DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING B. WING	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Carlisle	**680 Cole Street , Carlisle, Iowa, 50047**

(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 ✓ OK/CP	INITIAL COMMENTS Correction date: 06/22/2026 The following deficiencies resulted from the facility's annual recertification survey and investigation of complaints #2733826-C, #2961675-C, #2975976-C, #2975983-C, #2975995-C, #2979602-C, #2980523-C, #2992909-C, #3007594-C, #3012057-C, and facility reported incidents #2971581-I, #2975524-I, conducted May 17, 2026 to May 21, 2026. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F0000	Accura Healthcare of Carlisle 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 deficiencies. This plan of correction 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 and is in compliance with the requirements of participation, or that corrective action was necessary.	
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(l)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and	F0584	In continuing compliance with F584 Safe/Clean/ Comfortable/Homelike Environment, Accura HealthCare of Carlisle corrected the deficiency by having the carpets deep cleaned on 6/4/2026 by an outside contractor, the resident restroom floor repaired on 6/22/2026, by the Administrator and on 6/22/2026 the Administrator scheduled a plumber for repairs to Resident #35 sink. To correct the deficiency and to ensure the problem does not recur, the Environmental Services staff were educated by the Administrator and/or designee on maintaining a safe/clean/comfortable/homelike environment on 6/22/2026. The Administrator and/or designee will complete audits 3x/weekly x 4 weeks, then 2/xweekly x 4 weeks, then 1x/weekly x 4 weeks, then PRN to ensure continued compliance. As part of Accura HealthCare of Carlisle's ongoing commitment to quality assurance, the Adminstrator and/or designee will report identified concerns 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
	Executive Director	6/22/26

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F0584 SS = E	Continued from page 1 comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(l)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(l)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain a safe and clean environment throughout the facility's 3 of 3 carpeted hallways (100, 200, and 300 halls), and 1 of 1 residents reported issues of the dirty tiled floor in their rooms and broken sink (Resident #35). The facility reported a census of 78 residents. Findings include: 1.On 5/19/26 at 7:06 AM, a walkthrough of the facility revealed items stored on both sides of the 200 hallway. Two shower chairs sat on the left side when walking down from the dining room, and multiple wheelchairs, garbage cans, and resident transfer devices (lifts) lined the right side. On 5/20/26 at 12:01 PM, an observation of the 200 hallway revealed discoloration continued throughout the entire length of the carpeted flooring. On 5/21/26 at 12:39 PM, an interview and observation with the facility's Housekeeping and Laundry Supervisor (HLS) revealed she worked at the facility in her role since 2007, cleaned the 200 hallway carpet flooring every Tuesday, and confirmed staff last cleaned it on 5/19/26. While walking through the 200 hallway, the HLS confirmed black marks on the carpeted walls, a darker and different floor coloring on the perimeter of the hallway carpet, chipped paint on the metal door	F0584		

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F0584 SS = E	Continued from page 2 frames, and doors with scratches and rough wood exposed. On 5/20/26 at 2:00 PM, an interview with the facility Nurse Consultant, Director of Nursing, and Administrator revealed they redid so much, so they're working through it. They completed roof leak repairs, purchased a mower, laptops, a boiler, a washer and dryer, a mechanical transfer lift, and business office flooring. They haven't repaired the driveway or the call lights yet, but those projects are next on the list before they address the carpet. The carpet's on their radar, and they're just trying to finish up projects. 2. Observations on 5/17/26 at 11:35 a.m. revealed the 100 and 300 Hall carpets covered with multiple large dark and bleach-colored stains. 3. On 5/17/26 at 11:38 a.m., the sink in Resident #35's room had a large piece broken off in front. The edge of the broken piece was jagged. The floor around the resident's toilet was covered with black stains. The resident stated the floor was stained all around the toilet. On 5/20/26 at 11:06 a.m., the Administrator stated that resident furnishings should be in good working order. On 5/20/26 at 1:43 p.m. via email, the Administrator stated the facility did not have a policy related to a homelike environment.	F0584		
F0804 SS = E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on observation, clinical document review, resident interview, staff interview, and policy review	F0804	In continuing compliance with F804, Nutritive Value/ Appear, Palatable/Prefer Temp, Accura HealthCare of Carlisle corrected the deficiency by sister facility Maintenance Assistant repairing the plate warmer on 5/27/2026. To correct the deficiency and to ensure the problem does not recur, Dietary Staff and CNAs were educated by the Administrator and/or designee on expectation of food being served at palatable/prefer temperatures by 6/22/2026. The Administrator and/or designee will complete audits of food temperatures to ensure residents are being served food a palatable/prefer temperatures 3x/weekly x 4 weeks, then 2x/weekly x 4 weeks, then 1x/weekly x 4 weeks, then PRN to ensure continued compliance.	

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F0804 SS = E	Continued from page 3 the facility failed to provide food at an appetizing temperature to 1 of 8 residents (Residents #41) reviewed. The facility reported a census of 78 residents. Findings include: Review of Resident #41's Minimum Data Set (MDS) dated 3/5/26 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognitive functioning. Interview 5/18/2026 at 10:25 AM with Resident #41 revealed that she eats in her room, and the food is often cold when brought to her. Observation 5/19/26 at 12:03 PM a sample tray was obtained with food temperatures for the creamy pork chop measuring 122.7 degrees, and the broccoli measuring 132.3 degrees. The facility policy "Food Temperatures", dated 2021, stated hot food items should not fall below 135 degrees Fahrenheit after cooking. On 5/19/26 at 12:37 p.m., the Certified Dietary Manager(CDM) stated he expected hot foods held at 135 degrees Fahrenheit or above.	F0804		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F0812	In continuing compliance with F812, Food Procurement, Store/Prepare/Serve- Sanitary, Accura HealthCare of Carlisle corrected the deficiency by cleaning the ceiling vents, orange splatters next to the bottom of stove, the pudding splatters next to the refrigerator, crumbs on the red tray, the ice machine on 5/19/2026 by the Dietary Manager. The debris under the shelves containing dry goods, the fire suppression system spigots, buildup on wall slats behind the stove, shelf with steam pans were cleaned on 5/21/2026 by the Dietary Manager. The white buildup on the dishwasher was cleaned on 5/22/2026 by the Dietary Manager. To correct the deficiency and ensure the problem does not recur, Dietary Staff were educated by the Administrator and/or designee on expectation of Dietary Services areas remaining clean on 6/22/2026. The Administrator and/or designee will complete audits of Dietary Services areas to ensure cleanliness 3x/weekly x 4 weeks, then 2x/weekly x 4 weeks, then 1x/weekly x 4 weeks, then PRN to ensure continued compliance.	

