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	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Cresco	701 Vernon Road SW Cresco, IA 52136

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on schedule review, the Facility Assessment, and staff interviews, the facility failed to provide a Registered Nurse (RN) in the facility for eight (8) consecutive hours per day for 26 days between November 1, 2025 through January 25, 2026. The facility reported a census of 26 residents. Findings include: Review of the facility's nursing schedules for November 2025 lacked RN coverage for the following dates: 8th,9th ,15th,16th, 22nd, 23rd, 27th, 29th,and 30th. Review of the facility's nursing schedules for December 2025 lacked RN coverage for the following dates: 6th,7th,13th,14th, 20th, 21st, 25th, 27th, and 28th. Review of the facility's nursing schedules for January 2026 from the 1st through the 25th lacked RN coverage for the following dates: 1st, 3rd, 4th,11th,17th,18th, 24th, and 25th.On 1/28/26 at 10:10 AM the Administrator reported RN coverage is an ongoing issue that the facility is trying to fix. On 1/28/26 at 11:33 AM the Administrator verified the facility did not have RN coverage on the dates listed above. Review of the Facility assessment dated [DATE] documented the facility will continue working towards a staffing level that meets the minimum staffing final rule.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on record review and staff interviews the facility failed to employ an Infection Preventionist to implement, track, and oversee the infection control program from September 2025 to present (1/29/26). The facility reported a census of 26 residents. Findings include: In an interview on 1/28/26 at 3:48 PM with the Director of Nursing (DON) informed the prior Infection preventionist left in September 2025 and the Assistant Director of Nursing (ADON) took over in January 2026. In an interview on 1/29/26 at 9:40 AM with the ADON informed she has been trying to get her Infection Preventionist certificate, but it is showing she did not complete the course, she informed she knows she did it. She informed the facility is having her retake the course since she is unable to print the certificate. In an interview on 1/29/26 at 10:28 AM with the Administrator informed the ADON took on the Infection Preventionist role in January 2026 and her online course says she has all the courses done, but are having her reenroll as they are unable to get the certificate for proof. Review on 1/29/26 of and untitled and undated document, that was provided as the ADON's Infection Preventionist transcript revealed on 8/30/24 she took, Completion for Nursing Home Infection Preventionist Training course and did not pass the course.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interviews, and policy review the facility failed to ensure kitchen equipment, including the oven, stove, and griddle, were maintained in a clean and sanitary manner. The facility reported a census of 26 residents. Findings include:An initial tour observation of the kitchen on 1/26/26 at 10:34 AM dark brown-like sticky discoloration on oven door handles, white discoloration splatters oven doors, handles, and black and brown discoloration on the back splash in middle, left, and right sides. Black and brown-like sticky discoloration surrounding the edges of the griddle on all 4 sides. The left side of the wall and heat register by the sink and dishwasher had scattered brown discoloration. During a follow-up walk through observation on 1/27/26 at 8:25 AM the oven, stove, and griddle continued to have brown-like sticky discoloration. During an observation of the kitchen on 1/28/26 at 8:12 AM the oven, stove, and griddle continued to have brown-like sticky discoloration. During an observation of the kitchen cleaning checklist binder on 1/29/26 at 8:57 AM and cleaning tasks were completely signed off for 1/29/26 AM shift and 1/29/26 PM shift by Staff A, Cook. The oven, stove, and griddle continued to have brown-like sticky discoloration. On 1/29/26 at 9:00 AM, Administrator explained she was aware that the stove and oven had black and brown discoloration, and she was working on a new cleaning checklist form. On 1/29/26 at 9:03 AM, Staff A, [NAME] explained he had not completed the cleaning when he signed off the AM and PM Cleaning tasks because he was in a hurry, nervous, and had to cook pancakes this morning. Staff A agreed that he should not have signed off the cleaning checklist before completing the cleaning tasks. On 1/29/26 9:06 AM, the Dietary Manager, (DM) explained he was aware of the stove top and oven discoloration and noted he would be getting some cleaning products that would clean it off. The DM informed he would expect the cook to sign the cleaning schedule form until after cleaning, not before cleaning is completed. The facility's undated General Food Preparation and Handling policy directed the following: 1. The kitchen will be kept neat and orderly. a. The kitchen surfaces and equipment will be cleaned and sanitized as appropriate. b. All food service equipment should be cleaned, sanitized, air-dried, and reassembled after each use.