STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165490	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Cresco	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)
F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. (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 0569 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 Electronic Health Record (EHR) review, facility records, and staff interview the facility failed to close a Resident Trust Account within 30 days of discharge from the facility for 1 of 2 residents reviewed (Resident #2). Furthermore, the facility continued to record Resident's income deposited into the Resident Trust Account and withdraw funds from the Resident Trust Account without the knowledge or authorization of the resident for several months following discharge from the facility. The facility reported a census of 24 residents.Findings include:The Minimum Data Set (MDS) with an assessment reference date of [DATE] documented Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. The EHR Profile revealed Resident #2 was his own responsible party. The Census documented Resident #2 had been discharged from the facility on [DATE].A Progress Note dated [DATE] at 6:40 PM documented Resident #2 would not be readmitted . The Progress Notes lacked documentation that the Resident Trust Account had been closed with a refund processed for any balance remaining. The Authorization to Manage Resident Trust had been signed by Resident #2 on [DATE] and authorized a representative of the facility to handle the Resident Trust Account. The Authorization to Manage Resident Trust lacked direction upon discharge from the facility. The Bank statement dated [DATE] received by the facility for the Resident Trust Account recorded deposits on [DATE], [DATE], and a debit (withdrawl) on [DATE]. The Bank statement dated [DATE] received by facility for the Resident Trust Account recorded a deposit on [DATE], and a withdrawl on [DATE]. The Bank statement dated [DATE] received by the facility for the Resident Trust Account recorded a deposit on [DATE], and a withdrawl on [DATE]. The facility hadn't received a Bank statement for [DATE] at the time of this survey. The facility provided Trust Transaction History dated [DATE] documented debits (withdrawls) and deposits in July, August, September, and [DATE]. A Refund Request with a date of request of [DATE] listed the refund reasons as follows: Remaining balances in the resident trust account as of [DATE], was applied to his outstanding private pay balance, money for July, August, September was applied from resident trust account to private pay balance, and money to be refunded from Resident #2's private pay bill back to him for overpayment. The Refund Request was signed by a consultant of the facility on [DATE].A Cashier's Check payable to Resident #2 dated [DATE] was prepared for the facility but not yet mailed as of [DATE]. In an interview on [DATE] at 8:50 AM, the Administrator verbalized the facility didn't have a Business Office Manager at the present time. The Administrator verbalized Resident #2 was discharged from the facility. The Administrator acknowledged Resident #2 had a current Resident Trust Account with an approximate balance of $250.00. The Administrator stated the Resident Trust Account hadn't been closed and the facility was not the representative payee for Resident #2. The Administrator stated Resident #2 was his own responsible party and lacked a POA for financial decisions. The Administrator reported the facility had no documentation authorizing disbursements for the transactions that occurred following Resident #2's discharge from the facility. The Administrator acknowledged withdrawals form Resident #2's Resident Trust Account shouldn't have occurred after he had been discharged The facility Residents' [NAME] of Rights dated [DATE] documented:(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds.(i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, asspecified in this section.(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law.The facility Resident Trust Fund Policy and Procedure updated on [DATE] documented the Business Office Manager and the Administrator are responsible for ensuring the Resident Trust Funds are always in perpetual balance and recorded. Further direction included:1. No funds are to be deposited for discharge/deceased residents unless for account corrections.2. All disbursements from a resident's trust account must have the appropriate signature on the transaction receipt authorizing the disbursement. This can be signed by the resident, spouse, power of attorney (POA), guardian, conservator or representative

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. (continued on next page)

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F 0676 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 record review, staff and resident interview, and policy review the facility failed to provide documentation and rationale for stopping their restorative program after the designated Restorative Aide quit in the restorative nursing department for 3 of 3 residents reviewed (Resident #1, #3, and #6). The facility reported a census of 24 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 documented a Brief Interview for Mental Status (BIMS) of 11 out of 15, suggesting moderate cognitive impairment. The MDS revealed the need for setup assistance to moderate (staff completes less than half the effort) assistance for dressing and dependent on staff (staff does all the effort) for putting on or taking off footwear. The MDS also documented diagnoses of diabetes, obesity, and muscle weakness. Record review