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F0812 SS = E	Continued from page 4 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, policy review, and staff interview, the facility failed to prepare food under sanitary conditions for 2 of 2 kitchen observations. The facility reported a census of 78 residents. Findings included: 1. Observations during the initial kitchen tour on 5/17/26 at 10:38 a.m. revealed the following concerns: A. A thick debris and dust layer on the floor under the shelves containing cans and dry goods in the pantry. B. A thick black dust layer covering the ceiling vent above and diagonal to the clean side of the dish machine room. C. A thick crusty-looking white buildup on the outside of the dishwasher. D. Dust particles hung down on 2 spigots of the fire suppression system located above the stove burners. E. Heavy dust buildup on the wall slats behind the stove burners. F. Orange splatters between the bottom of the stove and the stove door. G. Heavy dust buildup on a shelf with multiple steam table pans sitting face down. H. Multiple pudding-like splatters on the right side floor of the Arctic Air #2 refrigerator. I Clear plastic bowls sat face down in crumbs on a red tray. J. A white plastic piece on the interior ceiling of the ice machine covered with a black substance. Water dripped from the black areas into the ice in the bottom of the machine. The Certified Dietary Manager(CDM) was present and stated it appeared to be water mold. He stated he would empty the ice and would not want residents to consume(this ice). 2. A follow-up visit to the kitchen on 5/19/26	F0812		

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F0812 SS = E	Continued from page 5 revealed that dust/debris remained on the shelves, ceiling vents, dishwasher, fire suppression spigots, and the wall slats behind the stove. On 5/19/26 at 12:37 p.m., the CDM stated he thought the sanitation in the kitchen was "pretty good". He agreed that surfaces should be clean and without debris and that vents should be clean. The undated, untitled dietary cleaning schedule directed staff to clean items including: refrigerators, the pantry, the dishwasher, and dish racks.	F0812		
F0909 SS = E	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interviews the facility failed to complete and/or maintain documentation of routine bed rail inspections for 10 of 10 residents with side rails. The facility reported a census of 78 residents. Findings include: A record review of Resident #32's current care plan revealed the resident used a side rail (bilateral half rails) to aid in repositioning and safety due to frequent falls out of bed. The goal, initiated on 6/27/25, directed that Resident #32 will remain free of falls out of bed and will assist with repositioning through the review date. A care plan intervention, initiated on 6/27/25, instructed staff to assist in resident independence with repositioning. On 5/20/26 at 9:48 AM, an observation and interview with the facility Administrator of bed rails revealed a resident had both upper quarter-length rails. The Administrator informed that the Housekeeping and Laundry Supervisor (HLS) currently oversees maintenance due to a recent staff changeover in that department. On 5/20/26 at 11:52 AM, an observation and interview with the Maintenance Director and Maintenance Assistant from a local sister facility revealed they're in Resident #32's room evaluating her bed rails, and one of the bed rails's removed and on the floor. They showed empty maintenance	F0909	In continuing compliance with F909, Resident Bed, Accura HealthCare of Carlisle corrected the deficiency by performing Bed Entrapment Inspections on 5/20/2026 on Resident #32 and all like residents by sister facility Maintenance Director and Maintenance Assistant. To correct the deficiency and to ensure the problem does not recur, the Administrator was educated by the Regional Clinical Specialist on expectation of bed rail inspections being completed in accordance with regulations on 6/22/2026. The Administrator and/or designee will complete audits of bed rail inspections to ensure bed rails are meeting regulations 3x/weekly x 4 weeks, then 2x/weekly x 4 weeks, then 1x/weekly x 4 weeks, then PRN to ensure continued compliance.	

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F0909 SS = E	Continued from page 6 inspection sheets and stated facility staff didn't provide them with any prior documentation of bed rail assessments, and corporate management called them in today to check all bed rails in the facility. They revealed they didn't see anything wrong with Resident #32's bed rails, but they aren't used to this type and aren't verifying that the entrapment zone measurements were correct. On 5/20/26 at 12:19 PM, an electronic mail (email) from the Administrator informed that staff follow the regulations for side rails. On 5/20/26 at 12:39 PM, an interview with the HLS revealed she started her role in 2007, denied she's in charge of the maintenance department, and stated the facility will hire someone new who won't be from this location. On 5/20/26 at 1:55 PM, an interview with the Administrator revealed she provided a list of Bed Entrapment Inspections for all residents with bed rails, stating corporate or sister facility staff completed them today. A record review of the undated document the Administrator provided titled Bed Entrapment Inspection revealed 10 resident beds passed the inspection, but the form did not show who completed the assessments.	F0909		
F0606 SS = D	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry	F0606	In continued compliance with F606, Not Employ/Engage Staff w/Adverse Actions, Accura HealthCare of Carlisle corrected the deficiency by the Administrator running a new background check for Staff A on 6/22/2026 and audited other like staff files. To correct the deficiency and to ensure the problem does not recur, the Business Office Manager was educated by the Administrator on expectation of background checks being conducted according to regulation on 6/22/2026. The Administrator and/or designee will complete audits of background checks on new hires 3x/weekly x 4 weeks, then 2/weekly x 4 weeks, then 1x/weekly x 4 weeks, then PRN to ensure continued compliance.	

