STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165382	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Knoxville, LLC	606 North Seventh Street Knoxville, IA 50138

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on clinical record review, policy review, and staff interviews, the facility failed to carry out a system to receive controlled substances for 1 of 1 residents reviewed for a missing narcotic(Resident #54). The facility reported a census of 45 residents. Findings included: The Minimum Data Set(MDS) assessment tool, dated 8/17/25, listed diagnoses for Resident #54 which included chronic pain syndrome, seizure disorder, and depression. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition. The facility policy Controlled Substances, updated 11/18/25, stated the facility would ensure staff handled, stored, and disposed of controlled drugs properly and carried out proper record keeping. Resident #54's October 2025 Medication Administration Record(MAR) listed a 9/27/25 order for fentanyl(a powerful synthetic pain medication) transdermal(delivered through the skin) patch 72 hour 25 micrograms(mcg)/hour(hr), apply every 72 hours for chronic pain. A Packing Slip Proof of Delivery document, stated the facility received 1 fentanyl patch 25mcg/hr on 10/25/25 at 6:10 p.m. Staff A Registered Nurse(RN) signed the delivery form. An undated, untitled facility investigation stated on 10/27/25, Staff E Licensed Practical Nurse(LPN) notified the pharmacy that Resident #54 did not have a fentanyl patch available. On 10/28/25, the pharmacy notified the Assistant Director of Nursing(ADON) that the pharmacy delivered a patch on 10/25/25 at 6:10 p.m. The facility carried out a search for the patch without success. Staff A stated she signed in a tote of medications on 10/25/25 and notified Staff G RN that the medications were in the medication room. The facility attempted to contact Staff G for information but was unable to reach her. Staff C RN reported that on 10/25/25 at approximately 8:00 p.m., she and Staff G went to the locked medication room to retrieve a medication delivery bag. Staff D LPN stated that Staff G gave her a medication that she placed in the Cubex machine(a machine which securely stores medications). In a written statement on 10/28/25, Staff D stated the only medication she received from Staff G was a tramadol(an opioid medication used to treat pain).The facility lacked documentation of the location of the fentanyl patch delivered on 10/25/25 after Staff A signed for the medication from the pharmacy. The facility lacked a narcotic sheet for the patch which documented the receipt of the medication. On 2/18/26 at 11:08 a.m., via phone, Staff A stated on the shift in question, the pharmacy delivered the medication around shift change. She stated she was an agency staff member so she didn't know that she had to open the package. She stated she signed for the medication and placed it in the medication room around 6:00 p.m. She stated she informed another nurse who took over for her that the medications arrived. Staff A stated she did not know at the time she needed to go through all of the medications to make sure all was accounted for. On 2/18/26 at 9:43 a.m., Staff E Licensed Practical Nurse(LPN) stated she needed to place a patch on Resident #54 and it was not available. She stated staff received the patch but it was not available to give. On 2/18/26 at 11:26 a.m., via phone, Staff C stated on the night in question, the nurse that she worked with handed a medication to the nurse in back. She stated she did not remember details about the (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bag as the other nurse handled this. On 2/18/26 at 2:52 p.m., via phone, Staff G agency RN stated she did not remember anything about a patch. On 2/18/26 at 3:00 p.m., the Director of Nursing(DON) stated when a medication arrived from the pharmacy, the floor nurse signed in the medications and input it into the log. She stated nurses should verify that the medications received matched the packing slip. She stated for a controlled substance, they would add a log sheet to the book. She stated controlled substances were kept double locked.