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	05/14/2026

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, Electronic Health Record (EHR) review, and policy review, the facility failed to complete appropriate hand hygiene for 3 of 4 residents observed (Resident #16, #19 and #20). The facility further failed to apply a gown when completing catheter care on a resident (Resident #2) with Enhanced Barrier Precautions (EBP). The facility reported a census of 24 residents. Findings include:1.The Minimum Data Set (MDS) dated [DATE] documented Resident #2 had a Brief Interview for Mental Status (BIMS) of 15 that indicated no cognitive impairment. The MDS also documented Resident #2 utilized an indwelling catheter. The MDS documented Resident #2 had a diagnosis of chronic kidney disease, stage 3A and 3B. Review of Resident #2's Care Plan documented a focus that Resident #2 was at risk for colonization with Multidrug-Resistant Organism (MDRO) related to catheter placement, goal was Resident #2 would remain free from MDRO through the review period and an intervention that Resident #2 was on EBP. On 5/12/26 at 11:26 AM an observation revealed Staff A, Certified Nurse Assistant (CNA) performed hand hygiene, applied gloves, failed to apply a gown for Personal Protective Equipment (PPE), and entered Resident #2's room. Staff A grabbed a cylinder and placed it inside a trash bag onto the floor. Staff A used an alcohol swab and cleansed the catheter drainage valve, opened the catheter drainage valve and emptied 750 ml urine output into the cylinder located in the trash bag. Staff A cleansed the catheter drainage valve with an alcohol swab, closed the catheter drainage valve and placed the catheter bag into the dignity bag attached to the wheelchair. Staff A walked into the bathroom, emptied the cylinder into Resident #2's toilet, rinsed out the cylinder, placed the cylinder on the back of the toilet and performed hand hygiene. On 5/12/26 at 2:13 PM the Director Of Nursing (DON) acknowledged facility staff needed to wear the appropriate PPE when emptying the catheter drainage bag and explained Staff A reported to her that she had forgotten to wear a gown during catheter care Resident #2 with the surveyor in the room. 2. The MDS dated [DATE] documented Resident #16 had a BIMS of 0 that indicated she was rarely / never understood. The MDS also indicated Resident #16 had a Percutaneous Endoscopic Gastrostomy (PEG) tube / feeding tube for nutritional supplement. On 5/12/26 at 11:54 AM an observation of medication administration by Staff C, Licensed Practical Nurse (LPN) to Resident #16's PEG tube with Assistant Director of Nursing (ADON) present during observation. Staff C pushed Resident #16 down the hall to her room, returned to the nurses station, obtained a computer from nurses station, obtained keys and returned to the medication cart medication. Staff C obtained medications, walked down the hall to Resident #16's bedroom, barrier placed on tray table, applied a gown, applied gloves, completed no hand hygiene, obtained 200 mL of (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	water from sink, completed residual check, 0 cc gastric content, small amount of pressure applied with 30 mL of water, 60 mL formula added with small amount of pressure to piston syringe and medications given individually with 10 mL of water in-between each medication. Staff C poured the supplemental formula into the syringe with water flushes in-between, the rest of the 200 mL of water poured into the syringe. Staff C pushed the last 40cc of water with piston syringe, extension removed, syringe rinsed in sink with extension, graduate rinsed in the sink, paper towel placed in graduate with syringe, gloves removed, gown removed no hand hygiene completed. Staff C pulled the garbage liner, walked out into the hall to the shower room, pushed code into the door, opened the door, placed the garbage liner in a large garbage can, left the room and completed hand hygiene right before the next room on the right at the sanitizer station on the wall. On 5/12/26 at 12:13 PM the ADON. RN stated she had no concerns with observation of medication administration with Resident #16 by Staff C. 3. The MDS dated [DATE] documented Resident #19 had a BIMS of 14 that indicated no cognitive impairment. The MDS further documented Resident #19 had skin tears and Moisture associated Skin Damage (MASD) with a nonsurgical dressing. On 5/12/26 at 10:37 AM an observation of Staff C change a dressing on Resident #19 with ADON present during wound care. Staff C applied decon wound wash to gauze cut with no gloves on. Staff C entered the room, donned gown, donned gloves, completed no hand hygiene, closed the curtain, pulled the sheet up across the body, removed previous dressing, cleansed area, removed gloves, applied gloves, completed no hand hygiene, dressing pressed into wound under scrotum and 4x4 applied over the area. Staff C removed gloves, doffed gown, removed trash can liner, obtained garbage liner and placed the liner into the garbage can. Staff C left the room with bedside table and garbage liner, entered shower room on right of hall, placed garbage in the shower room, moved up the hall to medication cart past the nurses station, opened medication cart applied gloves, cleansed the top of the bedside table, cleansed scissors, removed gloves, locked medication cart, returned to the nurses station and completed hand hygiene at the sink behind the nurses station. 