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	06/08/2026

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 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. Based on clinical record review, facility document review, facility state self- report intake review, staff interviews, and policy review the facility failed to report to the state agency within the required time frame of 2 hours for an allegation of abuse for 1 of 2 residents reviewed. (Resident #2) The facility reported a census of 52 residents. Findings include:The Minimum Data Set (MDS) for Resident #2 dated 5/4/26 documented diagnoses of intellectual disability, stroke and hemiplegia (paralysis of one side of the body) and was dependent on staff for all activities of daily living. The MDS documented a Brief Interview of Mental Status was unable to be performed due to resident rarely/never understood. State agency Intake Information form, tracking ID 3002328-I/Intake #143823, receipt date and time of 5/4/26 at 8:43 AM, revealed the following information: reporting type of allegation of abuse, occurred on 5/2/26 at 5 AM, reported to the Assistant Director of Nursing (ADON) on 5/4/26 at 6:30 AM that Staff C, Certified Nurse Aide (CNA) walked into Resident #2's room due to hearing her cry from the hallway and when Staff C entered the room, Staff D, CNA had Resident #2 naked on the bed facing the wall rolled over almost on her stomach. Staff D left the room to take the trash out. Staff D left Resident #2 in bed on stomach while she left the room. Resident #2 is not able to roll herself back over. When staff have resident up in the chair Staff D started to brush resident's hair, resident had braids in her hair still. Staff C stated to Staff D that there are braids in but Staff D kept brushing resident's hair and it was causing the hair to be pulled out and resident to vocalize pain. Staff C stopped Staff D from brushing resident's hair and took braid out and then Staff D started to brush resident's hair again and it started to pull the resident's hair out again. Staff C brought the resident out to the common area and helped her to calm down during this time. Staff C observed Staff D mocking the resident while she was crying.Facility Incident Report for Alleged Abuse for Resident #2, dated 5/2/26 at 5 AM, prepared by the ADON, documented the following: Notified 5/4/26 at 6:30 AM of incident that occurred on AM of Saturday 5/2/26 at approximately 5 AM, while getting resident up following last rounds. CNA reported that 200 floor CNA had been in resident's room to check/change and get ready for the day. CNA reports that she answered another resident's light and that resident was stating she was awoken from sleep due to Resident #2 screaming and crying at this time. CNA also reported floor CNA was in Resident #2's room with her rolled to the side, almost on abdomen naked. The resident is unable to turn herself, left her like this to go to the dresser and out in hallway to dispose of trash, put laundry in hall, and see what call lights are on. Upon transferring Resident #2 to wheelchair, floor CNA was aggressively brushing resident's hair with braid in hair from previous day. CNA reports she can hear Resident #2's hair snapping from brushing and resident was verbalizing pain, stating ouch, that hurts. No injuries observed at time of incident. Interview on 6/3/26 at 2:55 PM, Staff C stated on 5/2/26 about 5:15 - 5:30 AM, she reported to Staff E, Licensed Practical Nurse (LPN) that she didn't like what she just saw as Staff D was mean to Resident #2. Staff C stated she reported to Staff E at about 5 AM she could hear Resident #2 crying, she entered the resident's room, and Staff D was over by the dresser with the resident on her side in bed, naked head to toe. Staff C stated Staff D stood at the door and told Staff C she could get the resident done. Staff C stated she then proceeded to answer call lights, and then observed Staff D standing in the hallway (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and asked Staff D if she was ready to get Resident #2 up. Staff C stated after she and Staff D transferred the resident to her wheelchair, Staff D started brushing the resident's hair, Staff C told Staff D to stop as the resident still had a braid in her hair and Staff D stopped while Staff C took the braid out. Staff C stated Staff D then started brushing the resident's hair again from the top of the resident's head and Staff C told Staff D needed to brush from the bottom because that is the way Staff C always does it. Staff C stated she could hear the resident's hair snapping and breaking, the resident was saying ow and God damn it girl that hurts. Staff C stated the resident was crying and said that girl was mean to me. Staff C stated Staff D said the resident couldn't have candy that morning because she was crying. Staff C stated she told Staff E that she knew they only had 2 hours to report the abuse and asked Staff E if Staff C needed to write up her statement now. Staff C stated Staff E directed her to write up the statement that evening, when she came back to work at 6 PM. Staff C stated she did not write her statement regarding the incident until 5/4/26 after she got off at 6 AM. Staff C stated on 5/4/26 around 6 AM she sent a text message to the