

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 11/17/2025
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)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, resident, staff and receiving provider interviews, the facility failed to complete a discharge summary and provide it to the transferring facility for 2 of 3 residents reviewed (Resident #1 and #2). The facility reported a census of 29 residents. Findings include: 1. Resident #2's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. The MDS included diagnoses of cellulitis, lymphedema, and hypertension (high blood pressure). Resident #2's Progress Note dated 5/22/25 documented she exited the building at 11:10 AM in a wheelchair via transit for transport to a different facility. Resident #2's EHR lacked a discharge summary completed and lacked communication with the receiving provider. On 11/13/25 at 1:55 PM, Resident #2's receiving facility reported she had been in communication with the facility and they were to be sending admission orders with the resident and didn't, so it took them time to get orders and it delayed her medication and treatments. Resident #2 did not have any paperwork with her when she came, and said the facility did not send anything. Resident #2 did not have a discharge summary. On 11/17/25 1:49 PM the Administrator reported regarding discharge orders, the facility provided a hard copy of the discharge orders with the residents upon discharging from the facility and have recognized that did not document this at the time of discharge. Review charge papers she gave that were reportedly sent with the resident lacked a complete discharge summary to accurately describe the resident's status and needs. The Discharge Planning Process Policy dated 2/23/25 documented the facility 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. It further directs staff for 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. 2. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] documented a BIMS score of 13 out of 15, which indicated intact cognition. The MDS included diagnoses of depression, anemia and hypertension (high blood pressure). Resident #1's Electronic Health Record (EHR) Clinical Census tab documented the resident discharge on [DATE]. Resident #1's EHR lacked documentation of transferring to another facility on 11/12/25. It lacked a discharge summary completed and lacked communication with the receiving provider. On 11/13/25 at 2:05 PM Resident #1 reported she was discharged to another facility the day before. She reported the discharge was a complete mess. She verbalized she was in the shower when transport came to get her so the facility had to hurry and pack her things. She reported the facility did not send any discharge paperwork or orders with her. She reported the receiving facility had to call to try and get paperwork and it took awhile to get everything they needed. On 11/17/25 at 1:54 PM, the receiving facility for Resident #1 reported when she came to their facility, they had no discharge records and the resident did not have them with her. She reported that she had to reach out to the prior facility several times to get the information needed to care for Resident #1.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and policy review the facility failed to develop a Care Plan that addressed risk factors and interventions related to having a Peripherally Inserted Central Catheter (PICC) for 2 of 2 residents reviewed (Resident #4 and #5). The facility reported a census of 29 residents. Findings Include: 1. Resident #4's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 0 out of 15 indicating severely impaired cognition. The MDS included diagnoses of heart failure, anemia and hypertension (high blood pressure). The MDS documented Resident #4 had a central line (PICC) and received IV (intravenous) medications through the PICC while in the facility. Resident #4's Care Plan lacked documentation of having a PICC line, the risk factors and things to monitor for. On 11/17/25 at 12:20 PM the Director of Nursing acknowledged the Care Plans lacked addressing the PICC line and reported it should be on the Care Plan. The Comprehensive Care Plans Policy updated April 2025 documented the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. 2. Resident #5's MDS assessment dated [DATE] documented a BIMS score of 14 out of 15, indicating intact cognition. The MDS included diagnoses of osteomyelitis, pneumonia and hypertension. The MDS documented Resident #4 had a peripheral line and received IV medications while in the facility. Per the MDS, Resident #5 entered the facility on 10/27/25 from the hospital. Review of the resident's After Visit Summary from the hospital dated 10/2/25 to 10/27/25 revealed [Resident #5] was being discharged with a PICC Line. Resident #5's Care Plan lacked documentation of having a PICC line, the risk factors and things to monitor for.</p>

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and policy review, the facility failed to follow professional standards for assessing residents with Peripherally Inserted Central Catheter (PICC) for 2 of 2 residents (Resident #4 and #5) reviewed for PICC. The facility reported a census of 29 residents. Findings include: 1. Resident #4's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 0 out of 15 indicating severely impaired cognition. The MDS included diagnoses of heart failure, anemia and hypertension (high blood pressure). The MDS documented Resident #4 had a central line (PICC) and received IV (intravenous) medications through the PICC while in the facility. Resident #4's After Visit Summary admission orders from the hospital dated 7/11/25 documented the resident had a PICC line on admission. Resident #4 Electronic Health Record (EHR) lacked documentation of assessing the PICC site, location and length at any point while having the PICC line in the facility. Resident #4's admission Assessment lacked documentation the resident had a PICC line. Review of Resident #4's Discharge Summary from transfer to hospital on 7/27/25, date of service 7/28/25, revealed the central line was removed due to it being occluded. On 12/20/25 at 12:20 PM the Director of Nursing reported the nurses were to assess the site when administering the medication. She reported the nurses did not measure the catheter for the PICC to ensure it had not moved out of place. She reported there was no documentation to prove the PICC site was assessed. The Facility Policy for IV peripheral and PICC lines updated 7/31/23 directed nurses to monitor dressing, line, and resident every shift for signs of infection, malposition and/or occlusion, notify physicians as appropriate and document in the medical record. 2. Resident #5's MDS assessment dated [DATE] documented a BIMS score of 14 out of 15 indicating intact cognition. The MDS included diagnoses of osteomyelitis, pneumonia and hypertension. The MDS documented Resident #4 had a peripheral line and received IV medications while in the facility. Resident #5's After Visit Summary admission orders from the hospital dated 10/27/25 documented the resident had a PICC line on admission. Resident #5 EHR lacked documentation of assessing the PICC site, location and length at any point while having the PICC line in the facility. Resident #5's Assessment Assessment lacked documentation of the resident having a PICC line.</p>		