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 01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Aurelia, LLC	401 West Fifth Street , Aurelia, Iowa, 51005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 X DC	INITIAL COMMENTS Correction date:01/30/2026 The following deficiencies resulted from the facility's annual recertification survey conducted January 26, 2026 to January 29, 2026. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F0000	**PLAN OF CORRECTION** 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.	
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F0580	1 Accura Healthcare of Aurelia corrected the deficiency by notifying resident #2's physician of refusals to wear BIPAP and request to discontinue BIPAP order due to nonuse and resident's preference. 2. To correct the deficiency and to ensure the problem does not recur, all staff were provided with 1:1 education on following physician orders, notifying the provider of 3 or more refusals and documenting any changes on 1/29/26 or prior to their next scheduled shifts. The DON and/or designee will audit progress notes and MAR/TAR reports to ensure that any refusals are followed up with proper notification to the provider 3x a week for 4 weeks, 2x a week for 4 weeks, 1x a week for 4 weeks then PRN. 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.	01/29/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Executive Director	2/20/24

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 01/29/2026

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F0580 SS = D	Continued from page 1 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on a review of the clinical record, facility policy, and staff interviews, the facility failed to notify the physician when a resident with a history of cardiac and pulmonary conditions and oxygen dependence stopped using a Bilevel Positive Airway Pressure (BIPAP) machine at night for 1 of 12 residents reviewed. The facility reported a census of 35 residents. Findings include: The Minimum Data Set (MDS) assessment dated 1/8/25 for Resident #2 documented diagnoses of congestive heart failure (CHF), Chronic Obstructive Pulmonary Disease (COPD) and centrilobular emphysema. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. The Clinical Physician Orders dated 9/3/25 for Resident #2 showed the following:BiPAP on at bed time and off in the morningOxygen 3 liter per nasal cannula COPD and centrilobular emphysemaDuo Neb breathing treatments twice a day for COPDFluticase-Salmeterol inhaler twice	F0580		

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F0580 SS = D	Continued from page 2 a day for COPDPrednisone tablet daily for COPDTorsmide tablet daily for CHFEmpagliflozin tablet daily for CHFAlbuterol Sulfate inhaler every 6 hours as needed for shortness of breath and wheezing The Care Plan for Resident #2 revised on 8/15/25 showed the resident had a history of CHF, COPD, high blood pressure and arterial fibrillation (irregular heart rhythm). The goal for Resident #2 included the resident will not require hospitalization for her condition. The Care Plan lacked BiPAP usage and information. During an interview on 1/27/26 at 2:25 PM, Resident #2 reported the pulmonologist ordered her to wear a BiPAP at night related to CHF, COPD, and emphysema. When asked about the BiPAP location, the resident reported placing the device on a shelf due to personal preference not to use the machine because the mask fit poorly, despite trying several different masks. When asked about the duration it had been on the shelf, the resident stated at least three months. Upon clarification regarding nonuse during that period, the resident stated, "No, I haven't worn it at all for about three months." During an interview on 1/28/26 at 1:27 PM, Staff A, Certified Nursing Assistant (CNA), reported working the night shift in October when the resident began inconsistent BiPAP use. Staff A reported the resident stated, "I don't like it." Staff A further reported that in November the resident "stopped using it altogether." Review of the December 2025 and January 2026 Treatment Administration Record (TAR) failed to accurately reflect BiPAP usage. During an interview on 1/27/26 at 2:47 PM, the Director of Nursing (DON) reported learning of Resident #2's nonuse of the BiPAP "today." When asked if she knew the resident reported not using the BiPAP for the past three months, the DON stated, "No." When asked whether staff inaccurately documented BiPAP use, the DON stated, "I haven't looked at it." When asked if she felt physician notification was necessary, the DON reported yes. When asked why physician notification was necessary, the DON stated the resident could have breathing issues. During an interview on 1/28/25 at 9:45 AM, the DON stated, "They need to document that the resident refused the treatment and notify the physician." The DON also indicated notification was necessary because, if needed, the resident wanted to be resuscitated, and	F0580		

