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	03/12/2026

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on review of the nursing schedule, staff interviews, Payroll Based Journal Data Report, and facility policy review, the facility failed to provide a Registered Nurse (RN) in the facility for eight (8) consecutive hours per day for 19 days between December 1, 2025 - March 8, 2026. The facility reported a census of 59 residents. Findings include: Review of the facility's nursing schedules for December 2025 lacked RN coverage for the following dates: 6th, 7th, 20th, 21st, 25th, and 31st.Review of the facility's nursing schedules for January 2026 lacked RN coverage for the following dates: 1st, 3rd, 4th, 17th, 18th and 31st. Review of the facility's nursing schedules for February 2026 lacked RN coverage for the following dates: 1st, 12th, 14th, 15th, 24th, and 28th. Review of the facility's nursing schedules for March from the 1st through the 8th lacked RN coverage on the 1st. The Email communication on 3/9/26 at 2:53 PM, the Facility Administrator acknowledged the lack of consecutive 8-hour RN coverage and stated, they typically didn't have RN coverage every other weekend.Review of Centers for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report for Quarter 1 2026 (October 1 - December 31) triggered no RN hours, indicating four or more days within the quarter with no RN hours. No RN hours infraction dates included 10/11/25, 10/12/25, 10/25/25, 10/26/25, 11/8/25, 11/9/25, 11/22/25, 11/23/25, 11/27/25, 12/6/25, 12/7/25, 12/20/25, 12/21/25, 12/25/25.Review of the facility provided Nursing Services and Sufficient Staff Policy, updated 2/23/25, stated except when waived, the facility must use the services of a Registered Nurse for at least 8 consecutive hours a day, 7 days a week.

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 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 observations, interviews and record review, the facility failed to report a resident-to-resident altercation for 1 of 3 altercations reviewed (Resident #10 and Resident #43). The facility failed to report when Resident #43 yelled at Resident #10 that she better not go into his room again or Resident #43 would give Resident #10 something to cry about. The facility reported a census of 59 residents.Findings include: 1. Resident #10's Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) documented a score was 6 out of 15, which indicated severely impaired cognition. The MDS listed Resident #10 as independent for mobility in a manual wheelchair. The MDS included diagnoses of Alzheimer's disease and non-Alzheimer's dementia, pseudobulbar affect (a brain condition in which a person experiences sudden, intense, and uncontrollable episodes of laughter or crying that are disproportionate or unrelated to their actual feelings), anxiety and depression.A Progress Note written on 3/5/26, at 9:56 a.m., documented Resident #10 sat in a recliner at the nurses' station, when another resident approached her. The staff reported she told Resident #10 to stay the f*ck out of their room or they would give her something to cry about. When asked if anything happened that day, Resident #10 replied that man accused her of going into his locker, he's a liar. She added that woman across the hall from him is an instigator. When asked if she was okay, she responded no. The note described Resident #10's response as a typical day to day response. The staff saw Resident #10 shortly after the conversation resting peacefully in the recliner at the nurse's station. A Progress Note dated 3/5/26 at 6:14 p.m., documented the staff monitored Resident #10 for a room change, as she moved to CCDI (unit for residents with chronic confusion or dementia related conditions). The note reflected she had no behaviors or complaints about her room change.On 3/12/26 at 12:20 p.m., Staff A, MDS Nurse, stated she talked with Resident #10 after the altercation. She described as tearful but added this was normal for her. 2. Resident #43's MDS assessment dated [DATE], documented a BIMS score of 14 out of 15, which indicated intact cognitive functioning. The MDS listed Resident #43 as independent for mobility in a manual wheelchair. The MDS included diagnoses of stroke, depression, and hemiplegia (one sided paralysis).On 3/9/26 at 1:11 p.m., Resident #43 stated that his wheelchair (w/c) was gone last week. He explained the facility allowed another resident to come into his room and take his w/c. They brought it back. Resident #10's roommate saw Resident #10 come out of his room with his w/c. Resident #43 described himself as kind since he's been at the facility. When he came out, he saw Resident #10 in the dining room. He told Resident #10, if they ever went into his room again, he would give her something to cry about. Resident #43 stated Resident #10 cried all the