STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165451	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Marshalltown	2401 South Second Street Marshalltown, IA 50158

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, and staff interview, the facility failed to protect the resident's right to be free from physical abuse for 1 of 1 resident reviewed for abuse (Resident #1). As a Certified Nurse Aide (CNA) finished giving Resident #1 his bath, the CNA turned the water to cold and purposely sprayed him. Resident #1 became angry, grabbed the shower head and slapped it against the wall. The facility reported a census of 46 residents.Findings included:Resident #1's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 4, indicating severely impaired cognition. Resident #1 required substantial/maximal assistance with showering. The MDS included diagnoses of Alzheimer's, non-Alzheimer's dementia, and anxiety disorder.The facility's Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy, updated 10/19/22, stated all residents had the right to be free from abuse. The policy defined abuse as physical injury or assault of a dependent adult. The policy defined assault as the commission of any act generally intended to cause pain or injury to a dependent adult, or which generally intended to result in physical contact considered by a reasonable person to be insulting or offensive or any act intended to place another in fear of immediate physical contact which would be painful, injurious, insulting, or offensive, coupled with the apparent ability to execute the act. The Care Plan Focus dated 9/14/20 reflected Resident #1 had an altered thought process/cognition related to Alzheimer's disease. The Intervention directed to reassure Resident #1 in order to decrease frustration.The Care Plan Focus initiated 3/22/23 identified Resident #1 had the potential to be physically aggressive and throw things at staff.The Care Plan Focus revised 7/27/23 indicated Resident #1 had confusion due to the diagnosis of early onset Alzheimer's and dementia. The Interventions directed staff to remind him as needed due to being forgetful.The Health Status Note dated 6/17/25 at 5:00 PM indicated a staff member reported around 11:45 AM another staff member stated, watch this, then proceeded to spray Resident #1 with cold water. Afterwards, Resident #1 grabbed the shower head and banged it against the wall.A report entitled OnShift Time documented Staff A, Certified Nurse Aide (CNA) worked on the following days after 6/9/25: 6/13/25, 6/14/25, and 6/15/25.An Employee Corrective Action Form, dated 6/17/25, documented 2 CNAs witnessed Staff A intentionally spray a resident with cold water. The form identified the action as a direct violation of the facility's policy and the facility terminated Staff A.On 10/8/25 at 11:01 AM, via phone, Staff B, CNA, reported on 6/9/25, as she trained with Staff C, CNA, they helped Staff A with Resident #1 in the shower. Staff B described him as noncombative during the time. Staff B stated Staff A stood on Resident #1's right side and she (Staff B) stood behind her. Staff B had a clear view of Staff A and Resident #1. She explained at the end of the shower, Staff A stated, watch this and turned the shower to cold then sprayed Resident #1. She stated she did this for 5 full seconds and laughed at the time. Staff B stated she sprayed it on Resident #1's upper body and then he took the showerhead, he smacked it against the wall and it almost broke. Staff B stated after this, Resident #1 stated he didn't want his shower because it was cold. On 10/8/25 at 11:44 AM, via phone, Staff C verified being in the shower room with Resident #1, Staff A, and Staff B. Staff C described Resident #1 as aggressive as she (Staff C) put away towels. She reported she heard Resident #1 yelling; she turned around and saw Staff A spray him with cold water. Staff C stated Staff B and her told Staff A not to do that because it was rude, but she continued doing it for 10-15 seconds. Staff C stated she sprayed him on his back. She stated Resident #1 yelled, screamed, and told her to stop, as Staff A laughed. Staff C stated she knew it was wrong but, at first didn't think about it being abuse.On 10/8/25 at 3:38 PM, the Director of Nursing (DON) stated staff should treat residents with respect, dignity and, carry out cares correctly. She stated Resident #1 didn't like showering. She stated if staff witnessed potential abuse, she wanted them to report it immediately. She reported it didn't happen in this situation. As she completed competencies with a new CNA (Staff B), she hesitated to tell her at first but then reported what happened with Staff A and Resident #1.On 10/9/25 at 8:49 PM, the Assistant Director of Nursing (ADON) described Resident #1 as not easy to assist with showers and he only liked certain staff. She stated she didn't have any problems with Staff A prior to the alleged incident and stated she did not think Staff B and Staff A would make this up. She stated it was probably really hard for Staff C to report what happened because of being Staff A's cousin.On 10/9/25 at 9:33 AM, the Administrator stated he expected staff to treat residents with dignity and respect. He added, staff should report suspected abuse immediately. He explained if staff reported abuse, he would suspend the alleged abuser, conduct a formal investigation, and report to the State

