STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165434	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Ogden, LLC	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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interviews, clinical record review and facility record review, the facility failed to ensure a homelike environment for 1 of 13 residents reviewed. Resident #22 resided in a room that smelled of urine and needed painting and repairs. Staff failed to remove dirty dishes from the evening meal that remained in the dining room until after the breakfast service began. The facility reported a census of 42 residents.Findings include: 1) In an observation of the dining room and kitchen area on 9/3/25 at 6:30 AM, it was discovered that a multi-level cart contained dirty dishes from the previous day in the dining room area. The cart was not moved back into the kitchen area until 8:00 AM, after the breakfast service had began and the residents were eating. 2) According to the Minimum Data Set (MDS) dated [DATE], Resident #22 had a Brief Interview for Mental Status (BIMS) score of 15 (cognitive intact). She used a walker and a wheel chair due to lower extremity impairment. The resident required toileting hygiene with set up and clean up assistance.According to the Care Plan revised on 10/16/24, Resident #22 had the potential for activity deficit related to major depressive disorder and generalized anxiety disorder. The resident required assistance with toileting and peri care, and frequently declined assistance. Resident #22 would throw her soiled briefs on the floor. Her diagnoses included: heart failure, anxiety disorder, history of falling, paranoid personality disorder, insomnia, unspecified psychosis and morbid obesity,On 9/2/2025 at 11:41 AM, Resident #22 was in a wheel chair in her room. There was a very heavy smell of urine in the environment and there were soiled absorbent pads on the floor next to the bed. The resident said that she was able to get herself to the bathroom and she preferred to sleep in her recliner. The resident said that she was often soaked in urine by morning. The doors to the bathroom and to the hallways were dirty and stained. Many of the wood baseboards and trim areas had chipped paint all around the room.On 9/4/2025 at 7:12 AM, Staff H, Housekeeping, said that the resident told her she would allow anyone to come in and clean her room but she questioned whether the other staff would attempt. Staff H said that when she had a couple of days off for a weekend, by Monday, there would be a pile of urine-soaked briefs in the garbage and the room would smell terrible.On 9/4/25 at 7:30 AM, the Administrator said that Resident #22 would only allow one particular staff person in the room to clean it, and they felt they had done all they could to accommodate her needs as she would allow. She said that the resident was paranoid about staff stealing items in her room. The Administrator indicated that they did not have a policy related to maintaining a homelike environment.According to the Facility assessment dated [DATE], the purpose of the assessment was to determine what resources needed to care for residents during the day to day operations. The services and care offered would be based on the resident needs included behavioral and mental health to manage, identify and implement interventions to help support individuals with issue such as dealing with anxiety, and psychiatric diagnosis.Preventative maintenance and/or cleaning schedules would be in place according to manufacturers recommendations.As part of the facility assessment, staff, resident's family and vendors were interviewed to determine what the facility was lacking or needed in the future: Maintenance - the facility needed some updating and repair, staff was doing some painting, replacing (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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tiles, and beds and mattresses. Resident rooms were being updated and painted, the facility had some issues with maintenance completing work timely.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and policy review, the facility failed to develop and implement a comprehensive person-centered care plan for 1 of 12 residents reviewed (Resident #41). The facility reported a census of 42. Findings include: The Minimum Data Set (MDS) dated [DATE] documented Resident #41 had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The resident had diagnoses to include medically complex conditions, heart failure, hypertension and hyperlipidemia. The MDS revealed the resident was on high risk drug classes to include a diuretic in the look back period. Review of the Electronic Heath Record (EHR) for Resident #41 revealed a physician order of the medication Bumetanide (a diuretic medication) Oral Tablet 2 MG, give one tablet by mouth one time a day for edema with a start