| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165434 | A. Building<br>B. Wing | 05/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Accura Healthcare of Ogden, LLC | 625 East Oak Street<br>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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on clinical record review, staff interviews, and policy review, the facility failed to draw a dilantin (medication to treat seizures) blood level as ordered by the medical provider for 1 of 3 residents reviewed for assessment and intervention (Resident #1). The facility reported a census of 44. Findings include:The Minimum Data Set (MDS) Assessment completed on 2/16/26 noted Resident #1 could not complete a Brief Interview for Mental Status. Resident #1 was assessed as severely cognitively impaired to make daily decisions. Diagnoses include dementia and seizure disorder.The April 2026 Medication Administration Record (MAR) showed an order for Dilantin 100 milligrams to be administered twice daily. The start date noted as 5/15/24. Lab results from 11/12/25 showed Resident #1's Dilantin blood levels low at 4.7 micrograms per milliliters (ˆg/mL). The therapeutic reference range for dilantin is 10-20ˆg/mL. The Primary Care Provider (PCP) reviewed the results and ordered for a repeat level to be drawn in one month. The EHR lacked documentation that a repeat Dilantin blood draw was completed one month later. No lab order was identified in the EHR to direct staff to complete. No results were identified that indicated the lab was completed. During an interview on 5/4/26 at 1:30 PM, Staff A, Registered Nurse (RN) explained once lab orders are identified and signed off, staff will write the lab in the resident lab calendar to track. Staff A acknowledged the PCP written Dilantin lab order for Resident #1 from 11/12/25. Staff A also acknowledged that a member of the nursing staff signed off on the order. The current resident lab calendar did not go back far enough to verify if the lab was written down. During an interview on 5/5/26 at 10:45 AM, the Director of Nursing (DON) found the previous resident lab calendar. Upon review, the repeat Dilantin lab was not found in the calendar for the month of December 2025. At this point, the DON acknowledged the lab draw was missed and not drawn. The policy New Orders Triple Note Process, updated 3/29/21, outlined the following: A. Double Noting: Oncoming nurse of the next shift will review the order to ensure the order has been inputted into the EHR and all notifications have been completed B. Triple Noting: MDS nurse will review the order to ensure the order has been completed and Care Plan updated as necessary C. Once orders are signed by the physician, they will be placed in the resident's medical record |

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 |
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| | 165434 | A. Building<br>B. Wing | 05/06/2026 |

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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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on clinical record review, staff interviews, and policy review, the facilty failed to continue with neurological assessments (neuros) after an unwitnessed fall for 1 of 3 residents reviewed for assessment and intervention (Resident #3). The facilty reported a census of 44. Findings include:The Minimum Data Set (MDS) Assessment completed on 2/10/26 noted Resident #3 could not complete a Brief Interview for Mental Status. Resident #3 was assessed as severely cognitively impaired to make daily decisions. Diagnoses include schizophrenia and seizure disorder.The facility Incident Report #1262 detailed Resident #3 experienced an unwitness fall on 4/15/26 at 2:30 PM. The nurse completing the report documented they were unable to complete neurochecks, pupillary response only (eye assessment). Resident noted with an intellectual disability and was combative. Nursing Progress Notes in the EHR revealed the following: On 4/16/26 at 2:07 AM staff detailed the first documented unwitnessed fall follow-up assessment. Neuro assessment noted as within normal limits (WNL) for resident. Unable to obtain a blood pressure or oxygen saturation level. On 4/16/26 at 1:43 PM no latent injuries noted from the previous fall. No indications of pain or discomfort. Activities per usual for resident. On 4/17/26 at 12:43 AM neuro assessment WNL for resident. Unable to obtain blood pressure but able to obtain temperature, pulse, respiration rate, and oxygen saturation level. On 4/17/26 at 2:24 PM no latent injury noted from the previous fall. No indications of pain or discomfort. Activities per usual for residentThe electronic health record lacked documentation of completed or attempts to complete neuro checks at the specific timed intervals after unwitnessed falls. During an interview on 5/5/26 at 12:30 PM, the Director of Nursing (DON) explained neuro checks are documented on paper and then scanned into the EHR. The DON was unable to identify that neuro checks were initiated or completed on Resident #3 after the unwitnessed fall on 4/15/26. The DON acknowledged staff does struggle with getting vitals on Resident 3. However, they would expect staff to complete neuro checks as scheduled and assess as much as resident will allow. At the very least, the DON would want staff to document resident status (with or without vitals) at the scheduled neuro check intervals. During an interview on 5/5/26 at 1:00 PM, Staff B, Registered Nurse, acknowledged they were the nurse who assessed Resident #3 after the unwitnessed fall on 4/15/26. Staff B explained they attempted to get vitals and initiate neurochecks as per procedure. Due to the resident's intellectual disability, they were unable to complete and noted this in the EHR. Staff B acknowledged they did not attempt any further neurochecks for the remainder of their shift. Staff B believed they checked on Resident #3 one time after the unwitnessed fall. Staff B explained they placed the resident and the fall on Hot Charting. Meaning nursing staff will document resident status related to an event, per shift, for the next 72 hours. The Risk Management policy, updated 9/27/24, outlined the following regarding neurological assessments: 1. Must be completed with every unwitnessed fall or fall with possible head injury 2. Neuro Checks must be completed in the following time frames a. Every 15 minutes x 4 b .Every 30 minutes x2 c. Every hour x 2 d. Every 4 hours x 3 e. Every shift x 3 |