5/12/26 at 11:02 AM the ADON, RN stated she did not have any concerns with any of the wound care. 4. The MDS dated [DATE] documented Resident #20 had a BIMS of 15 that indicated no cognitive impairment. The MDS further documented Resident #20 had a nephrostomy tube (a thin, flexible catheter inserted through the skin and directly into the kidney to drain urine) placed for urine to drain. On 5/12/26 at 11:17 AM observation of nephrostomy tube emptied by Staff E, Certified Nurse Assistant (CNA) with the ADON present in the room. Observation revealed Staff E applied gown, applied gloves, did not complete hand hygiene, obtained graduated cylinder, placed barrier on the ground, utilized alcohol wipe to cleanse the tip of the catheter, emptied urine from catheter bag, utilized alcohol wipe to cleanse the tip, placed the urostomy bag clip back on shirt, emptied 300cc urine from graduate, cleansed graduate with toilet sprayer, removed gloves, removed gown and completed hand hygiene. On 5/12/26 at 11:23 AM ADON, RN stated no concerns with empty of urostomy On review of a facility provided policy updated 4/20/26 titled, Enhanced Barrier Precautions (EBP) documented EBP referred to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident care activities. An order for EBP would be obtained for residents with any of the following: wounds (chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (central lines, urinary catheters, feeding tubes) even if the resident is not known to be infected or colonized with a Multidrug-Resistant Organism (MDRO). On review of a facility provided policy titled, Hand Hygiene dated 11/13/24 documented when to perform hand hygiene included: Immediately before touching a resident, before performing aseptic techniques (indwelling device) or handling an invasive medical device, immediately before putting on gloves and after glove removal, after touching a resident or resident's immediate environment, after contact with blood, body fluids or contaminated surfaces, when hands are visibly soiled, before moving from a spoiled body site to a clean body site on the same resident.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review the facility failed to ensure resident's current code status was available for 1 out of 14 residents reviewed (Resident #10). The facility reported a census of 24 residents. Findings include: Resident #10's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 05, indicating severely impaired cognition. Resident #10 MDS's documented diagnoses of hypertension, thyroid disorder, arthritis, Alzheimer's disease and non-Alzheimer's disease. The Clinical Census revealed Resident #10 was admitted to the facility on [DATE]. The Baseline Resident Care Plan lacked documentation regarding Resident #10's code status. The Electronic Medical Record and the paper chart lacked documentation regarding Resident #10's code status. On [DATE] at 9:35 AM, Staff B, Registered Nurse (RN) reported she would first look at the electronic medical record to locate resident advance directives/code status. She said the advance directives are documented on the resident header under code status. She said the code status auto populates to the resident header from the Physician orders. She said if the code status was not listed on the resident header then she would go to the documents tab to look for the IPOST (Iowa Physician Orders for Scope of Treatment). She said if the IPOST was not in the electronic medical record then she would go to the paper chart. Staff B verified Resident #10's code status was not documented in the electronic medical record or in the paper chart. Staff B acknowledged and agreed having to look for the code status would slow down the response time if cardiopulmonary resuscitation (CPR) was needed. Staff B said Resident #10 was admitted from Assisted Living and all the residents who lived in the Assisted Living have a do not resuscitate (DNR) for a code status.On [DATE] at 9:47 AM, Staff B, RN reported she found Resident #10's IPOST on the Assistant Director of Nursing's (ADON) desk. Review of the IPOST revealed Resident #10's code status was CPR with limited additional interventions and the IPOST was completed/signed by the ADON on [DATE]. The IPOST was not signed or dated by the resident, legal representative or a Physician. An email provided by Staff B dated [DATE] revealed the ADON requested Resident #10's daughter to sign the IPOST and return it to the facility so the code status could be signed by the Physician and put into the system correctly. Staff B reported the daughter had not replied yet. Staff B seemed surprised Resident #10 was a full code and acknowledged there was a concern as she thought Resident #10 was a DNR. On [DATE] at 10:53 AM, the ADON