date of 5/17/25 and an order for Bumetanide Oral Tablet 1 MG, give 1 tablet by mouth two times a day related to heart failure, with a start date of 3/25/25 and a discontinue date of 5/16/25. Review of the EHR for Resident #41 showed a diagnosis list to include the diagnosis of Edema, unspecified, dated 4/1/25. Review of the EHR under Clinical Physician Orders for Resident #41 revealed an order for daily weights, call the Primary Care Physician (PCP) if weight gain of 3 pounds overnight or 5 pounds in one week, and an order to report to PCP any increase in edema, dyspnea, weight or decrease pulse oximeter, as well as an order for ted hose to apply in the AM and remove at HS (hour of sleep), two times a day for edema. The Care Plan for Resident #41, with an initiation date of 4/1/25, lacked a focus area, goals and interventions for edema and the use of a diuretic. During an interview 9/3/25 at 3:57 PM, the MDS coordinator stated an expectation the diuretic medication and edema be in the care plan, with a focus area, goals and interventions. She acknowledged this was not in the care plan. Review of the facility policy Comprehensive Care Plans, updated April 2025, documented it is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review the facility failed to complete the required documentation, staff education and nursing assessments for the Restorative Program (RP) for 2 of 2 residents reviewed (Residents #30 and #2.) The facility reported a census of 42 residents.Findings include:1) According to the Minimum Data Set (MDS) dated [DATE], Resident #30 did not complete a Brief Interview for Mental Status (BIMS) due to severe cognitive impairment. The resident was totally dependent on staff for toileting hygiene, and lower body dressing and required partial assistance with sit to stand, and transfers. The Restorative Program (RP) was performed for the 6 of the 7 days during the look back period. The Care Plan for Resident #30, dated 2/9/25, showed a focus area for the RP to include: active Range of Motion (ROM) to upper and lower extremities. Nu-step 1-7 times a week, active ROM to upper body exercises with a 1-pound dowel bar for bilateral upper extremities, 1-7 times a week and ambulation program to meals 1-7 times a week. On 9/3/25 at 12:44 PM, Resident #30 was sitting in her wheel chair at the dining room table. She was having some difficulty sitting up straight and leaned over the right arm of the chair. At 12:47 PM, she slowly pushed the wheels towards her room and said that she could use some help. The following was found on the Point of Care (POC) Response History for Ambulation Programs from 8/6/25 – 9/3/25 for Resident #30: a. Ambulate to meal approximately 150 feet, documented 15 times NA (Not Applicable) b. The active range of motion to upper body from 8/13 – 8/27 was not completed in that timeframe and documented 11 times NA. c. The active ROM to upper and lower extremities documented NA 10 times. A review of the Nursing Progress Notes showed that the most recent restorative summary was dated 4/29/25 at 1:48 PM, and included a notation that nursing would continue to monitor participation in the program and adjust according to residents needs and requests. On 9/3/25 at 1:14 PM, Staff A, Certified Nurse Aide (CNA) and Staff B, CNA said that they would document NA on the POC for the Restorative Program exercises when the resident was independent and the Staff didn't need to help them with the exercises. On 9/3/25 at 2:00 PM, Staff B CNA said that she was the primary staff member scheduled to the Restorative Program. Her regular schedule was from 7:30 AM – 4:00 PM, but from 7:30-11:30, she was expected to provide showers and baths, and many times she would be pulled to help with other CNA duties. She said that many times she had just a two-hour timeframe to work with the residents in the therapy room. Staff B said that the CNA's can do the ROM in the rooms with the residents when they are getting them dressed. She was not aware of any specific training for the CNA's on how they should safely provide the services specific to the residents. On 9/4/25 at 11:15 AM, Staff G, CNA said she did the restorative exercises with residents when she's (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	able. She said she hadn't had any specific education at the facility, but learned some in the CNA classes. The facility Orientation Education Schedule showed a list of 39 scheduled on-line classes. The list lacked education on restorative exercises. According to the facility policy titled: Restorative Program Process dated 2021, the purpose was to ensure residents achieved and maintained their highest level of functioning. Upon admission, quarterly and with significant change the resident's level of function would be assessed by the licensed nurse or in collaboration with therapy. The licensed nurse would monitor the daily restorative nursing program documentation in point of care and follow up with staff as needed. The licensed nurse would write a monthly restorative nursing summary to track the residents progress. According to the American Association of Post-Acute Care Nursing (AANAC) Guide to Successful Restorative Programs (found in the Restorative binder), nursing assistants and aides must be trained in the techniques that promote resident involvement. The Facility Assessment showed that they would provide specialized rehabilitation services, and would employ 1 restorative aide full time. The program would be supported with exercise programs lead by the activities director and the floor CNA, and incorporated into restorative tasks. 