

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165490	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER Accura Healthcare of Cresco		STREET ADDRESS, CITY, STATE, ZIP CODE 701 Vernon Road SW Cresco, IA 52136	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003</p> <p>Based on Clinical Record Review, Facility Policy Review, and Staff interviews the facility failed to notify family and the physician of resident to resident abuse for 1 of 1 resident reviewed (Resident #6 who was kicked by Resident #5). The facility reported a census of 29 residents.</p> <p>Findings include:</p> <p>1. Resident #5 Minimum Data Set (MDS) assessment dated [DATE] documented a BIMS score of 6, indicating severe cognitive impairment. The MDS documented during the look back period the resident had both physical and verbal behavior symptoms directed toward others that occurred 1 to 3 days. The MDS further documented the resident behaviors of wandering that occurred 1 to 3 days. The MDS included diagnoses of hypertension, diabetes, and depression.</p> <p>Review of Resident #5 Progress Notes documented on these dates and times the following behaviors:</p> <p>2/15/25 Resident #5 was kicking Resident #6 in the face. Nurse reported to Resident #5 that she has observed this behavior before. The nurse informed Resident #5 that his actions are assault.</p> <p>Review of the Progress Notes for Resident #5 lacked communication to the physician and family of the incident.</p> <p>During an interview on 5/14/25 at 3:15 PM the Administrator reported the family should have been made aware of the incident on 2/15/25.</p> <p>The facility Risk Management Policy updated 9/27/24 directed staff as follows for completing of incident reports:</p> <p>Resident to Resident Incident report to be completed.</p> <p>Actions: Agencies/People notified (Emergency Department (ED), Director of Nursing (DON), physician, family and law enforcement as appropriate) and a Progress Note to be in the resident's chart.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Resident #6 Minimum Data Set (MDS) assessment dated [DATE] documented the resident had severe cognitive impairment. During the look back period the resident had no behaviors noted. The MDS documented the resident has diagnoses of Alzheimer's disease, Down Syndrome, and moderate intellectual disabilities. The MDS documented the resident is on hospice care.</p> <p>Review of Resident #6's Progress Notes lacked documentation of the family and physician being notified of Resident #5 kicking him in the face.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003</p> <p>Based on clinical record review, staff interviews, and policy review, the facility failed to ensure staff protected and prevent resident to resident abuse for 1 of 1 resident reviewed (Resident # 6), when Resident #5 kicked Resident #6 in the face on 2/15/25 and the kicked Resident #6 in the legs on 4/11/25. The facility reported a census of 29 residents.</p> <p>Findings include:</p> <p>1. Resident #5 Minimum Data Set (MDS) assessment dated [DATE] documented a BIMS score of 6, indicating severe cognitive impairment. The MDS documented during the look back period the resident had both physical and verbal behavior symptoms directed toward others that occurred 1 to 3 days. The MDS further documented the resident behaviors of wandering that occurred 1 to 3 days. The MDS included diagnoses of hypertension, diabetes, and depression.</p> <p>Review of Resident #5 Progress Notes documented on these dates and times the following behaviors:</p> <p>1/19/25 Resident #5 attempted to kick at Resident #6 and the staff noticed he kept staring at the resident when the staff was watching him.</p> <p>2/9/25 Resident #5 ramming into Resident #6 in a recliner with his wheelchair.</p> <p>2/13/25 Resident #5 was short tempered with staff during cares</p> <p>2/15/25 Resident #5 was kicking Resident #6 in the face. Nurse reported to Resident #5 that she has observed this behavior before. The nurse informed Resident #5 that his actions are assault.</p> <p>2/20/25 Resident staring at Resident #6 and watching staff to see if he is being observed.</p> <p>3/20/25 Resident #5 running into staff 's shins with the wheelchair during med pass.</p> <p>3/23/25 Resident #5 swearing, calling Resident #6 a dummy and hitting with a stuffed toy. Later in the shift calling staff names and threatening to hit staff.</p> <p>3/26/25 Resident #5 cussing at staff and throwing a cup of water behind him.</p> <p>3/28/25 Resident #5 was verbally aggressive towards staff. Later in the shift was combative with staff both physically and verbally.</p> <p>3/31/25 Resident #5 was verbally and physically aggressive towards staff.</p> <p>4/2/25 Resident #5 hit the staff in the stomach and told them to shut up. Later attempted to go into another resident's room and was aggressive with staff during redirection.</p> <p>4/8/25 Resident #5 kicked another resident in the legs.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4/11/25 Resident #5 in Resident #6's room kicking him.</p> <p>4/17/25 Resident #5 attempted to kick staff and was verbally aggressive toward staff.</p> <p>5/4/25 Resident #5 told staff he wants to shoot them with a small pistol.</p> <p>5/6/25 Resident #5 attempting to hit staff as they walk by.</p> <p>Review of Resident #5's Care Plan lacked interventions for staff and residents when the resident would be verbally or physically abusive until 4/11/25 when focused area and interventions were added for the residents behaviors.