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F0606 SS = D	Continued from page 7 or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is NOT MET as evidenced by: Based on employee personnel record review, staff interview and policy review, the facility failed to ensure a thorough background check had been completed before hire prior to working with dependent adults for 1 of 3 staff personnel files reviewed. The facility reported a census of 78 residents. Findings include: On 5/18/26 at 1:06 PM, the Administrator reported in an email that Staff A, Certified Nursing Assistant (CNA) had a start date of 9/9/25. Review of the Iowa Criminal History Record Check Request SING form dated 9/3/25 revealed Staff A had a history of criminal convictions. The SING form did not contain further research documentation to confirm whether or not Staff A could work at the facility. Review of facility policy updated 10/19/22 and titled, Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy, the facility will conduct an Iowa criminal record check and dependent adult/child abuse registry check on all prospective employees and other individuals engaged to provide services to residents, prior to hire, in the manner prescribed under 481 Iowa Administrative Code §58.11(3). The facility will conduct a criminal record check and dependent adult/child abuse registry check on all current employees and other individuals engaged to provide services to residents who have criminal convictions or founded abuse determinations after hire, or where the facility received credible information that an employee has had a criminal conviction or a founded abuse determination subsequent to hire. See Iowa Code §135C.33(7). On 5/20/26 at 2:15 PM the Administrator acknowledged the facility did not have a copy of Staff A's completed background check including the results that indicated whether or not further research was required. The Administrator had requested the results from the Iowa Department of Public Service on 4/10/26 however due to a system change, the results were not able to be obtained.	F0606		

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F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §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 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. §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. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, policy review, and staff and resident interviews, the facility failed to report an allegation of abuse in a timely manner for 1 of 2 residents reviewed for abuse allegations(Resident #34). The facility reported a census of 78 residents. Findings included: 1. A 5/14/26 Brief Interview for Mental Status(BIMS) Evaluation listed Resident #83's score as 15 out of 15, indicating intact cognition. On 5/17/26 at 11:54 a.m., Resident #83 stated last night(5/16/26) staff yelled at her roommate(Resident #34). Resident #83 stated 3 staff assisted the resident on the toilet and they yelled at the resident. She stated she couldn't tell exactly what they said but stated they said if Resident #34 didn't do something, they would leave her on the toilet.	F0609	In continuing compliance with F609, Reporting of Alleged Violations, Accura HealthCare of Carlisle corrected the deficiency by conducting a one-on-one education with the Administrator and DON on reporting policies on 6/22/2026 by the Regional Clinical Specialist for Resident #34 and all like residents. To correct the deficiency and ensure the problem does not recur, all staff were educated by the Administrator and/or designee on expectation of reporting alleged violations to the Administrator and/or designee immediately on 6/22/2026. The Administrator and/or designe will complete audits of reports of alleged violations 3x/weekly x 4 weeks, then 2/ weekly x 4 weeks, then 1/weekly x 4 weeks, then PRN to ensure continued compliance.	

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F0609 SS = D	Continued from page 9 Resident #83 stated she didn't know why they were so irritated but they were angry with Resident#34. She stated this was around 9:00 p.m. Resident #83 stated she informed Staff B Certified Nursing Assistant(CNA) about this this morning(5/17/26). 2. The Minimum Data Set(MDS) assessment tool, dated 4/30/26, listed diagnoses for Resident #34 which included hemiplegia(one-sided paralysis), anxiety, and diabetes. The MDS listed the resident's BIMS score as 15 out of 15, indicating intact cognition. The MDS documented that the resident required staff assistance with toilet transfers, chair/bed-to-chair transfer, and sit to stand. On 5/18/26 at 3:02 p.m., Resident #34 stated on Saturday night(5/16/26) staff were "mean" to her and "screamed" at her. A 5/17/26 Grievance Form, completed by Staff B, Certified Nurses Aide (CNA) stated Resident #83 reported to her that 3 staff members screamed at Resident #34 last night and were "mean". Staff B wrote that Resident #34 also said they were being mean and did not want to take her to the bathroom. On 5/19/26 at 2:31 p.m., Staff B stated that she reported to the Assistant Director of Nursing(ADON) that Resident #34 reported to her that 3 girls that took care of her the night before were "mean" to her. Staff B stated she also filled out a grievance form. On 5/20/26 at 9:36 a.m., the Director of Nursing(DON) stated that she received a grievance related to Resident #34 on Monday(5/18/26). She stated the date on the grievance was 5/17/26. She stated she would want to know about something of this nature right away. On 5/20/26 at 9:42 a.m., the Assistant Director of Nursing(ADON) stated that she received a grievance on Sunday(5/17/26). She stated Staff B handed it to her but then took it back and stated she needed to add things to it. The ADON stated Staff B told her there was an issue with a resident but she didn't get any details. The ADON stated she probably should have determined whether it was a reportable situation. She stated Staff B placed the grievance in her mailbox and they talked about it on Monday(5/18/26). The facility lacked documentation they reported the allegation of abuse to the State Agency. On 5/20/26 at 11:06 a.m., the Administrator stated if	F0609		

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	165255	A. BUILDING B. WING	05/21/2026