time. The facility told Resident #43 that he was a direct threat to Resident #10, and sent him to the hospital for an evaluation. Resident #43 gave the hospital a urine sample and it came up negative. The hospital should not tell people they are going to stick a catheter in them if they can't give them a urine sample. The only reason they hauled me away was the facility thought he was threatening (toward Resident #10). They brought him back the next day. They moved Resident #10 to another room down the hall. On 3/10/26 at 12:40 p.m., the Social Services Designee (SSD) stated the resident across the hall from Resident #43 told him Resident #10 went into his room and took his w/c. The SSD didn't know if Resident #10 really took Resident #43's w/c. They said to talk to the Business Office Manager (BOM) about that, as the SSD took vacation the last week. A Health Service Progress Note dated 3/5/26 at 9:29 a.m., the nurse noted sitting in her office at the time when the BOM approached her stating staff observed Resident #43 yelling at another resident to stay the f*ck out of his room or he would them something to cry about. The BOM stated she tried to intervene and redirect Resident #43, when he began to yell at her as well. They asked Resident #43 to please leave the nurses station, away from the Resident #10 who sat in the recliner unable to move without staff assistance. Resident #43 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	proceeded to enter the dining room, and had a conversation with another resident. During the conversation, the nurse heard a resident make several similar comments to a separate resident about how he would take care of her so they didn't have to get themselves into trouble. He added what are they going to do if he took care of it, kick him out? The staff reported the events to the Director of Nursing (DON) and ED at this time.A Progress Note dated 3/5/26 at 10:05 a.m., documented the facility received a verbal order to send Resident #43 to the emergency room (ER) for a psychological evaluation for behaviors.A Progress Note dated 3/5/26 at 10:16 a.m., documented Resident #43 left the facility via ambulance with police present. Resident #43 didn't have behaviors during transfer.A Progress Note dated 3/5/26 at 5:50 p.m., documented the facility received a report to follow up with psychology (psych) and his Primary Care Provider, with no additional orders. His urinalysis and lab work returned within normal limits.The Health Status Note dated 3/5/26 at 6:47 p.m., indicated Resident #43 returned from the emergency room (ER) via an ambulance with no new orders, except to follow up with provider and psych in next 2-3 days.A Care Plan for Resident #43 revised 11/20/26, documented Resident #43 had a potential for behavior/altered coping related to documentation of manipulative behaviors exhibited by this resident, directed towards staff, other residents, and guests/family that belong to other residents. Staff were to assess contributing factors for behavior, administer medications as ordered, move this resident to a quiet area to deescalate behavior, and redirection as indicated. In an email response dated 3/10/26 at 1:36 p.m., when asked if the facility reported the incident, the Administrator responded they didn't report the incident. Immediately after the incident, they spoke with Resident #10, and she didn't exhibit mental anguish, nor could she recall the events of the alleged incident. The Administrator responded to the question about if the facility did an internal investigation by sending an undated and untitled attachment of the internal investigation.In an email stream dated 3/11/26 starting at 10:27 a.m. and ending 3/11/26 at 10:59 a.m., the Administrator wrote there is no truth to Resident #10 taking Resident #43's wheelchair out of his room. Another resident told Resident #43 that Resident #10 probably took his wheelchair out of his room. When told Resident #43 had said he woke up and needed to use the restroom and his w/c wasn't in the room. Was his w/c taken out of his room at any point without giving him another one in its place? The Administrator responded: No, as far as they know, he had his wheelchair in his room the entire time. Often times it's between the recliner and his bed and he doesn't catch it there.An undated and untitled internal investigation documentation included the following:On 3/25/26, at approximately 9:45 a.m., the BOM overheard Resident #43 telling Resident #10 to stay the f*ck out of his room or he would give her something to cry about. The staff interviewed Resident #10 and questioned about the incident that had transpired a few minutes prior. Resident #10 stated that man accused her of going into his locker, he's a liar. She added that woman across the hall from her is an instigator. When asked if she was doing okay, Resident #10 replied