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and staff interview, the facility failed to report an allegation of abuse in a timely manner for 1 of 1 resident reviewed for abuse (Resident #1). The facility reported a census of 46 residents. Findings included:Resident #1's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 4, indicating severely impaired cognition. Resident #1 required substantial/maximal assistance with showering. The MDS included diagnoses of Alzheimer's, non-Alzheimer's dementia, and anxiety disorder.The facility's Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy, updated 10/19/22, directed the facility to report allegations of abuse to the State Agency (SA) within 2 hours. The Health Status Note dated 6/17/25 at 5:00 PM indicated a staff member reported around 11:45 AM another staff member stated, watch this, then proceeded to spray Resident #1 with cold water. Afterwards, Resident #1 grabbed the shower head and banged it against the wall.An Employee Corrective Action Form, dated 6/17/25, documented 2 CNAs witnessed Staff A intentionally spray a resident with cold water. The form identified the action as a direct violation of the facility's policy and the facility terminated Staff A.On 10/8/25 at 11:01 AM, via phone, Staff B, CNA, reported on 6/9/25, as she trained with Staff C, CNA, they helped Staff A with Resident #1 in the shower. Staff B described him as noncombative during the time. Staff B stated Staff A stood on Resident #1's right side and she (Staff B) stood behind her. Staff B had a clear view of Staff A and Resident #1. She explained at the end of the shower, Staff A stated, watch this and turned the shower to cold then sprayed Resident #1. She stated she did this for 5 full seconds and laughed at the time. Staff B stated she sprayed it on Resident #1's upper body and then he took the showerhead, he smacked it against the wall and it almost broke. Staff B stated after this, Resident #1 stated he didn't want his shower because it was cold. She stated she would have reported this in a timelier manner, but she was new and Staff C was present in the room as well. On 10/8/25 at 11:44 AM, via phone, Staff C verified being in the shower room with Resident #1, Staff A, and Staff B. Staff C reported she heard Resident #1 yelling; she turned around and saw Staff A spray him with cold water. Staff C stated Staff B and her told Staff A not to do that because it was rude, but she continued doing it for 10-15 seconds, spraying his back. She stated Resident #1 yelled, screamed, and told her to stop, as Staff A laughed. Staff C stated she didn't report it to anyone that day. She stated Staff B and her talked about it, they thought should bring it to someone else's attention. Staff C stated she knew it was wrong but, at first didn't think about it being abuse.On 10/8/25 at 3:38 PM, the Director of Nursing (DON) stated if staff witnessed potential abuse, she wanted them to report it immediately. She reported it didn't happen in this situation. As she completed competencies with a new CNA (Staff B), she hesitated to tell her at first but then reported what happened with Staff A and Resident #1.On 10/9/25 at 8:49 PM, the Assistant Director of Nursing (ADON) reported it was probably really hard for Staff C to report what happened because of being Staff A's cousin.On 10/9/25 at 9:33 AM, the Administrator expected staff to report suspected abuse immediately. He explained if staff reported abuse, he would suspend the alleged abuser, conduct a formal investigation, and report to the SA within 2 hours. He explained the situation with Resident #1; he reported it to the SA when he found out. He stated the witnesses didn't realize it was abuse but there should have been no question.The facility lacked documentation they reported the allegation to the State Agency within 2 hours of the 6/9/25 incident.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and staff interview, the facility failed to investigate an allegation of abuse and separate an alleged perpetrator of abuse from residents in a timely manner for 1 of 1 resident reviewed for abuse (Resident #1). The facility reported a census of 46 residents.Findings included:Resident #1's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 4, indicating severely impaired cognition. Resident #1 required substantial/maximal assistance with showering. The MDS included diagnoses of Alzheimer's, non-Alzheimer's dementia, and anxiety disorder. The facility's Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy, updated 10/19/22, instructed the facility to implement measures to prevent further potential abuse such as suspending the employee. The Health Status Note dated 6/17/25 at 5:00 PM indicated a staff member reported around 11:45 AM another staff member stated, watch this, then proceeded to spray Resident #1 with cold water. Afterwards, Resident #1 grabbed the shower head and banged it against