STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165332	A. Building B. Wing	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Stanton	213 Halland Avenue Stanton, IA 51573

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 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on clinical record review, policy review, family interview and staff interviews the facility failed to provide adequate nursing supervision for 1 of 3 residents reviewed with a high risk for elopement (Resident #2). The facility reported a census of 40.Findings include:1. The Minimum Data Set (MDS) for Resident #2, dated 8/10/25 did not document a Brief Interview for Mental Status (BIMS). Review of Progress Notes dated 8/10/25 revealed a BIMS evaluation with a BIMS of 7 indicating moderate cognitive impairment documented. The MDS also documented diagnosis of unspecified dementia. Review of Risk Assessment: Elopement dated 6/10/25 documented Resident #2 was at high risk for elopement. Risk Assessment further documented Resident #2 was considered an elopement risk at that time, wore a wander guard and had a history of exiting the building. Review of document titled, Self Report for Resident #2 had documented on 7/3/25 at approximately 2:00 pm the Director of Nursing (DON) became aware that Resident #2 was not present at an outdoor supervised activity. At approximately 2:40 pm on 7/3/25 the Executive Director was notified by the DON of the incident. Resident #2 had been returned to the facility and had not sustained any injuries. On 7/3/25 at approximately 4:45 pm the state was notified via an online portal by the Executive Director.The last time Resident #2 was seen by staff before the incident was at approximately 1:45-1:50 pm when he pushed his wife out to the front patio for the activity. At approximately 2:00 pm a female resident notified the DON that Resident #2 was no longer present at the outdoor supervised activity. Staff immediately initiated a head count and started missing resident procedures. The DON notified Resident #2's Power of Attorney (POA) at 2:05 pm. On 7/3/25 at 2:06 pm Resident #2's son called the facility to report Resident #2 walked to the family home and they were returning with Resident #2. Head to toe assessment done on Resident #2 on 7/3/25 at 2:30 pm by the DON with no problems noted at this time, vitals assessed and WNL. Resident #2 had last eaten at approximately 11:30 am on 7/3/25. All staff (DON, BOM, Activities, nurse manager, dietary manager, and multiple CNA's in and out) present during the incident were interviewed and it was concluded that the resident was outside attending a supervised group activity. Staff were passing ice cream, providing entertainment, and assisting other residents when the DON was alerted by another resident of Resident #2's walking away from the group activity. Staff immediately initiated a head count and started missing resident procedures and resident was returned to the facility by family approximately 6 minutes after the notification to staff. The resident walked to his family home near the facility, returned without incident and no injuries observed.Resident #2's Care Plan at the time of the incident stated Independent for transfers/ambulation and the resident is an elopement risk/wanderer. The following interventions were listed on the plan of care: call family to see if they can take him to the farm as this usually calms him down for a period of time; distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book; provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes; serve me whiskey daily in the evening as ordered by my Dr as I have a history of attempts to elope to go home to get m whiskey/alcohol; the resident's triggers for wandering/eloping are wanting to go home and behavior is de-escalated by 1:1 or calling the family to come visit the resident. These interventions were being followed as stated in his care plan at the time of the incident.Review of Resident #2's Orders documented a physician's order with a start date of 10/24/23 for wander guard 24/7 and to check placement / function every shift for elopement risk.Review of Resident #2's Treatment Administration Record (TAR) for 7/25 documented a physician's order with a start date of 10/24/23 for wander guard 24/7 and to check placement / function every shift for elopement risk.Review of Resident #2's Care Plan related to elopement risk intervention with start date of 1/8/24 and revision on 6/30/25 documented to distract residents from wandering by offering pleasant diversions, structured activities, food, conversation, television and books. Also an intervention with a start date of 1/8/24 and revision date of 1/8/24 Resident #2's triggers for wandering / eloping are wanting to go home.On 10/6/26 at 11:28 Resident #2's Son stated the facility did not call him and he did not call the facility. Resident #2's Son stated he was headed to the family house because he helped with yard work at the house. Resident #2's Son stated he went into the house because doors were left open and apparently Resident #2 had just gotten there. Resident #2's Son stated he asked Resident #2 if the facility knew he was gone. Resident #2's Son stated once he pulled out of the driveway the facility staff were within a block of the house. Resident #2's Son stated he did not know how long Resident #2 had been away from the facility. Resident #2's Son stated the family house was about 3 blocks from the facility. Resident #2's Son stated Resident #2 was not injured