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on record review, policy review, and staff interviews, the facility failed to ensure an effective Quality Assurance Performance Improvement (QAPI) process to address previously identified quality deficiencies, resulting in repeated deficiency identified on the facility's current recertification and complaint survey previously identified during the prior two recertifications. The facility reported a census of 26 residents. Findings include: Review of the facility's Centers for Medicare and Medicaid Services (CMS)-2567 form from a recertification and complaint survey which occurred 2/12/24 to 2/20/24 documented, in part, the facility failed to maintain a sanitary kitchen. The facility's plan of correction for this survey revealed staff were educated regarding all policies related to the kitchen: kitchen sanitation requirements. The Executive Director (ED) and/or designee will audit kitchen staff twice weekly for 16 weeks to ensure policies and procedures are being followed based on education provided. The ED and/or designee will complete a kitchen sanitation audit weekly for 16 weeks to ensure all kitchen sanitation requirements are being followed to ensure continued compliance. Review of the facility's CMS-2567 form from a recertification and complaint survey in 2025 documented the facility failed to ensure the facility's kitchen stove top was free from excessive black burnt on buildup. The facility's plan of correction for this survey revealed staff were educated on regarding kitchen sanitation requirements. The Administrator and/or designee will audit for kitchen sanitation three times weekly for 4 weeks, twice weekly for 8 weeks, and then as needed to ensure continued compliance.The facility's current recertification and complaint survey initiated on 1/26/26 resulted in a deficient practice related to kitchen sanitation. On 1/29/26 at 11:24 AM, the Administrator acknowledged the kitchen has not been great in the cleaning process and the past few weeks have been trying to work on it. The facility policy titled Quality Assurance and Performance Improvement Plan (QAPI)/ Quality Assessment and Assurance (QAA) dated 5/23/23 documented the QAPI Committee monitors progress to ensure that interventions or actions are implemented and effective in making and sustaining improvements.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and family interview the facility failed to notify the resident or resident representative for 2 of 2 residents reviewed with significant weight loss (Resident #16 and Resident #24). The facility reported a census of 26 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #16 documented cognitive skills for daily decision making was severely impaired, and the resident needed partial to moderate assistance with eating. The MDS documented diagnoses of bipolar disorder, Alzheimer's disease, and down syndrome. Review of Resident #16 Weights in his Electronic Health Record (EHR) revealed the following:12/1/2025: 110.4 pounds (lb.)1/8/2026: 98.2 lb.This reflected a 12.2 lb. weight loss, or 11.1% weight loss, between 12/1/25 and 1/8/26.Resident #16 Progress Notes from 1/8/26 to 1/29/26 lacked documentation of notification to the family representative regarding his 12.2 lb. weight loss.2. The MDS assessment dated [DATE] for Resident #24 documented a Brief Interview for Mental Status (BIMS) of 4 out of 15, which indicated severe cognitive impairment. The MDS also revealed she was independent with eating. The MDS also documented diagnoses' of diabetes, thyroid disorder, and Alzheimer's. Review of Resident #24 Weights in his EHR revealed the following weights:12/8/2025: 140 lb.12/16/25: 134.4 lb.1/5/26: 130.8 lb.This reflected a 9.2 lb. weight loss, or 6.6% weight loss, between 12/8/25 and 1/5/26. Resident #24's Progress Notes from 1/5/26 to 1/29/26 lacked documentation of notification to the family representative regarding her 9.2 lb. weight loss.Interview on 1/26/26 at 1:18 PM with Resident #24's Resident Representative revealed he thought she might be around 140 lb. but was shocked to hear she was at 130.8 lb. and informed the facility did not notify him she has lost that much. In an interview on 1/29/26 at 10:15 AM with the Director of Nursing (DON) explained she did not have documentation for Resident #24 and Resident #16 resident representative being informed of their weight loss, and explained she thought the Dietician called the families, found out they do not, and she will need to going forward. In an interview on 1/29/26 at 10:28 AM with the Administrator informed the Dietician reviews weights weekly and writes Progress Notes, and after that either the floor nurse or the DON would notify the resident and/or resident representative and update them regarding their weight loss. On 1/29/26 at 11:55ˆAM, the Administrator shared the facility did not have a family notifications policy and follow the regulations/standard of care.