the wall.A report entitled OnShift Time documented Staff A, Certified Nurse Aide (CNA), worked on the following days after 6/9/25: 6/13/25, 6/14/25, and 6/15/25.An Employee Corrective Action Form, dated 6/17/25, documented 2 CNAs witnessed Staff A intentionally spray a resident with cold water. The form identified the action as a direct violation of the facility's policy and the facility terminated Staff A.On 10/8/25 at 11:01 AM, via phone, Staff B, CNA, stated she would have reported the incident sooner, but she was new and Staff C was present in the room as well. On 10/8/25 at 11:44 AM, via phone, Staff C verified being in the shower room with Resident #1, Staff A, and Staff B. Staff C described Resident #1 as aggressive as she (Staff C) put away towels. She reported she heard Resident #1 yelling; she turned around and saw Staff A spray him with cold water. Staff C stated Staff B and her told Staff A not to do that because it was rude, but she continued spraying his back for 10-15 seconds. She stated Resident #1 yelled, screamed, and told her to stop, as Staff A laughed.On 10/9/25 at 9:33 AM, the Administrator explained if staff reported abuse, he would suspend the alleged abuser, conduct a formal investigation, and report to the State Agency (SA) within 2 hours. He explained the situation with Resident #1; he reported it to the SA when he found out. He stated the witnesses didn't realize it was abuse but there should have been no question.The facility lacked documentation they separated Staff A from other residents and completed an investigation prior to 6/17/25.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on clinical record review, policy review, and staff interviews, the facility failed to store and/or handle controlled medications in accordance with professional standards to ensure medications were secure for 1 of 3 residents reviewed for the storage of controlled substances (Resident #2). The facility reported a census of 46 residents.Findings:Resident #2's Minimum Data Set (MDS) assessment, dated 6/5/25, identified a Brief Interview for Mental Status (BIMS) score as 14, indicating intact cognition. The MDS included diagnoses of anxiety disorder, schizophrenia, and hallucinations.The facility policy Controlled Substances updated 10/19/22, directed when a nurse received a controlled medication, the nurse needed to fill out the top of the controlled drug administration record including the first line on the section that counted the medications. They did this to indicate who signed in the medication from the pharmacy.Resident #2's August Medication Administration Record (MAR) listed an order dated 7/14/25 for lorazepam (used to treat anxiety) 0.5 milligrams (mg) twice daily for anxiety. A Packing Slip, dated 8/22/25, listed lorazepam 0.5 mg, quantity of 60, signed by Staff D, Licensed Practical Nurse (LPN). Above the signature, the document stated, by signing below, you acknowledge that the items above have been received.On 10/8/25 at 4:11 PM, Staff F, Registered Nurse (RN), stated on 8/23/25, she reordered Resident #2's lorazepam because they only had around 2 pills remaining. She stated the pharmacy faxed back they sent an entire card the day before. Staff F stated they searched every drawer of every cart but couldn't locate the medication. She stated when she checked in narcotics, she put them directly into the cart and filled out a sheet of paper with the medication quantity.On 10/8/25 at 4:21 PM, Staff E, LPN, stated (on 8/22/25), when she arrived for her shift, she received report from the Assistant Director of Nursing (ADON). About 10 minutes later, Staff D gave her 2 of Resident #2's medications, none of them narcotics. She placed the medications in the medication cart. She didn't receive any narcotic sheets.On 10/9/25 at 8:29 AM, Staff D stated the night in question, she checked in all of the medications individually, then gave Resident #2's medications to the ADON because she thought he moved to her hall. The ADON gave the medications to Staff E, who was actually Resident #2's nurse. She stated the next day, she got a call from the morning nurse who said they didn't have the medication there and the pharmacy said they delivered it the night before. Staff D stated they didn't have documentation she gave the medication to the ADON. She stated since the incident, if they hand medications to another nurse, they sign at that time.On 10/9/25 at 8:49 AM, the ADON stated Staff D accidentally gave her medications for the other hall. She gave them back to Staff D, then Staff E placed the medications in the correct cart. She reported the medications as Resident #2's clozapine (a sedative, not a controlled substance) and she didn't think Resident #2's lorazepam came in the pharmacy delivery.On 10/9/25 at 9:57 AM, the Director of Nursing (DON) stated she didn't know for sure what happened with the missing medication. She added that possibly the nurse was just nervous and accidentally checked the medication in. She stated after they checked in narcotics, they should place them in the locked box themselves. She stated after the incident, they now have 2 nurses sign in to receive narcotics.