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F0609 SS = D	Continued from page 10 a staff member heard that staff were mean, they should inform her or the DON right away. She stated if it was reportable, they should separate staff and complete an investigation. The "Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy" dated 10/19/22 stated the facility would report all allegations of abuse to the Iowa Department of Inspections and Appeals not later than two (2) hours after the allegation was made. The policy stated the facility would investigate the incident including witness statements.	F0609		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, policy review, and staff and resident interviews, the facility failed to investigate an allegation of abuse in a timely manner for 1 of 2 residents reviewed for abuse allegations(Resident #34). The facility reported a census of 78 residents. Findings included: 1. A 5/14/26 Brief Interview for Mental Status(BIMS) Evaluation listed Resident #83's score as 15 out of 15, indicating intact cognition. On 5/17/26 at 11:54 a.m., Resident #83 stated last	F0610	In continuing compliance with F610, Investigate/Prevent/Correct Alleged Violation, Accura HealthCare of Carlisle corrected the deficiency by conducting a one-on-one education with the Administrator and DON on investigation policies on 6/22/2026 by the Regional Clinical Specialist for Resident #34, and all like residents. To correct the deficiency and ensure the problem does not recur, the Administrator and DON were educated by the Regional Clinical Specialist on expectation of investigating alleged violations immediately on 6/22/2026. The Administrator and/or designe will complete audits of reports of alleged violations 3x/weekly x 4 weeks, then 2/weekly x 4 weeks, then 1/weekly x 4 weeks, then PRN to ensure continued compliance.	

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F0610 SS = D	Continued from page 11 night(5/16/26) staff yelled at her roommate(Resident #34). Resident #83 stated 3 staff assisted the resident on the toilet and they yelled at the resident. She stated she couldn't tell exactly what they said but stated they said if Resident #34 didn't do something, they would leave her on the toilet. Resident #83 stated she didn't know why they were so irritated but they were angry with her. She stated this was around 9:00 p.m. Resident #83 stated she informed Staff B Certified Nursing Assistant(CNA) about this this morning(5/17/26). 2. The Minimum Data Set(MDS) assessment tool, dated 4/20/26, listed diagnoses for Resident #34 which included hemiplegia(one-sided paralysis), anxiety, and diabetes. The MDS listed the resident's BIMS score as 15 out of 15, indicating intact cognition. On 5/18/26 at 3:02 p.m., Resident #34 stated on Saturday night(5/16/26) staff were "mean" to her and "screamed" at her. A 5/17/26 Grievance Form, completed by Staff B, stated Resident #83 reported to her that 3 staff members screamed at Resident #34 last night and were "mean". Staff B wrote that Resident #34 also said they were being mean and did not want to take her to the bathroom. On 5/19/26 at 2:31 p.m., Staff B, CNA stated that she reported to the Assistant Director of Nursing(ADON) that Resident #34 reported to her that 3 girls that took care of her the night before were "mean" to her. Staff B stated she also filled out a grievance form. On 5/20/26 at 9:36 a.m., the Director of Nursing(DON) stated that she received a grievance related to Resident #34 on Monday(5/18/26). She stated the date on the grievance was 5/17/26. She stated she would want to know about something of this nature right away. The DON stated she did not interview the resident's roommate because of the resident's high BIMS score. On 5/20/26 at 9:42 a.m., the Assistant Director of Nursing(ADON) stated that she received a grievance on Sunday(5/17/26). She stated Staff B handed it to her but then took it back and stated she needed to add things to it. The ADON stated Staff B told her there was an issue with a resident but she didn't get any details. The ADON stated she probably should have determined whether it was a reportable situation. She stated Staff B placed the grievance in her mailbox and they talked about it on	F0610		

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F0610 SS = D	Continued from page 12 Monday(5/18/26). The facility lacked documentation they completed an investigation into the alleged 5/16/26 incident prior to 5/18/26. On 5/20/26 at 11:06 a.m., the Administrator stated if a staff member heard that staff were mean, they should inform her or the DON right away. She stated if it was reportable, they should separate staff and complete an investigation. The "Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy" dated 10/19/22 stated the facility would report all allegations of abuse to the Iowa Department of Inspections and Appeals not later than two (2) hours after the allegation was made. The policy stated the facility would investigate the incident including witness statements.	F0610		
F0627 SS = D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for	F0627	In continuing compliance with F627, Inappropriate Discharge, Accura HealthCare of Carlisle corrected the deficiency by the DON completing the recapitulation of stay on 5/19/2026 and auditing discharge UDAs for Resident #82 and all like residents. To correct the deficiency and to ensure the problem does not recur, nurses and the Director of Social Services were educated by the DON and/or designee on expectation of the recapitulation of stay being completed timely. The DON and/or designee will complete audits of discharge assessments 3x/weekly x 4 weeks, then 2x/ weekly x 4 weeks, then 1x/weekly x 4 weeks, then PRN to ensure continued compliance.	

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F0627 SS = D	Continued from page 13 his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge.	F0627		

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F0627 SS = D	Continued from page 14 A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-	F0627		

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F0627 SS = D	Continued from page 15 (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data	F0627		

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F0627 SS = D	Continued from page 16 on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is NOT MET as evidenced by: Based on Electronic Health Record (EHR) review, document review, policy review, and staff interview the facility failed to complete a discharge summary that included a recapitulation of the resident's stay, a final summary of the resident's status, and reconciliation of all pre- and post-discharge medications for 1 of 3 residents reviewed (Resident #82). The facility reported a census of 78 residents. Findings include: Review of Resident #82's Minimum Data Set (MDS) dated 2/20/26 indicated Resident #82 was admitted to the facility on 12/10/25 and discharged on 2/20/26. Review of Resident #82's EHR page titled, Progress Notes indicated on 2/17/26 that Resident #82 was expressing a want to move to another facility. Further review of the Progress Notes revealed an entry 2/20/26 indicating transportation was at the facility to take Resident #82 to a new facility.	F0627		

