STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165568	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Cascade LLC	701 North Johnson Street NW Cascade, IA 52033

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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interviews, and facility policy review the facility failed to protect the resident's right to be free from physical abuse by a staff member for one out of one resident reviewed (Resident #14), when staff physically forced a resident to transfer. This deficient practice resulted in a bruised arm for Resident #14. The facility identified a census of 42 residents. Findings include: Review of Resident #14's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severely impaired cognitive skills for daily decision making. Per the MDS, the resident had a short and long term memory problem. The MDS did not have any behaviors indicated. The resident's diagnoses included heart failure, high blood pressure, Non-Alzheimer's Dementia, arthritis, and osteoporosis . The MDS indicated Resident #14 was independent with sit to stand transfer, chair to chair or bed transfer, and independent to walk 50 feet with two turns. Review of Resident #14's Care Plan revealed a focus area of self care deficit revised on 7/7/25. The intervention dated 9/18/24 revealed the resident was independent for bed mobility. The intervention revised 4/12/25 revealed for transfer/ambulation, Resident #14 was independent in room with cane. Independent in hallway with front wheeled walker. The care plan intervention dated 7/7/25 directed staff to continue to encourage compliance with cares. Send different staff, try at a later time, etc. Review of the resident's Care Plan revealed a focus area revised 10/6/25 that the resident had exhibited delusional thought processes. The intervention dated 12/10/24 directed staff to encourage Resident #14 to come to meals. If she refuses, encourage to sit up at the table in her room instead of sitting on the bed. Review of Resident #14's progress dated 4/23/26 at 5:41 PM revealed Power of Attorney (POA) notified via telephone of allegations of abuse. A staff member reported witnessed another certified nursing assistant (CNA) grab resident by both arms and yanked her out of her chair after Resident #14 said no when asked if she wanted to go to supper .Informed POA Resident #14 is complaining her arm hurts but will no longer allow staff to visualize her arm .Resident was sitting at the supper table feeding herself when this author observed her. Review of documentation from a Facility Self Report Investigation revealed, in part, the following per the timeline of incident: .On 4/23/26 at approximately 4:31 PM, Registered Nurse (RN), [Staff B], notified Director of Nursing, [Name Redacted] that a Certified Medication Aide/Certified Nursing Assistant (CMA/CNA) [Staff D] reported she witnessed CNA [Staff E] grab resident [Resident #14] by both arms and yank her out of her chair after resident stated no she didn't want to go to supper. On 4/23/26 at approximately 4:32 PM, DON, [Name Redacted], called nurses station 2 and informed Licensed Practical Nurse (LPN), [Staff F] to go visualize resident and check residents arms. The Facility Self Report Investigation further revealed, On 4/24/26 at approximately 4:45 PM, Executive Director, [Name Redacted] and Director of Nursing, [Name Redacted], called CNA [Staff D] in for questioning. During that conversation [Staff D] reported [Staff D] heard a commotion and when [Staff D] looked over [Staff E] was grabbing resident by both arms, yanking her up out of the chair. [Staff D] had heard [Resident #14] tell her she didn't want to get up for supper. [Staff D] told her to stop and she could eat her supper where she was. [Resident #14] started hitting her and [Staff D] don't blame her after seeing that incident (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
	165568	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Cascade LLC	701 North Johnson Street NW Cascade, IA 52033

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 - Actual harm Residents Affected - Few	DON, [Name Redacted], asked [Staff D] to demonstrate what [Staff D] observed so staff had an accurate description of hand placement. [Staff D] demonstrated by placing her hands on [DON]'s arms. [Staff D] stated it was excessive and over the top. The Facility Self Report Investigation further revealed, On 4/24/26 at approximately 4:51 PM, Executive Director, [Name Redacted] and Director of Nursing, [Name Redacted], called CNA [Staff E] in for questioning. During that conversation [Staff E] stated that she was unaware of any incidents that occurred that she would need to be questioned about. When Executive Director, [Name Redacted], asked [Staff E] if resident [Resident #14] wanted to go to supper, [Staff E] responded no. Executive Director, [Name Redacted] then asked CNA [Staff E] if resident went. CNA [Staff E] responded yes. Executive Director, [Name Redacted], asked CNA [Staff E] how did that interaction go, how did you get her to supper? [Staff E] responded I did a pivot transfer, she put her arms around my neck, I stood her up and turned her so she could sit in her wheelchair.Review of a Reporting Officer Narrative dated 4/23/26 at 6:15 PM revealed, in part, [Staff E] was reported to have begun aggressively pulling on [Resident #14's] arms in an attempt to get her to stand up which caused [Resident #14] pain .