved left hand, placed it on the surface, held the bread in place while using the right gloved hand to butter the bread. The staff used either gloved hand to place the bread on the plates. On 7/15/26 at 8:48 AM the Dietary Services Manager (DSM) stated all staff with beards were expected to wear beard nets and the kitchen had them available. When discussing and looking at the vent over the prep table, the DSM stated maintenance assisted with that and a work order would be submitted. The DSM stated staff should be using a barrier of some sort on the counters/prep table versus placing the utensils on the counters/prep table. When asked about the use of gloves and hand hygiene, the staff stated the kitchen staff should wash their hands prior to donning gloves and gloves were worn with any ready to eat food. The DSM stated staff should not touch food with gloved hands when they had touched other items with gloves on; the staff should have used tongs/utensils for the bread and lettuce. The DSM stated the dietitian had provided education on use of tongs with bread rather than the use of gloves. On 7/15/26 at 10:05 AM the Administrator with the Regional Nurse Consultant present stated staff should be completing hand hygiene prior to donning gloves and they should use utensils with food preparation. The facility's Food Safety and Sanitation Policy, dated 2021, revealed employees were required to wear beard nets when facial hair was visible. The facility's Hand Hygiene Policy, updated 11/13/24, revealed hand hygiene should be completed before donning gloves and after removing gloves.		

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	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, and interviews with the resident's family and facility staff, the facility failed to implement necessary interventions to protect 1 of 12 sampled residents (Resident #21) from abuse. The facility reported a census of 39 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #21 documented diagnoses of Alzheimer's disease, depression, and diabetes mellitus (DM). The MDS recorded a Brief Interview for Mental Status (BIMS) score of 08, indicating moderate cognitive impairment. During an interview on 7/15/26 at 12:25 PM, Resident #21's niece reported that on 3/5/2026, she was notified by the resident's banking institution regarding potentially fraudulent charges on the resident's personal account. According to the bank, these charges involved checks written by the resident's ex-stepdaughter. At that time, the ex-stepdaughter, identified as Staff F, served as the facility Administrator and was designated as one of the resident's [NAME] of Attorney (POA). The niece further reported concerns regarding medical decisions and care provided at that time. Additionally, the niece stated that she filed a protection order on behalf of Resident #21 against Staff F, which was served on 3/30/26. The Progress Note for Resident #21 on 3/9/26 at 10:15 AM documented the following: Adult Protection Services (APS) showed up on Saturday to see Resident #21 and asked for a medication list and said she would return on Sunday but did not come back on Sunday (3/11/26). During an interview on 7/15/26 at 3:25 PM, an Adult Protection Services Worker (APSW) reported that while at the facility, she informed Staff G, Executive Director of Operations, of the allegations of financial exploitation by Staff F regarding Resident #21 and concerns about the resident sleeping on the couch. The SW stated that when Staff G was informed, Staff G replied, They are allegations, we are going to leave them at allegations until APSW completes the report. The APSW noted that she would need to review her notes before providing the specific dates of her facility visit. During an interview on 7/15/26 at 2:15 PM, the current Administrator stated that Staff G, the Executive Director of Operations, was out of the office. While the Administrator was able to contact him by phone, he remained unavailable for the remainder of the day. The Administrator further reported that Staff F, the former Administrator, notified Staff G on 3/30/26, the day the court order was served, that she had received a restraining order regarding Resident #21. Staff F has not worked at the facility since 3/30/26, the date the protection order was served. The Administrator reported Staff G resigned on 5/19/26. During an interview on 7/15/26 at 3:37 PM, Staff H, former Director of Nursing (DON), acknowledged that Resident 21's niece had expressed concerns regarding financial and medical decisions made by Staff F, specifically involving hospice care and Power of Attorney (POA). Although Staff H could not recall the timing of this conversation, she reported communicating these concerns to Staff G, Executive Director of Operations. When asked whether the concerns should have been reported to the Department of Inspections, Appeals and Licensing (DIAL), Staff H stated, Until