no. Resident #10 could not recall the incident or exhibited any mental anguish regarding it. Resident #10 had diagnoses of pseudobulbar affect, dementia, Alzheimer's disease, and auditory hallucinations. Resident #10's provider provided an order to admit her into the CCDI unit for her benefit on 3/5/26. The facility started Resident #10 on social services visits 1 time a week for 4 weeks. Resident #43 voluntarily transported to the ER for a psychiatric evaluation on 3/5/26. Resident #43 returned the same day with no new orders and a new diagnosis of adjustment disorder with depressed mood. Resident #43 claimed he had no intention of harming anyone and was upset at that time because he claimed his wheelchair was stolen by Resident #10. He added another resident advised him Resident #10 probably took it. Resident #10 was not able to independently ambulate safely and there are no reports of Resident #43's wheelchair being missing. The resident's wheelchair is consistently found in his room next to his recliner, where he self-transfers. On 3/11/26 at approximately 10:15 a.m., the Administrator and the Nurse Consultant stated they discussed the incident with others including their corporation. They decided not to report as Resident #10 appeared to not be affected by the incident. They stated the documentation regarding her response in the progress notes when Resident #10 had said no after being asked if she was okay (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following the incident, was her typical response due to her disease process. Resident #10's ability to understand/impaired cognition was talked about as well as what a reasonable person's response would be in this situation. On 3/12/26 at 12:15 p.m., The Administrator and the Nurse Consultant acknowledged understanding of the reporting concerns. A Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy updated on 10/19/22, directed all residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. The Dependent Adult Abuse is defined under Iowa law, pursuant to Iowa Code Ch. 235E as:a) Any of the following as a result of the willful misconduct or gross negligence or reckless acts or omissions of a caretaker, taking into account the totality of the circumstances:Reporting: All allegations of Resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative. All allegations of resident abuse shall be reported to the Iowa Department of Inspections and Appeals not later than two (2) hours after the allegation is made. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to actively assist and plan a discharge from the facility for 1 of 2 residents reviewed (Resident #43). Resident #43 admitted to the facility for skilled care after a stroke, he desired to discharge from the facility. The facility could not provide documentation regarding active discharge planning with Resident #43 from 12/19/25 to 3/10/26. The facility reported a census of 59 residents.Findings include:A MDS dated [DATE], documented that Resident #43's diagnoses included stroke, depression, and hemiplegia (one sided paralysis). Resident #43 had a BIMS score of 14 out of 15, which indicated intact cognitive functioning. Resident #43 was independent for mobility in a manual wheelchair. Resident #43 was independent for eating, oral hygiene, toileting, upper and lower body dressing, putting on taking off footwear and personal hygiene. He was independent for rolling left and right, sitting to lying and lying to sitting on the side of bed, sitting to stand, chair/bed to chair transfer and toilet transfer. Resident #43 required partial to moderate assist for showering/bathing and transfer into shower/bath. The MDS documented that active discharge planning was not being done. It documented that a referral had not been made to the Local Contact Agency (LCA) and it documented the reason for the was his discharge date was more than 3 months away. A MDS dated [DATE] (admission MDS), documented that Resident #43's overall goal was to discharge to the community. A Census page for Resident #43, documented that Resident #43 admitted to the facility for skilled care. It documented that on 9/9/25, Resident #4 discharged from skilled care and started nursing home level of care where he has remained.A Care Plan initiated on 8/8/25, directed staff that Resident #43's goal was to return home. It directed to assist him by contacting outside resources he may need for a successful return home and to provide him with ongoing education in diet, medications, and safe activities to return home. A Social Services Progress Note dated 11/21/25 at 2:57 p.m., included the following documentation. A meeting was set up with therapy, Resident #43, Resident #43's friend, his wife, the MDS Coordinator, the Therapy Director and the Social Services Designee (SSD). They explained to Resident #43 and his friend that they were working with