of Resident #1, September 2025 Documentation Survey Report v2 revealed the following programs were discontinued on 9/11/25: a. Active Range of Motion (AROM): Seated cross-trainer machine (a stationary exercise machine that provides a low-impact, full-body cardiovascular workout. It simulates walking, jogging, or running without putting excessive stress on your joints) for 15 minutes. b. AROM: Both upper extremities with red band exercise protocol seated or seated or standing core activation with posture work.c. AROM: Both lower extremity exercises standing exercise protocol. Review of Resident #1's current Care Plan on 10/7/25 documented she needed one staff to assist with ambulation, dressing, toileting and bathing. Record review of Resident #1's Progress Notes from 6/1/25 to 10/7/25 lacked documentation of monthly restorative program review and rationale for discontinuation. 2. The MDS assessment for Resident #3 dated 7/17/25 documented a BIMS score of 8 out of 15, suggesting moderate cognitive impairment. The MDS revaled he was independent with mobility and self care functional abilities. The MDS documented diagnoses of hypertension, diabetes, and muscle weakness. Record review of Resident #3's Restorative Therapy Program dated 5/18/23 implemented he was to have four (4) AROM restorative programs. Record review of Resident #3's September 2025 Documentation Survey Report v2 revealed the following programs were discontinued on 9/11/25:a. AROM: Both lower extremity seated exercises. b. AROM: Both Upper extremity exercises with weights or bands and head and neck range of motion (ROM) exercises. Record review of Resident #3 Progress Notes from 6/1/25 to 10/7/25 lacked documentation of monthly restorative program review and rationale for discontinuation. 3. The MDS assessment for Resident #6 dated 9/18/25 documented a BIMS score of 13 out of 15, suggesting no cognitive impairment. The MDS documented he needed substantial/maximal (staff does more than half the effort) with bed mobility and transfers and that he did not ambulate. The MDS revealed he had diagnoses of heart failure, diabetes, anxiety, and depression. Record review of Resident #6, September 2025 Documentation Survey Report v2 revealed the following programs were discontinued on 9/11/25:a. AROM: Both lower extremities stretching, core exercises, and lymphedema exercises (gentle full-body movements like deep breathing, marching, and muscle pumps to stimulate lymph flow and reduce swelling). Record review of Resident #6's Progress Notes from 6/1/25 to 10/7/25 lacked documentation of monthly restorative program review and rationale for discontinuation. In an email correspondence with the Director of Nursing (DON) on 10/7/25 at 3:58 PM she revealed the facility did not have Registered Nurse (RN) monthly restorative reviews for the past six (6) months for any residents in the facility. During an interview on 10/8/25 at 1:19 PM with the MDS Coordinator revealed she oversaw the Restorative Program, did not know much about it, had minimal training, and she had not completed any charting for review of restorative plans since starting the position in July 2025. Per the MDS Coordinator, when the designated Restorative Aide stopped working at the facility they didn't have any Certified Nurse Aides (CNA) trained as Restorative Aides, so all restorative programs were resolved/discontinued until they could hire someone for that position. She then explained residents are not refusing the facility, the facility just does not have the staff at this time. She also revealed no residents have had a decline in their ability, but there probably could be a decline in resident functional ability eventually. During an interview on 10/8/25 at 1:46 PM with the DON, revealed all restorative programs were resolved/discontinued in September 2025 because the facility no longer had a Restorative Aide working at the facility. They kept the programs they could, and resolved/discontinued the rest for staff convenience. In an email correspondence with the DON on 10/8/25 at 2:49 PM queried regarding restorative policy, and explained the facility followed regulations with their restorative programs.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and policy review the facility failed to document an assessment by a nurse after the bath aide identified a bleeding scrotum for 1 of 3 residents reviewed (Resident #6). The facility reported a census of 24 residents.Findings include:The Minimum Data Set (MDS) dated [DATE] for Resident #6 documented a Brief Interview for Mental Status (BIMS) of 13 out of 15, which indicated intact cognition. The MDS also revealed the Resident has diagnoses of diabetes, heart failure (a progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), and chronic obstructive pulmonary disease (a progressive group of lung diseases that block airflow and make breathing difficult). The MDS revealed the Resident was dependent on staff to provide toileting hygiene and needed substantial/maximal assistance (Staff does more than half the effort) with transfers, was frequently incontinent of urine (7 or more episodes of urinary incontinence, but at least 1 episode of continent voiding). The resident was occasionally incontinent of bowels (1 episode of bowel incontinence). The resident was identified at risk for the development of pressure ulcers/injuries.Record review of Resident #6's Skin Monitoring: Comprehensive CNA Shower Review, dated June 2008, that was signed by Staff C, Certified Nurses Aid (CNA) on 9/29/25 revealed documentation the residents scrotum was open, red, and bleeding. Also revealed the Skin Monitoring: Comprehensive CNA Shower Review form was signed