STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165450	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Toledo	403 Grandview Drive Toledo, IA 52342

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff and resident interviews, the facility failed to monitor and provide adequate supervision for a resident who wandered into other resident rooms for 1 of 14 residents reviewed (Resident #1). The facility reported a census of 54 residents.Findings include:The Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #1 had a diagnosis of Non-Alzheimer's dementia. It indicated wandering occurred 1-3 days during the 7 day look back period and a wander alarm was used daily. His Brief Interview for Mental Status (BIMS) score was 3 out of 15, which indicated severe cognitive impairment. Per the MDS assessment, the resident walked independently and did not use a mobility device. The Care Plan initiated on 11/10/25 revealed the resident was an elopement risk related to Dementia and able to ambulate independently. The Care Plan intervention dated 11/10/25 indicated that a wander alert bracelet was utilized. The Care Plan focus area dated 12/8/25, revised on 4/15/26, revealed Resident #1 had a behavior problem as evidenced by (AEB) urinating in inappropriate places and running up and down hallways, wandering into others' rooms, kissing another female resident related to dementia. The intervention dated 12/8/25 revealed to intervene as necessary to protect the rights and safety of others, and indicated that staff should approach and speak in a calm manner and divert attention. Remove from situation and take to alternate location as needed. Another intervention dated 12/8/25 directed staff to monitor behavior episodes and attempt to determine the underlying cause by considering location, time of day, persons involved, and situations then document the behavior and potential causes. The Intervention dated 4/14/26 revealed, 1:1 (one to one) supervision when out of room until he is determined to be safe with others. The Electronic Health Record (EHR) documented behaviors related to wandering for Resident #1 as noted below: a. 11/11/25 at 9:44 PM: Observed wandering through the hallway appearing confused and disoriented. He was difficult to verbally redirect.b. 11/12/25 at 5:53 AM: Wandering and having difficulty finding his room.c. 12/25/25 at 12:11 AM: [Wander alert device] was in place but not functioning. No replacement in the facility so on-call staff monitored throughout the shift. The bracelet was also documented as not functioning again at 3:26 PM the same day.d. 1/4/26 at 11:08 PM: Wandering more than usual and trying to go to the casino.e. 1/9/26 at 3:57 AM: Wandering in halls around the facility with no attempts to enter other residents' rooms.f. 3/4/26 at 4:04 AM: Wandering around the facility all night and had not gone to bed.g. 3/5/26 at 4:41 AM: Resident was up all night wandering the facility. h. 3/13/26 at 5:44 AM: Walking around the facility and going into different rooms.i. 3/17/26 at 5:07 AM: Wandering around the hallways for the majority of the shift.j. 3/25/26 at 1:01 AM: Following staff into other resident rooms while they were answering call lights. Redirection caused increased agitation.Resident #1 and Resident #10:The Orders-Administration Note dated 3/28/26 at 7:26 PM present in Resident #1's clinical record revealed, Residents reported [to writer] this resident had become Sexually inappropriate with Resident [Resident #10] and was in her personal space trying to touch her. [Writer] went to and talked with resident and he stated that he didn't mean to make her feel uncomfortable, and that he just wanted to talk to her as friends. [Writer] told him that we need to give everyone their personal (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165450	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Toledo	403 Grandview Drive Toledo, IA 52342

