STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165529	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Shenandoah	1203 South Elm Street Shenandoah, IA 51601

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident council meetings, Electronic Health Record review, document review, resident interview, and staff interview the facility failed to provide nursing staff to assure residents safety by not responding to call lights in a timely manner for 4 of 18 residents reviewed (Resident #1, #2, #12 and #28). The facility reported a census of 40 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. On 9/16/25 at 9:33 AM Resident #1 stated it took the staff longer than 15 minutes at least twice a week to answer her call light. Resident #1 stated the staff have told her it took a while to answer the call lights because there just wasn't enough staff. Resident #1 explained it took longer than 15 minutes to answer her call light when she was on the toilet a lot of the time. Resident #1 stated it has happened at least twice in the last 7 days. 2. The Minimum Data Set (MDS) dated [DATE] documented Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. On 9/16/25 at 8:13 AM Resident #2 stated it had taken longer than 15 minutes for the staff to answer her light in the last 2 weeks a couple of times. Resident #2 stated she could not remember the exact dates. Resident #2 stated she could read the clock and knew it took longer than 15 minutes3. The Minimum Data Set (MDS) dated [DATE] documented Resident #12 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. On 9/15/25 at 1:57 PM Resident #12 stated it takes forever for someone to answer her call light in the evening, especially when she is on the toilet. Resident #12 stated she has a push button clock that tells the time so she is exactly aware of how long it took the staff to answer the call light. Resident #12 pressed the button on the clock and the clock responded with 2:01 PM. Resident #12 stated it can take up to 45 minutes. Resident #12 stated it takes longer than 15 minutes almost nightly. 4. The Minimum Data Set (MDS) dated [DATE] documented Resident #28 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. On 9/18/25 at 10:59 AM during a resident council meeting Resident #28 laughed and stated it would be nice if it only took 15 minutes to have a call light answered. Resident #28 stated it took longer than 15 minutes frequently to have the call light answered. Resident #28 stated it could take up to 45 minutes to have the call light answered.On 9/18/25 at 10:27 AM during a resident council meeting residents stated they had to call the nurses station with their phones because CNA's would come into the room, shut the call light off and never return. Review of documents titled, Grievance Forms documented on 8/7/25 a resident explained Certified Nurse Assistant (CNA) came into the room, shut off the call light and said they would be back and did not see her again for the rest of the day. On 7/30/25 documented CNA's come into the room turn off call light without addressing the problem. Staff tell the resident they would return but do not return. On 8/26/25 documented during care plan conferences call light wait times were brought up by multiple residents.Review of document titled, Resident Council dated 7/30/25 documented call light delays and response was a current concern that a grievance was filed for.On 9/16/25 at 2:55 PM Staff C, Registered Nurse (RN) stated did not think there was enough staff to provide adequate care to residents. Staff C stated taking residents to the bathroom and answering (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	call lights could be difficult to complete in a timely manner because of the lack of CNA's at the facility. Staff C acknowledged call lights frequently last longer than 15 minutes. On 9/17/25 at 10:24 AM Staff D, MDS Coordinator acknowledged residents had voiced concerns in the resident council about the length of call light times. Staff D stated the residents had complained about the amount of time it takes to answer call lights. Staff D stated the management had talked about a call light audit but does not know where to find it or if it had been started. On 9/17/25 at 1:25 PM the Administrator stated she had heard some reports of call light wait times and wrote up a call light audit. The Administrator stated it had been reported during resident council there were extended call light wait times. The Administrator stated she would have to look at the audits to see if there were any concerning times. The Administrator stated the facility's expectation was call lights would be answered in under 15 minutes. On 9/17/25 at 6:52 PM the DON stated she had seen a grievance from a resident about call lights and asked the situation. The DON stated she spoke to all the staff during an in-service about answering the call light and during 2 huddles. The DON stated she spoke with the staff about leaving the call light on if they have not finished what they had been doing. The DON stated she went back to the resident that filled the grievance and asked if the call lights had gotten better and he had stated yes they have. The DON stated Staff L brought up notes with any concerns from resident council the morning after resident council. The DON acknowledged she did not review the actual minutes from the resident council meetings. The DON stated she did not remember Staff L voicing any concerns with call light from resident council. The DON stated she started a call light