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F0627 SS = D	Continued from page 17 Review of Resident #82's EHR page titled, Clinical Assessment revealed a discharge planning review assessment that had not been completed as of 5/19/26. Interview 5/19/2026 at 9:12 AM with the Director of Nursing (DON) revealed that a recapitulation of stay should have been completed. The DON further revealed that the discharge assessment had been completed, but had not been locked out, but this should have been done since the resident had been discharged 2/20/26. Review of a facility provided policy titled, Discharge Planning Process with an updated date of 2/23/25 indicated the evaluation of the resident's discharge needs and discharge plan will be completely documented on a timely basis in the clinical record.	F0627		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material	F0641	In continuing compliance with F641, Accuracy of Assessments, Accura HealthCare of Carlisle corrected the deficiency by submitting a corrected discharge for Resident #50 and auditing all like residents on 6/18/2026 by the MDS Coordinator. To correct the deficiency and to ensure the problem does not recur, the MDS Coordinator was educated by the DON on expectation of accuracy of assessments on 6/22/2026. The DON and/or designee will complete audits of frequent rounding to ensure residents are receiving accurate assessments 3x/weekly x 4 weeks, then 2x/weekly x 4 weeks, then 1x/weekly x 4 weeks, then PRN to ensure continued compliance.	

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F0641 SS = D	Continued from page 18 and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews the facility failed to complete 1 of 4 residents discharge Minimum Data Set (MDS) assessments when they discharged home from the facility (Resident #50). The facility reported a census of 78 residents. 1.Review of Resident #50 Electronic Health Record (EHR) Census revealed she was admitted on 12/5/25 and discharged on 12/20/25. Review of Resident #50 Communication With family Note dated 12/17/25 at 11:30 AM documented she will discharge home on 12/20/25. Review of Resident #50 Discharge Summary Note dated 12/20/25 at 10:41 AM documented she discharged from the facility on 12/20/25 at 8:30 AM. Review of Resident #50 EHR MDS log on 5/19/26 revealed the facility has completed an Entry MDS on 12/5/25 and Admission MDS on 12/11/25, but has not completed a discharge MDS when she discharged on 12/20/25. On 5/20/26 at 11:59 AM, an interview with the facility Administrator and Nurse Consultant revealed staff follow the Resident Assessment Instrument (RAI) manual.	F0641		
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	F0644	In continuing compliance with F644, Coordination of PASARR and Assessments, Accura HealthCare of Carlisle resubmitted the PASARR document for Resident #8 on 5/20/2026 and auditing all like residents by the DON. To correct the deficiency and to ensure the problem does not recur, the DON, MDS Coordinator, and Nurses were educated by the Administrator and/or designee on expectation of coordination of PASARR and Assessments on 6/22/2026. The DON and/or designee will complete audits of PASARR and Assessments 3x/weekly x 4 weeks, then 2x/weekly x 4 weeks, then 1x/weekly x 4 weeks, then PRN to ensure continued compliance.	

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F0644 SS = D	Continued from page 19 significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on a record review and staff interviews, the facility failed to ensure all mental health diagnoses were on 1 of 3 residents' Preadmission Screening and Resident Review (PASRR) documents for (Resident #8). The facility reported a census of 78 residents. Findings include: 1. Review of a Resident #8 Medical Diagnoses in her Electronic Health Record (EHR) documented she received the diagnosis of Post-Traumatic Stress Disorder (PTSD; a mental health condition triggered by a terrifying event) on 6/8/2021. A record review of Resident #8's current PASRR dated 6/10/2025 lacked her diagnosis of PTSD. On 3/27/26, a record review of a visit titled Modified Progress Note documented Resident #8 was changing from weekly to biweekly visits for the next 3 months, and mental health professionals continued to see her for her diagnoses of post-traumatic stress disorder PTSD and major depression (persistent and severe sadness). On 5/20/26 at 12:19 PM, an electronic mail (email) from the facility Administrator informed that staff follow the regulations for PASRR documents. On 5/20/26 at 12:45 PM, an interview with the facility Administrator revealed that a different person in the facility completed the Preadmission Screening and Resident Review (PASRR) documents up until about a week and a half ago, and now staff complete them centrally. The Administrator then revealed she'd expect post-traumatic stress disorder (PTSD) and any qualifying diagnosis to be on the PASRR and updated if need be. On 5/20/26 at 2:00 PM, an interview with the facility Nurse Consultant, Director of Nursing, and Administrator revealed they hadn't submitted the PASRR for Resident #8 regarding her PTSD, but they'd do that today.	F0644		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care	F0656	In continuing compliance with F656, Develop/Implement Comprehensive Care Plan, Accura HealthCare of Carlisle corrected the deficiency by adding the use of diuretic medication to the care plan for resident #2 and all like residents by the MDS Coordinator on 5/20/2026. To correct the deficiency and to ensure the problem does not recur, the MDS Coordinator was educated by the DON on expectation of diuretic medications being on the care plan on 6/22/2026. The DON and/or designee will complete audits of diuretics on the care plan 3x/weekly x 4 weeks, then 2x/weekly x 4 weeks, then 1/weekly x 4 weeks, then PRN to ensure continued compliance.	

