

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165434	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2025
NAME OF PROVIDER OR SUPPLIER Accura Healthcare of Ogden, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 625 East Oak Street Ogden, IA 50212	

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165434	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2025
NAME OF PROVIDER OR SUPPLIER Accura Healthcare of Ogden, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 625 East Oak Street Ogden, IA 50212	
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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and resident interviews and facility policy review the facility failed to treat 2 of 3 residents (Resident #1 and #3) with dignity and respect. The facility reported a census of 40 residents. Findings include: 1. According to the quarterly Minimum Data Set (MDS) assessment with a reference date of 8/31/2025, Resident #1 had a Brief Interview of Mental Status (BIMS) score of 14. A BIMS score of 14 suggested no cognitive impairment. The MDS listed the following diagnoses for Resident #1: major depressive disorder, cancer, heart failure, diabetes mellitus, anxiety, depression, psychotic disorder, paranoid personality disorder, and obesity. A Care Plan Focus Area with an initiation date of 7/9/2024 documented Resident #1 has the potential for alteration in behavior and mood related to diagnoses depression, anxiety, and paranoid personality disorder. She is delusional and believes that nursing staff is changing her medications. She is paranoid and think others are stealing and spying on her. She refuses to stand up for in-house staff when she needs help at times. She is limiting her food and fluid intake on a routine basis. She declines for housekeeping staff to be in her room. I refuse counseling in house or out of facility. The following Progress Note documented by the MDS Coordinator on 10/24/2025 at 9:05 AM: Late entry for 10/23/2025 at 3:45 PM: resident was wheeling herself up the hallway in her wheelchair with a soaker pad in her lap. She reached the top of the hallway, where the threshold is and couldn't make it over the lip. This Registered Nurse (RN) went over to ask resident if she needed assistance and resident stated yes, I can't get over this. This RN attempted to push resident's wheelchair over the threshold with no success and then backed resident up and tried it again with no success. This RN stated to resident that she was going to take resident backwards over the threshold for her safety and resident said no, there's Staff A Certified Nursing Assistant (CNA). She can do it. So, per resident's request this RN asked Staff A to come assist with pushing resident over the threshold. Staff A did and then resident mumbled something about soaker pads and threw the dirty urine-soaked soaker pad at Staff A and called her a dumb b****. This RN stated to resident that was not called for and that she needed to go back to her room and calm down. Resident stated no. This RN then started to turn her wheelchair around and resident then grabbed for the wall and then started pinching Staff A. This RN stated to resident that she needed to stop immediately and then resident swung her arm to the back and hit/scratched this RN x 2 in the face. The RN stated it's time for quiet time in her own personal space. On 11/12/2025 at 11:38 AM Resident #1 denied staff members cursing in front of her or at her. When asked if staff have ever been rough or mean to her, she stated no but was told she had hit two staff members. Resident #1 could not recall this happening but stated if it happened then they probably deserved it. When asked how Staff A treated her, she could not recall who that was. 2. According to the significant change MDS assessment tool with a reference date of 8/19/2025, Resident #3 had a BIMS of 13. A BIMS of 13 suggested no cognitive impairment. The MDS listed the following diagnoses: anemia, heart failure, renal failure, hip fracture, seizures, malnutrition, anxiety, depression, bipolar, and schizophrenia. The Care Plan Focus Area with an initiation date of 5/10/2019 documented he had the potential for behaviors and altered coping related to: major depressive disorder, schizoaffective disorder, and anxiety, history of a traumatic brain injury and history of being sexually inappropriate. On 11/12/2025 at 7:25 PM Staff B Licensed Practical Nurse (LPN) stated she overheard Staff A talking with Resident #3 through his roommate's baby monitor. She heard Staff A f*** you too, to Resident #3. Staff B stated Staff A swears like a sailor all the time and has been talked to about it. She swears a lot in front of the residents and has been talked to about this. On 11/13/2025 at 1:36 PM Staff A stated Resident #1 assaulted her and the MDS Coordinator about 3 weeks ago. Resident #1 pinched her and clawed the MDS Coordinator in the face twice. Resident #1 had come down her hall and got stuck on the lip of the flooring. The MDS Coordinator was trying to help her when Resident #1 called for me to help. Once she was able to get her over the lip on the floor the resident threw a urine-soaked bed pad at her and called her a dumb b****. The MDS Coordinator stated we are not going to talk like that, we need to go to your room to calm down. Resident #1 reached around and pinched me. I moved her hands and said get your f***ing hands off me. Then she scratched the MDS Coordinator in the face twice. They called the Director of Nursing (DON) and the cops. When asked what Resident #1 said after she told her to get her hand off of her, Staff A stated she was just mumbling. Staff A acknowledged she said get your f***ing hands off me in the heat of the moment. When asked she assists Resident #3 she stated she has known him since she was [AGE] years old, was a</p>		