STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165414	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Pomeroy, LLC	303 East 7th Street Pomeroy, IA 50575

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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
	165414	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Pomeroy, LLC	303 East 7th Street Pomeroy, IA 50575

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide complete assessments and interventions for 1 of 5 residents reviewed. Staff reported that Resident #2 had on-going agitation that lead to hitting of staff, and regular bruising on his arms from various causes. The chart lacked documentation of these concerns until 7/5/25, when he reported allegations of rough treatment with dark bruising on his arms. The facility reported a census of 26 residents.Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #2 had a Brief Interview for Mental Status (BIMS) score of 10 (moderate cognitive deficits) The resident did not have behavioral symptoms, directed toward others such as hitting, kicking and pushing, and no rejection of care. He had verbal behavioral symptoms directed toward others 1-3 days during the look-back period. Resident #2 used a manual wheel chair and was able to wheel at least 150 feet and make 2 turns. He was frequently incontinent of urine and always incontinent of bowel. The resident had impaired movement of upper and lower extremities, and was totally dependent on staff for dressing, hygiene and transfers. The Care Plan updated on 3/17/25, showed that Resident #2 had coping deficits related to bipolar disorder, borderline personality disorder, with irritability and anger. He had a long standing history of behaviors with foul language, yelling, spitting, attempting to self-transfer, aggression and hitting.From 5/22/25 - 7/4/25, the Nursing Progress Notes lacked any reference to aggressive behavior, refusal of cares or new bruising.A Nursing Progress Note dated 7/5/25 at 8:22 PM, showed that staff discovered new, dark bruising on both forearms that were not there the previous evening. The resident stated that one of the girls last night did it when she yanked me.A Non-Ulcer Skin Assessment document, showed that his right arm had scattered dark bruising. Total area of 16 centimeters (cm) x 5cm. His left arm had scattered dark bruising; total area of 12cm x 7cm.The following entries were added to the Care Plan after 7/5/25;a. On 7/7/25; padded side rails to prevent skin injuries that might be caused due to intentionally hitting arms and or legs into stationary objects. He often refuses or removes interventions. Allow time to cool down and re-approach. b. On 7/8/25; Use 2 staff for all care due to history of allegations against staff. Intervention included observe for contribute factors for behavior, provide one on one activities as needed.c. On 7/20/25; the resident was combative in the Hoyer lift.d. On 7/25/25; resident refuses Geri sleeves.e. On 8/5/25; the resident runs his wheel chair into the walls, med carts, furniture and railings.f. On 8/7/25; staff to try to help resident identify his boundaries when propelling wheelchair.On 8/11/25 at 9:20 AM, Resident #2 was in the hallway near his room. He was propelling himself by pushing the wheels, and his feet were extended out over the top of the foot pedal. The resident was having some difficulty navigating the corner into his room. At 9:33 AM, he was still trying to turn into his room and his arm was squeezed up against the handrail.On 8/11/25 at 2:51 PM, Staff K, Licensed Practical Nurse (LPN) said that the resident could not bear weight but he thinks he can and it upset him when staff would tell him he can't get up on his own. When asked if he'd had any falls, Resident #2 pointed to the matt on the floor and said that they put it next to his bed. He then said I do it on purpose. He explained that he would roll out of bed on purpose and put himself on the floor so the alarm would go off and it would get their attention. When asked if there were any staff that have treated him rough, he said that there was one who grabbed his arm, mostly the right arm and said it's almost healed now. she was trying to prevent him from getting into the bathroom. He said that sometimes he would bump his arms on the side rails when they rolled him over in bed. On 8/12/25 at 8:21 AM, Staff G, CNA said that since 7/5 when Resident #2 made allegations of abuse, they started taking pictures of all new bruises. She said that there were many times that he would get combative with the staff when they provided cares and when they would report it, they were told that he just didn't like them and to step away from him. She said that there was an incident when they were transferring him with the mechanical lift, he raised his fist and hit the arm of the lift which bruised on his hand. On 8/12/25 at 9:02 AM, Staff C, CMA said that many times Resident #2 was combative and it wasn't documented. She displayed a bruise on her leg where he slammed his wheel chair into her. On 8/12/25 at 9:13 AM Staff I, CNA said that there were many incidences in past, that Resident #2 was combative and he hit her. She reported to Nursing and the Administrator and she was told to just get away from him. She did not see any new interventions or documentation completed.On 8/12/25 at 11:12 AM, Staff B, CNA said that Resident #2 often had bruising on his arms, he would get agitated when the staff tried to clean him. He would report to the nurses whenever it happened.On 8/12/25 at 1:11 PM the Director of Nursing said that Resident #2 often had bruises on his arms because he would bump them on the walls and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165414	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Pomeroy, LLC	303 East 7th Street Pomeroy, IA 50575