something is proven, there is nothing we can do. Staff H maintained that the allegations did not warrant reporting to DIAL, asserting that there were no issues with the resident's facility funds or billing. Instead of initiating an investigation or report, Staff H stated that Staff G instructed her to document and we will keep an eye on it. On 7/16/26 at 7:53 AM the APW provided the following via email: On 03/13/2026, the APSW contacted the Executive Director of Operations. He was informed of the concerns. He stated that Staff F will remain as the Administrator until the completion of the assessment. He stated that, to his knowledge, Resident #21 was being cared for and he had no (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concerns. The Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy updated on 10/19/22 identified: All allegations of Resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative. All allegations of Resident abuse shall be reported to the Iowa Department of Inspections and Appeals not later than two (2) hours after the allegation is made. All allegations of Resident neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation shall be reported to the Iowa Department of Inspections and Appeals, not later than two (2) hours after the allegation is made, if the events that cause the allegation result in serious bodily injury, or not later than twenty-four (24) hours if the events that cause the allegation involve neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation, but do not result in serious bodily injury. If there is a reasonable suspicion that the allegation of abuse also constitutes a crime committed against the resident by any person, whether or not the alleged perpetrator is employed by the facility, the Elder Justice Act requires the matter must also be reported to law enforcement. While the federal regulations require all abuse allegations be reported to DIA within 2 hours, the Elder Justice Act has a different time frame for reporting to the police/sheriff. If the allegation of abuse (that results from a crime) results in serious bodily injury to a resident, a report must be made to law enforcement not later than two (2) hours after the allegation is made. If the allegation of abuse does not result in serious bodily injury, a report must be made to law enforcement not later than twenty-four (24) hours. During an interview on 7/16/26 at 10:05 AM, the Administrator, DON, and Regional Nurse Consultant were present. The Administrator confirmed that the facility was required to notify DIAL as soon as the abuse allegations were reported to the facility.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, and interviews with the resident's family and facility staff, the facility failed to implement measures to prevent further potential abuse, neglect, exploitation, or mistreatment for 1 of 12 sampled residents (Resident #21). The facility reported a census of 39 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #21 documented diagnoses of Alzheimer's disease, depression, and diabetes mellitus (DM). The MDS recorded a Brief Interview for Mental Status (BIMS) score of 08, indicating moderate cognitive impairment. During an interview on 7/15/26 at 12:25 PM, Resident #21's niece reported that on 3/5/2026, she was notified by the resident's banking institution regarding potentially fraudulent charges on the resident's personal account. According to the bank, these charges involved checks written by the resident's ex-stepdaughter. At that time, the ex-stepdaughter, identified as Staff F, served as the facility Administrator and was designated as one of the resident's [NAME] of Attorney (POA). The niece further reported concerns regarding medical decisions and care provided at that time. Additionally, the niece stated that she filed a protection order on behalf of Resident #21 against Staff F, which was served on 3/30/26. The Progress Note for Resident #21 on 3/9/26 at 10:15 AM documented the following: Adult Protection Services (APS) showed up on Saturday to see Resident #21 and asked for a medication list and said she would return on Sunday but did not come back on Sunday (3/11/26). During an interview on 7/15/26 at 3:25 PM, an Adult Protection Services Worker (APSW) reported that while at the facility, she informed Staff G, Executive Director of Operations, of the allegations of financial exploitation by Staff F regarding Resident #21 and concerns about the resident sleeping on the couch. The SW stated that when Staff G was informed, Staff G replied, They are allegations, we are going to leave them at allegations until APSW completes the report. The APSW noted that she would need to review her notes before providing the specific dates of her facility visit. During an interview on 7/15/26 at 2:15 PM, the current Administrator stated that Staff G, the Executive Director of Operations, was out of the office. While the Administrator