reported she resent Resident #10's IPOST to her daughter today. She said she had been working on the floor as a charge nurse and thought she had received Resident #10's IPOST back. She said it was hard to track her emails while working on the floor. She said if a Resident's BIMs score was below a 12 then the Power of Attorney (POA) had to sign the IPOST. She reported Resident #10's daughter lived out of state and was not present during the admission process. The ADON said she tried to get the IPOST completed as soon as possible. The ADON said if the code status wasn't listed, the resident was considered a full code. She said all residents are a full code unless the IPOST directs otherwise. She said she had spoken to Resident #10's daughter on the phone on [DATE] and the daughter wanted a full code, changing from the Assisted Living's standard DNR. The facility policy titled Cardiopulmonary Resuscitation (CPR) updated [DATE] documented the facility would adhere to residents rights to formulate advance directives. The policy documented advance directives to define the scope of medical care would be discussed with the potential resident and/or resident representative at the time of admission. If a resident experienced a cardiac arrest, the facility staff would provide basic life support, including CPR, prior to the arrival of emergency medical services, and:a. In accordance with the resident's advance directives, orb. In the absence of advance directive or a Do Not Resuscitate order, and c. Unless in the professional opinion of a physician, the resident shows obvious signs of clinical death (pupils fixed, absence of respirations or pulse, skin cold to touch, rigor mortis, dependent lividity, decapitation or decomposition).

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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, Center for Medicare and Medicaid (CMS) Long Term Care (LTC) Facility Resident Assessment Instrument (RAI) User Manual and staff interview the facility failed to complete a Minimum Data Set (MDS) Significant Change in Condition Assessment (SCSA) for 2 of 14 residents reviewed (Resident #3 and #5). The facility reported a census of 24 residents. Findings include: 1. The MDS dated [DATE] documented Resident #5 had a BIMS of 1 that indicated severe cognitive impairment. The MDS documented no significant change assessment. Review of Care Plan with review history date of 1/26/26 documented Resident #5 required an assist of 1 staff with walker for transfers initiated on 3/3/25 and ambulation required an assist of 1 with a walker initiated on 3/3/25. Review of current Care Plan documented Resident #5 required an assist of 2 staff with mechanical sit to stand lift for transfers with revision on 5/3/26 and ambulation required an assist of 2 with a mechanical sit to stand initiated on 5/3/26. Review of MDS dated [DATE] documented Resident #5 required partial / moderate assistance where the helper did less than half the effort for walking 10 feet, walking 50 feet with 2 turns, and walking 150 feet. The MDS documented Resident #5 utilized a walker and a wheelchair. Review of MDS dated [DATE] documented Resident #5 did not attempt walking 10 feet, walking 50 feet with 2 turns, and walking 150 feet. The MDS documented Resident #5 no longer utilized the walker but only a wheelchair. Review of EHR titled Functional Abilities and Goals dated 5/20/25 at 6:56 AM documented Resident #5 required partial / moderate assistance where the helper did less than half the effort for sit to stand, chair to bed transfer, toilet transfer and walking 150 feet. The document also documented Resident #5 required supervision or touching assistance for walking 10 feet and walking 50 feet with 2 turns. Review of EHR titled Functional Abilities and Goals dated 4/22/26 at 1:37 PM documented Resident #5 was dependent on staff for sit to stand and bed to chair transfer. The document also documented walking was not attempted due to medical condition or safety concerns for Resident #5. Review of Resident #5's document dated 10/30/25 titled, PT Discharge Summary documented Resident #5 was non-ambulatory with maximal assistance for sit to stand, bed to chair transfers and toilet transfers with a front wheeled walker utilized for transfers. Documented Resident #15 currently utilized a sit to stand mechanical lift for transfers because Resident #15 was unable to straighten the knees. On 5/12/26 at 3:58 PM Staff F, Certified Nurse Assistant (CNA) stated does not get a chance to work with Resident #5 much because he prefers Staff G, CNA. Staff F stated Resident #5 does not walk at all. Staff F stated when she documented not applicable for Resident #5's restorative task it meant that the resident did not walk and stated had not walked in the 6 months. Staff F stated she had not said anything about Resident #5's inability to walk but she knew Staff G had said something about removing the task because he did not walk. