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	11/24/2025

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews the facility failed to provide to the resident or their representative a summary of the baseline care plan for 1 out of 2 residents reviewed (Residents #2). The facility reported a census of 54 residents. Findings include:Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of hypertension (high blood pressure), chronic kidney disease, type 2 diabetes mellitus, chronic respiratory failure and chronic obstructive pulmonary disease (COPD).The Clinical Census revealed Resident #2 was admitted on [DATE]. A facility form titled Baseline Resident Care Plan dated 8/22/25 lacked documentation a copy of the baseline care plan was given or reviewed with Resident #2 or the resident representative. The baseline care plan lacked Resident #2 and/or the resident representative signature and date.On 11/20/25 at 9:30 AM, the MDS Coordinator acknowledged the baseline care plan lacked Resident #2's signature. She said she went over the care plan with Resident #2 but failed to get his signature, so she did not have proof she did it. On 11/20/25 at 10:46 AM, the Administrator reported the facility did not have a baseline care plan policy as the facility follows the regulations. On 11/20/25 at 1:45 PM, Resident #2 reported he did not get a summary of his baseline care plan. He reported the staff did not review his care plan with him.

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility failed to provide care and services according to accepted standards of clinical practice for 1 of 3 resident reviewed (Resident #2) for Physician orders. The facility reported a census of 54 residents. Findings includes: Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of hypertension (high blood pressure), chronic kidney disease, type 2 diabetes mellitus, bacteremia (blood stream infection), chronic respiratory failure and chronic obstructive pulmonary disease (COPD).The Clinical Census revealed Resident #2 was admitted on [DATE] for a Medicare Part A stay.The August Medication Administration Record (MAR) directed staff to administer Daptomycin 830 mg (milligrams) (a powerful antibiotic used to treat serious infections caused by gram positive bacteria) intravenously (giving medication into a vein) one time a day for bacteremia until 9/26/25. The Hospital Outpatient Infusion Physician orders dated 8/21/25 directed to hold statin medications while on the Daptomycin medication.The Hospital Discharge summary dated [DATE] documented Atorvastatin medication (statin medication used to lower cholesterol and reduce risk for heart disease) 80 mg was stopped. The discharge summary documented the Magnesium Oxide (supplement) was changed to 400 mg per day. The Hospital Post Acute Discharge Report printed on 8/22/25 did not include directions on when to restart the Atorvastatin or whether to keep the medication discontinued after the Daptomycin medication was complete. In addition, the discharge report lacked physician orders or directions for the Magnesium Oxide medication.The Clinical Record lacked clarification orders on admission for the Magnesium Oxide and Atorvastatin medications.Review of Resident #2's MAR from 8/22/25 to 10/8/25 revealed the Magnesium Oxide medication was not administered and the Atorvastatin was not restarted after the Daptomycin was completed on 9/26/25. The Progress Note dated 10/8/25 revealed Resident #2 requested that the Magnesium Oxide 800 mg twice a day and Atorvastatin 80 mg every day be restarted as he had always taken the medications prior to admission. The Progress Note dated 10/9/25 documented the Primary Care Physician had reviewed lab levels from that morning and gave new orders to start Magnesium 800 mg BID and Atorvastatin 80 mg daily at bedtime. On 11/19/25 at 2:50 PM, Resident #2 reported he had high cholesterol and he had always taken Magnesium Oxide and Atorvastatin at home. He reported it took the staff 3-4 weeks to get the medication orders taken care of.On 11/20/25 at 2:00 PM, the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) acknowledged the facility received several documents from the hospital with conflicting information/orders regarding the Magnesium Oxide and Atorvastatin. The ADON and DON said they would expect the clarification orders to be obtained.On 11/20/25 at 2:21 PM, the Administrator reported the facility does not have a policy regarding Physician orders. He reported the facility follows the standard regulation and procedure of care.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, hospital nurse interview and resident interview, the facility failed to administer oxygen per Physician orders for 1 of 1 resident reviewed (Resident #2) for respiratory services. The facility reported a census of 54 residents. Findings Include: Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of hypertension (high blood pressure), chronic kidney disease, type 2 diabetes mellitus, bacteremia (blood stream infection), chronic respiratory failure and chronic obstructive pulmonary disease (COPD).The Care Plan with a target date of 2/13/26 documented Resident #2 had a diagnosis of COPD and hypertension and required the use of oxygen at 2 liters per minute. The care plan directed staff to make sure Resident #2 had the oxygen on and that he was using it correctly.The Physician Order dated 8/22/25 directed staff to administer oxygen at 2 liters per nasal cannula (n/c). Review of the Medication Administration Records (MAR) and Treatment Administration Records (TAR) from August to November 2025 lacked documentation of the physician order for oxygen (O2) at 2 liters per n/c.Review of the O2 Sats (percent's of hemoglobin in your blood carrying oxygen) Summary from August to November 2025 revealed O2 Sats documented on room air on the following dates: 8/22, 8/27, 8/29, 9/1, 9/3, 9/6, 9/7, 9/8, 9/9, 9/11, 9/15, 9/17, 9/20, 9/26, 9/30, 10/7, 10/8, 10/12, 10/18, 10/22, 10/28, 10/30, 11/1, 11/4, 11/13, and 11/18.The Skilled Progress Note dated 9/8/25 at 4:02 PM documented Resident #2 had his PICC line (peripherally inserted central catheter) replaced at the Emergency Room. On 11/19/25 at 2:50 PM, Resident #2 reported he had gone to the hospital in [NAME] Center in the facility van to have his PICC line replaced. He reported the staff did not send any oxygen with him when he went to the hospital. He said the hospital nurse had to send oxygen with him back to the facility. He reported he was breathing ok when he was without the oxygen. He reported he did not have a portable oxygen tank on his wheelchair at that time. On 11/20/25 at 8:31 AM, Staff A, Licensed Practical Nurse (LPN) reported she was not sure if Resident #2 had his oxygen on or not when he went to get his PICC line replaced. She reported Resident #2 was with it enough that he would have told the staff he needed the oxygen. She said he was on continuous oxygen so it should have been sent with him.On 11/20/25 at 9:30 AM, the MDS Coordinator verified the oxygen order was not on the MAR or TAR. The Assistant Director of Nursing (ADON) reported she thought the staff hit the wrong button on the electronic charting and made a mistake when documenting the oxygen saturations on room air. On 11/20/25 at 9:43 AM, the Hospital Infusion Registered Nurse (RN) reported Resident #2 came to the hospital with no oxygen. She said Resident #2 was pleasant, alert and reported that he wore oxygen continuously. She reported Resident #2 said the facility forgot the oxygen as they were in a hurry to get to the hospital. She said Resident #2's oxygen saturation was 88% on room air and that she placed him on oxygen as it was a necessity. She said she sent Resident #2 with an oxygen tank to use to get him back to the facility. She reported she did not recall any dyspnea or problems breathing prior to applying the oxygen. On 11/20/25 at 10:46 AM, the Administrator reported the facility did not have a formal oxygen policy as the facility follows the regulations. On 11/20/25 at 1:30 PM, the MDS Coordinator and Quality Assurance (QA) Nurse reported they would expect staff to follow the physician orders for the oxygen administration and would expect staff to send portable oxygen to physician appointments.