him at the wheelchair level for now because he had too much pain with his hip to continue working on trying to walk. Resident #43 had an appointment to see a vascular doctor to see if he qualified for any type of surgeries. His friend stated that would change the plans for discharge as the apartment they had found for him had stairs and wouldn't be doable for Resident #43 anymore. Resident #43 and his wife asked if he would be able to get his social security payment directly given to him a month before discharge, so he would have money to help pay for a deposit or rent. The SSD explained that typically that doesn't happen as he has to pay his client participation with the facility. The SSD explained that there was a waiver program that can assist with financial steps. The staff explained she would set up a meeting to see if Resident #43 qualified, but stressed that waiver programs could usually take up to 6 months, sometimes a year. The SSD had a phone meeting the following Monday with Resident #43's Medicaid Case Manager to start the waiver program process. On 12/19/25 at 12:27 p.m., a Social Services progress note documented the SSD sent a referral to another facility per Resident #43's request as he was not happy with the current facility. The other facility declined due to behaviors. The SSD let Resident #43 know and asked if there was anywhere (else) he would like to be referred too. Resident #43 declined and stated that he doesn't want to leave the area and that he wanted to go to a smoking facility. The SSD asked if he would like to go to a Veterans home. Resident #43 declined and stated that it was too long of a process and he didn't know where his [NAME] discharge paper was. The writer explained that she could assist him with it, and Resident #43 declined, stating, it was a waste of time.On 3/9/26 at 1:09 p.m., Resident #43 stated he had plenty to say. He stated he had a stroke 7 months ago and was put into the facility. He lost his apartment. He can no longer use his right side. Resident #43 stated he was pretty much stuck at the (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility. It seemed to him that the facility was not doing anything to help him get an apartment. Resident #43 stood up, transferred to his wheelchair and shut his door (as there was noise out in the hallway). Resident #43 stated he doesn't ask staff for anything other than assistance with his shower, or to help open up something as his right side was almost shot. He stated the SSD still had not got an application in for him. Resident #43 stated he had been asking the SSD about it for months. He stated the SSD was right next door. He has tried to go see her. He said he just wanted out of the facility. Resident #43 stated he wanted a handicap apartment. He was able to shower himself. They might come in once a week to help me clean up or something like that. He stated that he is a smoker. A Social Services Note dated 3/10/26 at 11:23 a.m., documented the SSD and Resident #43 called different apartment complexes in the area. The SSD got a hold of a rental for an apartment. They required an application fee, and Resident #43 wanted to talk to his friend (Emergency Contact) about the application fee and potential security deposit fee. The SSD was going to follow up with Resident #43 again regarding the application fee and go from there. A Social Services Progress Note dated 3/10/26 at 11:46 a.m., documented Resident #43 reached back out to his Medicaid Case Manager to see if there was any type of waiver program that he may qualify for that would help him get an apartment, and receive some financial assistance. Resident #43 didn't currently have the appropriate amount of funds for an application fee, security deposit, or first month's rent. Resident #43 didn't want to try the waiver program for a group home or a host home. The case Manager is going to try to research to see if there was any type of government assistance, or waiver program that may help. The (SSD) informed Resident #43 that they can take some time, and itis not a fast process if there is a waiver program that can help. On 3/10/26 at 12:34 p.m., the SSD stated Resident #43 didn't want to live in a group home and didn't want to wait for placement. Resident #43's Emergency Contact was working on taking Resident #43 to his Emergency Contact's house. That was a couple of months ago. Then the Emergency Contact kind of backed out. The SSD stated that Resident #43's former roommate along with the Emergency Contact were trying to find a place for him. The SSD stated there's nothing we can do for him. He doesn't have any money. His debit card was negative. He didn't want to wait the for the time it takes. He doesn't want to do the waivers. He doesn't want to wait a year. It takes a while. He only wants to live in the town he is in and he doesn't want a group home or a host