audit but did not put anything on a form. The DON explained she would go into a room, turn her stop watch on and time how long it took for the call light to be answered. The DON stated she did not have any call light responses longer than 8 or 10 minutes. The DON stated she did those audits morning and evening both. The DON stated her expectation was that call lights would be answered in less than 15 minutes.On 9/18/25 at 8:11 AM Staff A, Licensed Practical Nurse (LPN) stated the staff do the best they can to answer call lights. Staff A stated she could not remember any call lights specifically lasting longer than 15 minutes. Staff A stated she felt there was not enough staff to provide adequate care for the residents at the facility. Staff A stated all the baths do not get done, meals are served late, in the evening it seems if there was one more CNA the call lights would be answered quicker. On 9/18/25 at 8:33 AM Staff L, Director of Life Enrichment stated there had been hit or miss concerns during resident council meetings about delay in call light times. Staff L stated during resident council meetings residents reported when the call light was answered the CNA would enter the room, tell the resident they would be back later, the CNA would not return and the resident would have to turn the call light on again. Staff L stated during resident council it was reported that by the time the second light was turned on, the second time, the resident had soiled themselves already especially on the overnights. Staff L stated there are several 2 assist residents and he would say there should be more CNA's on the floor to care for the residents. Policy was not provided with regards to call light response.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on document review, staff interview and policy review the facility failed to ensure a Registered Nurse (RN) was in the facility for eight (8) consecutive hours for 6 of 90 days reviewed (April 1 - June 30, 2025). The facility reported a census of 40 residents.Findings include:Review of the Payroll Based Journal (PBJ) staffing data report for the fiscal year quarter three (April 1st through June 30th, 2025) revealed there was no Registered Nurse (RN) hours for 04/20, 04/26, 05/11, 05/18, 05/31, and 06/21/2025.In an interview on entrance date 9/15/2025 the Administrator confirmed that the facility did not have RN coverage listed on the PBJ. The Administrator confirmed these dates, and revealed that the facility only had one RN at the facility during this time. The Administrator revealed that her expectation would be for 8 hours RN coverage per day. Review of a facility provided document titled, Facility Assessment with a completed date of 7/27/2024 revealed:Federal regulations will require that facilities must provide 3.48 hours per resident day (HPRD) of direct care with 0.55 HPRD from registered nurses (RNs) and 2.45 HPRD from nurse aides (CNAs, NAs, or medication technicians/aides). The remaining 0.48 HPRD can be a combination of nurse staff (RNs, LPNs/LVNs, or nurse aides) to comply with the minimum. Listed below are some tables the facility can utilize to help determine their staffing needs based on the Federal minimum staffing standards, however, if State regulations require a higher standard, then the higher standard should be met. The minimum staffing standard is considered the floor of the standard. Facilities with higher resident acuities and needs may need to adjust their staffing numbers higher than the minimum standard.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, staff interviews, and policy review the facility failed to provide a well balanced diet that meets nutritional and special dietary needs by serving incorrect portion sizes for meals. The facility reported a census of 40 residents.Findings include:Continuous observation of lunch meal on 9/17/25 from 11:30 am to 2:30 pm revealed the following: Staff N, Dietary Cook/Aide placed 3 hot dogs into the blender to be pureed. After completing the process, the pureed food was transferred to a holding steel container without measuring the total volume of pureed food to be divided into 3 serving portions. Staff N continued to puree 3 servings of hot vegetables with 3 buns and prior to transferring the content into a steel container visualized the measurement marks on the blender and stated it was about 12 oz. Staff N completed serving lunch meal and stated she had served all pureed diets servings and had some left in the container. Along with pureed food items she also had mechanical soft diets for 3 residents and she also had left over hot dogs in that container. She stated she didn't know why she ended up having extra food left in the steel containers since she used the 8 oz portion scoops. She further stated she didn't use the volume chart at this facility but she did recall using such a chart to measure volume and divide between needed servings at a previous facility. In an interview with the Dietary Manager on 9/17/25 at 2:30 pm she stated that the cooks didn't use a food volume chart to measure altered food items but she will look into it. She then provided a pureed diet portion sizes/scoops chart and stated the chart will be used to measure the total volume of the food after it is pureed and then divided by the original number of potions. A review of the facility provided policy titled Policy & Procedure Manual, Portion Control dated 2021 documented: Individuals will receive the appropriate portions of food as outlined on the menu. Control at