was able to contact him by phone, he remained unavailable for the remainder of the day. The Administrator further reported that Staff F, the former administrator, notified Staff G on 3/30/26, the day the court order was served, that she had received a restraining order regarding Resident #21. Staff F has not worked at the facility since 3/30/26, the date the protection order was served. The Administrator reported Staff G resigned on 5/19/26. During an interview on 7/15/26 at 3:37 PM, Staff H, former Director of Nursing (DON), acknowledged that Resident 21's niece had expressed concerns regarding financial and medical decisions made by Staff F, specifically involving hospice care, nursing care and Power of Attorney (POA). Although Staff H could not recall the timing of this conversation, she reported communicating these concerns to Staff G, Executive Director of Operations. When asked whether the concerns should have been reported to the Department of Inspections, Appeals and Licensing (DIAL), Staff H stated, Until something is proven, there is nothing we can do. Staff H maintained that the allegations did not warrant reporting to DIAL, asserting that there were no issues with the resident's facility funds or billing. Instead of initiating an investigation or report, Staff H stated that Staff G instructed her to document and we will keep an eye on it. On 7/16/26 at 7:53 AM the APW provided the following via email: On 03/13/2026, the APSW contacted the Executive Director of Operations. He was informed of the concerns. He stated that Staff F will remain as the administrator until the completion of the assessment. He stated that, to his knowledge, Resident #21 was being cared for and he had no concerns. The Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	updated on 10/19/22 identified:Investigation Protocols:The administrator or designee will complete documentation of the allegation of Resident abuse and collect any supporting documents relative to the alleged incident. If there is physical evidence that can be preserved, attempt to do so, and maintain it in a safe location to minimize risk of evidence being tampered with.Initial/Immediate Protection During Facility Investigation: 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. 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: (1) suspending the employee; (2) 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 (3) 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. Following completion of the facility investigation, if the facility concludes that the allegations of resident abuse are unfounded, the employee may be allowed to return to job duties involving resident contact, but the employee must maintain a separation and have no contact with the resident alleged to have been abused, by reassigning the accused employee to an area of the facility where no contact will be made between the accused employee and the resident alleged to have been abused. This separation must be maintained until the Department concludes its investigation and issues the written results of its investigation. Note: if the DIA determines there was abuse (even though the facility did not substantiate the abuse), there is risk that DIA could cite the facility with Immediate Jeopardy, for allowing an abuser to have access to other residents while the matter was being investigated.During an interview on 7/16/26 at 10:05 AM, the Administrator, DON, and Regional Nurse Consultant were present. The Administrator confirmed that the facility was required to separate and protect the alleged victim from the alleged perpetrator.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and policy review the facility failed to develop and implement a program to maintain a resident's range of motion (ROM) and contracture management needs based on the comprehensive assessment and under the direct guidance of a Registered Nurse (RN) for 1 of 2 residents (Resident #1) reviewed. The facility reported a census of 40. Findings include: Resident #1's Quarterly Minimum Data Set (MDS) assessment dated [DATE] disclosed the resident had short term and long term memory deficits, and severe impairment with daily decision making. The document revealed the resident had an impairment in movement of both arms and both legs. The document included diagnoses of arthritis, Cerebral Palsy, and contracture of an unspecified foot. The document coded 0 days of at least 15 minutes in the past 7 days of the assessment period for Restorative Nursing Programs (RNP). Resident #1's Annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had an impairment in movement of both arms and both legs. The document coded 0 days of at least 15 minutes in the past 7 days of the assessment period for Restorative Nursing Programs (RNP). Resident #1's Care Plan revised 6/13/25 disclosed a focus area of participation in a restorative nursing program with a resolved date of 7/13/26. Interventions