

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165528	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2025
NAME OF PROVIDER OR SUPPLIER Accura Healthcare of Spirit Lake		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, staff interviews and policy review the facility failed to ensure proper temperatures for foods served to residents. The facility reported a census of 66 residents. Finding Include: During observation on 10/1/2025 at 11:19 a.m., Staff D, [NAME] checked the temperature of the food in the steam table. Staff D checked the temperature of the mashed potatoes which tempted at 131.9 degrees fahrenheit (F). Staff D proceeded with meal service and served the residents the mashed potatoes out of the steam table and did not reheat the potatoes to an appropriate safe temperature. Review of facility provided policy titled Food Temperatures dated 2013 revealed the following information: All hot foods items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 degrees F. Temperatures should be taken periodically to ensure hot foods stay above 135 degrees F. Interview on 10/1/2025 at 1:16 p.m., with the Dietary Manager (DM) revealed food in the steam table should be kept at least 135 degrees F if it falls below then should be reheated to ensure proper temperatures at meal service. The DM further revealed mashed potatoes should have been reheated prior to serving them to the residents.		

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 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 observations, staff interviews, and facility policy reviews the facility failed to ensure food was stored and prepared under sanitary conditions. The facility identified a census of 66 residents. Findings include: On 09/29/2025 11:21 a.m., during the initial walkthrough in the kitchen was conducted and following concerns were noted. Observations of the kitchen sinks labeled prep sinks were noted to have food debris in the bottom of the sinks and the far left sink was noted to have approximately 1/4 inch of water with food debris sitting in the bottom of the water. Observation of the floor by storage area was noted to have 3 straw wrappers laying on the floor in the walking path. Puree food preparation area noted to have dried food debris on the wall behind the food blender. Observation in the refrigerator of a flat of eggs ready for use with a cracked and empty egg shell on the flat of unused eggs. Observation in the refrigerator of a cart with meat thawing noted to have raw chicken on the bottom of the cart with a date of 9/23. Above the raw chicken was ham with a date of 9/25 and above the ham was raw ground beef with a date of 9/27. Review of the facility provided policy titled Food Storage Dated 2013 revealed food is stored in an area that is clean, dry and free from contamination. Food is stored, prepared and transported at appropriate temperatures and by methods designed to prevent contamination or cross contamination. Interview with the Dietary Manager at the conclusion of the initial walkthrough revealed the egg shell should not have been in the carton and should have been thrown away after the egg was used and the meat should not have been thawing in that order in the refrigerator and should have been in the correct order.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview the facility failed to notify the Long Term Care Ombudsman(LTCO) for 1 of 1 residents reviewed who transferred to the hospital (Resident #10). The facility reported a census of 66 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #10 documented diagnoses of anemia, diabetes mellitus, and chronic kidney disease. The MDS showed the Brief Interview for Mental Status (BIMS) score of 3 indicating severe cognitive impairment. Review of Resident #10's census tab revealed:10/31/2024- hospital leave-unpaid11/1/24- active2/4/25- hospital leave-unpaid2/6/25- active Review of Resident #10's Progress Notes revealed; 10/31/24 at 5:21 p.m., resident being transferred to a larger hospital with diagnosis of Urinary Tract Infection (UTI) and tear in colon. 11/5/24 at 12:05 p.m., resident arrives back to facility. 2/4/25 at 1:30 p.m., Resident sent to the emergency department from doctor appointment to be evaluated for lethargy and UTI symptoms. 2/6/25 at 11:03 a.m., Resident arrived back to the facility. Review of the facility document titled Notice of Transfer Form to Long Term Care Ombudsman dated October, November and February lacked Resident #10's name. The facility does not have a policy regarding reporting to the LTCO office. The facility follows the federal guidelines. Interview on 10/02/2025 8:47 a.m., with Staff H, Social Worker revealed if a resident goes to the hospital then she would report that to the LTCO office. Staff H verified Resident #10 should have been reported to the LTCO office when she went to the hospital in October and February.		