the point of service is necessary to assure that accurate portion sizes are served. Standardized recipes should be used to avoid waste caused by overproduction. Recipes should be adjusted as needed and the yield and serving size specified on each recipe. The menu should list the specific portion size for each food item. Menus should be posted at the tray line so staff can refer to the proper portions for each diet. Food should be served with ladles, scoops, spoodles, and spoons of standard sizes. Scales should be used as needed to weigh meat portions. Scoops should be leveled off (not overflowing) for the most accurate portion size.a. Portions that are too small result in the individual not receiving the nutrients needed.b. Portions that are too large increase food costs as well as providing the individual more food than needed.Food and nutrition services staff will receive training on proper portion sizes at regular intervals by the director of food and nutrition services. The director of food and nutrition services, registered dietitian nutritionist (RDN) or designee will observe meals on a routine basis to assure quality control of portion sizes

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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 interview, and policy review the facility failed to store food in accordance with professional standards. The facility reported a census of 30 residents.Findings include: On 9/15/25 from 11:00 am through 12:00 pm during initial kitchen tour observation revealed dry food storage items not stored properly:a. A box of white rice 25 lbs. half full lined with a blue plastic not sealed, open to air. b. 5 - 20 oz bottles of grape jelly and strawberry jelly expired.c. A box of Pan Asian sesame seed dressing 60 packets/box full expired 2/26/24. d. A box with Garden Wraps 12 inch containing 2 packs expired 10/22/24.e. A box of Catallia Premium Tortillas 8 inch 12 packs of 12/bag manufacturing date 3/17/25, box opened date 4/7/25, no date when to use by. f. A box of baking cocoa powder clear liner unsecured, open to air, labeled opened on 11/20/23. On 9/15/25 at 11:15 am in an interview with the Dietary Manager she revealed she wasn't aware the food items were expired or that the dry food storage area had to be checked for expired items regularly. She proceeded to discard expired food items and those that were not stored properly. A review of the facility provided policy titled Policy & Procedure Manual, Food Storage dated 2021 documented: Sufficient storage facilities will be provided to keep foods safe, wholesome, and appetizing.Food will be stored in an area that is clean, dry, and free from contaminants. Food will be stored, at appropriate temperatures and by methods designed to prevent contamination or crosscontamination.Food will be purchased in quantities that can be stored properly; and arranged in food groups for organized storage and inventory.Plastic containers with tight-fitting covers or sealable plastic bags must be used for storing grain products, sugar, dried vegetables, and broken lots of bulk foods or opened packages.All containers or storage bags must be legible and accurately labeled and dated.

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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 document review, staff interviews, and facility policy review the facility failed to demonstrate evidence of systematic identification of reporting, investigation, analysis, and prevention of adverse events. The facility failed to demonstrate the development, implementation, and evaluation of corrective actions or performance improvement activities. The facility reported a census of 40 residents.Findings include:Review of facility's provider Centers for Medicare and Medicaid Services (CMS) report revealed repeated deficient practices identified during the facility's annual surveys completed 10/17/2024, 06/29/2023 and current survey:F658F812F880During an interview on 09/18/2025 at 1:16 pm the Administrator acknowledged the facility had repeat deficiencies. The Administrator stated they reviewed progress during monthly and quarterly Quality Assurance & Performance Improvement (QAPI) and Quality Assessment & Assurance (QAA) review meetings. She stated that recently there has been a noted improvement in several areas.A review of the facility provided policy titled Quality Assurance & Performance Improvement (QAPI) and Quality Assessment & Assurance (QAA) dated 5/23/23 documented the following: Purpose: To ensure facilities develop a plan that describes the process for conducting QAPI/QAA activities, such as identifying and correcting quality deficiencies as well as opportunities for improvement, which will lead to improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life, and resident safety.