

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/21/2025
NAME OF PROVIDER OR SUPPLIER  Accura Healthcare of Aurelia, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  401 West Fifth Street Aurelia, IA 51005	

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 0600  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (continued on next page)

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review the facility failed to ensure that all residents were free from verbal abuse for 1 of 5 residents reviewed (Resident #2.) Staff reported that on several occasions, a Certified Nurse Aide (CNA) addressed Resident #2 in a disrespectful and derogatory manner. The facility reported a census of 34 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #2 had a Brief Interview for Mental Status (BIMS) score of 3 (severe cognitive deficits.) The resident was totally dependent on staff for toileting, dressing, rolling and transfers. She was always incontinent of urine and bowel, and was impaired on both sides of her upper and lower extremities. Diagnoses for Resident #2 included: heart failure, renal insufficiency and quadriplegia. The Care Plan for Resident #2, dated 4/15/25, showed that she was dependent on staff for activities of daily living related to unspecified intellectual disabilities. Staff were to converse while providing care. Resident #2 previously lived in a home for people with intellectual disabilities, and she was unable to care of herself. She required the assistance of two staff with the Hoyer (mechanical lift) for all transfers. Resident #2 could be verbally aggressive, staff were to monitor behaviors when resident became agitated, intervene before agitation escalated. A facility self-report to the Department of Inspections and Appeals and Licensing (DIAL) showed that on 5/1/25, the Executive Director (ED) had been notified that Resident #2 was being verbally abused by Certified Nurse Aide (CNA) Staff F. Staff A, CNA reported that while she and Staff F were transferring Resident #2 with the Hoyer mechanical lift, Staff F said: I hope this hits you in the head and we're not friends, don't call me Buddy. The self report lacked potential dates that the alleged incident occurred. On 10/20/25, Resident #2 was lying in bed as two CNA's prepared to change her brief and transfer her to the wheel chair. When addressed, the resident looked afraid and shook her head no. On 10/20/25 at 12:36 PM, Staff D, CNA said that she heard Staff F say to Resident #2 you need to be put on Hospice and this is why no one comes to visit you. She said that when Staff F would roll the resident over in bed, she would tug the bed pad quick and rough and the resident was afraid of falling. Staff F seemed annoyed by the resident and would just tell the resident to be quiet. On 10/20/25 at 2:04 PM, Staff B CNA, said that Resident #2 would always yell out when they provided incontinence care and transfers, but the resident was not able to swing her arms or hit them. Staff B said that when she and Staff F were transferring the resident with the Hoyer, Staff F threatened to put you down. Staff B interpreted that to mean that she was threatening to drop the resident out of the lift. Staff B said that Staff F said to the resident: You need to be put on hospice and you need to just go already, Staff B did not remember the date of these incidents and said she understood that she should have come forward sooner but she was afraid of retaliation. On 10/20/25 at 12:20 PM, Staff A, CNA, said that Staff F would tell Resident #2 that they weren't friends and she would pull hard on the resident when rolling her in bed. Staff A said that Resident #2 was afraid of falling out of bed and would say; please don't drop me. Staff F seemed annoyed by the resident. When transferring the resident with the mechanical lift into the wheel chair, the bars of the lift often came close to hitting the resident on the head. Staff A said that Staff F would pull back on the sling abruptly when the resident was being lowered down into the wheel chair said; I hope you hit your head on the bar of the lift. A written statement, dated 5/1/25 at 7:34 PM, from Staff H, CNA showed that Staff F was more mean to Resident #2 compared to other residents, more verbally aggressive. Staff H couldn't remember the date it had happened. On 10/21/25 at 12:24 PM, Staff F denied having ever told a resident to shut up and she only suggested that maybe the resident should be on Hospice because it would be a good thing to help her with her anxiety. Staff F said that she had known Resident #2 for over 19 years, worked with her when she was in a group home for intellectual disabilities so she was familiar with how to interact with her. Staff F acknowledged that Resident #2 was afraid of falling when they rolled her in bed, mostly when her head would be down and looking at the floor. Staff F said she just tried to reassure her that we're not going to let you fall. Staff F said that after the allegations in May, she thought it would be best not to care for Resident #2 so there wouldn't be any more false allegations An Employee Corrective Action Form, Written Warning, dated 5/6/25, showed that there were allegations of abuse against Staff F. The expectations were that staff would speak to residents with dignity, respect and to provide great customer services. Staff F was re-educated on the facility abuse policy and she was assigned education on abuse prevention to be completed before returning to work. The written report showed that Staff F had been confronted about her treatment of Resident #2. Staff F responded that she had known the resident for a long time and I just know</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and policy review the facility failed to report allegations of abuse in a timely manner for 1 of 1 residents reviewed. On 5/1/25, several staff members reported that Staff F was rude and verbally abusive to Resident #2. They did not have dates and times as to when these incidences occurred. The facility reported a census of 34 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #2 had a Brief Interview for Mental Status (BIMS) score of 3 (severe cognitive deficits.) The resident was totally dependent on staff for toileting, dressing, rolling and transfers. She was always incontinent of urine and bowel, and was impaired on both sides of her upper and lower extremities. Diagnoses for Resident #2 included: heart failure, renal insufficiency and quadriplegia. The Care Plan for Resident #2 dated 4/15/25, showed that she was dependent on staff for activities of daily living related to unspecified intellectual disabilities. Staff were to converse while providing care. Resident #2 previously lived in a home for people with intellectual disabilities, unable to care of herself. She required the assistance of two staff with the Hoyer (mechanical lift) for all transfers. Resident #2 could be verbally aggressive, staff were to monitor behaviors when resident became agitated, intervene before agitation escalated. A facility self-report to the Department of Inspections and Appeals and Licensing (DIAL) showed that on 5/1/25, the Executive Director (ED) had been notified that Resident #2 was being verbally abused by Certified Nurse Aide (CNA) Staff F. Staff A, CNA reported that while she and Staff F were transferring Resident #2 with the Hoyer mechanical lift, Staff F said: I hope this hits you in the head and we're not friends, don't call me Buddy. The self-report lacked potential dates that the alleged incident occurred. On 10/20/25 at 2:04 PM Staff B said that Staff F was disrespectful and rough with Resident #2. She did not know the dates that this had occurred and said she knew she should have come forward sooner but she was afraid of retaliation. A written statement dated 5/1/25 at 7:34 PM from Staff H, CNA showed that Staff F was more mean to Resident #2 compared to other residents, more aggressive verbally. Staff H couldn't remember when it happened. On 10/21/25 at 11:00 AM, the Director of Nursing (DON) said that they were made aware of the concerns with Staff F, on 5/1/25 but they did not know the date or dates when the incidents occurred. She said the staff that had concerns were educated about the importance of reporting allegations of abuse immediately. 10/21/25 1:10 PM the administrator said that the staff had all been educated on the facility abuse prevention policy and the importance of reporting concerns immediately. A facility policy titled: Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy; Mental abuse was defined as use of verbal or nonverbal conduct which caused or potential to cause the resident to experience humiliation, intimidation fear shame agitation or degradation. All allegations of resident abuse, neglect exploitation mistreatment injuries of unknown origin and misappropriations would be reported immediately to the charge nurse. The charge nurse would be responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative. All allegation of resident abuse would be reported to Iowa Department of Inspections and Appeals no later than two hours after the allegations was made.</p>		