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	space and that to be mindful of the other residents feelings.The Orders-Administration Note dated 3/30/26 at 1:00 PM present in Resident #1's clinical record revealed Interview conducted with other resident that this resident was allegedly was inappropriate with on 3/28. Other resident (Resident #10) is alert and oriented and stated that this resident (Resident #1) was not inappropriate at all with her. He did get close to her, but when she told him he was in her bubble he moved away without issues. Other resident said he did not touch her nor say anything inappropriate to her.In an interview on 4/27/26 at 8:52 AM Resident #10 stated that she had her stop sign put up on her door as wanderers were coming in and she did not like it. It was 8 months ago and they were all gone now. Resident #10 explained Resident # 1 had not come into her room and has only once got into her personal bubble once. She told him to get back and he did. Had not come into her room and she felt the stop sign worked well. Review of a list of Brief Interview for Mental Status (BIMS) scores provided by the facility revealed Resident #10 scored 15 out of 15, which indicated intact cognition. Resident #1 and Resident #2: The Communication with Physician Note dated 4/14/26 at 7:30 PM present in Resident #1's clinical record revealed Change in Condition: Increased confusion and wandering. He was found in another resident's room. He had kissed resident (Resident #2) on the lips while she was in the recliner and was trying to lie down in her bed.During an observation on 4/23/26 at 10:44 AM Resident #1 was not actually across the hall but was across the hall from Resident #2 diagonally. He had a staff member across from his door and an alarm attached to the outside of his door that activated with his wander alert bracelet. One on one staff outside of the room across the hall. On 4/28/26 at 10:30 AM Resident #1 still had a 1 on 1 in place.In an interview on 4/23/26 at 9:32 AM Resident #2 stated that she could not remember if she saw Resident #1 come in the door or if she awakened but he came into her room and kissed her on the lips and then went to her bed and laid down. She put on her call light or she had it on, she could not remember for sure. Stated she was not scared of him as he usually acts normal. She felt safe at the facility and gets good care. She felt bad that he had to have a 1 on 1. Review of a list of BIMS scores provided by the facility revealed Resident #2 scored 11 out of 15, which indicated moderate cognitive impairment. Resident #1 and Resident #7, #8, #13, and #14:In an interview on 4/23/26 at 9:36 AM Resident #8 with BIMS score 15 out of 15 stated that Resident #1 entered her room on 4/14/26. He looked out the window and left. He never said anything to her or touched her in any way. She reported got great care at the facility and felt safe.In an interview on 4/23/26 at 2:40 PM Resident #8 stated that Resident #1 only came into her room that one time on 4/14/26.In an interview on 4/23/26 at 9:40 AM Resident #7 with BIMS score 13 out of 15 stated that Resident #1 sat in her chair and watched TV. She was startled when she saw him but he got up and left. He didn't said anything to her or touch her in any way. She felt safe at the facility but hoped someone was watching him.In an interview on 4/23/26 at 2:40 PM Resident #7 stated that Resident #1 had been in her room watching TV about one month prior to 4/14/26. Only two times.In an interview on 4/23/26 at 2:50 PM Resident #13 with BIMS score 15 out of 15 stated that Resident #1 came into her room only one time on 4/14/26. He came in and took off his shoes and dropped his pants and asked to get in bed with her. Her and the staff told him to get out. It took a while to get him out. Nothing physical or sexual happened. She stated that she is not scared and felt safe. She heard he kissed another resident later that evening.In an interview on 4/27/26 at 9:57 AM Resident #14 explained, in part, that that Resident #1 couldn't remember where his room was anymore.Review of Plan of Care (POC) documentation indicated between 3/30/26 and 4/28/26, 15 shifts documented wandering. Grabbing was indicated on one shift, pushing was indicated on one shift, repeated movement was indicated on two shifts and sexually inappropriate was indicated on one shift. Six shifts were marked not applicable.In an interview on 4/23/26 at 9:47 Staff A, Registered Nurse (RN) stated Resident #1 remained across the hall with a 1 on 1 still in place. He also had an alarm that triggers if he left the room. She stated there were medication changes but not sure which ones. She knew his seroquel (antipsychotic medication) was increased a couple weeks prior to the incident.In an interview on 4/23/26 at 10:44 AM Staff B, Certified Nursing (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165450	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Toledo	403 Grandview Drive Toledo, IA 52342

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assistant (CNA) stated she was the 1 on 1 for Resident #1. He comes out every 5-10 minutes usually. She walked with him if he came out and redirected him if he tried entering other resident's rooms.In an interview on 4/23/26 at 12:38 PM the Administrator said that the 1 on 1 with Resident #1 would remain in place until they saw progress with the medication changes. The Administrator explained they changed some medications but he was really declining with his dementia. Hospice declined him since he was still physically in good health. They called [Redacted] for a locked unit and they were concerned with the kiss. They would look at him. In an interview on 4/23/26 at 2:35 PM Staff E, CNA stated that she knew Resident #1 had been wandering for a couple weeks but maybe longer as her days ran together. Maybe since November 2025. He was especially likely to go into another room if the TV was on. Stated that the incidents for rooms [six room numbers redacted] happened the same day. Resident #1 had been going into rooms prior to 4/14/26 but she never heard anything sexual prior to that. Resident #7 told her that he had been in her room before 4/14/26 but only watched TV. In an interview on 4/27/26 at 9:45 AM Staff C, CNA stated that Resident #1 wandered the halls for some time before the incident with Resident #2 on 4/14/26. He would occasionally go into others rooms and they would redirect him. He had not touched or interacted with other residents prior to this incident and now has a 1:1 with him.In an interview on 4/27/26 at 10:04 AM Staff D, CNA stated that Resident #1 has always wandered but mostly halls and around the nurse's station. If he went into a resident room, he would have been redirected. That was the only intervention prior to the incident with Resident #2 and the current 1 on 1.In an interview on 4/27/26 at 10:20 AM, the Administrator stated that Resident #1 had been wandering around the facility since admit and they placed a wander bracelet. He fairly recently started wandering into rooms but was easily redirected and never interacted with residents. For the last couple weeks he had been wandering and following staff and into other resident rooms. They tried Hospice but were unable to get that and they changed medications with psych involvement.In an interview on 4/27/26 at 2:40 PM the Administrator stated that after Resident #1's increase in behaviors they tried to get him into Hospice, changed his medications and had staff redirect when he would enter other residents' rooms. When reviewed Care Plan changes on December 8, 2025, she stated that there were no new interventions put in place until the incident on 4/14/26. She was aware that there was an incident on 3/28/26 with Resident #10 on 3/28/26 but it was not sexual in nature. He was only in her personal space. When questioned if that could be indicative of an escalation of his behaviors, she nodded.