</p> <p>The Facility Investigation dated 4/11/25 reflected Staff B, License Practical Nurse (LPN) she observed Resident #5 kicking Resident #6. It documented at the time of the incident the facility was following the Care Plan for Resident #5. No injuries note when Staff B assessed Resident #6.</p> <p>During an interview on 5/14/25 at 11:40 AM Staff B, LPN reported Resident #5 had gone into Resident #6's room while he was sleeping and was kicking him in the legs and was beginning to wheel over the mat on the floor towards him more when she walked into the room. She reported Resident #5 had blocked the door with the bed and had to move it to get to him. She reported that Resident #5 has sought out to get Resident #6 in the past and is not sure why Resident #5 is out to get him.</p> <p>During an interview on 5/13/25 at 1:20 PM Staff C, Certified Nurses Aide (CNA) reported she was here the night of the incident but was not in the room when Staff B found Resident #5. She reports Resident #5 is always trying to get Resident #6. She reports Resident #5 calls Resident #6 a baby.</p> <p>During an interview on 5/13/25 at 2:05 PM Staff E, Agency Registered Nurse (RN) reported that during a recent storm staff had residents by the nurses station due to bad weather and Resident #5 kept trying to get to Resident #6. She reported Resident #5 kept seeking Resident #6 out and they had to frequently move Resident #5 to keep him away.</p> <p>During an interview on 5/13/24 at 3:15 PM the Administrator reported staff are to report resident to resident abuse and it should be reported to the Department of Inspections, Appeals, and Licensing. She reported she was not aware of any other incidents between Resident #5 and #6 except the one on 4/11/25. She reported she has been aware that Resident #5 seeks out Resident #6 and staff should be aware of what to do. She reported if she would have been aware of the incident an investigation would have been done and interventions in place. She reported family and physician should have been notified of the incident.</p> <p>During an interview on 5/13/25 at 3:40 PM the Director of Nursing and Administrator (DON) reported there was nothing in place for Resident #5's behaviors prior to the incident on 4/11/25. The DON reported staff should have made them aware of the other incidents between Resident #5 and #6.</p> <p>The Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy updated 10/19/22 directed staff as follows:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Policy Statement: 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. This includes prohibiting nursing facility staff from taking acts that result in person degradation, including the taking or using photographs or recordings in any manner that would demean or humiliate a resident, and prohibits using any type of equipment (e.g., cameras, smart phones, and other electronic devices) to take, keep, or distribute photographs and/or recordings on social media or through multimedia messages. 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. of other agencies serving the resident, family members or legal guardians, friends or other individuals.</p> <p>-Physical abuse includes, but is not limited to hitting, slapping, pinching, and kicking. It also includes corporal punishment when used to correct or control behavior, including but not limited to, pinching, spanking, slapping hands, flicking, or hitting with an object.</p> <p>- Resident-to-resident physical contact that occurs, which includes but is not limited to where residents are hit, slapped, pinched or kicked and results in physical harm, pain or mental anguish is considered resident-to-resident abuse. Resident-to-resident sexual harassment, sexual coercion, or sexual assault is also considered abuse. The facility will presume that instances of abuse caused physical harm, or pain or mental anguish in residents with cognitive and/or physical impairments which may result in a resident unable to communicate physical harm, pain or mental anguish, in the absence of evidence to the contrary. An example would be a resident slapping another resident who is physically or cognitively impaired, even though the resident who was slapped showed no reaction (e.g., yelp or grimace), it is presumed the resident experienced pain.</p> <p>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.</p> <p>2. Resident #6 Minimum Data Set (MDS) assessment dated [DATE] documented the resident had severe cognitive impairment. During the look back period the resident had no behaviors noted. The MDS documented the resident has diagnoses of Alzheimer's disease, Down Syndrome, and moderate intellectual disabilities. The MDS documented the resident is on hospice care.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>48003</p> <p>Based on Clinical Record Review, Facility Policy Review, and Staff interviews the facility failed to report allegations of abuse to the Iowa Department of Inspections, Appeals, and Licensing (DIAL) for 1 of 1 resident reviewed (Resident #6 who was kicked by Resident #5). The facility reported a census of 29 residents.</p> <p>Findings include:</p> <p>Review of the facility report list to DIAL lacked documentation of reporting resident to resident abuse on 2/15/25.</p> <p>Review of Resident #5's Progress Notes documented he had kicked Resident #6 in the face in the dining room in which the dietary staff had witnessed the abuse.</p> <p>During an interview on 5/13/24 at 3:15 PM the Administrator reported staff are to report resident to resident abuse and it should be reported to the Department of Inspections, Appeals, and Licensing.