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F0656 SS = D	Continued from page 20 plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, staff interview, and policy review the facility failed to develop a comprehensive care plan that included problems, goals, or interventions for 1 of 5 residents (Resident #2) reviewed for a resident with diuretic medication usage. The facility reported a census of 78. Findings include: Review of Resident #2's Minimum Data Set (MDS) dated 2/26/26 revealed Resident #2 utilized diuretic medications during the 7 day look back period. The	F0656		

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F0656 SS = D	Continued from page 21 MDS documented that the resident was admitted to the facility on 4/13/2011. Review of Resident #2's Electronic Healthcare Record (EHR) page titled, Clinical Physician Orders revealed an order for Lasix (Diuretic medication) 40mg oral tablet to give 1 tablet twice a day with a start date of 8/26/25. Review of Resident #2's Care Plan with a revision date of 4/13/26 revealed no focus, goals, or interventions for diuretic use. Interview 5/20/26 at 12:42 PM with the Minimum Data Set (MDS) Coordinator revealed that Lasix should be in the care plan. The MDS Coordinator further confirmed Resident #2 had been on Lasix since August of 2025. Interview 5/20/26 at 12:44 PM with the Director of Nursing (DON) revealed that her expectation would be that the appropriate items are listed in the care plans. Review of a facility provided policy titled, Comprehensive Care Plans with an updated date of 12/3/25 indicated the comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment.	F0656		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on record review, resident and staff interviews, and policy review the facility failed to to provide the necessary care and services to ensure a resident received appropriate clinical monitoring, timely medical provider notification, and consistent administration of prescribed treatments for a Urinary Tract Infection (UTI) for 1 of 1 residents reviewed for UTI (Resident #31). Specifically, facility staff failed to	F0684	In continuing compliance with F684, Quality of Care, Accura of Carlisle corrected the deficiency by providing staff education regarding providing necessary care and services for a UTI for resident #31 and all like residents. To correct the deficiency and to ensure the problem does not recur, all Nurses were educated by the DON and/or designee on expectation of treatment and services provided to prevent/manage UTI in accordance with doctor's orders on 6/22/2026. The DON and/or designee will complete audits of UTI management 3x/weekly x 4 weeks, then 2x/weekly x 4 weeks, then 1/weekly x 4 weeks, then PRN to ensure continued compliance.	

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F0684 SS = D	Continued from page 22 conduct nursing assessments across two separate antibiotic regimens, delayed follow-up with an unresponsive medical provider regarding a recurrence of symptoms, omitted a scheduled antibiotic dose without clinical justification, and failed to update the resident's care plan to reflect a suspected multidrug-resistant infection and use of antibitoics. The facility reported a census of 78 residents. Findings include: A review of all Progress Notes and clinical records from 4/1/26 to 5/20/26 established a timeline of Resident #31's antibiotic therapies for a urinary tract infection (UTI), which included an initial order for Macrobid 100 milligrams twice a day for seven days on 4/25/26, a subsequent change to Cefdinir 300 milligrams twice a day for seven days on 4/27/26, and a new course of Ciprofloxacin Hydrochloride (Cipro) 500 milligrams twice a day for seven days ordered on 5/15/26. Resident #31's Minimum Data Set (MDS) dated 3/12/26 documented a Brief Interview for Mental Status score of 15, indicating intact cognition. The MDS revealed Resident #31 had functional limitations to both lower extremities, depended on staff for all transfers and to go from a sitting to a standing position, and staff did not attempt to walk him due to his medical condition. The MDS further documented Resident #31 was occasionally incontinent of urine, frequently incontinent of bowel movements, and was not on a toileting program. The MDS recorded diagnoses of cancer, diabetes (a chronic condition affecting blood sugar regulation), Parkinson's disease (a progressive nervous system disorder affecting movement), and depression. On 5/18/26 at 11:37 AM, an interview with Resident #31 revealed he denied issues with all care and had no concerns related to his UTI (an infection in any part of the urinary system). A review of Medical Diagnoses in the Electronic Health Record (EHR) documented a current diagnosis starting on 4/24/26 of a UTI, site not specified. The Progress Notes from 4/1/26 to 5/20/26 recorded the following chronological entries: A Progress Note dated 4/23/26 at 3:23 PM recorded that staff called the local laboratory to follow up on a urine sample collected and sent the previous Thursday. The laboratory reported they never received the specimen. Staff re-collected the sample on 4/23/26 to send via courier the following day.	F0684		

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F0684 SS = D	Continued from page 23 A Progress Note dated 4/25/26 at 2:03 AM recorded that staff received urinalysis results from the laboratory. Staff placed a call to the on-call medical provider to request antibiotic orders, and received a new order for Macrobid 100 milligrams by mouth twice a day for seven days. the note recorded staff would call when final culture and sensitivity results became available. A Progress Note dated 4/25/26 at 2:08 AM recorded that staff pulled the first dose of Macrobid from the facility's on-hand medication supply and administered it. A Progress Note dated 4/27/26 at 11:32 AM recorded that staff received the final culture and sensitivity laboratory results. Following the provider's review, a change of antibiotic was ordered to discontinue Macrobid and initiate Cefdinir 300 milligrams by mouth twice a day for seven days. A Progress Note dated 4/27/26 at 8:17 PM recorded that vital signs were blood pressure 151/91, pulse 68, and temperature 98.0°F. Staff noted the resident continued on Cefdinir 300 milligrams for a UTI, with no adverse side effects observed at the time of the assessment. Progress Notes from 4/27/26 to 5/20/26 revealed that staff charted clinical updates on 4/28/26, 4/29/26, 4/30/26, and 5/2/26 indicating the resident denied burning or discomfort and fluids were encouraged. However, the progress notes lacked required daily nursing assessments regarding Resident #31's UTI signs, symptoms, and antibiotic usage on 5/1/26, 5/3/26, 5/4/26, 5/5/26, and from 5/7/26 through 5/12/26. A Progress Note dated 5/5/26 at 2:05 AM recorded that the resident was seen by the medical provider on 5/4/26, with no new orders documented at that time. A Progress Note dated 5/6/26 at 4:09 PM recorded a late entry noting that staff transmitted a fax to the provider to notify them that the resident continued to experience symptoms of burning with urination and minimal urinary urgency. A Progress Note dated 5/8/26 at 2:11 PM recorded a late entry noting that staff received no response from the provider. Staff re-faxed the communication to let the provider know that Resident #31 continued with symptoms after completing the antibiotic treatment.	F0684		