ADON asking if Staff E had reported anything to her about the incident on 5/2/26 with Resident #2 and the ADON returned a text that stated she hadn't been notified of the incident by Staff E. Staff C stated the ADON then called her and Staff F, Interim Director of Nursing (DON) and Staff C reported the incident to both of them.Facility document provided of Staff E ?s interview on 5/4/26 revealed the following: Staff E states Staff C voiced concerns Saturday morning (5/2/26) that Staff D was antagonizing Resident #2, that she was picking on her to get a response, brushing the resident's hair without taking the braids out. Staff E stated she did nothing with the information. Staff E stated it did not click in her head that it was abuse. Staff E stated that Staff C told her that when Staff D was brushing the resident's hair out she was pulling it. Staff E stated that after the conversation, she checked the resident's head for marks and ensured it was ok. When asked why Staff E was worried enough to check her hair but not report the situation, she didn't know. Staff E stated she knows that it should have been reported.Interview on 6/8/26 at 10:48 AM, the ADON stated on 5/4/26 at 5:42 AM she received a text message from Staff C asking what time she was coming in to work. The ADON stated Staff C continued to text her reporting that Staff D was being verbally, emotionally and physically abusive to Resident #2. The ADON further stated Staff C told her she reported the incident to Staff E right away on 5/2/26 after the incident happened. The ADON stated she then notified Staff F, doing a 3-way phone call including Staff C. Interview on 6/8/26 at 11:51 AM, the Executive Director (ED) stated she was notified on 5/4/26 at approximately 8 AM of the alleged incident on 5/2/26 with Resident #2 and Staff D. The ED stated she reported the incident to the facility's regional office and completed the self-reported incident to the state office on 5/4/26 at 8:43 AM. Facility Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy, updated 10/19/22, revealed 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 and all allegations of resident abuse shall be reported to the state department not later than 2 hours after the allegation is made.Interview on 6/2/26 at 11:56 AM, the ED stated her expectation for allegations of abuse to be reported to management right away and then to be reported to the state office within 2 hours. The ED acknowledged the reported allegation of abuse for Resident #2 was not reported timely.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, staff interviews, and policy review the facility failed to provide appropriate incontinence care for 1 of 3 residents reviewed (Resident #3). The facility reported a census of 52 residents. Findings include:The Minimum Data Set (MDS) assessment for Resident #3, dated 4/29/26, included diagnoses of diabetes and morbid obesity. The MDS identified the resident was dependent on staff for toilet hygiene and was frequently incontinent of urine and occasionally of bowel. The MDS indicated the resident had a Brief Interview for Mental Status score of 15, indicating no cognitive impairment for decision making.Observation on 6/4/26 at 9:10 AM, with the Director of Nursing (DON) in attendance, Staff A, Certified Nurse Aide (CNA) and Staff B, CNA applied gloves and gowns. With Resident #3 lying in bed, Staff A cleansed the front peri area wiping more than once with the same wipe. Staff A and Staff B turned the resident to her left side and removed a visibly wet attends. Staff A, with 3 wipes together, repeatedly wiped up and down on both inner buttocks using the same side of the gathered wipes and then got a new wipe and wiped between the resident's buttocks 3 times with the same wipe, failing to cleanse the resident's outer buttocks and hips. Staff A, with the same gloves on, placed the lift sling under the resident. Staff A and Staff B removed gloves and applied new gloves, failing to complete hand hygiene when changing gloves. Staff A and Staff B placed leg wraps on the resident and Staff A proceeded to remove her gown and gloves, no hand hygiene, exited the resident's room and went down the hall and returned with a full body mechanical lift. Staff A applied a new gown and gloves and with Staff B, transferred the resident from the bed to a commode. Facility Competency for Peri Care form, updated 5/11/21, revealed when cleansing the peri area to use a new wipe for each area and one swipe technique, remove gloves before turning resident to their side, wash anal area, buttocks and both hips, and remove gloves, wash hands, and roll resident to side. Facility Hand Hygiene Policy, updated 11/13/24, revealed staff should always complete hand hygiene before donning gloves and after removing gloves, and between resident care sites. Interview on 6/4/26 at 9:35AM, the DON acknowledged staff did not complete any hand hygiene during care and would expect to complete hand hygiene every time the gloves are changed and before exiting the room. The DON further stated the facility policy is 1 swipe with each wipe and acknowledged she observed the staff wipe multiple times with the same wipe and the stated staff failed to do complete peri care by failing to cleanse all of the peri area, buttocks and hips.