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Medication Administration Record - Treatment Administration Record (MAR-TAR) review, Electronic Health Record (EHR) review, resident interviews, staff interviews and policy review the facility failed to provide dignity and respect during interactions with a resident and failed to provide medication when a resident requested for 1 of 16 residents reviewed (Resident #1). The facility reported a census of 40 residents.Findings include:The Minimum Data Set (MDS) dated [DATE] documented Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. On 9/16/25 at 9:38 AM Resident #1 stated a couple months ago Staff A, Licensed Practical Nurse (LPN) was going to give her a respiratory treatment and Resident #1 questioned Staff A about the amount of times a day the order was for. Resident #1 stated Staff A threw the nebulizer mask down and told her not to call her if she is short of breath because she would not help. Resident #1 stated Staff A also refused to put voltaren gel on her neck. Resident #1 stated she reported the incident to the Director of Nursing (DON) and there was a CNA present at that time. Review of Resident #1's EHR titled, Orders documented a physician's order for DuoNeb solution to inhale one vial twice a day for shortness of breath and diclofenac sodium (voltaren gel) to be applied to the right shoulder topically two times a day for pain.Review of Resident #1's MAR-TAR documented a physician's order for DuoNeb solution to inhale one vial twice a day for shortness of breath and diclofenac sodium (voltaren gel) to be applied to the right shoulder topically two times a day for pain.On 9/16/25 at 11:57 AM Staff B, Certified Nurse Assistant (CNA) stated she used to work the 2:00 PM -10:00 PM shift but she switched about a month ago. Staff B stated she had noticed a couple of times where staff were being short, unkind, and did not provide dignity or respect to the resident. Staff B stated she had reported a couple of the CNA's to the nurse and to the DON but had not gone to the Administrator. Staff B explained she had reported Staff A to the DON. Staff B stated Staff A was very short, rude and very snappy with the residents. Stated the nurse invalidated the residents feelings. Staff B stated Resident #1 told her Staff A refused to apply voltaren gel to the back of her neck and was short to her about a respiratory treatment in the past. Staff B stated she did not remember the dates but did discuss the incidents with the DON.On 9/16/25 at 2:55 PM Staff C, Registered Nurse (RN) stated she did not think there was enough staff to provide adequate care to residents. Staff C stated Resident #1 had complained to her that Staff A told her that she would not give her the voltaren gel that she had requested. On 9/17/25 at 10:24 AM Staff D, MDS Coordinator stated Resident #1 spoke to her about a nurse not providing medications when requested. Staff D explained Resident #1 stated she told Staff A that she did not want the breathing treatment at that moment and Staff A told her that she would not give it to her at all then. Staff D stated she thought there was something written up about it. Staff D acknowledged she reported the incident to the DON. Staff D stated she did not remember the date but the incident happened sometime last month. Staff D stated Resident #1 told her that she did not think that Staff A liked her. On 9/17/25 at 1:25 PM the Administrator stated the facility had reports of staff being short with some residents. The Administrator stated she thought there was a report that a nurse had said something to a resident but did not know if that was related to when the medication was due. The Administrator acknowledged there was corrective action that was being drafted but had not been completed. The Administrator explained the corrective action was for Staff A. The Administrator acknowledged the corrective action was related to Staff A telling Resident #1 if she did not take the breathing treatment at that time she, she did not want to hear she was having trouble breathing later and not applying voltaren cream to Resident #1's neck when requested. On 9/17/25 at 6:52 PM the DON stated she recently overheard Resident #1 talking to a CNA about who she could complain to about medications. The DON stated to the CNA to bring Resident #1 in right now. The DON explained Resident #1 told her Staff A (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	told her if she did not take the breathing treatment now she didn't want to hear about her not taking it later. The DON stated Resident #1 also stated Staff A refused to apply voltaren gel to her back after going to the nurse's station. The DON stated she had just worked on a corrective action related to these incidents. The DON stated Staff E, Office Manager was going to come in and present the corrective action while she was on vacation. The DON acknowledged it is not always an opportune time when residents request medications but the residents have to know all their needs will be met. The DON stated Resident #1 came into her office and she seemed irritated. The DON acknowledged Resident #1 wanted the voltaren gel because she had a pain in her neck. The DON stated she told Resident #1 she would address the situation and Resident #1 seemed to be alright with the resolution. The DON explained she did not feel Resident #1 was provided the dignity and respect she deserved in those incidents.On 9/18/25 at 11:56 AM Staff F, Certified Nurse Assistant (CNA) stated she had not heard of any staff being short or rude to the residents. Staff F stated she watched Staff A not give the voltaren gel to Resident #1 when she requested the gel. Staff F stated she had to repeatedly ask nurse Staff A to put the gel on Resident #1's shoulders and knees. Staff F stated after the 6th time of asking Staff A did apply the voltaren gel to Resident #1. On 9/18/25 at 8:11 AM Staff A, LPN stated had worked at the facility about a year. Staff A stated she had not heard any staff being short with the residents or talking down to them. Staff A stated she had never heard of any staff talk down to the residents. Staff A stated she had not heard of any staff telling residents no to any requested medications. Staff A stated if there was the resident was probably requesting the medication too early. Staff A stated she had not told any residents that she would not give the residents Tylenol, breathing treatment or voltaren gel. Staff A stated she felt the staff treated the residents with dignity and respect at the facility. Review of policy revised 1/30/24 titled, Promoting / Maintaining Resident Dignity documented It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. Respond to requests for assistance in a timely manner. Speak respectfully to residents; avoid discussions about residents that may be overheard. Each resident will be provided equal access to quality care regardless of diagnosis, severity of condition or payment source.