home. He wants the facility to pay for him to move out and for the facility to pay him his social security. He's not willing to wait out the time. He had an apartment before he came but had to let it go because he can't walk up the stairs. There's income-based apartments. He refuses as he does not like the owner. His Case Manager said they would assist with waiver programs and the money follows the person. The SSD stated she and Resident #43 have spoken about the before. He ends up leaving because he gets very upset. He wants the facility to stop taking his client participation but the facility can't do that. He's not always nice to his Case Manager. He has called the SSD a retard. The SSD stated she reached out to his Case Manager. He doesn't want to be here. The SSD stated her hands were tied unless he wanted to cooperate. He doesn't understand why he has to pay to stay at the facility. He won't fill out the paperwork to be waitlisted. The facility called about an apartment. The apartment needed $20 for an application fee. Resident #43's Emergency Contact did not have the money and Resident #43's debit card had a negative balance. He doesn't know his email or his password to check into the transactions, so they hit a wall with that. On 3/11/26 at 9:01 a.m., Resident #43 stated he had a roommate that was trying to help him get out of the place. His roommate was discharged from the facility and lived in an apartment right now. He stated the problem was that he needed his birth certificate and he's been waiting for 2 months. He stated he was born right here (in the town that the facility is located) and it shouldn't be a big deal to get it. He explained the real problem as, they take his social security money $1300 every month to live at the facility. That is plenty of money to live on outside of the facility. He stated if the facility wouldn't take it all he would be able to move out. He said he has gotten frustrated when the topic comes up. The SSD was supposed to be filling out the paperwork for help with the deposit and with getting his birth (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	certificate. He stated she went to him yesterday to talk with him about things. He said he'd just see how long the was going to take. It's like he just sits there waiting. Resident #43 stated the SSD is the one that worked at the facility and she didn't talk with him. He didn't know what all things are available or how to go about doing them. On 3/11/26 at 9:53 a.m., the Administrator and Nurse Consultant stated that there has been work done with Resident #43 regarding his discharge. They were working with him to get his birth certificate. He didn't want it emailed because it cost money. He is supposed to get $50 a month but only gets $9/month as it goes to alimony or child care. So it's difficult to get him in to an apartment when he doesn't have the money for a down payment, processing, etc. The Administrator and the Nurse Consultant would look for the documentation that showed the facility worked with Resident #43 to get him discharged . On 3/11/2026 11:21 a.m., the Administrator stated that they cannot find specific information. That they have had conversations with him, and the conversations can take an hour to an hour and half. Sometimes after the conversations, a person can be exhausted and forget to document. He stated Resident #43's Emergency Contact took over trying to find Resident #43's placement. The Emergency Contact let the facility know he could no longer assist Resident #43 with discharging because the Emergency Contact had a new job. The Administrator stated that the happened approximately 2 weeks ago and at that time the SSD took the responsibility back over. There is no documentation of the change. On 3/12/26 at 10:06 a.m., Resident #43's Emergency Contact stated he tried to help Resident #43 with finding housing somewhere but he wasn't able to find any handicap accessible. The Emergency Contact said that at the time he had a conversation with the facility and they were going to take over. He said that has been a couple of months ago. The Emergency Contact stated he thinks it's ridiculous that Resident #43 is still at the facility. Resident #43 was supposed to be discharged after a month after entering the facility but he is still there. The Emergency Contact stated he was glad the was being looked into as Resident #43 should be able to live on his own with some services provided. A Discharge Planning Process Policy dated 2/23/25, instructed to develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. Definitions: Discharge planning is a process that generally begins on admission and involves identifying each resident's discharge goals and needs, developing and implementing interventions to address them, and continuously evaluating them throughout the resident's stay to ensure a successful