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/26 at 9:18 AM Staff H, CNA stated had worked at the facility for about a week. Staff H stated she had completed training and had been on the floor a couple of days by herself. Staff H explained she was not familiar with restorative care yet she had not had to do it. 2. Resident #3's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS identified Resident #3 required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with bed mobility, all transfers and ambulation. Resident #3's MDS included diagnoses of viral hepatitis, diabetes mellitus, chronic pain syndrome and cerebral infarction. The Progress Note titled Fall dated 3/30/26 at 7:47 AM revealed Resident #3 was lowered to the floor due to her right knee giving out. Resident #3 complained of right knee/leg pain and received as needed (PRN) tramadol (opioid pain medication). The Progress Notes dated 4/2/26 revealed Resident #3 returned from a Physician's appointment. Resident #3 had an x-ray of her right knee. The x-ray revealed an acute non-displaced fracture of the fibular neck, no dislocation and mild tricompartmental osteoarthritis of the right knee. Resident #3 was scheduled for an orthopedic appointment on 4/6/26 at 9:45 AM. Resident to be nonweight bearing until appointment. The Progress Note dated 4/6/26 revealed Resident #3 returned to the facility from orthopedic appointment with order to be weight bearing as tolerated to the right lower extremity. The Progress Note dated 4/7/26 documented Resident #3 had significant pain to the right knee and remained non-weight bearing throughout the shift. The Progress Note dated 4/9/26 documented the staff continued to use the mechanical lift for transfers due Resident #3 did not want to put weight on the right lower extremity. The Progress Note dated 4/14/26 documented Resident #3 continued to require the use of a mechanical lift for transfers as weight bearing remains painful. The Progress Note dated 4/16/26 documented Resident #3 continued to require the use of a mechanical lift for transfers due to discomfort. The Progress Note dated 4/17/26 documented Resident #3 continued to use the mechanical lift for transfers with the assistance of two staff members. The Care Plan with a target date of 5/12/26 revealed the following: a. Resident #3's ambulation was put on hold on 3/30/26 until her knee healed. Staff to use a wheelchair- revised 4/7/26 b. Staff to use a mechanical lift with assistance of two staff members for transfers- Initiated 4/2/26 c. Staff may use mechanical sit to stand lift for transfers per therapy recommendations- revised 5/12/26 (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Resident #3 to use a bed pan and staff to provide peri care due to incontinence - revised 4/3/26 Review of Resident #3 MDS Tracking page revealed Resident #3 had not been set up for a Significant Change in Status MDS assessment within 14 days after determination that significant change in resident's status had occurred. On 5/12/26 at 1:07 PM, the Director of Nursing (DON) reported Resident #3 continued to use the mechanical lift for transfers. The DON said therapy would like Resident #3 to use the mechanical sit to stand lift for transfers but she refuses. On 5/12/26 at 4:45 PM, the Assistant Director of Nursing (ADON) reported the Regional Reimbursement Specialist told her that she could either change the quarterly MDS with ARD (assessment reference date) of 5/1/26 to a Significant Change in Status MDS since it had not been exported or open up a new MDS. The ADON reported she opened up a new Significant Change in Status MDS assessment with an ARD date of 5/15/26. On 5/13/26 at 8:27 AM, the DON acknowledged a Significant Change in Status MDS should have been done. She said they were going to complete one now. The DON said she thought Resident #3 would have recovered quicker than she did as she was weight bearing as tolerated. On 5/13/26 at 1:41 PM, the DON reported the facility did not have a policy for Significant Change in Status MDS. She said they follow the RAI manual. The CMS LTC RAI 3.0 User's Manual, Version 1.20.1 October 2025, Chapter 2 under Significant Change in Status Assessment (SCSA) directs the SCSA is a comprehensive assessment that must be completed when the interdisciplinary team (IDT) has determined that a resident meets the significant change guidelines for either a major improvement or decline. A Significant Change is defined as a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without interventions by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting. 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. The RAI manual directed the ARD to be set no later than the 14th calendar day after determination that significant change in resident's status occurred (determination + 14 calendar days).