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interviews and document review the facility failed to ensure 1 of 1 resident's personal property was protected from loss or theft when Resident #32 reported a missing ring and necklace and no personal inventory sheet was completed upon entry to the facility or updated throughout time living at the facility. The facility reported a census of 40 residents. Findings include:The Minimum Data Set (MDS) dated [DATE] for Resident #32 documented a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS also documented an admission date of 11/21/22.On 9/15/25 at 3:19 PM Resident #32 explained she had a nice diamond necklace and her engagement ring that were missing since she had entered the facility. Resident #32 stated she had talked to the Administrator about the missing jewelry. Resident #32 stated a couple of nurses came in and looked through the drawers but did not find anything. Resident #32 stated her daughter was more upset than she was. Resident #32 stated she had a feeling someone took it. Resident #32 stated it had been quite a while since she saw the jewelry. Resident #32 opened the drawer in the table next to her chair to reveal a small box inside of another box with jewelry and stated this is where I kept my ring and the missing necklace for special occasions. Resident #32 stated she had brought the item to the facility when she moved into the facility. Resident #32 stated her son told her that she should be able to have the jewelry at the facility when she moved in and that she was not able to bring that much stuff. On 9/17/25 at 11:27 AM Resident 32's daughter and Power of Attorney (POA) stated Resident #32 had her original diamonds from her original wedding ring and had it reconstructed into more of a cocktail ring. Resident 32's daughter and POA stated Resident #32 had the necklace and ring when she entered the facility. Resident 32's daughter and POA stated she had a diamond necklace on a gold chain with 3/4 carat diamond that was a gift from her husband. Resident 32's daughter and POA stated both were missing. Resident 32's daughter and POA stated she talked to the Administrator about it and sent her a picture that she drew of it. Resident 32's daughter and POA stated she also looked through everything at home. Resident 32's daughter and POA stated she was told that the jewelry was not on Resident #32's inventory sheet. Resident 32's daughter and POA stated Resident #32 had worn it at the facility several times. Resident 32's daughter and POA stated Resident #32 was very private and did not want anyone to know the jewelry had come up missing. Resident 32's daughter and POA stated those are family heirlooms. Resident 32's daughter and POA stated she did not take those items home but looked there just in case and did not find them. Observation on 9/17/25 at 12:47 PM revealed an inventory sheet on the back of the door in Resident #32's room. The inventory sheet had 2 items on the sheet from 2024. Observation of Resident #32's room revealed numerous bracelets, earrings and numerous necklaces on a jewelry stand, picture frames, a telephone, a small indoor light lit tree with pumpkin ornaments and sunflowers. Review of document titled, Resident #32's Item Description List documented to write in all clothing items of resident and date when they were brought in. When you take things home please cross item out and initial and date it. Items on list Pink / silver dressy top dated 4/25/24 and 3 sweaters colors rust, white and light blue dated 9/16/25.On 9/17/25 at 10:24 AM Staff D, MDS Coordinator stated inventory was completed upon entrance. Staff D stated Resident #32 was missing a ring. Staff D stated it was brought up in a care conference that she was present at. Staff D stated it was reported to the Administrator and she had talked to Resident #32's daughter. Staff D stated she thought there was a grievance filled out. Staff D acknowledged she did not fill out a grievance form. Staff D stated the care conference was on 8/12/25. Staff D stated she did not know if the ring was found. Staff D stated she filled out a statement or questionnaire about the missing ring. Staff D stated it was not on the residents inventory. Staff D stated Resident #32 thought it was missing and her daughter thought she had taken it home.On 9/17/25 at 6:52 PM the DON stated she knew that (continued on next page)

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	165529	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Shenandoah	1203 South Elm Street Shenandoah, IA 51601

