STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165425	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Cherokee, LLC	**921 Riverview Drive , Cherokee, Iowa, 51012**

(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: 11/05/2025 The following deficiencies resulted from investigation of complaints #2598710-C, and #1803586-C conducted October 27, 2025 to October 30, 2025. Complaints #2598710-C and #1803586-C resulted in a deficiency. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F0000	Accura Healthcare of Cherokee denies it violated any federal or state regulations. Accordingly, 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 d eficiencies. 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.	
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen	F0550	1. In continuing compliance with F550 Dignity Preserved, Accura Healthcare of Cherokee corrected the deficiency by educating staff on November 5th, 2025, on Promoting and Maintaining Resident Dignity, Nursing Facility Abuse Preventions, Identifications, Investigation and Reporting by the Director of Nursing. 2. To correct the deficiency and to ensure the problem does not recur the Director of Nursing and/or designee will audit employees to ensure understanding of the Accura Healthcare of Cherokee a buse policy 3x a week for 4 weeks, 2 x a week for 4 weeks, 1x a week for 4 weeks then PRN to ensure compliance. The Director of Nursing and/or designee will audit resident responses to being treated with dignity and respect 3x a week for 4 weeks 2x a week for 4 weeks 1x a week for 4 weeks then PRN to e nsure compliance. 3. As part of Accura Healthcare of Cherokee's ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns quarterly through the community's QA Process.	

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	(X6) DATE
Samantha DeWitt	Executive Director	12/16/2025

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F0550 SS = D	Continued from page 1 or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, resident interviews, family interviews, staff interviews, and policy review the facility staff failed to interact with residents in a kind and considerate manner during cares for 2 of 5 residents (Resident #1, and #5) reviewed. The facility reported a census of 33 residents. Findings include: 1. Review of Resident #1's Minimum Data Set (MDS) dated 8/26/25 revealed a Brief Interview for Mental Status (BIMS) score of 10 Indicating moderate cognitive impairment. Interview on 10/28/25 at 2:05 PM with Resident #1 revealed that she could recall something had happened several months ago, but she could not recall the names of the staff and didn't want to say someone was mean and call them by the wrong name. 2. Review of Resident #9's MDS dated 10/1/25 revealed a BIMS score of 12 indicating moderate cognitive impairment. Interview on 10/28/25 at 9:30 AM with Resident #9 revealed that Staff B Licensed Practical Nurse (LPN) does not treat him with dignity and respect. Resident #9 further revealed that Staff B needs to work on their attitude. Review of a facility provided document titled, CNA meeting dated 8/27/25 documented: Complaints: 1. Call lights	F0550		

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F0550 SS = D	Continued from page 2 2. Watch what you are saying to residents-"just wet the bed." 3. Nightshift can get people up. Review of a facility provided document titled, Annual Employee Performance Evaluation dated 7/8/25 for Staff C revealed: 1. Staff C does not accept coaching with a positive outlook, this needs improvement. Review of Staff B and Staff C's personnel files revealed no disciplinary action related to speaking to residents with dignity and respect. Interview on 10/27/25 at 10:55 AM with Staff A LPN revealed that Resident #1 had told her that Staff B LPN does not listen to her. Staff A further revealed that Resident #1 had told her that Staff B and Staff C Certified Nursing assistant (CNA) had told her just to pee herself and then they would clean her up. Staff A then revealed that these issues have been brought to management, and nothing has been done. Interview on 10/28/25 at 8:47 AM with Staff D CNA revealed that she had heard hearsay that staff had asked residents to urinate on themselves and that they would clean it up. Staff D further revealed Resident #9 had a lot of complaints about Staff B, and that grievances had been filled out. Staff D stated while getting report the past weekend that Staff B had stated Resident #9 had hit his call light three times wanting to get up and Staff B stated she was making a point to wait until the morning shift got Resident #9 up. Staff D revealed that she had also heard Staff B, and Staff C were taking resident's call lights away from them. Staff D stated Staff E CNA was about to quit related to nothing being done with Staff B, even with it being turned into management. Interview on 10/28/25 at 9:09 AM with Staff F CNA revealed that Staff B would sometimes come across as rude with her tone. Interview on 10/28/25 at 10:21 AM with Staff G LPN revealed that she had heard of Staff C not answering call lights. Staff G further revealed that she has heard these complaints have gone to the management team. Interview on 10/28/25 at 12:30 PM with Staff C revealed that she had heard Staff B tell Resident #1 to just go ahead and pee yourself, and that they would clean	F0550		

