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	01/08/2026

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, policy review and staff interviews, the facility failed to complete smoking assessments for 1 of 1 resident reviewed for smoking (Resident #50). The facility reported a census of 53 residents. Findings include: Resident #50's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) of 7 out of 15, indicating severe cognitive impairment. The MDS further indicated that the resident admitted to the facility on [DATE], had a diagnosis of non-Alzheimer's dementia and was independent with mobility. The Care Plan initiated 8/12/25 revealed Resident #50 was a smoker with goals the resident will not smoke without supervision and will not suffer injury from unsafe smoking practices. During the survey process, the facility provided a list of residents that smoked and Resident #50's name was documented. Review of Progress Notes for Resident #50 revealed she had smoked on the following dates:a.8/24/25b.8/28/25c.9/2/25Further review of Progress Notes revealed on 10/8/25 Social Services spoke to Resident #50 about complaints that the resident had been smoking in her room. The resident agreed to allow the Administrator and Social Services to search the room for smoking materials. Clinical record review revealed a smoking assessment had been completed on Resident #50 on 11/21/25, and revealed the resident required a smoking apron and supervision. The clinical record lacked additional smoking assessments for the resident. Review of facility policy titled, Resident Smoking Process, updated 4/21/22 revealed a Smoking Evaluation with Care Plan interventions addressing safety issues must be completed upon admission, quarterly, annually and for change in condition assessments. On 1/7/26 at 2:35 PM, the Director of Nursing (DON) revealed smoking assessments should have been for completed for Resident #50 with her MDS assessments. On 1/7/27 at 2:50 PM, the Administrator revealed it is an expectation residents have a smoking assessment completed prior to smoking at the facility.

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, clinical record review, staff interview and resident interview the facility failed to follow physician orders for oxygen use for 1 of 2 residents reviewed for respiratory care (Resident #37). The facility reported a census of 53 residents. Findings include: The Minimum Data Set (MDS) Assessment for Resident #37 dated 11/13/25 documented a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated intact cognition. The MDS further documented the resident had diagnoses of paraplegia, heart failure and respiratory failure. The MDS documented oxygen therapy usage. The Care Plan focus dated 3/22/23, revised 6/12/25, revealed Resident #37 had altered respiratory status, difficulty breathing related to history of pulmonary embolism (blood clot in lung) and acute and chronic respiratory failure with hypoxia (referring to lack of oxygen) and heart failure. The Physician Order dated 5/30/25 for R#37 documented oxygen (O2) 2 liters/minute per nasal cannula, every shift related to acute and chronic respiratory failure. On 1/5/26 at 11:51 AM Resident #37 relayed had wanted to wean off oxygen (02), was using 02 via nasal cannula, and said the setting should be set at 2 liters.An observation on 1/5/26 at 11:51 AM revealed Resident #37 lying in bed used 02 per nasal cannula. The 02 cannister setting was set at 3.5 liters. An observation on 1/6/26 at 2:45 PM revealed Resident #37 lying in bed used 02 per nasal cannula. The setting was set at 3 liters.An observation on 1/7/26 at 2:00 PM revealed Resident #37's oxygen cannister setting at 3.5 liters. An interview on 1/7/26 at 3:50 PM, Staff C, Certified Medication Aide (CMA) relayed the nurses monitor residents oxygen and also check their oxygen saturation levels (referred to use of pulse oximetry device to monitor blood oxygen levels). On 1/7/26 at 3:52 PM Staff D, Licensed Practical Nurse (LPN), Staff D queried about R#37 oxygen. Staff D relayed 02 would be checked during the shift, had an eight-hour shift to check resident's oxygen.On 1/7/26 at 3:55 PM the Director of Nurses (DON) relayed believed Resident #37's oxygen should be set at 2 liters, followed the DON, and observed the 02 cannister was set at 3.5 liters. The DON turned down to 2 liters and voiced the CMAs and nurses should monitor for correct setting. On 1/8/25, the Administrator relayed the facility did not have a policy for following physician 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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on clinical record review, resident interview, staff interview and policy review the facility failed to ensure follow up dental care for one of one resident reviewed for dental services (Resident #37). The facility reported a census of 53 residents. Findings include: The Minimum Data Set (MDS) Assessment for Resident #37 dated 11/13/25 documented a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition. The MDS further documented the resident had diagnoses of paraplegia, heart failure and respiratory failure. Per the MDS assessment, the resident required setup or clean-up assistance for oral hygiene. The Care Plan initiated 3/22/23, revised on 3/29/23, relayed Resident #37 had paraplegia. The Care Plan initiated 3/22/23, revised on 6/12/25, revealed the resident had chronic pain. The intervention dated 4/14/23, revised 6/12/25, revealed to administer analgesia as per orders, and the intervention dated 4/14/23, revised on 11/6/24, revealed to evaluate effectiveness of pain interventions. Resident #37's Progress Notes revealed the following:On 4/6/25, acetaminophen 650 milligrams (mg) administered for teeth pain.On 4/10/25, acetaminophen 650 mg administered for teeth pain.On 4/24/25, acetaminophen 650 mg administered for teeth pain.On 5/29/25, acetaminophen 650 mg administered for teeth pain.On 6/20/25, acetaminophen 650 mg administered for teeth pain.A document dated 9/12/25 from the visiting Medicaid dental provider relayed Resident #37's chief complaint, had pain with root tips, recommended root tip extraction on six teeth. A Progress Note dated 9/20/25 reflected visiting dental provider recommendation relayed there are six teeth, recommended extraction, referral to outside office will be made, after extractions and insurance authorization, upper and lower partial plates are recommended.A document dated 11/4/25 from the visiting Medicaid dental provider relayed Resident #37 refused teeth cleaning but, would like his teeth extracted. A referral was sent to facility for extraction of six teeth, and directed the facility to please coordinate a visit with an outside facility for resident to get these extractions taken care of.An interview on 1/7/2025 at 2:05 PM, Resident #37 relayed lost several teeth since came to the facility and needed dental services but, had just waited. Resident #37 relayed at times still had teeth pain, ate potatoes, rice and other soft foods as a result of not being able to chew in the back. Resident #37 relayed had dental services for cleaning, the dentist said, Resident #37 needed to go to town for additional services to get partial/dentures, was ready and willing, difficulty chewing with only front teeth and had intermittent pain. Resident #37 relayed would go anywhere to get the dental work and continued to wait. An interview on 1/8/26 at 12:32 PM with Social Services, Staff B revealed recently took on the role of setting up appointments and had set up an appointment today with the dentist in town due to past dental provider recommendations and alerted Resident #37. An interview 1/8/26 at 1:00 PM with the Administrator, relayed had new processes to ensure dental appointments. The facility policy titled Denture Services updated 10/19/22 documented the facility will assist residents in obtaining routine and 24-hour emergency dental care.