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and staff interview the facility failed to accurately code 1 of 2 Minimum Data Set (MDS) (a standardized, comprehensive assessment of functional, medical, psychosocial, and cognitive status) for Preadmission Screening and Resident Review (PASRR) assessment (a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) level outcome for one of three residents reviewed for PASRR (Resident #6). The facility reported a census of 26 residents. Findings include: Review of Resident #6's PASRR dated 4/23/25 documented a Level II outcome with short term approval ending 9/20/25. The MDS for Resident #6 dated 5/26/25 documented a Brief Interview for Mental Status (BIMS) of 15 out of 15, which indicated no cognitive impairment. The MDS also documented he was not considered to be a PASRR level II. The MDS also documented he had diagnoses of anxiety, depression, and Post Traumatic Stress Disorder (PTSD)Review of Resident #6 PASRR dated 10/8/25 documented a Level II outcome, short term approval. In an interview on 1/29/26 at 10:28 AM, the Administrator explained she recently started working at the facility and is working on getting all residents PASRR's reviewed and updating them, and she would of expected the MDS Coordinator that completed the 5/26/25 MDS assessment for Resident #6 to code the MDS accurately to reflect his Level II outcome.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to resubmit a Preadmission Screening and Resident Review (PASRR) (a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) after a new diagnosis of psychosis for 1 of 2 residents reviewed for PASRR (Resident #3). The facility reported a census of 26 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #3 documented a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating no cognitive impairment. The MDS also documented diagnoses of depression and psychotic disorder. Resident #3 Medical Diagnoses in his Electronic Health Record (EHR) documented on 1/10/25 he received a new diagnosis of unspecified psychosis not due to a substance or known physiological condition, and needs medical management for the diagnosis. Resident #3 most recent and current PASRR as of 1/29/26 revealed it had not been submitted for review since 12/23/24, and at that time his PASRR did not include a psychosis diagnosis. In an interview on 12/29/26 at 10:28 AM with the Administrator informed she is working on getting all resident PASRR's reviewed, and explained with Resident #3's diagnosis of psychosis should have been submitted for review.The Administrator explained on 1/29/26 at 11:55ˆAM the facility did not have a PASRR policy and followed the regulations.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to revise 1 of 1 Resident's (Resident #4) Care Plan when homicidal comments were documented in his medical record to ensure proper interventions were in place. The facility reported a census of 26 residents. Findings include:Resident #4's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident scored 8 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated moderately impaired cognition. The MDS included diagnoses of depression and anxiety. Resident #4's Encounter Psych Progress Note dated 10/6/25 documented continue to monitor patient due to homicidal and suicidal comments and follow in 4 weeks or as needed.Resident #4's current Care Plan lacked instruction and interventions related to homicidal comments. On 1/28/26 at 3:36 PM, the Director of Nursing (DON) reported the nurses on the floor are to be reading and making sure that psych notes are addressed and the facility is care planning properly. She acknowledged the homicidal should be addressed on the care plan with interventions in place.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews the facility failed to provide treatment as ordered to promote the healing and prevent infection of existing pressure ulcers for 1 of 3 residents reviewed (Resident #13).The facility reported a census of 26 residents. Findings include:Resident #13's MDS assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. The MDS included diagnoses of paraplegia and stage 4 pressure ulcer (full thickness skin and tissue loss) of the sacral region. Resident #13's orders from the wound clinic dated 12/18/25 documents the sacral pressure ulcer orders to Apply Acetic Acid dampened gauze to the wound base and the skin around and allow to stay in place for 10-15 minutes then remove, apply Calmoseptine around the left buttock wound, apply Melgisorb Ag (Calcium Alginate) to the wound base and pat dry and allow for air time for 30 minutes, then return and place ABD and secure with Medipore tape. On 1/28/26 at 2:25 PM Staff G, Registered Nurse (RN) went to complete the wound treatment to the sacral area. Staff G looked at the order on the computer and then did hand hygiene. She applied gloves and opened a gauze package. Placing half the gauze on the supplies without a barrier under, she went to the computer to read the order again touching the computer with her gloved hand then took the acetic acid and dampened some gauze with it. Staff G cleansed the wound with the dampened gauze. Staff G did not leave it on the wound for 10-15 minutes as the order states. Staff G then rolled Resident #13 onto her back with no barrier under her, placing the resident down on the bed after cleansing the area and not covering it, to apply pain cream to the shoulder on the right side. At 2:35 PM Staff G did hand hygiene and assisted