STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165455	A. Building B. Wing	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Carroll	2241 North West Street Carroll, IA 51401

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and policy review the facility failed to revise and implement care plans for 1 of 3 residents (Resident #1) reviewed. The facility reported a census of 47 residents. Findings include: Review of Resident #1's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS further revealed diagnoses of heart failure, renal insufficiency, diabetes mellitus, hyperlipidemia, and morbid obesity.Review of Resident #1's Care Plan revealed that Resident #1 was at risk for falls related to weakness with an intervention for Resident #1 to have on the proper footwear prior to transfers initiated 1/29/23. The Care Plan further revealed Resident #1 had activities of daily living deficit related to weakness with an intervention for transfers with assistance with two staff with a walker and gait belt dated 1/11/23. Review of a facility provided document titled, Physical Therapy Discharge summary dated [DATE] revealed Resident #1 was discharged from physical therapy for meeting the goals of transferring from chair/bed-to-chair with supervision or touching assistance with contact guard assistance and four wheeled walker. Interview 10/14/25 at 10:30 AM with Resident #1 revealed that she has muscle jerks from time to time. Resident #1 revealed that she was sitting on the side of the bed, and her walker was in front of her and her wheelchair was to the side to be transferred too. Resident #1 revealed she stood up and became dizzy and the Certified Nursing Assistant (CNA) had her sit back down. Resident #1 revealed that she did have a gait belt on for the transfer, but asked the CNA to remove the gait belt as she was nauseous. Resident #1 then revealed that she had a jerking moment and fell onto the floor. Interview 10/15/25 with the Director of Nursing (DON) revealed that Resident #1's care plan was not correct with the transferring assistance as it was saying assist with two staff with a walker and gait belt when it should have been assisted with one staff with a gait belt and walker. The DON further revealed that her expectation would be for care plans to be updated appropriately. Interview 10/15/25 at 9:06 AM with Staff A CNA was the bath aide on the day of the incident with Resident #1. Staff A revealed that she was the bath aide that day and that Staff B CNA had put Resident #1's shoes on. Staff A revealed that Resident #1 was a transfer assist of one with a gait belt and walker. Staff A further revealed that Resident #1 preferred the gait belt to be worn high under her armpits as she was a larger resident. Staff A revealed that Resident #1 was sitting on the side of the bed with the gait belt on and a walker in front of her. Staff A then revealed when Resident #1 stood up she began to become shaky so Staff A then had Resident #1 sit back down. Staff A then revealed that she took the gait belt off to readjust the belt as Resident #1 stated she was nauseous and wanted the belt off for a moment. Staff A revealed that Resident #1 became anxious, and stood up and started to fall diagonally and forward. Staff A revealed that she reacted as fast as she could, and then grabbed Resident #1's gown, but could not hold Resident #1 up. Staff A revealed that Resident #1 fell to the floor on her stomach. Staff A then revealed that she radioed for help. Staff A revealed that a nurse came to the room and four staff members utilized a full body mechanical lift with a sling to transfer Resident #1 to a motorized wheelchair. Staff A revealed that Resident #1 was not complaining of any pain except for a little pain to a toe. Staff A revealed that Resident #1 did not complain of any pain in the ankle until later in the day. Interview 10/15/25 at 9:17 AM with Staff C CNA revealed that she was called to Resident #1's room for assistance after the incident. Staff C revealed that when she entered the room Resident #1 was laying on the floor on her stomach. Staff C revealed that there were a couple of nurses and CNAs already present in the room when she arrived. Staff C revealed that she obtained the full body mechanical lift and sling and helped reposition Resident #1 onto her back after the nurse completed an assessment. Staff C revealed that Resident #1 was complaining of toe pain at the time. Staff C revealed that Resident #1 was moving her feet around, and did have shoes on at that time. Staff C then revealed that Resident #1 was an assist of one with a gait belt and four wheeled walker for transfers. Interview 10/15/25 at 9:27 AM with Staff D Licensed Practical Nurse (LPN) revealed that she was called to Resident #1's room after the incident by Staff A on the walkie system. Staff D revealed that Resident #1 was laying on the floor on her stomach when she entered the room. Staff D then revealed that she assessed Resident #1 while she was on the floor. Staff D then revealed that Resident #1 was complaining of ankle and toe pain, but was not complaining of hip or leg pain. Staff D revealed that Resident #1 stated she slipped out of bed first, and then stated that she had a jerky moment and fell. Staff D revealed that staff helped assist Resident #1 to her back, and then Staff D assessed more. Staff D revealed that Resident #1 did not complain of pain once staff rolled her to her back. Staff D

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident interview, staff interview, and policy review the facility failed to provide nursing staff to assure residents safety by not responding to call lights in a timely manner. The facility reported a census of 47 residents.Findings include: 1. Review of Resident #1's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS further revealed diagnoses of heart failure, renal insufficiency, diabetes mellitus, hyperlipidemia, and morbid obesity. Interview 10/14/25 at 10:30 AM with Resident #1 revealed that call lights take longer than 15 minutes often, especially on the evenings and weekends. 2. Review of Resident #2's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition. The MDS further revealed diagnoses of diabetes mellitus, hyperlipidemia, anxiety disorder, respiratory failure, post polio syndrome, and morbid obesity. Interview 10/14/25 at 2:05 PM with Resident #5 revealed call lights take over 15 minutes in the mornings, and the weekends often. 3. Review of Resident #4's MDS dated [DATE] revealed a BIMS score of 14 indicating intact cognition. The MDS further revealed diagnoses of hyperlipidemia, arthritis, hip fracture, osteoporosis, and need for assistance with personal care. Interview 10/14/25 at 1:49 PM with Resident #4 revealed call lights often take over 15 minutes, and it always feels like the facility is short staffed. 4. Review of Resident #5's MDS dated [DATE] revealed a BIMS score of 12 indicating moderate cognitive impairment. The MDS further revealed diagnosis of cirrhosis, diabetes mellitus, anxiety disorder, and bipolar disorder. Interview 10/14/25 at 1:55 PM with Resident #5 revealed that he feels that there is not enough staff on the pm shift or on the weekends, and call lights can take longer than 15 minutes at a time.Interview 10/15/25 at 8:20 AM with the Director of Nursing (DON) revealed that call lights are an issue, and the facility is working on getting them better. The DON provided the call light log with response times up to 39 minutes. The DON then revealed that her expectation is for call lights to be answered in 15 minutes or less.Review of a facility provided document titled, Building Escalation Hourly Summary Report, dated 10/9/25 through 10/15/25 revealed call light response times ranging from 16 minutes in length to 39 minutes on multiple occasions. Follow up interview 10/15/25 at 9:40 AM with the DON revealed that the facility does not have a call light policy, and that the facility just follows the standards of care.