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

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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on staff interview, personnel file review, and facility policy review, the facility failed to designate a person to serve as the director of food and nutrition services who met the minimum qualifications to carry out the food and nutrition services. Findings include: During an interview on 2/16/26 at 9:15 a.m. with the Dining Services Manager, she revealed she had been promoted from cook to Dining Services Manager last month, January 2026. Further interview on 2/17/26 at 10:30 a.m. with the Dining Services Manager revealed she had been hired 9/8/23 as a housekeeper and soon after her hire, she then accepted a position in the facility's kitchen as dietary aide. She then accepted a position as [NAME] in January 2024. She stated another dietary aide and her had managed the dietary department during the month of December 2025, after the previous Dining Services Manager had abruptly quit. During that time she had accepted the role as Director of Dining Services and on January 1, 2026 she was fully in her role as the Dining Services Manager. She stated she was currently completing an online course for Food Manager Certification. She stated she had started the course on January 13, 2026 and was currently preparing to take the final test of the course. She agreed that she did not have the class completed prior to taking the position as Dining Services Manager and confirmed that she had not completed the course yet. She also confirmed she did not have a current ServSafe certification. During an interview on 2/18/26 at 11:50 a.m. with the Administrator, he stated he thought they had six months to get an individual qualified for the Dining Services Manager. Further interview that day at 12:16 p.m. with the Administrator revealed the job description Director of Dining Services was signed by the current Dining Services Manager on 12/12/25 and he agreed that he had hired a person who was not qualified. He stated that he had to get someone hired urgently as the previous dining services manager had quit abruptly. He confirmed the facility did not currently have a qualified Dining Services Manager. Personnel file review on 2/19/26 of the Dining Services Manager revealed her personnel file had not contained qualification or background that included one of the following: Certified dietary manager.Certified food service manager.National certification for food service management and safety from a national certifying body.An associate's or higher degree in food service management or in hospitality. Two or more years of experience in the position of director of food and nutrition services in a nursing facility setting and had completed a course of study in food safety and management that included topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving. Review of the 7/18/24 job description for the Director of Dining Services revealed:Job Summary: The Director of Dining Services directs the day to day planning, organizing, developing and management of the overall operation of the Dietary Services Department in accordance with current federal, state, and local standards, guidelines and regulations governing the facility . Education and Qualifications: ServSafe certification or willingness to obtain ServSafe certification prior to employment. Certification as a food service manager preferred. Must also meet State requirements for food service managers or dietary managers.

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual review, the facility failed to complete a significant change in status assessment for one (1) of two sampled residents who had been admitted to hospice care (Resident#1). Findings include: The Minimum Data Set (MDS) dated [DATE] identified Resident #1 without any memory problems and independent with his cognitive skills for daily decision making, which indicated intact cognition. The MDS listed diagnoses included: chronic obstructive pulmonary disease (a progressive, incurable, yet treatable lung disease that obstructs airflow and makes breathing difficult), congestive heart failure (CHF), diabetes mellitus, and peripheral vascular disease (a progressive condition where plaque buildup reduces blood flow to the legs and feet). The MDS documented the resident had one fall with major injury and two falls with no injury since his prior MDS assessment on 8/26/25. The MDS assessed the Resident #1 needed maximal assistance from staff for toileting, transfers, showers, lower body dressing, and footwear; moderate assistance from staff for upper body dressing and personal hygiene (combing hair, shaving, washing/drying face and hands); and was independent with eating, oral hygiene, and mobility once he was in his wheelchair. The MDS indicated the resident was always continent. The MDS indicated the resident had recently received hospice care. Review of Resident #1's Care Plan, Date Initiated: 1/18/24 revealed a Focus area to address Resident at risk for injury from falls/seizures related to his impaired mobility, CHF, morbid obesity, DM, and convulsions. Interventions included, in part: Encourage Resident to use walker when ambulating in room. Date Initiated: 6/24/25. Resident to use call light for assistance if he feels unsteady or weak at the time ofneeds. Education given. Date Initiated: 08/22/2025. Educate me to ask staff to place my walker and wheelchair away from me while not in use to promote use of call light. Date Initiated: 9/3/25. Resident #1's Care Plan had not addressed his need for hospice care, but had the following documentation for his Focus area addressing his advance directives On readmission [DATE], resident opted out of readmitting to hospice level of care. Date Initiated: 10/31/25. Review Resident #1's electronic medical record (EMR) revealed: He was admitted to the facility on [DATE]. A significant change in status MDS assessment dated [DATE] documented: readmission on [DATE] from a hospital stay. A Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident had no condition or chronic disease that resulted in a life expectancy of less than 6 months. The resident had not recently received hospice care. A census change on 9/11/25 to Hospice Medicaid. A 9/11/25 hospice