for staff included participating in group exercises for the Restorative Nursing Assistant (RNA), Activities Department, and Certified Nursing Assistant (CNA), PROM for the upper and lower body to be completed by nursing, RNA and CNA. The document included a focus area for potential for pain due to limited mobility and contractures with interventions for pain medication, repositioning and observation for signs of pain. The clinical record's Clinical Medical Diagnoses included unspecified intellectual disabilities and quadriplegia (partial or total loss of sensory and motor function in all four limbs and torso). The clinical record's Point of Care documentation revealed no Restorative Nursing Program documentation. The clinical record's Plan of Care History revealed a program for passive range of motion (PROM) for lower body flexion and extension of hip and knees 1 set of 10 repetitions, 1 to 6 days a week with a resolved date of 2/27/26. The clinical record's Plan of Care History revealed a program for PROM for upper body flexion and extension of the shoulder and elbow 1 set of 10 repetitions, 1 to 6 days a week with a resolved date of 2/27/26. The clinical record's Progress Notes from 7/1/25 to 7/14/26 revealed the following entries: 7/8/25 10:02 AM Restorative Nursing Note - resident completed 13 days and 3 evenings of restorative program with no documented refusals. 8/26/25 4:29 PM Quarterly Nursing Assessment - resident had upper extremity functional limitation in ROM of both sides of the body, lower extremity functional limitation in ROM of one side of the body, and participated in a restorative nursing program. 11/26/25 3:40 PM Quarterly Nursing Assessment - resident had upper extremity functional limitation in ROM of both sides of the body, lower extremity functional limitation in ROM of one side of the body, and participated in a restorative nursing program. 12/4/25 11:38 AM Restorative Nursing Note - resident had a PROM program and was compliant with staff when offered in November with no signs of pain or discomfort. 12/25/25 1:28 PM Restorative Nursing Note - resident showed no signs of pain or discomfort with PROM for upper and lower body. 2/26/26 11:45 AM Quarterly Nursing Assessment - resident participated in a restorative nursing program. 5/27/26 2:00 PM Quarterly Nursing Assessment - resident had upper extremity functional limitation in ROM of both sides of the body, lower extremity functional limitation in ROM of one side of the body, and did not participate in restorative nursing program. On 7/14/26 at 10:44 AM the Director of Nursing (DON) with the Regional Nurse Consultant present stated there was not a (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse in charge of the Restorative Nursing Program, and acknowledged the facility did not have a Restorative Nursing Program. The Regional Nurse Consultant indicated that was something they were working on. On 7/15/26 at 10:26 AM the Administrator and Regional Nurse Consultant acknowledged the facility did not have a restorative nursing program and could not explain why and when the program stopped. The Administrator reported that she and the DON were both new to their positions and are still learning/working to put systems back in place. 7/15/26 10:40 AM The DON with the Regional Nurse Consultant present, stated she had started her position as DON in the past 2 months, and had recognized there was not a Restorative Nursing Program in place. The staff stated she was working to address this by changing the scheduling and working to identify the staff for this program. The DON stated there was a position allocated in the budget for the Restorative Nursing Program. The Facility Assessment approved 6/6/26 revealed the facility provided mobility and fall prevention through restorative nursing and contracture prevention and care. The document disclosed the facility had 1 full time equivalent position for a Restorative Nursing Assistant. The facility's Restorative Program Process document, updated 10/26/21, revealed a resident's level of function would be assessed upon admission, quarterly or with a significant change by the licensed nurse or with collaboration of therapy. The document included the licensed nurse would develop a RNP with recommendations from therapy for strategy and adaptive equipment needs. The document disclosed the licensed nurse would educate the staff on the program, monitor the staff and resident(s) to ensure compliance daily, and write a monthly restorative nursing summary to track the resident(s) progress.