the resident to her right side. Staff G looked at the computer to read the order for the sacral area and applied gloves not doing hand hygiene after touching the computer. Staff G took the tube of calmoseptine and used her gloved finger to get some cream from the tube. She applied it with the gloved finger to the first wound in the sacral area. Then with the same gloved finger, took more out of the tube and applied it to the second wound. Staff G with the same gloved hand she used for the calmoseptine, took melgisorb ag (calcium alginate), cut it to size and placed it on the wound base. She then removed her gloves and applied new gloves. No hand hygiene done between. Staff G took an ABD and placed over the wounds and secured it with tape. She rolled the resident onto her back. She then removed her gloves and went to the computer and signed off on the treatments completed. On 1/29/26 at 10:05 AM, the Director of Nursing (DON) explained they expected the nurses to follow the order correctly for wound cares. The DON acknowledged the treatment was not completed per orders.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews and policy review the facility failed to complete root cause analysis and implement new interventions as needed for 1 of 2 residents reviewed for accidents and falls (Resident #16). The facility reported a census of 26 residents. Finding include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #16 documented the resident's cognitive skills for daily decision making was severely impaired. The MDS revealed he needed partial to moderate assistance with eating. The MDS documented diagnoses of bipolar disorder, Alzheimer's disease, and down syndrome. Review of the Care Area Worksheet (CAA) attached to the MDS documented he would not be Care Planned for falls. 1.Review of a Witness Fall Report dated 12/19/25 at 10:45 AM for Resident #16 documented he fell out of his wheelchair by the nurses station and his wheelchair landed on top of him. The report lacked an in-depth root cause analysis of what caused the fall and interventions put in place 2. Review of a an Unusual Event Report dated 12/23/25 at 2:00 PM for Resident #16 documented he was in the hallway when a resident with an electric wheelchair ran over his hand. The report lacked an in-depth root cause analysis of the incident event and interventions put in place to prevent in the future. 3. Review of a Witnessed Fall report dated 1/27/26 at 5:10 PM for Resident #16 documented he slid out of his wheelchair in the dining room onto the floor. The facility lacked an in-depth root cause analysis of why the fall occurred, but implemented staff education on not leaving him unattended in dining room when he is in his wheelchair. Review of Resident #16 current Care Plan on 1/28/26 lacked interventions related to the root cause of his fall on 12/19/25, 12/23/25 and 1/27/26. The Care Plan did instruct to not leave him in the Dining Room unattended. His Care Plan also informed he is independent with ambulation and prefers to sit on the floor and scoot.In an interview on 1/29/26 at 10:15 AM, the Director of Nursing (DON) revealed the facility staff did frequent checks for the resident, and if they saw him walking they kept an eye on him. She explained regarding the 12/23/25 unusual event regarding his hand being ran over by a wheelchair, they talked to the resident that ran his hand over but it was not documented. She further explained the resident needed to be supervised or do his thing on the floor, but he could not be in his wheelchair unattended. On 1/29/26 at 10:28 AM, the Administrator explained they were doing better at keeping track of him and knowing where he was at frequently. The Administrator explained on 1/29/26 at 11:55ˆAM the facility did not have a fall policy and followed the regulations/standard of care.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on facility record review, staff interview, and policy review, the facility failed to have the minimum required members at the Quality Assessment and Assurance (QAA) meetings to identify issues with respect to which quality assessment and assurance activities are necessary. The facility identified a census of 26 residents. Findings include:Review of the facility QAA sign in sheets revealed the Administrator, Medical Director, Director of Nursing (DON), and at least two other staff were present at the meetings. The Infection Preventionist was not present at the November 2025 quarterly meeting. On 1/28/26 at 3:48 PM, the Director of Nursing (DON) reported at the quarterly in November there was no Infection Preventionist present at the meeting. The DON reported the facility did not have an Infection Preventionist at the time. Review of the facility's Quality Assurance and Performance Improvement Plan updated on 5/23/2023 revealed the QAA Committee was to meet at least quarterly and would include the DON, Medical Director, Infection Preventionist Nurse, and 3 other staff members which one must be the Executive Director or another individual on the leadership team.