[Resident #14] was spoken to about the incident where she was unable to recall much of the incident. [Resident #14] was however was able to recall that when [Staff E] was pulling on her arms it caused her pain. [Resident #14] stated, It hurt like h*ll. As mentioned above, upon speaking to [Resident #14] further, she was unable to recall any of the incident outside pain being caused to her arms. Review of Resident #14's progress note dated 4/23/26 at 7:36 PM revealed, .Resident did state to the sheriff that it hurt at the time but it doesn't hurt now. Review of Resident #14's progress note dated 4/23/26 at 7:54 PM revealed a full head to toe assessment completed at 6:00 PM. The skin section noted skin was warm, dry and intact, with 2 new bruises noted on left forearm. Review of the wound sheet for Resident #14 dated 4/23/26 revealed a new wound, in-house acquired, to the left (L) outer forearm. The wound was described as bruising which measured 0.84 centimeters (cm) by 0.99 cm length. Another wound sheet dated 4/23/26 revealed a second bruise, in house acquired, on the L outer forearm which measured 1.28 cm length by 1.29 cm width. On 5/26/26 at 11:45 AM, Resident #14 sat on a couch in main area, got up per self with cane, and ambulated independently to the table for the meal in the main area. Observation revealed the resident's gait steady, and no difficulty noted with transfer. On 5/27/26 at 12:12 PM, Staff D stated she worked on 4/23/26 with Staff E and she was in the common area of the dementia unit. She heard Staff E tell Resident #14 to get up off the couch for supper. Staff D observed Staff E pulling on Resident #14's forearms. Resident #14 twisted and turned and attempted to get away from Staff E. Staff E did not have a gait belt on Resident #14 and she pulled on her arms. Staff D attempted to tell Staff E could make accommodation and to leave Resident #14 alone. She repeated this three times and Staff E told her Resident #14 had to go to supper. Staff D revealed she observed Staff E physically try to pick up Resident #14 with one arm between residents leg and one on her side and physically force her into a wheelchair. Resident #14 got ahold of her cane, swung it, and tried to hit Staff E. Prior to this incident Resident #14 did not have behaviors. On 5/27/26 at 1:23 PM, Staff E stated she transferred Resident #14 and she refused at first so Staff E left and then Staff E came back to Resident #14. Staff E talked to her and she agreed to transfer to a wheelchair. Staff E gently put her arms around Staff E's neck and then Staff E put her arms under her arms and gently lifted her up and turned her to a wheelchair. Resident #14 was in the main area in the dementia unit and she was sitting on the couch. Staff E explained Resident #14 did hit Staff E, but Staff E really don't why [Resident #14] hit her and then after it she was fine. Staff E explained might have startled her but that was not Staff E's intention. Staff E explained did not reach for her arms. Staff E explained the resident hit her with just her hand. The cane was put to the side and Staff E did give her cane back when Staff E got her in the wheelchair. Staff E explained she did not use a gait belt because she (resident) was independent with transfers. Normally she was independent. Staff E asked her if she wanted help and she said yes is why Staff E assisted her with the transfer. She stated she had no history of problems with Resident #14. On 5/27/26 at 1:37 PM, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165568	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Cascade LLC	701 North Johnson Street NW Cascade, IA 52033

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 - Actual harm Residents Affected - Few	Staff G, Registered Nurse (RN) stated Resident #14 transferred independently. Staff G explained didn't know if Resident #14 would vocally come out and ask for assist. Staff G explained if the resident looked like she was having hard time getting off the couch Staff G would assist. Staff G revealed Resident #14 didn't frequently need assistance, and Staff G explained didn't even know if in the past 4 months Staff G had even provided assistance with her. Per Staff G, the resident used a cane and was pretty mobile. On 5/27/26 at 2:24 PM Staff H, LPN stated about Staff E sometimes it would be more her tone how she would talk to residents and you addressed that with her and she would improve around me. Staff H did talk to her multiple times regarding her tone with residents. Staff H had one CNA report to Staff H that she didn't like the way Staff E was talking to someone, and Staff H explained reported it to the Administrator and they investigated it. On 5/27/26 at 2:35 PM, Staff J, Licensed Practical Nurse (LPN) revealed they did work with Staff E, and there were complaints