</p> <p>The Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy updated 10/19/22 directed staff as follows:</p> <p>All allegations of Resident neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation shall be reported to the Iowa Department of Inspections and Appeals, not later than two (2) hours after the allegation is made, if the events that cause the allegation result in serious bodily injury, or not later than twenty-four (24) hours if the events that cause the allegation involve neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation, but do not result in serious bodily injury.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003</p> <p>Based on Clinical Record Review, Facility Policy Review, and Staff interviews the facility failed to investigate and put interventions in place for resident to resident abuse for 1 of 1 resident reviewed (Resident #6 who was kicked by Resident #5). The facility reported a census of 29 residents.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Resident #5 Minimum Data Set (MDS) assessment dated [DATE] documented a BIMS score of 6, indicating severe cognitive impairment. The MDS documented during the look back period the resident had both physical and verbal behavior symptoms directed toward others that occurred 1 to 3 days. The MDS further documented the resident behaviors of wandering that occurred 1 to 3 days. The MDS included diagnoses of hypertension, diabetes, and depression. <p>Review of Resident #5 Progress Notes documented on these dates and times the following behaviors:</p> <p>1/19/25 Resident #5 attempted to kick at Resident #6 and the staff noticed he kept staring at the resident when the staff was watching him.</p> <p>2/9/25 Resident #5 ramming into Resident #6 in a recliner with his wheelchair.</p> <p>2/13/25 Resident #5 was short tempered with staff during cares.</p> <p>2/15/25 Resident #5 was kicking Resident #6 in the face. Nurse reported to Resident #5 that she has observed this behavior before. The nurse informed Resident #5 that his actions are assault.</p> <p>2/20/25 Resident staring at Resident #6 and watching staff to see if he is being observed.</p> <p>3/20/25 Resident #5 running into staff's shins with the wheelchair during med pass.</p> <p>3/23/25 Resident #5 swearing, calling Resident #6 a dummy and hitting with a stuffed toy. Later in the shift calling staff names and threatening to hit staff.</p> <p>3/26/25 Resident #5 cussing at staff and throwing a cup of water behind him.</p> <p>3/28/25 Resident #5 was verbally aggressive towards staff. Later in the shift was combative with staff both physically and verbally.</p> <p>3/31/25 Resident #5 was verbally and physically aggressive towards staff.</p> <p>4/2/25 Resident #5 hit the staff in the stomach and told them to shut up. Later attempted to go into another resident's room and was aggressive with staff during redirection.</p> <p>4/8/25 Resident #5 kicked another resident in the legs.</p> <p>4/11/25 Resident #5 in Resident #6's room kicking him.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4/17/25 Resident #5 attempted to kick staff and was verbally aggressive toward staff.</p> <p>5/4/25 Resident #5 told staff he wants to shoot them with a small pistol.</p> <p>5/6/25 Resident #5 attempting to hit staff as they walk by.</p> <p>Review of Resident #5's Care Plan lacked interventions for staff and residents when the resident would be verbally or physically abusive until 4/11/25 when focused area and interventions were added for the residents behaviors.</p> <p>During an interview on 5/13/24 at 3:15 PM the Administrator if she would have been made aware of the resident to resident abuse on 2/15/25 she would have investigated it.</p> <p>During an interview on 5/13/25 at 3:40 PM the Director of Nursing and Administrator (DON) reported there was nothing in place for Resident #5's behaviors prior to the incident on 4/11/25. The DON reported staff should have made them aware of the other incidents between Residents #5 and #6.</p> <p>The Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy updated 10/19/22 directed staff as follows:</p> <p>Should an incident or suspected incident of Resident abuse be reported or observed, the administrator or his/her designee will designate a member of management to investigate the alleged incident.</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003</p> <p>Based on observation, clinical record review, and staff interviews the facility failed to ensure residents were safe from accidents and hazards for 1 of 3 residents reviewed (Resident #1). Resident #1 with history of elopement risks and history of wandering went through a key coded door and fell down the basement steps resulting in a hematoma to the face and right forearm, an abrasion and bruise to the left hand. The facility reported a census of 29 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #1 had a Brief Interview for Mental Status score (BIMS) of 6 indicating severe cognitive impairment. The MDS documented he required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for sit to stand and ambulation. The MDS further documents he has diagnoses of dementia, disorientation, weakness, and hypertension.</p> <p>The Care Plan for Resident #1 documented he was at risk for elopement/wander due to dementia and directed staff to assess for fall risk and distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television and books. The Care Plan further documented he was at risk for fall due to unsteady and unbalanced gait. The Care Plan directed staff to encourage him to utilize the busy box when he is anxious.