progress note at 7:12 p.m. documented Hospice came in to work on admit paperwork with resident. No significant change in status MDS assessment had been completed after the resident's admission to hospice care on 9/11/25 and prior to the resident's discharge to the hospital on [DATE]. A census change on 10/17/25 to Hospital Leave. A discharge return anticipated MDS assessment dated [DATE]. A census change on 10/28/25 to Managed Medicaid. A significant change in status MDS assessment dated [DATE]. During a staff interview on 2/19/26 at 2:00 p.m. with the Assistant Director of Nursing she revealed she had been working 17 years at facility as a Licensed Practical Nurse (LPN) which included five years as the MDS Coordinator before working as the Assistant Director of Nursing for the past seven years. She agreed that a significant change in status (SCSA) MDS assessment should have been completed when Resident #1 enrolled in a hospice program. She confirmed that a SCSA MDS assessment had not been completed when Resident #1 enrolled in a hospice program and that a SCSA MDS assessment had not been completed when Resident #1 discontinued the hospice program. She stated Resident #1 had been on a hospice program from 9/11/25 to 10/17/25. The October 2025 Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual revealed: Item A310 Type of Assessment review stated If a nursing home resident elects the hospice benefit, the nursing home is required to complete an MDS Significant Change in Status Assessment (SCSA). A SCSA is required to be performed when a (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	terminally ill resident enrolls in a hospice program. The ARD (Assessment Reference Date) must be within 14 days from the effective date of the hospice election. An SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. It is a CMS [Center for Medicare and Medicaid Services] requirement to have an SCSA completed EVERY time the hospice benefit has been elected, even if a recent MDS was done and the only change is the election of the hospice benefit. The nursing home is required to complete an SCSA when the resident comes off the hospice benefit (revoke). An SCSA is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care). The ARD must be within 14 days from one of the following: 1) the effective date of the hospice election revocation (which can be the same or later than the date of the hospice election revocation statement, but not earlier than); 2) the expiration date of the certification of terminal illness; or 3) the date of the physician's or medical director's order stating the resident is no longer terminally ill. The 4/25/25 State Operations Manual, Appendix PP, F637 revealed the following guidance A Significant Change in Status MDS is required when: A resident enrolls in a hospice program. A resident receiving hospice services discontinues those services.

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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, staff interviews, and resident interview the facility failed to accurately complete a Minimum Data Set (MDS) assessment correctly for 2 of 10 resident's reviewed in the sample (Resident #4 and Resident #6). The facility reported a census of 45 residents.Findings include:1. Resident #4, Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. Diagnosis included malignant bladder cancer. Resident #4 was not coded for receiving hospice care. The Care Plan for Resident # 4 initiated 11/20/25 documented the resident received hospice services.The Clinical Census record for Resident #4 documented the resident entered the facility on 11/19/25 under hospice care.The Hospice Plan of Care report for Resident #4 revealed hospice were initiated on 11/14/25. On 2/18/26 at 1:18 PM Resident #4 reported participation of hospice visits three to five times a week, and expressed satisfaction with hospice services.2. Resident#6, Annual MDS assessment dated [DATE] revealed Resident #6 scored 5 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated severe cognitive impairment. Psychiatric mood disorders included depression, bipolar and schizophrenia. The MDS did not code resident to have a serious mental illness or related condition. The Preadmission Screening and Resident Review (PASRR) screening dated 3/31/22 for Resident #6 identified evidence of a PASRR condition included serious mental illness or related condition and directed the MDS to reflect the findings in section A1500 and A1510 of the MDS. The Care Plan revision date of 1/20/25 reflected PASRR level II documented specialized services needed due to mental illness. On 2/19/26 at 11:12 AM the MDS nurse coordinator, Staff F relayed was new at this position, did not have a back ground in MDS assessments, included that several staff worked on MDS assessments in the recent past included staff nurses and corporate nurses. Staff F looked at Resident #4 and #6 MDS assessments and confirmed it was not coded correctly. On 02/19/2026 at 1:27 The Administrator relayed did not have a policy on MDS coding, expected staff to follow the standards of care, included should follow the Resident Assessment Instrument (RAI) manual for coding and is aware improvements are needed with MDS assessments and coding.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, clinical record review, staff interview, the facility failed to provide the opportunity for the resident to participate in the development, review and revision of his care plan for 1 of 1 (Resident #3) reviewed for care conferences and failed to update a care plan for 1 of 2 reviewed for hospice (Resident #1). The facility reported a census of 45 residents. Findings include: 1. Resident #3 Quarterly Minimum Data Set (MDS) dated [DATE] documented Resident #3 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 indicating moderately impaired cognition. The MDS further documented the resident had a diagnosis of diabetes and stroke. The Care Plan focus revised on 11/18/25 for Resident #3 revealed the resident would remain in long term care. Care Plan interventions included the following; staff to assist the resident to be independent as possible, resident would participate in activities of choice, staff to invite encourage and remind daily the resident to attend activities, documented the resident had impaired