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F0580 SS = D	Continued from page 3 staff recently had a code. During an interview on 1/28/26 at 12:15 AM, the DON reported the facility failed to have a policy regarding physician notification and that the facility followed the standards of care.	F0580		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review and staff interview, the facility failed to refer 1 resident with a negative Level I result for the PreAdmission Screening and Resident Review (PASRR), who was later identified with newly evident or possible serious mental disorder, intellectual disability, or other related condition, to the appropriate state-designated authority for Level II PASRR evaluation and determination for 1 out of 2 residents (Resident #27) reviewed for PASRR requirements. The facility reported a census of 35 residents. Findings include: The Minimum Data Set (MDS) assessment dated 11/12/25 for Resident #27 documented diagnoses of dementia, Anxiety Disorder, adjustment disorder with depressed mood, depression and suicidal ideations. The MDS included a Brief Interview for Mental Status (BIMS)	F0644	1Accura Healthcare of Aurelia corrected the deficiency by submitting a new PASRR for resident #27 and reviewing all other current residents' PASRR and updating diagnoses and medications as necessary. 2. To correct the deficiency and to ensure the problem does not recur, the DON and Social Services/Activities Director were provided with 1:1 education on PASRR requirements on 1/29/26. The DON and/or designee will perform random audits to ensure PASRRs reflect the current plan of care, medications and diagnoses of the residents 3x/week x 4 weeks, 2x/week x 4 weeks, 1x/week x 4 weeks then PRN to ensure continued compliance. 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.	01/29/2026

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F0644 SS = D	Continued from page 4 score of 13, which indicated intact cognition. The Medical Diagnosis list for Resident #27 revealed the following diagnoses:General Anxiety Disorder, dated 5/27/25Major depressive disorder, dated 6/12/2Suicidal ideation, dated 7/24/25Adjustment disorder with depressed mood, dated 8/6/25 The Clinical Orders for Resident #27 revealed the following medications:Memantine 2.5 mg tablet for dementia, dated 3/27/25Prozac 40 mg tablet daily for dementia, dated 6/25/25Zyprexa 5 milligram (mg) tablet daily for adjustment disorder with depressed mood, dated 9/7/25 The Telehealth Psych Progress Note dated 1/27/25 for Resident #27 showed the resident received psych services and is scheduled for a future appointment. During an interview on 1/27/25 at 2:47 PM with the Administrator, Director of Nursing (DON), and Social Worker (SW), the SW reported submission of a new PASRR earlier that morning for Resident #27. When asked whether a PASRR should be submitted when a new mental health disorder, mental health medications, and mental health services are present, the SW stated yes. During an interview on 1/28/25 at 9:45 AM, the DON reported asking whether responsibility for resubmission of the PASRR applied to her role. The Administrator instructed that responsibility rested with the Social Worker (SW). The DON further explained that future morning meetings will include team review of medications, new diagnoses, and services to identify the need for PASRR resubmission. During an interview on 1/28/26 at 12:15 AM, the DON reported the facility failed to have a policy regarding PASRRs and that the facility followed the standards of care.	F0644		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F0842	1Accura Healthcare of Aurelia corrected the deficiency by providing 1:1 education to the DON and all staff that documented inaccurate use of the BiPAP during the months of December and January that the medical record must contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress, including his/her response to treatments and/or services, and changes in his/her	01/29/2026

			condition, plan of care goals, objectives and/or interventions. 2. To correct the deficiency and to ensure the problem does not recur, all staff were provided with 1:1 education that the medical record must contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress, including his/her response to treatments and/or services, and changes in his/her condition, plan of care goals, objectives and/or interventions on 1/29/26 or before their next scheduled shifts. The DON and/or designee will perform random audits to ensure there is accurate and complete documentation 3x/week x 4 weeks, 2x/week x 4 weeks, 1x/week x 4 weeks then PRN to ensure continued compliance 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.	