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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, staff interview and facility policy, the facility failed to provide complete and appropriate incontinence care in a manner to prevent urinary tract infections for 2 of 3 residents observed (Resident #10 and #51). The facility reported a census of 66 residents. Finding include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #10 documented diagnoses of dementia, Diabetes Mellitus. The MDS showed the Brief Interview for Mental Status (BIMS) score of 10, which indicated severe cognitive impairment. Observation on 10/1/25 at 9:57 AM revealed Staff A, Certified Nursing Assistant (CNA) and Staff B, CNA completed hand hygiene, donned gloves, and lowered the resident's pants to complete perineal care. Staff B removed Resident #10's soiled briefs, removed gloves, then applied new gloves without performing hand hygiene. Staff A performed front perineal care using different areas of the same cleansing wipe. Staff A then cleansed the resident's buttock using different areas of the same cleansing wipe. Staff A failed to cleanse the entire surface area of the resident's buttock area. Staff A and Staff B removed gloves, failed to perform hand hygiene, then pulled up the resident's pants, arranged the blankets and bed controls. In an interview on 10/1/25 at 10:11 AM, Staff C, RN educated staff to perform hand hygiene after removing gloves, use a new cleansing wipe with every swipe of the skin, and to cleanse the entire buttock area including the hips. 2. Observation on 10/01/2025 at 9:57 a.m., with Staff F, CNA and Staff G, CNA assisted Resident #51 with incontinence care. Staff F and G entered the room and performed hand hygiene and applied gloves and explained to Resident #51 what they were going to do. Staff F with gloved hands lowered the side rail on the bed and assisted in removing Resident #51's clothing to get to incontinence brief. Staff F with the same gloves opened and lowered the incontinence brief and performed perineal care with the same soiled gloves. When finished with the incontinence care on the front of the resident Staff F with the same soiled gloves on assisted Staff G in turning Resident #51 to her side. Staff F with the same soiled gloves touched Resident #51's shoulder and hands with soiled gloves before continuing to perform perineal care. Staff F with a wipe used 3 wiping strokes over the hip area prior to turning the wipe. Staff F completed perineal care. Staff F removed the soiled gloves and performed hand hygiene and applied another pair of gloves. Staff F applied a clean incontinence brief and fastened the brief. Staff F assisted Staff G with pulling dressing Resident #51. Staff F removed her gloves and did not perform hand hygiene. Staff F assisted to cover Resident #51 up and used the bed controls to lower the bed and ensure the resident was comfortable. Staff F performed hand hygiene after finishing with the resident. Interview on 10/2/25 at 9:22 a.m., with the Director of Nursing (DON) revealed the facility does not have a policy on incontinence care. The facility follows standards of care and uses competencies for staff evaluations. Review of facility provided Competency for Peri Care with an updated date of 4/20/2021 revealed step 11 remove gloves prior to turning to their side unless using the buddy system. During an interview on 10/2/25 at 9:22 a.m., the DON revealed the staff should not have been touching (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	everything with their gloves on and should have performed hand hygiene right away after removing their gloves. The staff received education yesterday after the completion of cares.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, staff interviews and facility policy review the facility failed to ensure residents received the proper diet texture to meet the residents needs. The facility reported a census of 66 residents. Findings Include: During an observation on 10/1/2025 at 11:37 a.m., during meal service Staff D, cook dishd up a puree meal for Resident #17. Staff D placed mashed potatoes on the plate and placed serving of puree beef tips with gravy over the potatoes. Observation of the puree beef tips revealed chunks of beef on the plate. Asked Staff D if that was a puree meal and was she serving that portion to Resident #17, Staff D replied yes. Asked the Dietary Manager (DM) if the plate can be served to Resident #17 and the DM replied no not with the chunks of beef like that. The DM removed the plate from service and remaining portion of puree beef tips from the steam table and pureed new portions for the residents. Resident #24 requested cottage cheese. Resident #24 is a puree diet and Staff D served regular consistency cottage cheese to the resident. Staff D stated the resident has an order for regular cottage cheese. Requested order from DM for Resident #24 to have regular cottage cheese consistency and not pureed consistency. Review of the facility provided policy titled Dysphagia Diets dated 2013 revealed the food service department will be responsible for prepping and serving the diet and fluid consistency as ordered. Interview on 10/1/1025 at 2:38 p.m., with Staff E, Dietician revealed if a resident is a puree diet then the food needs to be pureed properly when serving it to the resident. Staff E explained unless the facility had an order for the cottage to be regular consistency it should have been pureed prior to giving it to the resident. Interview on 10/1/2025 at 1:16 p.m., with the DM revealed she knows that the puree consistency during meal service was a concern and should not have been served. The DM explained the facility was unable to find an order for Resident #24 to have regular cottage cheese and she should not have served it.		