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #32 reported a necklace and ring missing. The DON stated the room was searched with Resident #32's permission. The DON stated she had spoke with Resident #32's family about the incident to find out if they were taken home. The DON stated the family stated they did not take the items home. The DON stated after this incident the residents if they had anything of value in their room and offered them lock boxes. The DON stated the inventory sheet is part of the admission packet. The DON stated the inventory sheet is then placed on the back of the door so it could be updated. The DON stated it was everyone's responsibility to make sure the inventory sheet was filled out and updated. On 9/17/25 at 12:15 PM the Administrator stated the facility conducted closet audits and sent out letters to families to fill out the inventory sheet on the back of the door. The Administrator stated the staff are supposed to check off what the family had filled out on the inventory sheet to ensure the items match the inventory sheet. The Administrator acknowledged she did have a report of jewelry missing. The Administrator stated it was with Resident #32. The Administrator stated it was reported to a staff member by the daughter and Resident #32 that a ring and a necklace were missing. The Administrator stated she did not think there was any theft involved. The Administrator stated Resident #32 stated she had worn jewelry a couple years ago. The Administrator stated there was an inventory sheet on the back of Resident #32's door that the daughter was responsible to fill out. The Administrator stated that the investigation did not suspect any theft so the item was not replaced. The Administrator stated she did not speak to the family about the incident after the investigation was complete. The Administrator stated it was the facility's opinion the resident did not have the item at the facility. The Administrator acknowledged the initial inventory sheet from when Resident #32 had entered the facility was either not filled out or not completed appropriately. The Administrator stated she was unable to find any other inventory sheet except the sheet where the daughter had added the two items. The Administrator stated it was on the family to fill the inventory sheet out on admission and there was no expectation of staff to ensure that the inventory sheet is filled out. The Administrator stated nursing has been going over the inventory sheet with the family members. The Administrator stated the Admissions Agreement had language for the responsibility of the facility with regards to lost property. On 9/17/25 at 1:25 PM the Administrator stated she did not know if she did a grievance on the ring or if she just did the investigation. The Administrator stated she would have written up a grievance on the ring but she was trying to determine if it was reportable or not. On 9/18/25 at 8:11 AM Staff A, LPN stated one of the staff had mentioned Resident #32 was missing a necklace in the past. Staff A stated Resident #32 did have jewelry because they found a jewelry box in her trash can. Staff A stated one of CNA had found the jewelry in the trash can. Staff A stated there was a box in the cabinet and she told every nurse that came on duty about it. Staff A stated an agency CNA found the box in the trash can. Review of investigation dated 8/13/25 documented the facility had notified Resident #32 daughter the inventory sheet did not have the missing jewelry documented on it. The investigation documented Resident #32's daughter was advised any items brought in the facility need to be added to the inventory sheet so that the facility was aware of what Resident #32 had in the event something was missing. The investigation documented Resident #32's daughter verbalized understanding. Review of document titled, Admissions Packet documented the facility shall not be liable for loss or damage to the resident's property caused by fire, theft, or other casualty, nor for any injuries from the use of the facility by the resident.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Medication Administration Record (MAR) - Treatment Administration record (TAR), Electronic Health Records (EHR) review, resident interviews, staff interviews and policy review the facility failed to represent an accurate assessment of the resident's status during the observation period of the MDS by not accurately assessing the use of insulin for 1 of 5 residents reviewed (Resident #1). The facility reported a census of 40 residents.Findings include:The Minimum Data Set (MDS) dated [DATE] documented Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. On 9/16/25 at 9:36 AM Resident #1 stated she had not been on insulin since being at that facility. Resident #1 stated she used to be on Ozempic. Review of Resident #1's MDS dated [DATE] documented 1 day insulin injections were received during the last 7 days and no order for insulin.Review of Resident #1's EHR titled, Orders documented no current order for insulin.Review of Resident #1's EHR titled, Orders documented an order for Ozempic subcutaneous solution inject 2 mg subcutaneously discontinued 7/17/25.Review of Resident #7's MAR - TAR for the month of June, July, August and September revealed no orders for insulin.On 9/17/25 at 10:01 AM Staff D, MDS Coordinator / RN stated Resident #1 was on Ozempic and then her insurance would not cover the medication. Staff A stated Ozempic was discontinued. Staff D stated Resident #1 was on Ozempic until 7/17/25. Staff A stated she was told that Ozempic was an insulin. Staff D explained Ozempic was on the insulin medication list when she did the initial training on MDS. On 9/17/25 at 1:48 PM Staff G, Nurse Consultant acknowledged Ozempic was not a type of insulin and would not be identified as insulin on the MDS. Staff G explained Ozempic was not considered an insulin according to the Resident Assessment Instrument (RAI) manual either. Review of policy updated 4/25 titled, Conducting an Accurate Resident Assessment documented the purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas. The appropriate, qualified health professional will correctly document the resident's medical, functional, and psychosocial problems and identifies resident strengths to maintain or improve medical status, functional abilities, and psychosocial status. A registered nurse will coordinate the RAI completion process with the appropriate participation of health professionals. The registered nurse is responsible for certifying that the assessment has been completed.