2. The MDS dated [DATE] for Resident #2, documented the resident had a BIMS score of 13 indicating intact cognition. The MDS identified diagnoses as anxiety disorder, depression, bipolar and schizophrenia. The MDS also documented that Resident #2 was coded dependent with toileting, lower body dressing, personal hygiene and required maximum assistance with sit to stand and partial assistance with sit to lie and [NAME] to sitting on the side of the bed. The care plan for Resident #2 showed a focus area for the RP to include an ambulation program: may walk 50 to 75 feet with assist of 1 and walker with wheelchair to follow 1-7 times weekly. Dressing/grooming program: encourage the resident to participate in am and pm care 1-7 times weekly and transfer practice: supervision with walker for transfers in room [ROOM NUMBER]-7 times weekly. The following was found on POC response history for ambulation programs from 8/6/25-9/4/25 for Resident #2: Ambulation program: may walk 50 to 75 feet with assist of 1 and walker with wheelchair to follow 1-7 times weekly, documented 59 times NA. Dressing/grooming program: encourage resident to participate in AM and PM care 1-7- times weekly, documented 24 times NA Transfer practice: supervision with walker for transfers in room [ROOM NUMBER]-7 times weekly, documented 55 times NA. A review of the nursing progress notes showed that the most recent restorative summary was dated on 4/29/25 and stated the facility will continue to monitor participation in the program and will adjust program according to resident needs/requests. Interview on 9/3/25 with staff F, Director of Therapy, stated that the process when the residents are discharged from a therapy, therapy puts together a restorative program. This restorative program (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	goes to the MDS Coordinator, then the MDS Coordinator puts it together for the restorative aid (RNA). Staff F stated the Restorative Programs can vary from walking, to 1:1's, ROM and group exercises. Staff F stated depending on the program, the floor staff are able to do the ambulation with the resident. Staff F stated the RNA is supposed to do the ROM exercises. She stated the activity person just started so they have started group exercises with the residents. Staff F stated that occasionally she will do some screens to make sure the program is working with the residents, but usually the therapy department would be notified from the staff if there is a change in condition or if the resident is not participating in restorative. Interview on 09/04/2025 at 10:25 AM with Staff F stated that when they make the restorative programs and specify 1 to 7 days, this gives flexibility to the restorative aid/staff time to get the program completed. She stated that sometimes the RNA gets pulled to the floor or if the resident refuses, this gives staff time to complete the program. She stated the goal of the program is to keep the resident at their baseline and maintain their strength. She stated for the resident to maintain their baseline, they would ideally need to be seen more than once. She acknowledged that one day a week was not sufficient enough to maintain the resident's baseline and strength.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview, clinical record review and policy review the facility failed to adequately assess and intervene to prevent skin wounds for 1 of 2 residents reviewed. Resident #6 was on hospice, developed an abrasion on his coccyx and the treatment did not start for two days after it was discovered. The resident was observed to be in his wheel chair for over 2 hours, and when his brief was changed, staff failed to apply barrier cream. The facility reported a census of 42 residents. Findings include:According to the Minimum Data Set (MDS) dated [DATE], Resident #6 had a Brief Interview for Mental Status (BIMS) score of 14 (intact cognitive ability). He required total dependence for toileting hygiene and lower body dressing, and substantial assistance with rolling, sitting and toileting. The resident had an indwelling urinary catheter.The Care Plan showed that Resident #6 had the potential for changes in skin integrity related to a decline in