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F0550 SS = D	Continued from page 3 Resident #1 up afterwards. Staff C stated that there was a staff meeting about staff to staff and staff to resident interactions about how they talk to one another. Interview on 10/28/25 at 2:20 PM with the Director of Nursing (DON) revealed that staff and a family member stated that a CNA had taken the call lights from a resident. The DON stated she went and talked with the family member and the staff. The DON further revealed that she did a follow up visit with the family member. The DON revealed it is a concern if staff were telling residents to urinate themselves, and this would be a dignity issue. The DON then revealed that she does get complaints about the gruffness of Staff B. Interview on 10/28/25 at 3:05 PM with Staff B revealed that she had never heard of any staff withholding call lights from residents. Staff B stated she had heard through a day shift staff member that Staff C had told a resident to go ahead and urinate on themselves and that they would clean that resident up afterward. Staff B heard that it happened on a shift they were working, but did not witness or hear Staff C say this. Interview on 10/29/25 at 1:39 PM with Staff E CNA stated during an all staff meeting on 8/27/25 that it was brought up that Staff B and Staff C made Resident #1 urinate in her bed. Staff E further revealed that Staff B and Staff C had moved the call light out of Resident #1's reach. Follow up interview on 10/29/25 at 1:50 PM with the DON revealed that she conducted the meeting on 8/27/25. The DON stated that there were issues with the night shift not getting residents up as often as they should. The DON then revealed that there was an incident where she was told that one of the CNAs took a resident's call light away. The DON stated she was never told which CNA it was as the complaint came from a resident's daughter. The DON confirmed this was for Resident #1. The DON revealed the resident's daughter had reported the complaint to her on the 23rd or 24th of October. The DON revealed that this was not filled out in a grievance form, and that the daughter was upset about the situation. The DON reported that she offered to come in and talk to the daughter, and the daughter did not want to talk at that time. The DON further reported she came in the next nightshift, and no staff could give her an answer as to what happened. The DON stated that none of the nightshift staff would admit it was them. The DON then reported that most of the complaints on Staff B are related to poor bedside manners. The DON stated she had reports that Staff B is rough around the	F0550		

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F0550 SS = D	Continued from page 4 edges. The DON further revealed that she has talked with Staff B multiple times about how Staff B is very dry, and direct when talking to the residents. Interview on 10/29/25 at 2:18 PM with the Administrator revealed that she was present for the meeting on 8/27/25. The Administrator then reported that the call light issue in the meeting was that a staff member did not give the call light to a resident for them to use, and the Administrator thought this was related to Resident #1. The Administrator then revealed this call light issue was related to the evening/overnight shift. The Administrator stated it was reported to her by the DON that staff had encouraged a resident to be incontinent, and that staff would come back and clean them up. The Administrator further revealed there were no particular staff brought up with the concern. The Administrator stated that her understanding was that when the DON investigated the issue with the call light and wetting the bed they were unable to determine which staff member it was that was being accused. Interview on 10/29/25 at 4:10 PM with the DON, and the Administrator revealed that their expectation would be for residents to be treated with dignity and respect at all times. Interview on 10/30/25 at 8:58 AM with Resident #1's family member revealed that Resident #1 told them about being told to urinate in the bed, and taking the call lights away from her. The family member then revealed it was taken care of, and it had never happened again. The family member revealed that the facility addressed it with the staff, and it was taken care of. Review of a facility provided policy titled, Promoting/Maintaining Resident Dignity dated 1/30/24 revealed: 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights.	F0550		