by the MDS Coordinator on 10/3/25.Review of Progress Note on Resident #6 revealed that on 10/3/25 at 8:11 AM the MDS Coordinator charted the following Health Status Note: Shower sheet from 9/29/25 noted the resident's scrotum was open, red, and bleeding. The progress notes from 9/29/25 through 10/3/25 lacked documentation of any assessments to the resident's scrotum or notification to the physician.During an email correspondence with the Director of Nursing (DON) on 10/8/25 at 9:02 AM, the DON explained the resident's scrotum was not assessed by a nurse at that time and it was not brought to the DON's attention. The DON did not see any open areas, just the redness that was a chronic issue with his skin folds during weekly rounds for skins/wounds.An email correspondence with the DON on 10/8/25 at 9:07 AM informed that if a new skin site was identified on a resident's bathing sheet or during routine care, she would expect the nurse on duty to assess at that time and notify the doctor for treatment orders.An interview on 10/8/25 at 10:03 AM with Staff E, Certified Nursing Assistant (CNA) revealed the CNAs use Skin Monitoring: Comprehensive CNA Shower Review forms to document new skin issues and they report to the nurse on duty. Blank Skin Monitoring forms were located in the shower room. The Director of Nursing (DON) kept the completed forms in a binder in her office.An interview on 10/8/25 at 1:19 PM with the Minimum Data Set (MDS) Coordinator revealed the DON completed skin assessments now. The Bath Aide should complete the shower skin sheets for any new areas and reporting the to floor nurse who is working during that shift. The shower sheets ha been getting placed into [MDS Coordinator's] mailbox, they charted a progress note, and should have verified with the DON that it area had been tracked or monitored. Interview on 10/8/25 at 1:46 PM with the Director of Nursing (DON) revealed she did not see an open area on Resident #6 scrotum on 10/7/25. The DON expected a risk management to be completed for documentation of the skin issue so it could be monitored, and expalined would have expected staff notification to the DON, doctor, and family.Review of the facility's Skin Management Protocol policy last updated on 5/16/23 instructed the following:a) Notify Director of Nursing (DON) and Wound Nurse of new skin alteration or skin ulcer.b) Complete Incident Report in Risk Management [Electronic Health Record] and Skin Sheet (paper). c) All Skin Sheets, non-ulcer or ulcer Assessment will be updated weekly by designated Wound Nurse. d) The community will report to the physician if there is any deterioration or signs of infection is observed. The policy also had un dated hand written instructions: Agency nurses are trained how to do risk management in [Electronic Health Record]. The Skin Sheets are at nurses station to be filled out and turned into the DON's box if not there.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and policy review the facility failed to administer routine medications as ordered for 1 of 3 residents reviewed (Resident #3). The facility reported a census of 24. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #3 documented a Brief Interview for Mental Status (BIMS) of 8 out of 15, which indicated moderately impaired cognition. The MDS also revealed the Resident had a diagnoses of diabetes, dementia, and hemiplegia (a medical condition that causes paralysis or weakness on one side of the body).Review of Resident #3's September 2025 Medication Administration Record (MAR) revealed from 9/10/25 through 9/24/25 the resident did not receive his order for artificial tears solution 0.1-0.3% instill (administer) 1 drop in both eyes four times a day for dry eyes, which resulted in not receiving this order for 14 days and 55 doses. Review of Progress Notes on Resident #3 from 9/10/25 through 9/24/25 lacked documentation of physician notification that the supply of artificial tears was not available and the resident was not receiving artificial tears as ordered. During an email correspondence with the Director of Nursing (DON) on 10/7/25 at 3:58 PM, the DON responded there was no documentation on Resident #3 artificial tears as they didn't do progress notes on phone calls to the pharmacy. An interview on 10/8/25 at 1:19 PM with the Minimum Data Set (MDS) Coordinator, explained she worked on 9/30/25, did not have stock supply for Resident #3 eye drops, and his artificial tears were on back order with the facility stock supply distributor. The MDS Coordinator further explained should have been ordered through the pharmacy. Interview on 10/8/25 at 1:46 PM with the DON revealed she would have expected the doctor to be notified of medications not received. An email correspondence with Staff B, Executive Director of the Facility's local Pharmacy on 10/9/25 at 8:06 AM. Staff B reviewed phone calls for Resident #3. A nurse called at both 9:18 AM and 9:58 AM on 9/24/25, requested artificial tears eye drops, and mentioned that the facility was no longer able to get house stock supply. These eye drops were sent out on the same day and received at 9:10 PM by Staff C, Licensed Practical Nurse (LPN).The facility's Medication Management-Medication Administration policy last updated on 10/19/22 instructed the following:3) The nurse is notified if supplies are inadequate or equipment fails to work properly. The nurse reports equipment and supply deficiencies (a lack, shortage, or inadequacy of something that is needed) to the director of nursing.The policy lacked instructions on what to do when a resident's medication(s) are not available for administration, to contact the prescriber, or contact the pharmacist.