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on clinical record review and staff interviews, the facility failed to provide care and services according to accepted standards of clinical practice for 1 of 1 resident reviewed (Residents #15) for insulin administration. The facility reported a census of 24 residents.Findings include: The Minimum Data Set (MDS) assessment for Resident #15 dated 4/1/26 identified a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS included diagnoses of diabetes mellitus and long term use of insulin. The MDS documented Resident #15 received insulin injections and hypoglycemic medications during the last 7 days. The Care Plan with a target date of 6/30/26 revealed Resident #15 was at risk for alteration in blood glucose levels related to diagnosis of diabetes mellitus. The Care Plan directed to administer blood sugars per order, observe for side effects and effectiveness of medications. The Physician Order dated 6/22/25 directed staff to administer Novolog FlexPen (rapid-acting insulin) 100 units/ml (milliliter), inject 28 units subcutaneously (layer of fatty tissue beneath the dermis) two times a day. The order directed to hold the insulin if the blood sugar was less than 120 mg/dl (milligrams per deciliter). Review of March 2026 to May 2026 Treatment Administration Records (TAR) revealed the Novolog Insulin 28 units was administered when the blood sugar was below 120 mg/dl on the following dates/times:March TAR-3/7 AM- BS-98- insulin given3/19 AM- BS-103- insulin givenApril TAR-4/7 AM- BS 77- insulin given4/7 PM- BS 113- insulin given4/8 AM- BS 114- insulin given4/26 AM- BS 111- insulin givenMay TAR-5/4 AM- BS-87- insulin given On 5/13/26 at 10:45 AM, the Assistant Director of Nursing (ADON) acknowledged the Novolog insulin was documented as given when the blood sugar was below 120 mg/dl. The ADON reported she would expect the physician order to be followed. On 5/13/26 at 1:41 PM, the DON reported the facility did not have a policy regarding following physician orders. She said they follow standards of care.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, resident interview and Electronic Health Record (EHR) review the facility failed to provide treatment and services to residents that had decreased range of motion to prevent further decrease in range of motion to 2 of 4 residents (Resident #5 and #16). The Facility reported a census of 24 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] documented Resident #5 had a Brief interview for Mental Status (BIMS) of 1 that indicated severe cognitive impairment. Review of Resident #5's Care Plan with review history date of 1/26/26 documented Resident #5 required an assist of 1 staff with walker for transfers initiated on 3/3/25 and ambulation required an assist of 1 with a walker initiated on 3/3/25. The Care Plan documented an intervention of a walker and wheelchair for adaptive equipment with revision date of 6/8/25. Review of Resident #5's current Care Plan documented Resident #5 required an assist of 2 staff with mechanical sit to stand lift for transfers with revision on 5/3/26 and ambulation required an assist of 2 with a mechanical sit to stand initiated on 5/3/26. Review of Resident #5's EHR titled, Task documented an ambulation program to walk with assistance of one staff to and from meals with front wheeled walker, gait belt and wheelchair to follow. Frequency: 3 times daily as tolerated, 5-7 days per week as tolerated with resident refusal on 4/14, 4/15, 4/16, 4/18, 4/19, 4/21, 4/22, 4/23, 4/28, 4/30, 5/7 and 5/11 all on the 2:00 PM - 10:00 PM shift. All other documentation for 3 times a day 5-7 days a week was documented as not applicable. Review of Resident #5's document dated 3/3/26 titled, OT Discharge Summary documented Resident #5 was dependent on toilet transfers.Review of Resident #5's document dated 10/30/25 titled, PT Discharge Summary documented Resident #5 a restorative program was established/trained with leg exercises for bilateral lower extremity strengthening and Resident #5 was to participate in leg exercises. On 5/12/26 at 3:58 PM Staff F, Certified Nurse Assistant (CNA) stated does not get a chance to work with Resident #5 much because he prefers Staff G, CNA. Staff F stated Resident #5 does not walk at all. Staff F stated when she documented not applicable for Resident #5's restorative task it meant that the resident did not walk and stated he had not walked in the 6 months. Staff F stated she had not said anything about Resident #5's inability to walk but she knew Staff G had said something about removing the task because he did not walk. On 5/14/26 at 9:18 AM Staff H, CNA stated had worked at the facility for about a week. Staff H stated she had completed training and had been on the floor a couple of days by herself. Staff H explained she was not familiar with restorative care yet she had not had to do it. 2. The MDS dated [DATE] documented Resident #16 had a BIMS of 0 that indicated she was rarely / never understood. The MDS also indicated Resident #16 had diagnoses of scoliosis, cramp and spasm, Developmental disorder of scholastic skills, and rett's syndrome.On 5/11/26 at 12:44 PM Resident #16's Mother stated she would like some therapy to prevent or decrease the possibility of contractures. Review of Resident #16's EHR documented no restorative therapy, range of motion, or screening by therapy since admission.On 5/12/26 at 4:32 PM Staff G, CNA stated had worked at the facility for 20 years. Staff G stated Resident #5 has been unable to walk for about 6 or 8 