nutritional status, limited mobility, incontinence, and suprapubic catheter use. On 8/18/25 it was discovered that he had an abrasion on the upper buttock. Staff were to monitor skin with care and notify nursing and the doctor of any changes in skin integrity, and provide treatment as ordered. His diagnoses included benign prostatic hyperplasia, repeated falls, dysphagia following cerebral infarction, protein calorie malnutrition and retention of urine.According to the Skin Sheet-non-ulcer Assessment (SSNUA) dated 8/18/25 at 3:18 PM, a new area, described as an abrasion, was discovered. The skin was pink, the document lacked measurements. A follow up SSNUA dated 8/25/25 at 3:43 PM, indicated that the first layer of skin was off, and measurements included: length 2.5 centimeters (cm) x 1.5 cm width. The resident had pain with touching and the doctor was notified. The chart lacked a weekly follow up assessment due to be completed on 9/01/25.The Quarterly Braden Scale for Prediction Pressure Sore Risk was dated 8/04/25 at 3:45 PM, but completed on 8/20/25 at 3:46 PM, and showed that he was at high risk for pressure sores.A faxed order written on 8/18/25, showed that staff were to apply calmoseptine cream on the skin, topical to upper left buttock/coccyx three times a day and as needed (PRN). According to the Medication Administration Record/Treatment Administration Record (MAR/TAR) The treatment did not begin until 8/20/25. On 9/03/2025 at 6:35 AM, Resident #6 was sitting in the wheel chair at the breakfast table. At 8:42 AM, he had wheeled himself near the nurse station and said bed time several times. At 8:48 AM, his voice got much louder and he said bed! bed! bed! At 8:50 AM, Staff B, Certified Nurse Aide (CNA) took him back to his bedroom.On 9/03/2025 at 10:50 AM, Staff A CNA, Staff B, and Staff C (LPN) prepared to provide personal cares to the resident. He moaned many times as they moved and wiped him with disposable wipes. As they turned him on his side, it was revealed that his left buttocks had a very red spot with a small open area. The staff cleaned the area and applied a clean brief without having applied a barrier cream. On 9/03/2025 at 11:10 AM, Staff D Registered Nurse (RN) said that she saw the spot on the resident's buttocks and agreed that it looked to be open. She said she had contacted Hospice and told them it wasn't getting better and maybe needed new order. The SSNUA dated 9/3/25 at 3:15 PM, showed a measurement of 2.5 cm x 1.5 cm. The document included a note that the nurse had attempted to assess the resident on 9/2/25, but he was in the wheel chair, and on 9/3 he was sleeping when she went to assess him. A facility policy titled: Weekly Skin Assessment and Documentation Process updated on 1/20/23, showed that staff would provide weekly skin assessments. The facility would choose a specific day of the week for the assessment and documentation. When the nurse on the floor observed a new skin alteration they should utilize the fax forms to notify the physician. If a skin wound alteration exhibited any decline or non-healing the nurse would notify the physician. The facility policy, updated on 1/20/23, titled: Weekly Skin Assessment and Documentation Process, showed that skin ulcer and non-ulcers will be assessed and documented weekly by the facility wound nurse.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical chart review and staff interview the facility failed to implement policies and procedures regarding the technical aspect of checking placement for gastrostomy tubes by failing to check placement for 2 of 2 residents (Resident #2 and Resident #33). The facility reported a census of 42 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #33, documented the resident did not have Brief Interview for Mental Status (BIMS) completed due to Resident #33 is rarely/never understood. The MDS identified diagnosis as anxiety, psychotic disorder, severe intellectual disability and encephalopathy. The MDS also documented that the resident received nutrition through a gastric feeding tube.Observation completed on 9/3/25 at 11:40 a.m. with Staff H, Registered Nurse (RN) and Staff I, Certified Nursing Assistant, (CNA) completed hand hygiene in Resident #33's room. Staff H applied gloves to both hands and hooked up the tube feeding to Resident #33. Staff H did not check placement of the gastrostomy tube. After Staff H hooked up the feeding, she removed her gloves and completed hand hygiene.Interview with Staff H on 9/3/25 at 11:50 a.m. acknowledged that they are supposed to be checking placement of the g-tube, she stated that she does not check the placement due to it would be traumatic to Resident #33. Review of the resident record lacks information regarding checking placement of the g-tube.Review of the Progress Notes dated 9/4/25 for Resident #33 revealed a fax was received from the primary physician to check placement on the gastrotomy