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F0842 SS = D	Continued from page 5 (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for-	F0842		

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F0842 SS = D	Continued from page 6 (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interviews and facility policy review the facility failed to accurately document Bilevel Positive Airway Pressure (BiPAP) machine usage for 1 of 12 residents (Residents #2). The facility reported a census of 34 residents. Findings include: The Minimum Data Set (MDS) assessment dated 1/8/25 for Resident #2 documented diagnoses of congestive heart failure (CHF), Chronic Obstructive Pulmonary Disease (COPD) and centrilobular emphysema. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. The Clinical Physician Orders dated 9/3/25 for Resident #2 showed an order for a BiPAP on at bedtime and off in the morning. During an interview on 1/27/26 at 2:25 PM, Resident #2 reported the pulmonologist ordered her to wear a BiPAP at night related to CHF, COPD, and emphysema. When	F0842		

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F0842 SS = D	Continued from page 7 asked about the BiPAP location, the resident reported placing the device on a shelf due to personal preference not to use the machine because the mask fit poorly, despite trying several different masks. When asked about the duration it had been on the shelf, the resident stated at least three months. Upon clarification regarding nonuse during that period, the resident stated, "No, I haven't worn it at all for about three months." During an interview on 1/28/26 at 1:27 PM, Staff A, Certified Nursing Assistant (CNA), reported working the night shift in October when the resident began inconsistent BiPAP use. Staff A reported the resident stated, "I don't like it." Staff A further reported that in November the resident "stopped using it altogether." Review of the December 2025 Treatment Administration Record (TAR) for Resident #2 showed staff inaccurately documented the resident applied and/or removed the BiPAP every day of the month of December. Review of the January 2025 Treatment Administration Record (TAR) for Resident #2 showed staff inaccurately documented the resident either applied, and/or removed the BiPAP, or failed to document every day of the month of January. During an interview on 1/27/26 at 2:47 PM, the Director of Nursing (DON) reported learning of Resident #2's nonuse of the BiPAP "today." When asked if she knew the resident reported not using the BiPAP for the past three months, the DON stated, "No." When asked whether staff inaccurately documented BiPAP use, the DON stated, "I haven't looked at it." During an interview on 1/28/25 at 9:45 AM, the DON reported reviewing BiPAP usage documentation for Resident #2 and identified inaccurate staff documentation indicating BiPAP use despite resident nonuse. The DON stated, "We are going to have education to remind staff not to get in the habit of documenting things were done. They need to document the resident refused the treatment and notify the physician." During an interview on 1/28/26 at 12:15 AM, the DON reported the facility failed to have a policy regarding documentation and that the facility followed the standards of care.	F0842		
F0880 SS = D	Infection Prevention & Control	F0880	1 Accura Healthcare of Aurelia corrected the deficiency by completing catheter care competencies with all staff.	01/29/2026

			2. To correct the deficiency and to ensure the problem does not recur, 1:1 education on and competencies were completed with all staff on 2/6/26 or prior to their next shift. The DON and/or designee will perform catheter care audits ~~3x/week x 4 weeks, 2x/week x 4 weeks, 1x/week x 4 weeks~~ then PRN to ensure continued compliance. 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.

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F0880 SS = D	Continued from page 8 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F0880		

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F0880 SS = D	Continued from page 9 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, staff interviews and policy reviews, the facility failed to provide proper hand hygiene before and after catheter care for 1 of 2 residents reviewed (Resident #31). The facility reported a census of 34 residents. Findings include: During an observation on 1/28/26 at 1:08 PM, Staff A, Certified Nursing Assistant (CNA), failed to perform hand hygiene prior to donning personal protective equipment (PPE) and emptying urine from the catheter bag, per policy. Staff A then doffed PPE, failed to perform hand hygiene, and proceeded to arrange the catheter bag, privacy bag, and the resident's blanket before exiting the room. The Hand Hygiene Policy last updated on 11/13/24 identified hand hygiene is required immediately before donning and doffing gloves. During an interview on 1/27/26 at 2:47 PM, the Director of Nursing (DON), reported she expected staff to perform hand hygiene immediately before applying gloves and when staff removed gloves.	F0880		

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F0880 SS = D	Continued from page 10 During an interview on 1/27/26 at 3:31 PM, the Infection Preventionist indicated staff are expected to perform hand hygiene prior to putting on gloves, immediately after removing gloves, and when the staff leave the resident's room.	F0880		