months. Staff G stated he had brought it up to the Assistant Director of Nursing (ADON) about 3 weeks ago. Staff G stated he charted not applicable because he required a sit to stand mechanical lift for transfers. Staff G acknowledged he did work with Resident #16 and does not complete any restorative therapy or range of motion with her. Staff G stated he was unaware of any expectation by management for him to complete any restorative therapy that wasn't on the resident's task. Staff G stated there used to be a restorative aide position but that was eliminated. Staff G stated he had no training for restorative therapy. On 5/14/26 at 9:43 AM Staff I, Certified Medication Assistant (CMA) stated she had used a sit to stand mechanical lift for transfers on Resident #5. Staff I explained Resident #5 used to walk with a walker. Staff I said Resident #5 walked about 5 or 6 months ago. Staff I stated she put not applicable because (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	05/14/2026

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #5 did not walk anymore and used a sit to stand mechanical lift for transfers. Staff I explained until therapy saw Resident #5 staff could not walk him. Staff I stated she could not remember if she had ever told any management or Director of Nursing (DON) or ADON about Resident #5 not walking. Staff I explained she completed restorative with anyone that has a restorative task. Staff I explained when she got Resident #16 dressed she would stretch her arms and stuff because she really doesn't move her extremities by herself. Staff I stated she did not know if she was supposed to or not. Staff I stated she was trained years ago not sure how long ago. On 5/13/26 at 2:31 PM Staff J, Regional Director of Operations / Occupational Therapy (OT) treated Resident #16 recently 2-9-26 thru 3-3-26. Staff J stated Physical Therapy (PT) did an eval only on October 22 2025. Staff J stated there was an evaluation, a daily treatment, and a discharge for Resident #16. Staff J stated had not had Resident #16 on caseload for PT, OT, or speech herself. Staff J explained a lot of time when working with the facilities evaluations are determined during Medicare meetings, review screens or any declines with residents and then they request orders. Staff J explained the facility would also request orders outside of that meeting if they feel the resident needs therapy. Staff I stated if there was any decline then she would be able to see the resident. Staff I said if they would have turned the restorative plans into the facility the facility would have those notes. Staff I stated had worked with the facility since 2019. Staff I stated she was not sure why there was no screening completed with Resident #16 when she entered the facility. Staff I stated Resident #16 was in their system but there was no documentation for her because she was not evaluated. On 5/13/26 at 5:06 PM Staff K, Certified Occupational Assistant, started working at the facility for about a month. Staff K stated she had not discussed any restorative program with the facility. Staff K stated she was not sure how this facility did therapy screening. Staff K stated at other facilities they screen all the residents once a quarter. Staff K stated all residents are supposed to be screened quarterly. Staff K stated they usually develop the restorative plan where they give suggestions on what the residents can work on, they write that up and give it to the DON usually. On 5/14/26 at 10:01 AM Staff L, Speech Therapy stated she worked part time and was not at the facility unless there is a need for speech therapy. Staff L stated she had been at the facility through a contract for about a year. Staff L stated any staff can notify if there was a decline and can reach out to the physician to obtain orders. Staff L explained there are quarterly screens she does not do but there was a list of patients to screen quarterly. Staff L stated everyone at the facility was screened quarterly. Staff L stated the facility did not have a restorative department. Staff L acknowledged she was not as familiar with this building as she was with others. Staff L stated she had not developed a restorative plan for the facility since working at the facility. Staff L stated she was not sure if there was CNA that did restorative at the facility. On 5/14/26 at 11:45 AM the Director of Nursing (DON) stated the facility got restorative plan from therapy. The DON stated the facility had identified that the restorative review was not being completed appropriately. The DON stated the ADON was the Registered Nurse (RN) that overseen the restorative programs. The DON stated the MDS Reimbursement Specialist was going to come to the facility to retraining the ADON on restorative reviews. The DON explained therapy screened off of the quarterly MDS calendar but that was the only process they currently had. The DON stated there were residents at the facility that are not on therapy that would benefit from a restorative plan. The Administrator stated the facility did not have a policy for range of motion or restorative therapy.