STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165549	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Ottumwa	Three Pennsylvania Place Ottumwa, IA 52501

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 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. Based on clinical record review, observation, facility policy review and staff interview, the facility failed to ensure staff respected the dignity of residents while transporting residents to and from the shower room for 3 of 4 observations of residents (Residents #5, #53 and #54) transported to the shower room by staff. The facility reported a census of 53. Findings include:1. The Minimum Data Set (MDS) assessment for Resident #53, dated 7/9/25, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated a severe cognitive impairment. The resident assessed dependent on staff for bathing, and required maximum/substantial assistance for transferring. The MDS listed a diagnosis of diagnosis of dementia. Review of the Care Plan, last revised 7/10/25, identified Resident #53 dependent on staff for meeting emotional, intellectual, physical, and social needs. The resident required substantial/maximum assistance of one staff for bathing/showering, dependent on assistance of two staff with a gait belt and walker for ambulation, and dependent on one staff for wheelchair use. During an observation on 9/23/2025 at 7:36 AM, Resident #53 sat in a shower chair in the middle of the hallway approximately 8 feet from the shower room. The resident faced the south end of the hall, in the opposite direction of the bathing/shower room. The resident wore a gown, and had been covered with a blanket. Staff A, Certified Nursing Assistant (CNA), approached Resident #53 and pulled the resident backwards in the shower chair approximately 8 feet into the shower room. While pulling the resident backwards, Staff A told the resident she could not push him forward, because the resident's chair did not have foot pedals on it. 2. The MDS assessment for Resident #5, dated 8/6/25, indicated the resident had a BIMS score of 4 out of 15, which indicated a severe cognitive impairment. The resident dependent on staff for showering/bathing, transferring and lower body dressing. The MDS listed a diagnosis of dementia and anxiety. Review the Care Plan, last revised 8/12/25, identified Resident #5 dependent on staff for meeting emotional, intellectual, physical, and social needs. The resident required total assist of one staff for bathing/showering, did not ambulate, required assist of one for wheelchair use, and required total assist with a non-mechanical lift or assist of two staff using a gait belt. During an observation on 9/23/25 at 3:53 PM, Resident #5 sat in a shower chair at the entrance to her room. Staff B, CNA, pulled the resident backwards down the hallway from the resident's room to the shower room approximately 30 feet. During an observation on 9/23/25 at 4:12 PM, Staff B, CNA, pulled Resident #5 down the hallway in a shower chair with the resident facing the opposite direction of the direction pulled. Staff B pulled the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident backwards approximately 30 feet and stopped approximately 5 feet into the resident's room. The resident faced the open doorway, unclothed and covered with a sheet. When the resident shifted in the chair, she exposed herself from her abdomen to her feet. 3. Review of the MDS assessment, dated 8/20/25, revealed Resident #54 had a BIMS score of 10 out of 15, which indicated moderate cognitive impairment. The list of diagnoses included left femur fracture, adult failure to thrive, and adjustment disorder with depressed mood and anxiety. The MDS indicated Resident #54 required substantial to maximal staff assistance for bathing and transfers. Review of the Care Plan, last revised on 6/24/25, revealed Resident #54 required 1 staff, partial to moderate amount of assistance, for showering twice weekly and as necessary. During an observation on 9/23/25 at 1:06 PM, Staff A, CNA, transported Resident #54 in a shower chair through the hallway with a bath sheet placed over resident's lap. Staff A turned the shower chair to enter the shower room and Resident #54's unclothed left side, from her hip to foot was exposed During an interview on 9/24/2025 at 1:39 PM, Staff A, CNA, reported that when she placed the residents in shower chairs to transport to and from the shower, she would pull the resident down the hall backwards with the resident facing the opposite direction she was pulling. Staff A explained if she pushed a resident forward in the shower chair, the residents would be at risk of putting their feet down and breaking their feet. During an interview on 9/24/25 at 2:55 PM, Staff C, CNA, explained she thought staff treated residents with dignity and respect. Staff C reported that when she assisted residents with showers, she pushed them in their wheelchair to the shower and transferred them to the shower chair while the resident was in the shower room. During an interview on 9/25/25 at 8:50 AM, when asked how staff should transport residents to the shower room, the Director of Nursing (DON) stated that she knew the question was in regards to a resident being drug down the hall backwards in the shower chair. The DON explained that the Assistant Director of Nursing (ADON) had told her about seeing a staff pull a resident backwards in a shower chair on Tuesday (9/23/25). The DON reported that the staff had not received any official direction and the DON had no expectation for how the staff transport the residents to the shower room. The DON explained her only expectation was that the resident's got their shower. The DON reported the shower room in the 100 hall was not big enough for a mechanical lift, wheelchair and shower chair, and staff would have to use the shower room in the 200 or 300 hallways. The DON explained this could create a problem with staff being able to get all of the residents' showers done. During an interview on 9/25/2025 at 9:07 AM, the ADON reported she saw Staff A, CNA, pull a resident in a shower chair backwards down the hall. The ADON reported staff should not pull people down the hallway backwards, and explained this was a dignity concern. The ADON reported she provided education to Staff A, CNA. The ADON reported she reminded Staff A to take the residents in a wheelchair to the shower room and transfer them to the shower chair in the shower room. Remind to take in a w/c to the shower and transfer them there. Review of an undated facility policy, titled Shower Policy, directed the staff to take the residents to the shower room, remove the residents' clothing and transfer them to the shower chair in the shower room.