discharge. The Compliance Guideline directed the facility would: a) The facility will support each resident in the exercise of his or her right to participate in his or her care and treatment, including planning for discharge. b) The facility will determine the resident's expected goals and outcomes regarding discharge upon admission, routinely in accordance with the MDS assessment cycle, and as needed. i) Initial information and discharge goals will be included in the resident's baseline care plan. ii) Subsequent assessment information and discharge goals will be included in the resident's comprehensive plan of care. c) If discharge to community is determined to not be feasible, the facility will document in the clinical record who made the determination and why. d) In cases where the resident wishes to be discharged to a setting that does not appear to meet his or her post-discharge needs, or appears unsafe, the interdisciplinary team will treat the situation similarly to refusal of care: i) Discuss with the resident, (and/or his or her representative, if applicable) and document the implications and/or risks of being discharged to a location that is not equipped to meet his/her needs and attempt to ascertain why the resident is choosing that location. ii) Offer other, more suitable, options of locations that are equipped to meet the needs of the resident. Document any discussions related to the options presented. iii) Document refusals of other options that could meet the resident's needs. iv) At time of discharge, follow policies regarding discharges Against Medical Advice, and refer to Adult Protective Services (or other state entity charged with investigating abuse and neglect), as necessary. e) If discharge to community is a goal, an active discharge Care Plan will be implemented and will involve the interdisciplinary team, (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including the resident and/or resident representative. The plan shall be. f) An active individualized discharge care plan will address, at a minimum: i) Discharge destination, with assurances the destination meets the resident's health/safety needs and preferences. ii) Identified needs, such as medical, nursing, equipment, educational, or psychosocial needs. iii) Caregiver/support person availability and the resident's or caregiver's/support person's capacity and capability to perform required care. iv) Resident's goals of care and treatment preferences. g) The ongoing process of developing the discharge plan will include a regular re-evaluation of the resident to identify changes that require modification of the discharge plan, and updating of the discharge plan, as needed, to reflect the modifications. h) The facility will document any referrals to local contact agencies or other appropriate entities made for the purpose of the resident's interest in returning to the community. i) The facility will update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. j) The facility will assist residents and their resident representatives in choosing an appropriate post-acute care provider (i.e., another SNF, HHA, IRF, or LTCH) that will meet the resident's needs, goals, and preferences. i) The Social Services Director, or designee, shall compile available data on other post-acute care options to present to the resident, including, but not limited to: A) Data on providers within the resident's desired geographic area, where available. B) Quality measure data, based on standardized patient assessment data, publicly available on the CMS Care Compare website. C) Data on resource use to the extent the data is available, such as number of residents/patients are discharged to the community, and rates of potentially preventable hospital readmissions. ii) The facility will ensure that the data used is relevant and applicable to the resident's goals of care and treatment preferences. iii) The facility will comply with the Federal Anti-Kickback statute when making referrals to other provider types. iv) The facility will present provider information to the resident and resident representative, if applicable, in an accessible and understandable format, and will answer any questions to assist in the resident's/representative's understanding. k) The evaluation of the resident's discharge needs and discharge plan will be completely documented on a timely basis in the clinical record. l) The results of the evaluation and the final discharge plan will be discussed with the resident or resident's representative. All relevant information will be provided in a discharge summary to avoid unnecessary delays in the resident's discharge or transfer, and to assist the resident in adjustment to his or her new living environment. m) Education needs, as identified in the discharge plan, will be provided to the resident and/or family member prior to discharge.