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, document review and staff interviews, the facility failed to refer a resident with a negative Level I result for the Preadmission Screening and Resident Review (PASRR), who had an identified mental disorder, intellectual disability, or other related condition that was not addressed on PASRR completed prior to admission to the facility, to the appropriate state-designated authority for Level II PASRR evaluation and determination for 1 resident (Resident #2) reviewed for PASRR requirements. The facility reported a census of 40 residents.Findings include:The Minimum Data Set (MDS) dated [DATE] documented Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. The MDS revealed Resident #2 had a diagnosis of bipolar disorder upon admission to the facility on 7/10/25.Review of the document dated 7/1/25 titled, Notice of PASRR Level 1 Screen Outcome documented no diagnosis of bipolar under the diagnosis of mental health diagnoses portion of the screening. On 9/17/25 at 10:00 AM Staff D, MDS Coordinator stated bipolar disorder should have been identified on the PASRR for Resident #2 upon admission to the facility. Staff D stated a new PASRR would be completed when there were any medication changes. Staff D stated that PASRR was completed at the hospital for Resident #2 prior to admission to the facility. Staff D stated when residents come to the facility from the hospital she tried to review all diagnoses to ensure the appropriate diagnoses are identified Staff D acknowledged Resident #2 did not have the diagnosis of bipolar disorder on her PASARR that was completed 7/1/25. Staff D explained the diagnosis should have been on the PASRR dated 7/1/25.On 9/17/25 1:58 PM Staff G, Nurse Consultant stated it was her expectation that Resident #2 would have the diagnosis of bipolar disorder documented on the PASSR. Staff G stated the missed diagnosis should have been noticed and submitted upon admission to the facility. Staff G acknowledged Resident #2 had a diagnosis of bipolar disorder. Staff G acknowledged Resident #2's PASSAR dated 7/1/25 did not have the diagnosis of bipolar disorder documented under the mental health diagnoses portion. On 9/17/25 at 5:58 PM the DON documented in an email the facility did not have a policy on PASRR completion.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on clinical record review, observations, staff interviews, and facility policy review, the facility failed to provide respiratory care and services in accordance with professional standards of practice for 1 of 2 residents reviewed (Resident #35) requiring the use of oxygen. The facility reported a census of 40 residents.Findings include: The Minimum Data Set (MDS) for Resident #35 dated 8/8/25 documented admission to the facility on 7/24/23. The MDS documented the need for oxygen in the last 14 days.The Care Plan dated 11/24/23 revealed interventions for respiratory abnormalities related to oxygen dependance to change oxygen tubing on concentrator including humidifier bottle on Sunday night shift. The Medication Administration Record (MAR) for the month of September of 2025 documented an order to change oxygen tubing, humidifier, and clean concentrator every Sunday, every night shift for protocol, start date 6/1/25. Documented dates of completion were 9/7, 9/14. During an observation on 9/15/25 at 3:10 pm the oxygen concentrator in Resident #35's room was set to 1L/min with a humidifier bottle containing sterile water at about 1/4 of the bottle full, dated 9/8/25. The tubing connecting the humidifier bottle to the oxygen concentrator was also dated 9/8/25. The tubing from the humidifier bottle connecting the nasal cannula was dated 9/15/25. Observation on 9/17/25 at 9:50 am revealed the same dates on the humidifier bottle and tubing as on the initial observation. In an interview on 9/17/25 at 10:45 am with Staff M, Licensed Practical Nurse (LPN) stated the tubing was scheduled to be changed every Sunday night and all components of the oxygen therapy needed to be changed and labeled with a date and staff initials. In an interview on 9/18/25 at 11:00 am with the facilities Infection Preventionist, she confirmed Sunday overnight staff were supposed to changed oxygen tubing and humidifier sterile water and date it. Facility provided policy titled Respiratory Equipment Cleaning Procedure updated 11/13/24 documented the following: a) O2 tubing, nasal cannula/mask will be changed weekly. O2 tubing will, also, be changedwhen tubing (nasal prong area) is noted lying on the floor.c) Pre-filled Humidifier bottle needs to be replaced weekly & prn (date and initial). RefillableHumidifier receptacle needs to be cleaned weekly.