communication related to the stroke, is usually understood, and unclear at times. A goal for the resident to be able to communicate for needs to be met . On 2/16/2026 at 9:31 AM Resident #3 quired about care conferences, resident relayed he wanted to go to his care conferences, and only recalled attending a long time ago. On 2/19/2026 at 10:58 AM during follow up a interview Resident #3 reported probably would go to the care plan conference if invited and yelled loudly, felt they don't want to hear, what I have to say. On 2/19/2026 at 11:50 AM The MDS nurse coordinator, Staff F reported is new to the position, several changes in staff for the role included setting up care conferences, could not explain what happened in the past in regards to care plan meetings due to lack of documentation. Staff F reported they had ensured Resident #3's care conference was this week while surveyors were in the building. On 02/19/2026 at 1:27 PM the Administrator relayed could only locate three form letters over the last year sent to the emergency contact to inform of care conference dates. The form letters were not dated and relayed care conference to be held on 2/15/25, 5/2/25 and 2/17/26. The Administrator added could only locate two documents indicating the care meetings took placea. form dated 5/25/25 outlined summary ,box checked resident invited chose not to participate -noted is able to make needs knownb. form dated 2/17/26 took place during survey, box checked resident chose not to participateThe Administrator relayed realized the meetings should be quarterly, needed to work on process to ensure care conferences are conducted and documented, understood the resident right to participate, and did not have a policy on the process and should follow the standards of care. 2. Resident #1's MDS dated [DATE] identified the resident was without any memory problems and independent with his cognitive skills for daily decision making, which indicated intact cognition. The MDS listed diagnoses included: chronic obstructive pulmonary disease (a progressive, incurable, yet treatable lung disease that obstructs airflow and makes breathing difficult), congestive heart failure (CHF), diabetes mellitus (DM), and peripheral vascular disease (a progressive condition where plaque buildup reduces blood flow to the legs and feet). The MDS assessed Resident #1 needed maximal assistance from staff for toileting, transfers, showers, lower body dressing, and footwear; moderate assistance from staff for upper body dressing and personal hygiene (combing hair, shaving, washing/drying face and hands); and was independent with eating, oral hygiene, and mobility once he was in his wheelchair. The MDS indicated the resident was always continent. The MDS indicated the (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident had recently received hospice care. A documented focus concern of discharge planning with initiated date of 1/18/24 on the residents Care Plan included the following intervention for the facility staff; Allow resident to express feelings and concerns about remaining in the nursing home. Review of Resident #1's Care Plan, Date Initiated: 1/18/24 revealed the following Focus areas: At risk for injury from falls and seizures. PASARR (Pre-admission Screening and Resident Review) identified rehabilitative services and other supports needed. Pain and pain control options. Activities of Daily Living self-care performance deficits. Potential for altered nutrition. Chronic Obstructive Pulmonary Disease (COPD) and hypertension (HTN, the medical term for high blood pressure). Use of side rails. Diabetes. Urinary incontinence. Anticonvulsant drug use. History of trauma. Advance Directives. Discharge Planning. Activity Involvement. Potential for behavior. Potential for risk of abnormal bleeding. Impaired cognitive function. At risk for alteration in blood glucose levels. At risk for fluid imbalance. At risk for dehydration. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At risk for adverse effects from psychotropic medications. At risk for alteration in air exchange. Actual and potential for alteration in skin integrity. Review Resident #1's electronic medical record (EMR) revealed: He was admitted to the facility on [DATE]. A census change on 9/11/25 to Hospice Medicaid. A 9/11/25 hospice progress note at 7:12 p.m. documented Hospice came in to work on admit paperwork with resident. No significant change in status MDS assessment had been completed after the resident's admission to hospice care on 9/11/25 and prior to the resident's discharge to the hospital on [DATE]. A census change on 10/17/25 to Hospital Leave. A discharge return anticipated MDS assessment dated [DATE]. A census change on 10/28/25 to Managed Medicaid. During a staff interview on 2/19/26 at 2:00 p.m. with the Assistant Director of Nursing she revealed she: Had worked 17 years at the facility as a Licensed Practical Nurse (LPN) which included five years as the MDS Coordinator before working as the Assistant Director of Nursing for the past seven years. Stated Resident #1 had been on a hospice program from 9/11/25 to 10/17/25. Agreed that a significant change in status (SCSA) MDS assessment had not been completed when Resident #1 enrolled in a hospice program. Agreed that a SCSA MDS assessment had not been completed when Resident #1 discontinued the hospice program. Agreed that Hospice had not been addressed on the resident's individualized care plan. During an interview on 2/19/26 at 3:20 p.m. with the Administrator, he revealed the facility did not have a hospice policy. The October 2025 Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual revealed An SCSA [Significant Change in Status Assessment] is required to be performed when a terminally ill resident enrolls in a hospice program. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. Refer to F637. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's 12/3/25 policy on Comprehensive Care Plans revealed: The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. The care plan will be updated in a timely manner to ensure that services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.

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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 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.