tube. 2. The Minimum Data Set (MDS) dated [DATE] for Resident #2, documented the resident had a BIMS score of 13 indicating intact cognition. The MDS identified diagnosis as anxiety disorder, depression, bipolar and schizophrenia. The MDS also documented that the resident has a gastric feeding tube.Review of the resident record lacks information regarding checking placement of the g-tube.Interview with the Director of Nursing (DON) on 9/3/25 at 1:30 p.m. stated the expectation is to check placement for G-tubes, she stated that they are checking placement for Resident #10, but not for Resident #2 and Resident #33. She stated both of them have specialized gastrotomy tubes. Interview with the DON on 9/3/25 at 1:48 p.m. she stated that they do not have a policy regarding feeding tubes, she stated they have a competency checklist for them. The DON revealed she found out they have to check placement on those specialized tubes so she will be placing a call to their primary physician to get orders.

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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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview, record review and policy review the facility failed to implement adequate infection control practices for 2 of 5 residents reviewed (Residents #33 and #6). Staff failed to use Enhanced Barrier Precautions (EBP) while providing care to Resident #33 who had a tube feeding, and during a transfer for Resident #6, who had a urinary catheter. The facility reported a census of 42 residents. Findings include:1) According to the Minimum Data Set (MDS) dated [DATE], Resident #6 had a Brief Interview for Mental Status (BIMS) score of 14 (intact cognitive ability). He required total dependence for toileting hygiene and lower body dressing, and substantial assistance with rolling, sitting and toileting. The resident had an indwelling urinary catheter. The Care Plan initiated 10/30/24 showed that Resident #6 had the potential for changes in skin integrity related to a decline in nutritional status, limited mobility, incontinence, and suprapubic catheter use. On 8/18/25 it was discovered that he had an abrasion on the upper buttock. Staff were to monitor skin with care and notify nursing and the doctor of any changes in skin integrity, and provide treatment as ordered. His diagnoses included benign prostatic hyperplasia, repeated falls, dysphagia following cerebral infarction, protein calorie malnutrition and retention of urine. The Care Plan lacked specific information and instructions for the use of EBP. On 9/3/25 at 8:50 AM, Staff B, Certified Nurse Aide (CNA) took Resident #6 back to his bedroom to transfer him into bed. The resident was in a Wheel Chair (WC,) and there was a urinary catheter hooked under his WC. With ungloved hands, Staff B held onto the catheter tubing, reached down under the WC, unhooked the catheter and hooked it to a pocket on the side of her scrub pants and assisted the resident into bed. Staff B then put the catheter bag in a tub on the floor. The staff member failed to wash her hands before leaving the room, then used a hand sanitizer as she walked down the hallway. On 9/4/25 at 12:07 PM, the Infection Preventionist said that Staff B should have used EBP while transferring Resident #6 into bed. She said that the catheter should not be hooked onto her person, and she would provide education on hand hygiene and catheter care. According to the facility policy titled: Enhanced Barrier Precautions updated on 11/13/24, an order for EBP would be obtained for residents with: indwelling medical devices including urinary catheters and feeding tubes. EBP barrier precautions would be found outside the resident's room when performing transfers and assisting during when anticipating close physical contact while assisting with transfers and mobility. 2) The MDS dated [DATE] for Resident #33, documented the resident did not have BIMS completed due to Resident #33 is rarely/never understood. The MDS identified diagnoses as anxiety, psychotic disorder, severe intellectual disability and encephalopathy. The MDS also documented that the resident received nutrition through a gastric feeding tube. Review of the Care Plan dated 5/22/25 documented enhanced barrier precautions (EBP) is in place. On 9/3/25 at 11:40 a.m. observed Staff H, Registered Nurse (RN) and Staff I, Certified Nursing Assistant, (CNA) hook up the feeding to Resident #33. After Staff H hooked up the feeding, she removed her gloves and completed hand hygiene. Both staff members failed to apply EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Staff H on 9/3/25 at 11:50 a.m. stated they do not wear the EBP due to the resident will pull and grab at the gowns and the gloves. Interview on 9/3/25 at 2:39 p.m. with the Corporate Nurse stated she would expect the staff to apply EBP while providing care on a resident with a gastrostomy tube.