about her from the residents and staff. The residents would complain that she was very quick and she would not slow down to listen. Sometimes residents would say she was little bit rougher with transfers and we did educate her on transfers and techniques and repositioning and Staff J felt that got better. Per Staff J, didn't think told Administration about it because it would happen, Staff J would talk to Staff E about it, and it would get better. Staff J explained did remember asking for her not to be in the Alzheimer's unit because she had a very excitable energy and the residents would feed off of that. It was quite a while ago and it was when she became a certified medication aide. Staff J further explained she thought it was a prior Director of Nursing that Staff J discussed it with at the time. They didn't put her back there for a while and then they did schedule her for it again. On 05/27/26 at 2:42 PM Staff I, CNA reported worked with Staff E and she did her work but she would try to get things done quick. Staff E was always in a hurry. Staff I stated she would rush the residents and would try to hurry them along. Everyone noticed it and the nurses would see it, Staff I knew she was talked to about taking a breath and to slow down with cares. On 5/27/26 at 2:51 PM Staff F, LPN reported she worked on 4/23/26 and Staff D reported to her Staff E picked up Resident #14 by the arms aggressively. Staff F explained she reported it to the Director of Nursing (DON) and went to do an assessment. Resident #14 complained of right arm pain and on the left arm she had a bruise. Staff F was not sure of the time but the minute Staff F was told about it, Staff F reported it to the DON and the Administrator. The DON and the Administrator started the investigation. Staff F revealed had worked with Staff E in the past and she was very rough with the residents. We had to tell her multiple times not to yell at the residents and not be so rough. We had told her multiple times not to be doing that. Per Staff F, had told the DON about it and Staff F was not sure what came of it. Staff F explained heard her yell at residents but did not see her be aggressive, but others had reported it to Staff F. Staff F did hear her yell at them and Staff F would have to tell her not to do that. On 5/27/26 at 3:30 PM, Staff K, LPN stated she had worked with Staff E, and Staff K did not like her working in the dementia unit as she did not understand the dementia residents. Staff K explained thought Staff E felt if she gave a simple direction they should be able to follow it. Staff K didn't think she (Staff E) had the patience to be working with dementia residents. Staff K had expressed it to a prior DON a few times. Staff K confirmed told the prior DON 3 -4 other times about Staff E not appropriate to work with dementia residents. Staff K was not aware of any time they had not let Staff E work in the Alzheimer's unit. Staff K just felt she did not have the understanding or the patience to work with residents on the dementia unit. On 5/28/26 at 9:05 AM, Staff L, CNA revealed Resident #14 transferred independent and supervision. Staff L had not had to provide assist to Resident #14 for her to transfer. Staff L did work with Staff E and it appeared to Staff L she was always in a hurry, she was demanding of the residents, and not giving them a chance to do things on their own. For example, she would not wait for a resident to move herself and Staff E would be in a hurry and would want to help her stand up. On 05/28/2026 at 9:46 AM, Staff M, CMA, Business Office Manager stated she also worked in a Human Resource role. She revealed she did not do the disciplinary actions, the supervisors were responsible for them. There was incident when Staff M was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165568	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Cascade LLC	701 North Johnson Street NW Cascade, IA 52033

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 - Actual harm Residents Affected - Few	working in the Alzheimer's unit as medication aide where a resident did not want Staff E in his room he would not elaborate on it. Staff M informed the nurse and the Administrator. Staff M did Staff E's termination paperwork but no disciplinary actions. On 5/28/2026 at 10:31 AM, the DON revealed worked on 4/23/26. She got a phone call from the nurse that night and was told a CNA reported Staff E grabbed Resident #14 and pulled her up. Staff D reported it was rough and Resident #14 did not want to get up. The DON directed the nurse to do an assessment. We initiated an abuse investigation. Prior to this incident Staff E would need some direction she would get flustered and you would have to guide her to settle down but the DON had never seen her be rough with resident. There were no reports from staff about her behavior until this one reported to her by the nurse (Staff F). The DON denied Staff E ever had any disciplinary actions. The DON stated she was not aware of how Staff E treated or talked to residents prior to this incident. After the incident staff were talking about Staff E's behaviors. The DON