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, document review, interviews, and policy review the facility failed to provide a well balanced diet that meets nutritional and special dietary needs of residents by not following the approved menu for a meal. The facility reported a census of 40 residents. Findings include: Continuous observation of the meal service on 7/14/26 beginning at 11:30 AM noted the following: Staff C, Cook, removed 2 pork loins from the oven, placed on the prep table and proceeded to cut the meat into serving sizes. Staff C stated during serving of the goulash, he did not have a #6 scoop, but used the closest size he had and was using heaping servings to get to 6 ounces (oz.). Staff C prepared 3 pureed plates that consisted of goulash, cauliflower with cheese, mashed sweet potatoes, and twisted strawberry shortcake. Staff C stated he was not pureeing the asparagus as it was too difficult to modify due it being a stringy vegetable. Staff C pureed 3 servings of goulash with almond milk and after achieving the consistency divided the modified food onto the 3 plates. Staff C pureed 3 servings of cauliflower with cheese and after achieving the consistency divided the modified food onto the 3 plates. Staff C pureed 3 servings of twisted strawberry shortcake and after achieving the consistency divided the modified food onto the 3 plates. The facility's menu spreadsheet for the noon meal on 7/15/26 for regular diets provided the residents were to be served 3 oz. glazed pork loin, 1 baked yam, 4 oz. cauliflower with cheese, bread with margarine, and twisted strawberry shortcake. The pork loin was not weighed as it was cut or before plating, and consisted of varying sizes. The facility's menu spreadsheet for the noon meal on 7/15/26 for pureed diets provided the residents were to be served (1) 3 oz. serving of pureed pork loin, 8 oz. scoop of mashed sweet potatoes, (1) 4 oz. serving of cauliflower with cheese, pureed bread with margarine, and pureed twisted strawberry shortcake. The alternate pureed menu consisted of 6 oz of pureed goulash and 4 oz. serving of asparagus. The staff did not follow the menu for either the main option or the alternate option when preparing the pureed plates. The staff did not measure or refer to the serving size guide for portions following the modification of the goulash, cauliflower with cheese, and twisted strawberry shortcake. The facility failed to follow the menu for all residents on a regular menu who received the pork loin option due to the variance in portion sizes. The facility failed to serve and differentiate portion sizes for residents with therapeutic diets. On 7/15/26 at 8:48 AM the Dining Services Manager (DSM) stated the preparation for pureeing (3) serving sizes consisted of: obtaining 3 serving sizes of the food option, adding a liquid if necessary with the example of gravy, use the Robo Coup or hand immersion blender to achieve the desired consistency, use a measuring cup to measure how much food was modified, and refer to the guidance chart posted to obtain the correct serving size for the 3 residents. The dietary manager acknowledged by the staff serving the food directly onto the plates the residents did not receive the correct serving size. When asked about Staff C's statement of not having a #6 scoop so was heaping on the available scoop the DSM acknowledged the residents did not receive the correct serving size. When asked about the process for cutting the pork loin for serving the Dietary Manager stated the kitchen had a scale and the staff should have been weighing the meat to ensure 3 oz. servings. The staff stated she observed there was no scale present during the meal service preparation but did not want to disrupt the survey process. The DSM concurred the pork loin portions were not all the same size. When reviewing the items prepared and served to the residents on a pureed diet, the DSM stated the staff did not follow the menu for providing the necessary food items for the residents. On 7/15/26 at 10:05 AM the Administrator stated the staff should have used the appropriate serving scoop for serving the goulash. The Administrator stated residents were allowed choices for (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interviews, and policy review the facility failed to prepare, serve and distribute food in accordance with professional standards. The facility failed to provide food at a palatable, attractive, and a safe and appetizing temperature for 7 of 40 meals provided. The facility reported a census of 40 residents. Findings include: Continuous observation on 7/14/26 at 11:30 AM of noon meal service revealed the following: Staff C, Cook, prepared 3 pureed servings of goulash using almond milk, distributed them onto 3 plates, added pureed cauliflower and cheese, and mashed sweet potatoes. Staff C took the temperature of the goulash on the first plate and obtained a temperature of 119 degrees. The staff placed the loaded plate in the microwave, reheated the plate for 1 minute, removed, and took the temperature of the goulash. The temperature read 132 degrees. The staff moved the plate to the window for serving. The staff placed the second plate in the microwave for reheating for 1 minute, removed, and placed in the serving window without