STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165324	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Pleasantville, LLC	909 North State Street Pleasantville, IA 50225

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review, family, staff, and long term care ombudsman interviews, and facility policy review, the facility failed to complete a thorough and accurate discharge summary for one of two residents (Res #52) reviewed for discharge. The facility reported a census of 42 residents.Findings include: The Minimum Data Set (MDS) Assessment of Resident #52 dated 3/6/26 identified an admission to the facility date of 3/3/26. The MDS identified a BIMS score of 08 which indicated moderate cognitive impairment. The MDS documented the resident experienced delusions, and exhibited behavioral symptoms during the look-back period. The MDS documented diagnoses that included dementia with agitation, anxiety disorder and depression. The Care Plan reflected a Focus Area of Discharge Planning, dated 3/10/26. The Care Plan failed to reveal any discharge planning updates regarding the resident's discharge from the facility on 3/20/26.The Communication Note dated 3/19/26 documented a transport service would be transporting the resident to another nursing facility on 3/20/26.The Health Status Note dated 3/20/26 documented the resident discharged from the facility and the physician orders and face sheet were faxed to the receiving facility. The receiving facility was also called and given a report on the resident. The resident's Electronic Health Record (EHR) failed to reveal any documentation of discharge planning or the reason for the discharge.The resident's EHR additionally failed to reveal a recapitulation of stay.The form titled Resident Discharge Instructions dated 3/20/26 for Resident #52 documented the resident had orders for a dietary supplement twice a day and seven medications. A review of the Medication Administration Record for March of 2026 for Resident 52, when compared to the resident Discharge Instructions completed on 4/29/26 revealed the following discrepancies:Amlodipine 10 mg was included on the discharge summary, but no frequency or time of day was includedDonepezil, 10mg, was not included on the discharge summaryLisinopril, 5 mg, was not included on the discharge summaryResident #52 had orders for Memantine 20 mg, once a day. The discharge summary inaccurately noted 10 mg to be given twice a day. Buspirone, 10 mg twice a day, was not included on the discharge summaryResident #52 had orders for Seroquel, 50 mg, twice a day. The discharge summary inaccurately noted this to be given once a day. Several as needed medications for constipation were not included on the discharge summary. On 4/29/26 at 10:45 am, a family member of Resident #52 stated the family initiated the discharge process for the resident due to being unhappy with the care received at the facility. No documentation of the family member initiating the discharge was found in the resident's EHR.On 4/29/26 at 4:15 pm, the Administrator stated the resident transferred to a sister facility. The Administrator added the receiving facility had full access to the resident's EHR to see all orders and medications, etc.On 4/29/26 at 5:02 pm, the Regional Nurse Consultant stated the facility does have an assessment used for resident discharges in the EHR software. She verified the omission of this assessment in Resident #52's record and acknowledged the multiple medication discrepancies on the discharge summary form. However, she clarified the receiving facility used copies of the physician orders, not the discharge summary for the current medication list. On 4/30/26 at 12:05 pm, the Long Term Care Ombudsman reported she had not been aware of any concerns during Resident #52's stay at the facility and stated nobody had contacted her during the resident's stay. She did verify her (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	office had received notice of the resident transferring. The facility policy titled Discharge Planning Process, revision date 2/23/25 documented the following: Policy: It is the policy of this facility to develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions.Definitions: Discharge planning is a process that generally begins on admission and involves identifying each resident's discharge goals and needs, developing and implementing interventions to address them, and continuously evaluating them throughout the resident's stay to ensure a successful discharge.Policy Explanation and Compliance Guidelines:Point 2: The facility will determine the resident's expected goals and outcomes regarding discharge upon admission, routinely in accordance with the MDS assessment cycle, and as needed. a) Initial information and discharge goals will be included in the resident's baseline care plan. b) Subsequent assessment information and discharge goals will be included in the resident's comprehensive plan of care. Point 6: An active individualized discharge care plan will address, at a minimum:a) Discharge destination, with assurances the destination meets the resident's health/safety needs and preferences. b) Identified needs, such as medical, nursing, equipment, educational, or psychosocial needs. c) Caregiver/support person availability and the resident's or caregiver's/support person's capacity and capability to perform required care. d) Resident's goals of care and treatment preferences.Point 7: The ongoing process of developing the discharge plan will include a regular re-evaluation of the resident to identify changes that require modification of the discharge plan, and updating of the discharge plan, as needed, to reflect the modifications.Point 9: The facility will update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.Point 11: The evaluation of the resident's discharge needs and discharge plan will be completely documented on a timely basis in the clinical record. Point 12: The results of the evaluation and the final discharge plan will be discussed with the resident or resident's representative. All relevant information will be provided in a discharge summary to avoid unnecessary delays in the resident's discharge or transfer, and to assist the resident in adjustment to his or her new living environment. Point 13: Education needs, as identified in the discharge plan, will be provided to the resident and/or family member prior to discharge.