

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/30/2025
NAME OF PROVIDER OR SUPPLIER  Accura Healthcare of Cherokee, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  921 Riverview Drive Cherokee, IA 51012	

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 0550  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.  (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
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, resident interviews, family interviews, staff interviews, and policy review the facility staff failed to interact with residents in a kind and considerate manner during cares for 2 of 5 residents (Resident #1, and #5) reviewed. The facility reported a census of 33 residents. Findings include: 1. Review of Resident #1's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10 Indicating moderate cognitive impairment. Interview on 10/28/25 at 2:05 PM with Resident #1 revealed that she could recall something had happened several months ago, but she could not recall the names of the staff and didn't want to say someone was mean and call them by the wrong name. 2. Review of Resident #9's MDS dated [DATE] revealed a BIMS score of 12 indicating moderate cognitive impairment. Interview on 10/28/25 at 9:30 AM with Resident #9 revealed that Staff B Licensed Practical Nurse (LPN) does not treat him with dignity and respect. Resident #9 further revealed that Staff B needs to work on their attitude. Review of a facility provided document titled, CNA meeting dated 8/27/25 documented: Complaints: 1. Call lights 2. Watch what you are saying to residents-just wet the bed. 3. Nightshift can get people up. Review of a facility provided document titled, Annual Employee Performance Evaluation dated 7/8/25 for Staff C revealed: 1. Staff C does not accept coaching with a positive outlook, this needs improvement. Review of Staff B and Staff C's personnel files revealed no disciplinary action related to speaking to residents with dignity and respect. Interview on 10/27/25 at 10:55 AM with Staff A LPN revealed that Resident #1 had told her that Staff B LPN does not listen to her. Staff A further revealed that Resident #1 had told her that Staff B and Staff C Certified Nursing assistant (CNA) had told her just to pee herself and then they would clean her up. Staff A then revealed that these issues have been brought to management, and nothing has been done. Interview on 10/28/25 at 8:47 AM with Staff D CNA revealed that she had heard hearsay that staff had asked residents to urinate on themselves and that they would clean it up. Staff D further revealed Resident #9 had a lot of complaints about Staff B, and that grievances had been filled out. Staff D stated while getting report the past weekend that Staff B had stated Resident #9 had hit his call light three times wanting to get up and Staff B stated she was making a point to wait until the morning shift got Resident #9 up. Staff D revealed that she had also heard Staff B, and Staff C were taking resident's call lights away from them. Staff D stated Staff E CNA was about to quit related to nothing being done with Staff B, even with it being turned into management. Interview on 10/28/25 at 9:09 AM with Staff F CNA revealed that Staff B would sometimes come across as rude with her tone. Interview on 10/28/25 at 10:21 AM with Staff G LPN revealed that she had heard of Staff C not answering call lights. Staff G further revealed that she has heard these complaints have gone to the management team. Interview on 10/28/25 at 12:30 PM with Staff C revealed that she had heard Staff B tell Resident #1 to just go ahead and pee yourself, and that they would clean Resident #1 up afterwards. Staff C stated that there was a staff meeting about staff to staff and staff to resident interactions about how they talk to one another. Interview on 10/28/25 at 2:20 PM with the Director of Nursing (DON) revealed that staff and a family member stated that a CNA had taken the call lights from a resident. The DON stated she went and talked with the family member and the staff. The DON further revealed that she did a follow up visit with the family member. The DON revealed it is a concern if staff were telling residents to urinate themselves, and this would be a dignity issue. The DON then revealed that she does get complaints about the gruffness of Staff B. Interview on 10/28/25 at 3:05 PM with Staff B revealed that she had never heard of any staff withholding call lights from residents. Staff B stated she had heard through a day shift staff member that Staff C had told a resident to go ahead and urinate on themselves and that they would clean that resident up afterward. Staff B heard that it happened on a shift they were working, but did not witness or hear Staff C say this. Interview on 10/29/25 at 1:39 PM with Staff E CNA stated during an all staff meeting on 8/27/25 that it was brought up that Staff B and Staff C made Resident #1 urinate in her bed. Staff E further revealed that Staff B and Staff C had moved the call light out of Resident #1's reach. Follow up interview on 10/29/25 at 1:50 PM with the DON revealed that she conducted the meeting on 8/27/25. The DON stated that there were issues with the night shift not getting residents up as often as they should. The DON then revealed that there was an incident where she was told that one of the CNAs took a resident's call light away. The DON stated she was never told which CNA it was as the complaint came from a resident's daughter. The DON confirmed this was for Resident #1. The DON revealed the resident's daughter had reported the complaint to her on the 23rd or 24th of October. The DON</p>		