STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165528	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Spirit Lake	1912 Zenith Avenue Spirit Lake, IA 51360

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, and staff interview, the facility failed to ensure a safe, clean, comfortable, and homelike environment for 8 residents (Resident #2, #4, #10, #12, #13, #14, #15, and #16). The facility reported a census of 72 residents.Environmental observations:On 4/14/26 at 2:12 p.m. Resident #4 upset her bedside table was sticky. Verified it felt sticky. Resident #4 unsure how long it had been that way. On 4/15/26 at 9:03 a.m. Resident #4 again complained of her table being sticky. The center of the table felt sticky. The toilet seat in the resident's bathroom had large areas discolored brown. On 4/20/26 at 8:56 a.m. Staff A Certified Nursing Assistant (CNA) and Staff B CNA assisted Resident #4 with cares. Staff B thought the toilet seat was stained due to loose stools. Staff A didn't know what caused it.On 4/14/26 at 2:15 p.m. Resident #12's bathroom had used washcloths on the floor.On 4/14/26 at 2:21 p.m. Resident #13's bathroom had clothes on the floor, and the toilet not flushed with a strong odor.On 4/15/26 at 9 a.m. Resident #14's bathroom had an open bag of incontinent pads spilling out onto the floor. On 4/15/26 at 9:12 a.m. Resident #10's bathroom floor had used paper towels on it, and a soiled pad in the trash can, with visible incontinence. On 4/15/26 at 9:16 a.m. Resident #15's bathroom had garbage on the floor (by the trash can), and a grip strip partially pulled up (in front of the toilet).On 4/15/26 at 9:19 a.m. Resident #16's bathroom had a used pad in the trash can, and used gloves on the floor. On 4/20/26 at 8:25 a.m. Resident #2's bathroom had a used incontinent pad in the garbage can, and a towel, an article of clothing, and a disposable glove on the floor. Resident #2 sat in her wheelchair in the room.On 4/21/26 at 9 a.m. the Assistant Director of Nursing (ADON) stated the CNA's should clean up (remove clothing that needed laundered, removing incontinent products) after assisting a resident with cares. The Administrator stated the toilet seat discoloration had been that way for a while. They could put a new seat on the toilet.On 4/21/26 at 1:50 p.m. the Environmental Services Supervisor stated the CNA's usually picked up linens and removed pads after they provided care. Clothing and linen should not be on the floor.The undated facility Handling Soiled Linen policy documented linen should be treated as potentially contaminated. Linen should not be allowed to touch the floor.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165528	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Spirit Lake	1912 Zenith Avenue Spirit Lake, IA 51360

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility failed to ensure residents with a catheter received appropriate treatment and services to prevent infection for 3 of 3 residents reviewed (Resident #1, #7, and #8). The facility reported a census of 72 residents.1) According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident had an indwelling urinary catheter. Diagnoses included neurogenic bladder.The Care Plan initiated 3/10/25 identified Resident #1 had a suprapubic (inserted through the abdomen to the bladder) catheter related to a bladder dysfunction. Resident #1 had the potential for urinary tract infections. The March 2026 Treatment Administration Record (TAR) included Resident #1 had the order to change the suprapubic catheter monthly on the 11th with a start date of 11/11/25, and change the urinary leg bag 2 times a month on the 12th and the 26th every month. The TAR documented the catheter was changed on the 11th, and the drainage bags were changed the 12th.The April 2026 TAR documented Resident #1 was in the hospital on the 11th and 12th so the catheter change and bag changes were not completed on those dates. The TAR documented monitor the catheter every 2 hours during the day, two times a day with a start date of 4/29/25. During an observation on 4/20/26 at 10:14 a.m. Staff A Certified Nursing Assistant (CNA) emptied resident #1's catheter leg bag, dated 3/26/26. Staff A stated they emptied the catheter bag about every 4 hours, and the resident let them know when it was full also.The clinical record lacked documentation Resident #1's catheter bag was monitored every 2 hours or who monitored it every 2 hours.On 4/21/26 at 9 a.m. the Assistant Director of Nursing (ADON) said Resident #1's family member wanted the catheter bag checked every 2 hours. She said the nurses were to monitor the leg bag every 2 hours to ensure it was getting emptied. The ADON verified the leg bag was not changed (since 3/26/26).2) According to the MDS assessment dated [DATE], Resident #7 scored 9 on the BIMS indicating moderate cognitive impairment. The resident had an indwelling urinary catheter. Diagnoses included a hip fracture.The Care Plan identified Resident #7 had a catheter due to urinary retention.On 4/14/26 at 1:53 p.m. Resident #7 slept in the recliner. The catheter bag hung from the trash can.On 4/15/26 at 10:02 a.m. Resident #7's catheter bag hung from the trash can, while the resident sat in the recliner The trash can contained garbage.On 4/21/26 at 9 a.m. the ADON stated the catheter bag could hang from the trash can if it was only used for that, and did not collect trash.3) According to the MDS assessment dated [DATE], Resident #8 scored 15 on the BIMS indicating no cognitive impairment. The resident had an indwelling urinary catheter, and diagnoses included a neurogenic bladder. The Care Plan revised 2/11/26 identified Resident #8 had an indwelling catheter related to neurogenic bladder. The resident had the potential for UTI's. At times the resident would empty his catheter bag himself.On 4/20/26 at 10:03 a.m. Staff A prepared to empty Resident #8's catheter bag. Staff A washed her hands and put on gown and gloves. She placed a graduate on a barrier on the floor. Staff A moved the resident's oxygen tubing that was on the floor, over with her gloved hand, and proceeded to handle the catheter bag and open the drain wearing the same gloves. Staff A completed the procedure before removing her gloves and doing hand hygiene. On 4/21/26 at 9 a.m. the ADON stated she would have changed gloves after touching the tubing on the floor.The Guideline for Prevention of Catheter-Associated Urinary Tract Infections (2009) included ensuring that only properly trained persons who knew the correct technique of aseptic catheter insertion and maintenance were given the responsibility, and using Standard Precautions, including the use of gloves and gown as appropriate, during any manipulation of the catheter or collecting system.