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	03/12/2026

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

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide ongoing restorative services for 1 of 1 resident reviewed (Resident #2). Resident #2 did not receive Passive Range of Motion (PROM) on a consistent basis, nor did he receive PROM per his plan of care directions. The facility reported a census of 59 residents.Findings include: Resident #2's Minimum Data Set (MDS) assessment dated [DATE] at, documented a Brief Interview for Mental Status (BIMS) documented a score of 15, indicating intact cognition. The MDS listed Resident #2 as dependent on staff for toileting, lower body dressing, and putting on and taking off footwear. diagnoses for included non-traumatic spinal cord dysfunction, paraplegia, pressure ulcer injury, and depression. This resident had a pressure reducing device for his chair and his bed. It documented he had 0 days of PROM provided during the lookback period. A Care Plan initially dated 10/16/25, directed staff Resident #2 had an active restorative program. The goal listed He would participate with his restorative program. The Intervention directed PROM to bilateral lower extremities (BLE) as he tolerated 1-3 days a week. On 3/9/26 at 1:26 p.m., observed Resident #2 lying in bed. He stated he didn't get up in his electric wheelchair and/or his manual wheelchair because he can't bend his knees well. When asked if staff assisted him with range of motion on his legs, Resident #2 stated they used to but people get so busy with things, they put the staff on something else. A Plan of Care (POC) Response History printed 3/10/26 at 2:47 p.m. for the past 30 days, directed to document the number of minutes spent providing Range of Motion (passive). The task question reflected the number of PROM to his bilateral lower extremities (BLE) 1-3 days a week or as he allowed. In the past 30 days, documentation reflected he received PROM on 2/9/25, 2/12/25, 2/17/25, 2/19/25, and refused PROM on 2/26 at/25 at 1:59 p.m. There were no refusals documented since 2/26 at/25. A Progress note dated 2/26 at/26 at 7:16 p.m., documented Resident #2 went to the Emergency Room. Resident #2's Clinical Census reflected he went to the hospital on 2/26 at/26 at and returned on 3/2/26 at. On 3/11/26 at 9:16 a.m., Resident #2 stated that he hasn't had PROM done since his return from the hospital. He said Staff B, Restorative Aide, stopped in the day before and said she would start it up again. Resident #2 stated he didn't know when that would be. On 3/11/26 at 3:01 p.m., Staff B stated she worked at the facility for about 7 or 8 weeks. She stated she frequently got pulled to work the floor. She stated normally she would start ambulating residents who needed assistance and then she would do a group activity with anyone who wanted to participate. She added she got pulled to the floor that day. She explained she went in to work with Resident #2 that day. She just did PROM on his lower extremities. He gets very dry skin and so afterwards she put lotion on him. She stated that she had to be very careful with him because of his heels. He's pretty easy going. Staff B stated that she felt bad because of the frequency she can't get in there to do his PROM with him. Staff B stated they told her to do what she could and she didn't know how to prioritize. Staff B assisted the residents in the bathroom to transfer and she also assisted residents to dine. She stated she worked with another CNA that day on the hall where Resident #2 lived and they ran around all day. Staff B stated normally when she is at the facility, she is the 5th person. Staff B stated the residents still received the care, it's just not as quick as when they have 5 there compared to 4. After Resident #2 returned from the hospital he had diarrhea. She stated she went in there and the girls would clean him up, he would say he had diarrhea. So, she left a few times that happened last week. Staff B explained she went in the day before and he said he didn't have diarrhea anymore so she told him she would start with him that day. Staff B stated she just finished doing PROM with him.On 3/12/26 at 12:02 p.m., Resident #2 stated he had some diarrhea for a couple of days. He stated Staff B came in yesterday. Prior to going to the hospital, she would come in and work with him when she could. However, because she got pulled to the floor often and couldn't work on his lower extremities. He stated the exercises really helped him, as he felt (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	better after having them done. On 3/12/26 at 12:20 PM Administrator and Nurse Consultant acknowledged concerns. A Restorative Program Process policy updated on 10/26/21, directed to ensure the resident(s) achieve and maintain their highest level of function. The licensed nurse will monitor staff and resident(s) to ensure compliance with the restorative nurse program.