


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165535	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/21/2025
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NAME OF PROVIDER OR SUPPLIER Accura Healthcare of Aurelia, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 401 West Fifth Street , Aurelia, Iowa, 51005
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F0000 X DC	<p>INITIAL COMMENTS</p> <p>Correction date: <u>10/21/2025</u></p> <p>The following deficiencies resulted from investigation of complaints #2612085-C, conducted October 20, 2025 to October 21, 2025.</p> <p>Complaints #2612085-C resulted in deficiencies.</p> <p>See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.</p>	F0000	<p>PLAN OF CORRECTION</p> <p>This plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.</p>	
F0600 SS = D	<p>Free from Abuse and Neglect</p> <p>CFR(s): 483.12(a)(1)</p> <p>§483.12 Freedom from Abuse, Neglect, and Exploitation</p> <p>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>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.</p>	F0600	<p>1 Accura Healthcare of Aurelia corrected the deficiency by ensuring safety of Resident #2 and all like residents on 5/1/25. Staff F was re-educated on the Accura Nursing Facility Abuse Prevention Identification Investigation and Reporting Policy and assigned Abuse Prevention education to be completed prior to returning to work. Staff F was also given a written warning.</p> <p>2. To correct the deficiency and to ensure the problem does not recur all staff were educated on 5/2/25 and 10/21/25 on the facility Abuse Prevention Identification Investigation and Reporting Policy by the ED. The DON and/or designee will audit residents for freedom from abuse and neglect 4 times per week for 4 weeks, 3 times per week for 4 weeks, 2 times per week for 2 weeks, 1 time per week for 2 weeks, then PRN to ensure continued compliance. The DON and/or designee will audit staff knowledge of the Accura Abuse Prevention Identification Investigation and Reporting Policy 3x a week for 4 weeks, 2x a week for 4 weeks, 1x a week for 4 weeks then PRN to ensure continued compliance</p> <p>3. As part of Accura Healthcare of Aurelia's ongoing commitment to quality assurance, the DON and/or designee will report identified concerns quarterly through the community's QA Process.</p>	10/21/2025

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 reverse for further 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 <i>Administrator</i>	(X6) DATE <i>10/19/25</i>
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F0600 SS = D	<p>Continued from page 1</p> <p>Findings include:</p> <p>According to the Minimum Data Set (MDS) dated 7/29/2025, 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.</p> <p>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.</p> <p>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.</p> <p>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."</p> <p>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.</p>	F0600		

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F0600 SS = D	<p>Continued from page 2</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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"</p>	F0600		

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F0600 SS = D	<p>Continued from page 3</p> <p>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 how she is." Management counseled her to consider her tone and how it may be perceived by other staff and visitors. Staff F and Management agreed that she would not to work with Resident #2 for the time being.</p> <p>On 10/21/25 at 8:30 AM, the ED and the Director of Nursing (DON) stated that they were first informed of the concerns with Staff F on 5/1/25 but did not have dates that the incidents had occurred. The ED said that a family member for Resident #2 reported that when the resident was in the group home, they had to treat her as if she was a 4-year-old. The ED responded that this was not acceptable in the nursing home environment.</p> <p>A facility policy titled: Freedom From Abuse Notice to Employees Resident/Patient Abuse, Neglect and Mistreatment of Belongings. Among the rights specified in the federal and state laws, each resident and patients had the right to a dignified existence and to be free from verbal, sexual, physical or mental abuse; Abuse included but not limited to: verbal abuse, oral, written, gestures language, including sarcastic remarks and derogatory statements, directed to residents' family members or significant others.</p>	F0600		
F0609 SS = D	<p>Reporting of Alleged Violations</p> <p>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the</p>	F0609	<p>1 Accura Healthcare of Aurelia corrected the deficiency by reeducating staff member B on 5/2/25 on the abuse policy and timely reporting by the ED.</p> <p>2. To correct the deficiency and to ensure the problem does not recur all staff were reeducated on 5/2/25 on the Abuse Policy and Timely Reporting by the ED. The DON and/or designee will audit staff knowledge of timely abuse reporting 4 times per week for 4 weeks, 3 times per week for 4 weeks, 2 times per week for 2 weeks, 1 time per week for 2 weeks,, then PRN to ensure continued compliance.</p> <p>3. As part of Accura Healthcare of Aurelia's ongoing commitment to quality assurance, the DON and/or designee will report identified concerns quarterly through the</p>	10/21/2025

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165535

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
10/21/2025

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Accura Healthcare of Aurelia, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
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F0609 SS = D	<p>Continued from page 4 allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>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.</p> <p>Findings include:</p> <p>According to the Minimum Data Set (MDS) dated 7/29/2025, 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.</p> <p>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.</p>	F0609		

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F0609 SS = D	<p>Continued from page 5</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	F0609		

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F0609 SS = D	Continued from page 6 Inspections and Appeals no later than two hours after the allegations was made.	F0609		