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff and resident interviews, and policy review the facility failed to implement standard infection control practices and Enhanced Barrier Precautions (EBP) (involves the use of gowns and gloves during high-contact resident care activities for residents known to be colonized, infected and at increased risk of Multidrug Resistant Organisms (MDRO) (bacteria that are resistant to three or more families of antibiotics) for 2 of 2 residents who received routine wound care for pressure ulcers (Resident #5 and Resident#13). The facility also failed to review their infection policy yearly. The facility reported a census of 26 residents. Findings include: 1. Resident #5's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating moderate cognitive impairment. The MDS included diagnoses of urinary tract infection and stage 4 (full thickness skin and tissue loss) pressure ulcer of the sacral region. The Care Plan Focus dated 12/17/25, revised 1/27/26, indicated Resident #5 needed EBP related to the chronic wound. The Interventions directed the staff to use EBP precautions (wear a gown and gloves when caring for the resident). On 1/27/26 at 11:45 AM Observed Staff D and Staff E, Licensed Practical Nurses (LPN)s do wound care and peri cares for Resident #5. Staff D gathered supplies and put on a barrier. Staff D and Staff E did hand hygiene and applied a gown and gloves. Resident #5 was incontinent of urine and the brief was saturated with urine front and back. No peri cares completed prior to wound treatment. Staff D removed the soiled brief and applied disposable incontinence pad as a barrier under the resident. Staff D cleaned the wound with Vashe on a gauze about a half inch around the wound. Staff D removed her gloves, did hand hygiene and applied new gloves. Staff D then turned the barrier under him over touching the wound with the dirty side of the barrier. Staff D did not reclean the wound areas. Skin prep then applied around the wound about a half inch. The rest of the back side of Resident #5 that the urine was left unclean. She packed the wound with silver Ag and then covered with a sacral mepilex that covered several inches past the outside wound edges which covered areas not cleaned from being incontinent. A new brief applied and rolled the resident onto his back and not cleaning the back side that was dirty from urine. Staff D removed her gloves and gown to get wipes to clean Resident #5 due to being incontinent when they had removed the brief prior to starting wound care. Staff D returned with wipes, did hand hygiene and applied gloves. She used wipes to clean and do peri care on the front side only. Staff D was not wearing PPE and did not clean the back half of the resident. Once peri cares were completed on the front they pulled up the brief and pants. Staff D and Staff E removed the gloves and gown and did hand hygiene. On 1/27/26 at 12:15 PM Staff E, LPN and Staff F, CNA enter Resident #5's room to transfer the resident to the wheelchair for lunch. Staff E and Staff F did not wear PPE and no hand hygiene was performed prior to transferring Resident #5. Hand hygiene done post cares. On 1/27/26 at 12:25 PM observation of Resident #5's door lacked a sign for EBP. On 1/28/26 at 3:40 PM Director of Nursing (DON) reported all staff know who is on EBP because there are signs on the door and a list at the nurses station. Staff are required to wear gown and gloves for all cares for EBP residents. Review of the facility's Competency for Peri Care dated 5/11/21 documented to wash buttocks and both hips when soiled. (continued on next page)

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	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Cresco	701 Vernon Road SW Cresco, IA 52136

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #13's MDS assessment dated [DATE] identified a BIMS score of 15 out of 15, indicating intact cognition. The MDS documented Resident #13 has an indwelling catheter. The MDS included diagnoses of neurogenic bladder, paraplegia and stage 4 pressure ulcer of the sacral region. On 1/28/26 at 2:10 PM Observed Staff G, Registered Nurse (RN) doing Resident #13's treatments for the left hip, sacral pressure wound, labia, right foot and flush the catheter. Staff G gathered her supplies and entered the room. Staff G set the supplies in the basket down on the nightstand by the bed and the computer next to it. Staff G then pulled up on the computer the treatment to the left hip. Staff G applies gloves and a gown with no hand hygiene. Staff G assisted Resident #13 to her right side. Staff G washed the area to the left hip with normal saline and wiped the area clean. She removed her gloves and applied new gloves. No hand hygiene between. Staff G then covered the area with an ABD (a highly absorbent, multi-layered, sterile medical dressing designed for managing heavily draining wounds, post-surgical incisions, and trauma) and secured with tape. During this care the gown kept falling down and she kept pulling it back up. Staff G then removed her gloves and did hand hygiene. On 1/28/26 at 2:25 PM Staff G went to complete the wound treatment to the sacral area. Staff G looked at the order on the computer and then did hand hygiene. She applied gloves and opened a gauze package, placing half the gauze on the supplies without a barrier under, she went