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F0684 SS = D	Continued from page 24 A Progress Note dated 5/13/26 at 11:02 AM recorded that staff obtained a urinalysis as ordered in a clean urinal, and they sent the specimen to the local laboratory. A Progress Note dated 5/15/26 at 4:15 PM recorded that staff received the urinalysis results back after the provider reviewed them, resulting in a new order for ciprofloxacin hydrochloride (Cipro) 500 milligrams twice a day for seven days, which staff faxed to the pharmacy and entered into the MAR. A review of the Medication Administration Record (MAR) for May 2026 showed Resident #31 received all doses as ordered for Cefdinir 300 milligram oral capsule, with directions to give one capsule by mouth two times a day for a UTI for seven days, starting on 4/27/26 at 8:00 PM. The May 2026 MAR further revealed a new order for Cipro 500 milligrams twice a day to be started on 5/16/26 for seven days. Staff did not give the medication on 5/16/26, and the record noted to see the progress notes. A review of the progress notes for 5/16/26 revealed no entry explaining why staff did not give the medication. A review of the Care Plan dated 4/21/26 identified Resident #31 had bladder incontinence related to impaired mobility. The goal directed that Resident #31 would remain free from skin breakdown due to incontinence and brief use through the review date. Interventions instructed staff to clean the perineal area with each incontinence episode and monitor and document for signs and symptoms of a UTI, including pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul-smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns. Facility staff didn't revise the care plan to reflect Resident #31's recent antibiotic usage and recurrent UTI. A review of Assessments in the EHR from 4/1/26 to 5/20/26 revealed staff completed an Infection Screening Evaluation on 4/24/26, an Infection Screening Evaluation on 5/6/26, and an Antibiotic Time Out on 5/6/26. The EHR lacked daily nursing assessments to monitor Resident #31's UTI signs, symptoms, and antibiotic usage. On 5/19/26 at 12:40 PM, an interview with the Infection Preventionist (IP) revealed that the EHR system completes the clinical criteria and creates an infection control case. The IP stated staff follow a protocol when completing UTI antibiotics, and she confirmed staff should document assessments or	F0684		

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F0684 SS = D	Continued from page 25 progress notes regarding side effects for UTIs. The IP further confirmed staff should chart more clearly and concisely. On 5/19/26 at 12:51 PM, an interview with the Director of Nursing (DON) revealed that staff follow McGreer's criteria (surveillance definitions for infections in long-term care facilities) through the EHR system. The DON stated staff should complete close monitoring and documentation for antibiotics the entire time a resident takes the medication. The DON further confirmed Resident #31 was a different case because a laboratory result came back showing a possible multidrug-resistant organism (bacteria resistant to multiple antibiotics), so management decided to continue the antibiotics to ensure they treated the infection completely. On 5/21/26 at 9:08 AM, an interview with Staff C, Certified Nursing Assistant (CNA), revealed she knew Resident #31 had a UTI during the past month and was on his second round of antibiotics. Staff C stated Resident #31 seemed to be doing okay and had no complaints of pain, burning, or urgency to her. Staff C recalled hearing during a nursing report that staff possibly caught the infection because he acted a little off. On 5/21/26 at 9:21 AM, an interview with Staff B, CNA, revealed she knew Resident #31 had a UTI and was on his second round of antibiotics. Staff B stated she asked him about it, and he reported he felt better and that the medications helped. Staff B reported Resident #31 had no complaints of pain, burning, or urgency to her, and he was doing well. On 5/21/26 at 9:48 AM, an interview with Staff D, Registered Nurse (RN), revealed she knew Resident #31 was on an antibiotic for a UTI diagnosed at the end of April. Staff D stated Resident #31 acted normal per his baseline, had no complaints of pain or burning, and was doing great. Staff D reported that when a resident has a UTI, staff must assess and document vital signs, urinary frequency, urgency, pain, and burning once every shift. A review of the facility's policy titled Urinary Symptom Monitoring Protocol, dated 5/14/24, revealed that for residents exhibiting urinary symptoms, staff were required to notify the medical provider by phone, request orders for Vitamin C 1,000 milligrams (mg) daily, and initiate enhanced shift-by-shift tracking. The protocol strictly mandated that staff must document fluid intake in cubic centimeters (cc's) on the electronic Treatment Administration Record (eTAR) every shift, and utilize	F0684		

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F0684 SS = D	Continued from page 26 the facility's 24-hour sheet to document the resident's temperature, encouragement of fluids, and any observable symptoms every shift. The policy further directed that if at any time during the monitoring period the resident's condition appeared to be declining, staff were to notify the medical provider immediately. On 5/21/26 at 8:57 AM, an interview attempt was made to Resident #31's Doctor of Nursing Practice (DNP), but the provider didn't return the call.	F0684		
F0697 SS = D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on record review, resident and staff interviews, and policy review the facility failed to ensure that an effective pain management regimen was consistently implemented in accordance with professional standards of practice and the comprehensive plan of care for 1 of 1 resident reviewed for pain management (Resident #64). Specifically, the facility failed to administer prescribed pain medication as ordered, resulting in a failure to meet the resident's goals for care and preferences. The facility reported a census of 78 residents. Findings include: Resident #64's Minimum Data Set (MDS) dated 4/25/26 documented a Brief Interview for Mental Status score of 13, indicating intact cognition. The MDS revealed staff admitted him to the facility on 4/21/26. The MDS revealed he uses a wheelchair, does not walk, and depends on staff for transfers. The MDS documented diagnoses of peripheral vascular disease (a circulatory condition where narrowed blood vessels reduce blood flow to the limbs), arthritis (joint inflammation causing pain and stiffness), malnutrition, asthma, and dislocation of the left hip. He occasionally experiences pain, and he rated his worst pain in the past five days as a seven out of 10. On 5/18/26 at 10:46 AM, an interview with Resident #64 revealed he had a lot of pain when getting in	F0697	In continuing compliance with F697, Pain Management, Accura HealthCare of Carlisle corrected the deficiency by providing education regarding expectation of pain management and education to clinical management of reviewing 24/72HR report for administration record for resident #64 and all like residents. To correct the deficiency and to ensure the problem does not recur, Nurses and CMA were educated by the DON and/or designee on expectation of pain management in accordance with doctor's orders on 6/22/2026. The DON and/or designee will complete audits of pain management 3/weekly x 4 weeks, then 2x/weekly x 4 weeks, then 1x/weekly x 4 weeks, then PRN to ensure continued compliance.	