</p> <p>Review of Resident #1's Incident Report on 5/10/25 at 4:25 PM documented the resident was sitting in the dining room visiting with staff when last observed by the nurse prior to going missing. Staff had looked for the resident and at 4:53 PM the resident was found at the bottom of the basement steps by staff. The resident went into a key code locked door that led to the basement with his wheelchair and fell down the stairs. The Incident Report documented he had injuries of a hematoma to the face and right forearm, an abrasion and bruise to left hand. He was sent to the emergency room for further evaluation.</p> <p>Resident #1's Progress Note on 5/11/25 documented the resident returned to the facility with no broken bones and no new injuries noted.</p> <p>During a confidential interview staff reported concerns that Resident #1 cracked the code to the basement door and fell down the basement stairs. Staff reported Resident #1 now has a black eye. He had gone missing and the police were called and staff then found him after some time in the basement.</p> <p>During an observation on 5/13/25 noted the door to the basement has a key code lock and the Administrator opened the door which opened to 13 steps leading to the basement. The key code had a deadbolt latch on the back side of the key code to the door that can be turned and if it is turned the key code would not be needed to open the door. The keys still light up when putting the code in when the deadbolt is turned but the door is unlocked.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/13/25 at 1:25 PM the Dietary Manager reported she was visiting with Resident #1 in the dining room between 4-4:20 PM and went back into the kitchen to finish supper after she redirected him to the area by the nurses station. She reported she heard staff calling due to Resident #1 was missing. She then was told to go look outside and she did. She then came back in to recheck in the kitchen and then decided to check the basement. She reported she didn't think to look in the basement prior because the door had been closed and locked. She then went to the door, pushed in the code and opened it. She reported Resident #1 was at the bottom step sitting and his wheelchair was halfway up the stairs. She reported she yelled for staff at this time. She reported when she reached him he had blood on his head and hand. She reported he was alert and talking to her. She reported he was saying something about checking the furnace. She said the other staff and the nurse came at the time and she returned to the kitchen.</p> <p>During an interview on 5/13/25 at 2:12 PM Staff E, Register Nurse (RN) reported she had asked if anyone had seen Resident #1 and Staff B, Licensed Practical Nurse, had reported she had seen him in the dining room talking to the dietary staff around 4:00 PM. She reported staff had started looking for him and they didn't find him so staff began looking outside for him and she called 911. She reports Staff B during that time called the Director of Nursing (DON) . When the police arrived she reported Staff B went to talk to the officer. Staff E reported around 4:50 PM she heard screams from staff by the basement door and she went to investigate. She reported at the time she did not know the door led to the basement. She was not aware the facility had a basement. She reported Resident #1 had blood on his head and hand. Staff E reported she immediately started to assess him. She reported the resident said something about checking the furnace. Staff called 911. Resident #1 was sent to the emergency room for further evaluation. She reported she had never seen the door open nor anyone go into that door.</p> <p>During an interview on 5/13/25 2:35 PM the DON reported the door is normally locked and there is a code to get into it. She reports she is not sure how he could have got in and went down the basement. She reported Staff B, LPN had notified her Resident #1 was missing and then notified her of finding him in the basement after falling down the stairs. She reported then the facility immediately began an investigation.</p> <p>During an interview on 5/13/25 at 3:25 PM the Administrator reports that Resident #1 must have put the code in right to get the door open and fell down the basement stairs.</p> <p>During an interview on 5/14/25 at 12:00 PM the Maintenance man reported he was called in after Resident #1's fall to assess the door. He reported the lock was working properly and the door shut automatically and locked upon shutting. He reported he had assessed all the doors in the facility on 5/8/25 and all doors were locked and working properly. He reported he is not aware of any time the basement door has ever been unlocked. He reported very few staff use the basement and the few that do use the key pad to open the door.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>48003</p> <p>Based on personnel file reviews, facility policy review, and staff interview, the facility failed to provide dependent adult abuse training within 6 months of hire for 1 of 5 employees reviewed (Staff A). The facility identified a census of 29 residents.</p> <p>Findings include:</p> <p>The personnel file for Staff A, Dietary Manager documented a hired date of 1/20/23. Staff A's personnel file lacked documentation of Dependent Adult Abuse required training.</p> <p>Review of a facility policy titled: Dependent Adult Abuse Awareness and Training Policy, with a revision date of 12/30/20 revealed each employee shall be required to take a 1 hour recertification training within 3 years of the initial 2 hour training and every three years thereafter.</p> <p>On 5/14/25 at 4:20 PM, the Administrator acknowledged and verified Staff A's dependent adult abuse is not in her employee file. She reported Staff A said she took it back in 2023 but cannot find proof of it.</p>