taking the temperature. The staff placed the third plate in the microwave for reheating for 1 minute, removed, and placed in the serving window without taking the temperature. During the course of the meal service Staff C warmed 4 individual cans of soup in the microwave by pouring each in a bowl, microwaving for 1 minute and serving them either to the dining room or room trays. The facility failed to achieve required serving temperatures and take temperatures for foods reheated in the microwave. On 7/15/26 at 8:48 AM the Dining Services Manager (DSM) stated the process for warming soup would be to pour the soup in a bowl, microwave it and take the temperature to ensure the correct temperature. The staff stated temperatures should be taken when warming soup to ensure it reached the correct temperature. The DSM stated at the end of the pureeing process the food's temperature should be checked to ensure it is at the correct serving temperature which the staff stated was 135 degrees. The staff stated if it was not 135 degrees it needed to be reheated in the microwave to reach the correct temperature. The DSM could not provide the temperature of what foods should be if they required reheating in the microwave. On 7/15/26 at 10:05 AM the Administrator acknowledged foods should be provided at the required temperatures. The facility's Resource: Minimum Cooking, Holding, and Reheating Temperatures Policy and Procedure, dated 2021, revealed the minimum cooking food temperature and holding time for reheating foods that are cooked, cooled, and reheated is 165 degrees for 15 seconds, and food that is taken from a commercially processed, hermetically sealed container or intact package is 135 degrees for no specific time.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165311	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Accura Healthcare of Le Mars		STREET ADDRESS, CITY, STATE, ZIP CODE 954 7th Avenue SE Le Mars, IA 51031	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **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 provide infection prevention measures with hand hygiene during wound care for 1 of 1 residents (Residents #20) reviewed. The facility reported a census of 40 residents. Findings include: Review of the clinical record's Minimum Data Set (MDS) tab revealed Resident #20's admission MDS Assessment and Medicare - 5 Day MDS assessment dated [DATE] were in progress. The in progress Care Plan revised 7/13/26 revealed a focus area of a pressure area on the left heel with interventions of reminding the resident to reposition every 2 hours as resident allows, pressure reducing mattress and monitoring of skin areas (identified on 7/3/26). The clinical record's Clinical Physician Orders contained an order to cleanse the left heel with saline, paint with Betadine and cover with a bandaid daily and as needed. Continue to off load heel at all times and notify the physician if the wound worsens. Observed on 7/14/26 at 11:05 AM Staff A, Licensed Practical Nurse (LPN), provide wound care to Resident #20 with the following noted: A. Staff A completed hygiene upon entering the room and placed supplies on a barrier. B. Staff A donned a gown and gloves. C. Staff A placed a barrier under the resident's foot, removed heel protector and sock. D. The staff changed gloves without hand hygiene. E. The staff cleansed the wound with saline, painted the wound with Betadine, allowed it to dry and placed a bandaid. F. Staff A changed gloves without hand hygiene. G. The staff gathered dirty supplies, placed them in the trash, secured the top, and gave it to housekeeping outside the door. H. The staff washed their hands and applied the resident's sock and heel protector. I. Staff A applied gloves without hand hygiene, obtained saline wash from table, placed on barrier at sink. J. The staff removed gloves and gown, washed their hands, and left the room with saline wash. On 7/15/26 at 10:15 AM the Administrator with the Regional Nurse Consultant present stated hand hygiene should be completed with glove changes. On 7/15/26 at 10:45 AM the Director of Nursing (DON) with the Regional Nurse Consultant present stated the expectation was for staff to complete hand hygiene with each glove change with either hand sanitizer or washing hands. The facility's Competency for Dressing Change (Non-Sterile), updated 5/11/21, revealed opportunities for hand hygiene with each glove change and glove changes to occur following removal and discarding of soiled dressing and performing of treatment. The facility's Hand Hygiene Policy, updated 11/13/24, revealed alcohol based hand sanitizers should be used immediately before putting on gloves and after glove removal. The facility's Using Gloves Policy, updated 11/13/24, revealed hand hygiene must be performed after removing gloves and did not replace hand hygiene. The document included gloves must be replaced as soon as practical when contaminated.		