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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165414	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Pomeroy, LLC	303 East 7th Street Pomeroy, IA 50575

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review the facility failed to administer medications as ordered for 2 of 5 residents reviewed (Resident #1 and #3.) Within a 5-week timeframe staff reported 3 medication errors for Resident #1. Staff left medications for Resident #3 unattended, and the cup of pills was later discovered on the food tray in the kitchen. The facility reported a census of 26 residents. Findings include: 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #1 was absence of spoken words, she was rarely/never understood. She was unable to participate with a Brief Interview for Mental Status (BIMS) assessment and her cognitive skills were severely limited. Resident #1 was totally dependent on staff for toileting, dressing, hygiene, and transfers and used a wheel chair. He diagnoses included diabetes mellitus, aphasia, seizure disorder, malnutrition and Rett's Syndrome (neurological disorder that causes severe muscle movement) The Care Plan last updated on 4/8/25, showed that Resident #1 had artificial nutrition per gastrostomy tube. She was completely dependant with care, and used a mechanical lift for transfers. The resident had a history of seizures and used psychotropic medications related to Rett's Syndrome, Aphasia, Epilepsy, Scoliosis and spasticity. On 8/11/25 at 9:30 AM, Resident #1 was sitting in front of the television in the dayroom. Her wheel chair was in the upright position, arms crossed at her chest. She had contractures of the hands and her eyes were closed. At 12:00 PM, Staff K, Licensed Practical Nurse (LPN) pushed her back to her room and at 1:10 PM she was in bed with the head of the bed elevated.On 8/11/25 at 2:14 PM, a Family Member (FM) for Resident #1 said she had been up to visit the resident and talked to the nurse that forgot to give the resident her evening medications in May. FM said that there were a couple of temporary staff that didn't give the seizure medication as ordered and the mistakes seemed to always happen on a holiday weekend. According to the Orders tab, Resident #1 had an order for clobazam 2.5 milligrams per milliliter (mg/ml) give 2 ml one time a day in the morning, give 4ml at bedtime.Incident Reports for Resident #1 showed the following:a. On 5/23/25 at 8:30 PM the overnight nurse realized that she had forgotten to give Resident #1 her night medications or feeding.b. On 5/27/25 at 3:10 PM during the morning medication pass the nurse gave the nighttime dose of Clobazam 4 milliliters (ml) instead of the 2 ml. morning dose.c. On 7/5/25 at 7:00 AM during shift change it was discovered that the previous nurse had given 2ml instead of the ordered 4ml night dose.On 8/12/25 at 2:15 PM, Staff J, Registered Nurse (RN) said that she got busy on the evening of 5/23/25 and had forgotten the evening medication and feeding. She said that it was still sitting on the nightstand the following morning.On 8/12/25 at 11:55 AM, The Assistant Director of Nursing (ADON) acknowledged that they'd had a problem with the clozabam and ensuring that the medication was being given as ordered because they've gone back and forth from a bottle and pre-filled syringes.2) According to the MDS dated [DATE], Resident #3 had a BIMS score of 15 (cognitive intact) She was totally dependent on staff for toileting, dressing, rolling and sit to stand. Her diagnoses included: heart failure, renal insufficiency, diabetes mellitus, hip fracture, anxiety and depression. The resident rejected evaluation or care 1-3 days during the look-back period. High-risk drugs included antianxiety, antidepressant, opioid, antiplatelet and hypoglycemic medications.The Care Plan for Resident #3 last updated on 7/10/25, showed that Resident #3 had altered cardiovascular status related to history of acute and chronic diastolic congestive heart failure, bradycardia, obesity, staff were to administer medications as ordered. She had the potential for constipation related to decreased physical mobility and obesity, diverticulosis and diabetes mellitus.On 8/12/25 at 9:38 AM, Resident #3 was in her recliner with a bedside tray pulled up to where she could reach items. She said that she preferred to stay in her room and she took her meal trays in the room as well. She said there was an agency nurse that put her cup of pills in front of her one evening and then left the room. The tray was taken back to the kitchen with the pills and another nurse found them and brought them back to her to take.On 8/12/25 at 2:15 PM, Staff J said that it was a Sunday night when agency staff set a cup of medications for Resident #3 and it was left on the food tray without the resident's knowledge. The kitchen staff picked up the tray and found the medications, and gave them to Staff J, she then took the medications to the resident to take.On 8/13/25 at 10:30 AM the Administrator said that they do not have any residents that have been assessed to be able to administer their own medications unsupervised. She said we don't do that here She said that the nurses should know the 5 rights of medication administration and double check during medication pass.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165414	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Pomeroy, LLC	303 East 7th Street Pomeroy, IA 50575