stated she would expect staff to treat residents with respect and when you enter their room it is like entering their house. Per the DON, provided education recently for the entire staff 3/11/26 about gentle care and dignity. The prior DON said she did 1:1 education about not talking over residents and the DON went through past DON paperwork and found she had only one signed. The DON wanted staff to know her expectations going forward as the DON. On 5/28/26 at 10:52 AM, the Administrator revealed on 4/23/26 she was informed by the DON that a CNA had made a comment with concerns about an incident in the unit. We immediately started an investigation, separated Staff E from the residents, and subsequently she was terminated. The outcome of our investigation was decided to terminate her position within corporation due to the lack of professionalism and the allegation of abuse. On 5/28/26 at 11:28 AM, Staff M, RN reported she worked with Staff E and she was very incompetent. She was inappropriate with family and residents. Staff M stated with providing cares Staff E was very rough and the residents would complain she was rough with cares. For example, she just would just push and pull residents instead of asking them to grab the bed rail she would just shove the residents over on their side. She didn't do her cares, residents would be wet after she said she would have completed them. Per Staff M, did tell administration about these concerns multiple times. The two prior DON were both told of concerns. Review of employee file for Staff M revealed a hand written note from Staff M dated 6/24/25 addressed to management which stated as licensed RN, Staff M would not train or supervise Staff E as a CMA. Per the letter, Staff M had witnessed too many red flags with her as a CNA. The letter expressed, in part, Many staff and residents have complained about her incompetence, then nothing is done. She is rude and rough with residents. Review of employee file for Staff E revealed no disciplinary actions regarding care provided to residents or any incidents mentioned by coworkers during interviews. The employee file did have a employee termination worksheet dated 5/1/26 for termination date 5/1/26. The termination reason was abuse. The facility provided a policy titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy updated 10/19/22 directed Physical abuse includes, but is not limited to, hitting, slapping, pinching, and kicking. It also includes corporal punishment when used to correct or control behavior, including but not limited to, pinching, spanking, slapping of hands, flicking, or hitting with an object.The policy further revealed, Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165568	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Cascade LLC	701 North Johnson Street NW Cascade, IA 52033

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, staff interviews, and facility policy review the facility failed to ensure a nurse remained with a resident after medications were provided to the resident for one of three residents reviewed (Resident #7). The facility reported a census of 42 residents. Findings include: The Minimum Data Set (MDS) Resident #7 dated 3/4/26 listed diagnoses of atrial fibrillation, heart failure, diabetes mellitus (DM), Schizophrenia, and Post Traumatic Stress Disorder (PTSD). The Brief Interview for Mental Status (BIMS) showed a score of 15 out of 15, which indicated intact cognition. The Care Plan for Resident #7 revealed a current intervention to give medications as ordered.On 5/27/26 at 8:10 AM, Staff B Registered Nurse prepared the oral medications scheduled for Resident #7. At 8:24 AM, Staff B walked over to Resident #7 as Resident #7 sat at the dining room table with two other residents.Staff B set the pill cup that held 17 different medications down on the table next to Resident #7. Staff B reported she could leave her medication here, Resident #7 liked to take her pills on her own. Staff B walked back to the medication cart and continued to administer medication to other residents in the dining room. The nurse's back was turned away from the resident several times.On 5/27/26 at 8:58 AM, Resident #7 called out she took all her pills.On 5/27/26 at 3:50 PM, Staff C, Licensed Practical Nurse reported none of the resident in the front were able to self-administer medications. She said she would give Resident #7 her medications and as long as she was out in the dining room. Staff C reported she would keep an eye on her, but kept working as Resident #7 took her medication.On 5/28/26 at 8:46 AM, Staff A, Certified Medication Aide reported she knew not to leave meds with the resident to take independently. She reported they needed to watch the resident take all the medication when administered. On 5/28/26 at 10:08 AM, the Director of Nursing reported the nurses were expected to stay with and watch them to ensure all medication was taken. Walking away from a resident with a cup of medication was unacceptable.The facility provided a policy titled Medication Administration dated 12/3/25, which directed to observe resident consumption of medication.