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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 observations, Medication Administration Record / Treatment Administration Record (MAR/TAR) review, Electronic Health Record (EHR) review, policy review, and staff interviews the facility failed to provide appropriate infection prevention practices when blood glucose sample was obtained and when providing care to a residents on Enhanced Barrier Precautions (EBP) for 2 of 4 residents reviewed (Resident #4 and #8). The facility reported a census of 40 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. Review of Resident #4's EHR titled, Orders revealed a physician's order with a start date of 3/26/25 for NovoLog injection solution with siding scale 4 times a day.Review of Resident #4's MAR-TAR documented a physician's order with a start date of 3/26/25 for NovoLog injection solution with siding scale 4 times a day.Observation on 9/16/25 at 7:18 AM of Staff C, Registered Nurse (RN) complete the administration of medications to Resident #4 and obtain a blood glucose sample. Staff C obtained insulin pens, completed hand hygiene, applied gloves, utilized alcohol wipe to cleanse the tip of the insulin pen, Staff C wasted 2 units to ensure patency, dialed up basaglar 35 units, knocked on residents door, placed glucose monitor on plastic container on residents bedside table, no barrier placed on the container, medication handed to resident in medication cup, resident self administered oral medication, left room, removed gloves, obtained breathing treatment from medication cart, applied gloves, completed no hand hygiene, entered room, cleansed 5th digit on Resident #4's left hand, obtained blood sample, 169 blood glucose, area on left thigh cleansed with alcohol wipe, insulin administered, placed nebulizer mask on resident, removed gloves, exited the room, opened medication cart, placed insulin back into medication cart, completed hand hygiene, placed blood glucose machine on the medication cart did not cleanse, left blood glucose machine on the medication cart and moved to the next resident's room. On 9/17/25 at 12:00 PM Staff H, Licensed Practical Nurse (LPN) acknowledged all the residents used the same blood glucose machine. Staff H stated after use on a resident the blood glucose machine was wiped down for 5 or 6 minutes with a moist wipe. Staff H stated the blood glucose machine is then wrapped in a wipe and left to sit. Staff H acknowledged the sanitization wipes that were utilized had directions that documented once item was cleansed it was to remain wet for 2 minutes to be effective in sanitization.On 9/17/25 at 6:52 PM the DON stated she expected there would have been a barrier placed when the glucose machine was brought into the room and the glucose machine should be cleaned once the machine was returned to the medication cart and left moist for 2 minutes according to the cleansing wipes. On 9/18/25 at 8:11 AM Staff A, LPN stated after taking the resident's blood glucose sample she would wipe the blood glucose machine with an alcohol wipe on the outer surface and put the machine back in the drawer. On 9/18/25 at 1:21 PM Staff I, Infection Preventionist stated she would like to see the facility move to have individual blood glucose machines for each resident the required blood glucose monitoring. 2. The Minimum Data Set (MDS) dated [DATE] documented Resident #8 had a Brief Interview for Mental Status (BIMS) score of 7 indicating severe cognitive impairment. The MDS also identified skin tears as a wound with the application of nonsurgical dressings.Review of Resident #8's EHR titled, Orders revealed a physician's order with a start date of 8/22/25 to cleanse left upper thigh posterior side area, pat dry, apply xeroform and dry dressing with abdominal pad and secure with kerlix, to be changed daily. A physician's order with start date of 8/21/25 to cleanse right posterior mid-thigh skin tear wound, pat dry, apply Vaseline gauze, cover with abdominal pad and secure with kerlix to be changed daily.Review of Resident #8's MAR-TAR documented a physician's order with a start date of 8/22/25 to cleanse left upper thigh posterior side area, pat dry, apply xeroform and dry dressing with abdominal pad and secure with kerlix, to be changed daily. A physician's order with start date of 8/21/25 to cleanse right posterior mid-thigh skin tear wound, pat dry, apply Vaseline gauze, cover with abdominal pad and secure with (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	kerlix, to be changed daily.Observation on 9/18/25 at 9:40 AM revealed EBP supplies on the wall outside of Resident #8's room.Observation on 9/18/25 at 9:41 AM Staff J, Licensed Practical Nurse (LPN) and Staff K, Certified Nurse Assistant (CNA) completed a dressing change on Resident #8. Staff J and Staff K completed hand hygiene, applied gloves, removed the dressing on the right leg with scissors, removed gloves, completed hand hygiene, applied gloves, cleansed area, removed gloves, completed hand hygiene, applied gloves, applied Vaseline gauze to area on right leg calf, applied an abdominal pad with gauze wrapped loosely, removed gloves, completed hand hygiene, applied gloves, removed the dressing on left upper leg with scissors, removed gloves, completed hand hygiene, applied gloves, cleansed the area on left leg back of thigh, removed gloves, completed hand hygiene, applied gloves, applied xeroform to area, removed gloves, completed hand hygiene, applied gloves, wrapped gauze loosely, removed gloves, completed hand hygiene. On 9/18/25 at 9:54 AM Staff K, CNA acknowledged she should have worn a gown into Resident #8's room. Staff K explained the staff are to wear gowns when interacting with the resident and during wound dressing changes. On 9/18/25 at 9:59 AM Staff G, Nursing Consultant stated the facility's expectation was EBP would have been followed with gowns worn during treatment to Resident #8's dressing change.Review of policy updated 5/11/21 titled, Competency for Cleaning of Glucometers documented Staff member would wear gloves to disinfect the glucometer. Staff would wipe away any visible soil with a sanitizing wipe. Alternatively the meter may be disinfected with a sanitizing wipe per manufacturer's recommended cleansing and drying time. Review of policy updated 11/13/24 titled, Enhanced Barrier Precautions documented the policy of the facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced barrier precautions would be utilized during wound care with any skin opening requiring a dressing change.