to the computer to read the order again touching the computer with her gloved hand then took the acetic acid and dampened some gauze with it. Staff G cleansed the wound with the dampened gauze. Staff G did not leave it on the wound for 10-15 minutes as the order states. Staff G then rolled Resident #13 onto her back with no barrier under her placing the resident down on the bed after cleansing the area and not covering it to apply pain cream to the shoulder on the right side. Staff G changed her gloves and applied the pain cream. She removed her gloves and did hand hygiene. Staff G then read on the computer the treatment to the right heel. Staff G told the resident she was out of the silvadene for heel but would wrap it per order and once it came from the pharmacy would be back to put the cream on it. The order was to cleanse the area with normal saline, pat dry, apply silvadene and cover with ABD and kerlix. Staff G proceeded to wrap the left toe area with kerlix. At 2:35 PM Staff G did hand hygiene and assisted the resident to her right side. Staff G looked at the computer to read the order for the sacral area and applied gloves not doing hand hygiene after touching the computer. Staff G took the tube of calmoseptine and used her gloved finger to get some cream from the tube. She applied it with the gloved finger to the first wound in the sacral area. Then with the same gloved finger, took more out of the tube and applied it to the second wound. Staff G with the same gloved hand she used for the calmoseptine, took melgisorb ag (calcium alginate), cut it to sized and placed it on the wound base. She then removed her gloves and applied new gloves. No hand hygiene done between. Staff G took an ABD and placed over the wounds and secured it with tape. She rolled the resident onto her back. She then removed her gloves and went to the computer and signed off on the treatments completed. She read the treatment for the labia. She explained to the resident the two creams for the area are on order from the pharmacy and when they come she would do the treatment to it but she found the antifungal power and will apply that. She applied gloves and took a wipe and cleaned the peri area wiping from back to front and using the wipe multiple times. She took another wipe to clean around the catheter area and used the wipe multiple times still wiping in the opposite direction from back to front. She then with the same gloves applied the antifungal powder. She removed her gloves and went to the computer and signed off on the treatment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/26 at 2:55 PM, observed Staff G, RN go to flush the catheter with 60 milliliters with sterile water. Hand hygiene competed and gloves applied. Staff G used the syringe to flush the water into the catheter. An Alcohol wipe was used to clean port pre and post flushing. Throughout the process the gown was hanging down at the bottom of the arms and not on properly. On 1/28/26 at 3:15 PM Resident #13 then sat up in bed looking down at her feet and asked Staff G why she wrapped her left toe area. The staff member reported because the order said so. Resident #13 then verbalized it was supposed to be their right foot and the area is on my heel. Staff G then looked at the order again and said she was confused when she was laying on her side. She removed the dressing on the left toe area and wrapped the right heel with kerlix and did not apply an ABD like ordered. Throughout all treatments the gown was hanging down the lower part of the arms and was not properly worn. Staff G then gathered her supplies and left the room. She put the basket of supplies back without cleaning the basket bottom that was on the nightstand without a barrier. No hand hygiene was completed. On 1/28/26 at 3:30 PM, Staff G, RN reported the gown could not stay up during the cares and acknowledged the infection control concerns noted during the cares. On 1/29/26 at 10:05 AM, the Director of Nursing (DON) reported staff are to be wearing EBP properly and if having trouble with the gowns staff are to ask other staff for assistance and not just wear it hanging at the arms. The facility policy titled Hand Hygiene dated 11/13/24 documented staff are to hand sanitize immediately before putting on gloves or after glove removal. Review of the facility's Competency for Peri Care dated 5/11/21 documents to wash the labia area from front to back and if using disposable wipes to use a new wipe for each area and one swipe wipe technique. 3. Review of the facility's General Infection Prevention and Control Surveillance revealed it was last updated on 10/5/23. On 1/29/26 at 10:15 AM, the Director of Nursing (DON) explained she had never seen the facility's overall infection control surveillance plan and had never reviewed it since becoming the DON in May 2025. On 1/29/26 at 10:28 AM, the Administrator explained the General Infection Prevention and Control Surveillance, dated 10/5/2023, was what is in place and was unable to locate documentation it has been reviewed. She explained she had been working at the facility for approximately 3 months and it had not been reviewed in that time period, but she would expect it to be reviewed annually.