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F0697 SS = D	Continued from page 27 and out of bed. A review of the Medication Administration Record (MAR) for May 2026 revealed Resident #64 had an order starting on 5/7/26 at 8:00 PM for oxycodone hydrochloride (a strong opioid medication used to treat severe pain) five milligram capsule by mouth twice a day. Staff didn't manage the medication as ordered because: a. The staff missed both doses on 5/8/26 while Resident #64 rated his pain a two out of 10 each time. b. On 5/9/26, staff missed both doses while Resident #64 rated his pain a six out of 10 in the morning, and staff didn't assess his pain at bedtime. c. On 5/10/26, staff missed both doses while Resident #64 rated his pain a five out of 10 in the morning and a two out of 10 at bedtime. d. On 5/11/26, staff missed the morning dose, and Resident #64 rated his pain a six out of 10 when he finally received the medication on the night of 5/11/26. e. On 5/13/26, Resident #64 had worse pain with an eight out of 10 in the morning and a seven out of 10 in the evening. A review of the May 2026 MAR also showed that once the pharmacy filled the prescription, staff gave an as-needed dose on 5/11/26 at 2:47 PM for a pain rating of nine out of 10. The order directed staff to give oxycodone five milligram capsule every eight hours as needed for pain starting on 5/7/26. Resident #64 ran out of his scheduled twice-daily pain medications because the pharmacy didn't receive a written prescription after the doctor gave the order. The order remained on file, but the pharmacy couldn't fill it. A review of a Nurses Note dated May 2026 at 6:34 AM recorded that staff contacted the pharmacy because Resident #64 didn't receive his narcotic medication, and he continued to request a pain pill. A pharmacy technician stated Resident #64 didn't have a current prescription. The pharmacy technician reported they sent a refill prescription request on May 1st and still hadn't received a response. Staff couldn't pull the medication from the automated medication dispensing system because they didn't have a current prescription. Staff provided the on-call telephone number so the pharmacist could	F0697		

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F0697 SS = D	Continued from page 28 reach out to the on-call medical provider for a current prescription to deliver the medication. A review of a Nurses Note dated May 2026 at 1:26 PM recorded that staff awaited a three-day emergency prescription for Oxycodone before receiving a new prescription. Resident #64 showed continued pain to his left hip. A review of the Care Plan dated 4/21/26 identified Resident #64 had a potential for pain or actual pain related to chronic wounds and his disease process. The goal directed that Resident #64 would verbalize satisfaction with pain control over the next review period. Interventions instructed staff to assess for signs and symptoms of pain, give medications as ordered, and notify the physician of uncontrolled pain. Facility staff didn't follow the care plan interventions when they failed to provide the pain medications as ordered by the physician. On 5/20/26 at 9:20 AM, an interview with Resident #64 revealed his asthma (a respiratory condition causing breathing difficulties) is why he called emergency medical services (EMS) earlier in the month and wanted to see his local provider, it was not due to his pain. A review of an Administrator Email dated 5/20/26 at 12:30 PM recorded the facility did not have a policy for physician orders, and staff followed standards of practice. On 5/21/26 at 9:08 AM, an interview with Staff C, Certified Nursing Assistant (CNA), revealed Resident #64 complains about pain all the time. Staff C stated Resident #64 always complains about his hip and always complains about getting up. Staff C reported Resident #64 seems very uncomfortable a lot, and he always asks for pain pills. On 5/21/26 at 9:21 AM, an interview with Staff B, CNA, revealed Resident #64 complains about pain all the time, always wants pain medications, and always yells that he is in pain when staff change him. Staff B reported Resident #64 always complains about his hip. On 5/21/26 at 9:48 AM, an interview with Staff D, Registered Nurse (RN), revealed Resident #64 has complained about pain to her. Staff D reported Resident #64 has scheduled pain medications. Staff D stated if a resident had an order for pain medication but the pharmacy didn't receive a prescription, she would call the pharmacy and see if she could pull the medication from the emergency	F0697		

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Accura Healthcare of Carlisle	**680 Cole Street , Carlisle, Iowa, 50047**

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F0697 SS = D	Continued from page 29 medication kit. Staff D reported she would try to call as soon as possible, would talk to the Director of Nursing, and then would call the doctor. On 5/21/26 at 8:57 AM, an interview attempt was made to Resident #64's Doctor of Nursing Practice (DNP), but the provider didn't return the call. The Pain Management Policy last revised on April 2025 directed staff to recognize when a resident is experiencing pain, manage or prevent pain consistent with the comprehensive assessment and plan of care, and develop, implement, monitor, and revise interventions to manage each individual resident's pain. The policy instructed staff to notify the practitioner if the resident's pain is not controlled by the current treatment regimen, and to revise the pain management regimen and plan of care if reassessment findings indicate pain is not adequately controlled.	F0697		