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that staff were orientated and trained to care for residents. Temporary nurses and Certified Nurse Aides (CNA) were expected to perform the job duties without proper training. The facility reported a census of 36 residents.Findings include: On 8/12/25 at 1:00 PM, the Administrator and the Assistant Director of Nursing (ADON) stated they had orientation checklists for agency staff. In the absence of the Director of Nursing (DON) they would look for documentation that the following temporary staff had been oriented: Staff C, CNA, Staff E, CNA, and Staff D, Registered Nurse (RN). In an observation on 8/12/25 at 1:10 PM, Staff L, CNA was assisting residents with transfers too and from their rooms. Staff L said that she was with a staffing agency it was her second day at this facility. The last time she worked at this facility was 6 months previous. She said that she did not get an orientation, and she didn't remember any education checklists offered to her before she worked independently with the residents.On 8/12/25 at 10:05 AM, Staff E, CNA said that she worked the overnight shift on the previous Sunday, and it was a difficult night because she was the only aide on floor. She had worked several other shifts at this facility and she tried to transfer Resident #2 without the use of the mechanical lift because he told her that he could stand. When she found that he wasn't standing, she lowered him back down onto the bed. Staff E said that she did not get an orientation or education before she worked independently with the residents. On 8/12/25 at 10:14 AM, Staff M, CNA said that she worked the overnight shifts and she did not get any orientation or education. She said that she knew how to transfer residents and provide cares because she was a CNA for a long time.On 8/12/25 at 10:23 AM, Staff D, RN said that she usually worked the weekends at this facility. She said when she first started she was expected to come in an hour early and another nurse showed her around the building. She did not remember getting a complete orientation or a signed checklist.On 8/12 at 9:45 AM, Resident #5 was in her wheel chair in the dayroom. She had bruising on her left arm and said it was from a recent hospitalization. She said that she was on dialysis and was feeling much better. The resident said that she was concerned about good staff that were leaving and the temporary aides don't know what they are doing. She said that on that morning, she had to explain to the CNA how to help her with her catheter and toileting needs.On 8/13/25 at 11:00 AM, the Administration said that many orientation checklists were on the DON's desk except for the 3 staff that were requested.A form titled: Agency Staff Checklist indicated that the following items would be included in orientation:a. Facility layout with tourb. Shift routine/general duties. Resident care, mechanical lifts, documentation, narcotic count, medication deliveries, change in condition guidelines, 24 hour report, Pocket Care Plans, Medication administrationc. Communication; Door alarms, telephone use, walkie use,d. Abuse Policy; what to report and whene. Resident Incident Reports; falls, skin protocol, medication errors, deathf. Emergencies; physician contacts, hospital contactsg. Emergency Procedures: fire, weather, elopement, leave of absence, emergency carth. DON notificationi. Concern [NAME] signing, staff acknowledged that they had received training for all of the above guidelines and information to perform the job. The orientation was not intended to cover every situation which may arise while on assignment but was a general guideline.