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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165217	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER: Caring Acres Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 Hillcrest Drive, Anita, IA 50020	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, interview and record review the facility failed to develop a care plan for 1 of 4 residents reviewed. Resident #1 was admitted to the facility on [DATE], as of 11/26/24 the clinical record lacked a care plan. The facility reported a census 24 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 was admitted to the facility on [DATE] from the hospital. A Brief Interview for Mental Status (BIMS) assessment, dated 10/30/24 at 8:41 AM, showed that Resident #1 had a score of 15 (cognitively intact). A document titled: Functional Abilities and Goals, dated 11/5/24 at 8:31 AM, showed that Resident #1 had lower extremity impairment on both sides. He was totally dependent on staff for toileting hygiene, lower body dressing, and showering. He required substantial assistance with rolling over and sit to lying. Sit to stand, bed to chair transfers, toilet transfers and walking were not attempted in the 3 day look back period due to medical conditions and safety concerns. On 11/25/24 at 9:52 AM, Resident #1 was lying in a bariatric bed and there was a bariatric chair, wheel chair, commode and walker in the room. Resident #1 expressed that he was upset about the lack of planning related to his admission to the facility. He had been transferred to the facility for rehabilitation, with a goal of going back home. When he arrived, the bed was too small for him, they didn't have a large enough commode, walker or chair, and he was delayed in getting Physical Therapy (PT) so he had lost ground on the progress he had made in the hospital. He said that from October 29th through November 13th, he was mostly bed-ridden and the staff were giving him bed baths and using a bed pan that was too small for him. According to a Care Plan Conference Summary, date 11/7/24 at 1:17 PM, staff had discussed the resident's nursing needs and the Care Plan was updated. As of 11/26/24, the electronic record for Resident #1 did not include a Care Plan. On 11/26/24 at 1:00 PM, the Director of Nursing (DON) said that they did not have policy on care planning and that the facility follows the regulations. She said that Resident #1 had a care conference where they discussed his goals but she was surprised to hear there was no care plan in the electronic record.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observations, staff and resident interviews, clinical record review and facility document review the facility failed to ensure that they provided adequate nurse staffing to meet the needs for 3 of 4 residents reviewed. Residents #1, #3 and #4 indicated that many times there were only 2 staff on duty and they waiting a long time to get a response to their call lights. When the facility didn't have anyone else to work, Staff D, Licensed Practical Nurse (LPN) worked 23 consecutive hours and 49 hours in a three-day period. The facility reported a census of 24 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment, dated 10/29/24, Resident #1 was admitted to the facility on [DATE]. A Brief Interview for Mental Status (BIMS) assessment, dated 10/30/24 at 8:41 AM, showed that Resident #1 had a score of 15 (cognitively intact). A document titled: Functional Abilities and Goals, dated 11/5/24 at 8:31 AM, showed that Resident #1 had lower extremity impairment on both sides. He was totally dependent on staff for toileting hygiene, lower body dressing, and showering. He required substantial assistance with rolling over and sit to lying. Sit to stand, bed to chair transfers, toilet transfers and walking activities were not attempted in the 3 day look back period due to medical conditions and safety concerns. On 11/25/24 at 9:52 AM, Resident #1 was lying in bed and indicated that he was unhappy about his admission to the facility. He said that he was transferred to the facility for rehabilitation with a goal of going back home and there was a delay in starting Physical Therapy (PT) because they did not have the proper bariatric equipment. Resident #1 said that the call light response had been really long many times, with 45 to 90 minute waits before staff responded. Once they got to his room, the staff would tell him that they only had one Certified Nurse Aide (CNA) on the floor and they were trying to get to the residents as soon as they could. 2) According to the MDS dated [DATE], Resident #4 was admitted to the facility on [DATE]. She had a BIMS score of 12 (moderate cognitive deficit) and was totally dependent on staff for toileting, dressing and sit to stand transfers. Her diagnosis included heart disease, renal insufficiency and diabetes mellitus. The Care Plan for Resident #4, updated on 6/12/24, showed that she was at risk for skin breakdown and staff were to provide peri-care and barrier cream with incontinent episodes. Staff were to encourage the resident to use her call light for assistance. On 11/26/24 at 11:00 AM Resident #4 was in her wheel chair in her room. She said that the call lights take forever. She said that she was incontinent and needed frequent changes because she's a heavy a wetter. Resident #4 said that she'd had skin breakdown in the past and the staff would come in and tell her she needed to get off her bottom, but what can I do, I'm in a wheel chair. Resident #4 said that the staff would often come in and shut off the call light, she would turn the light back on when they didn't return in a timely manner. They often said they didn't have enough staff. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) According to the MDS dated [DATE], Resident #3 had a BIMS score of 15 (intact cognitive ability). She was admitted to the facility on [DATE] and was totally dependent on staff for dressing, hygiene, toileting and transfers. Her diagnosis included; Cerebrovascular Accident (CVA) hemiplegia or hemiparesis, chronic pain and constipation. The Care Plan updated on 6/5/24 showed that Resident #3 was at risk for skin breakdown, staff were to provide peri care as needed after incontinence episode. She was in an electric wheelchair and able to relieve pressure by tilting or adjusting wheelchair. The resident likes to go to her room after meals and lie down. Staff were to anticipate here needs and reassure her that they would assist as soon as possible. On 11/26/24 at 8:42 AM, Resident #3 was in a motorized wheel chair, her body leaned to the left and her speech was slow and soft. Resident #3 stated the call lights take forever. She was not able to say how long she had to wait to get help, but the staff would usually tell her that they didn't have enough help to get there any sooner. 4) On 11/25/24 at 3:45 PM, Staff D, Licensed Practical Nurse (LPN) said that there were many times when they had just one CNA working. She said that, at times, the office staff would say they were going to help out but, that didn't happen very often. She said that some CNA's were better than others at getting to the residents when they were working alone. Staff D said that there was a weekend in August where she was the only nurse available so she worked over 40 hours straight, and then a 12-hour shift after that. She said that they provided an extra aide during that time so she could take naps. According to the timesheets for Staff D, on 8/2/24 she worked 23.25 hours straight with just two, 30-minute breaks and on 8/3/24 she worked 14.25 hours with one, 30-minute break. Over a three-day period (8/2 - 8/4) Staff D worked 49.25 hours. On 11/25/24 at 2:05 PM, Staff B, CNA said that at least once a month, she is expected to work without another CNA, and she admitted that she had transferred residents that required 2 staff, without another staff person. She acknowledged that it did take a long time to respond to the call lights during these times. On 11/26/24 at 8:40 AM, the Administrator said that the only time they would operate with just one CNA was on the night shift. During the day they need 2 CNA's or the office staff would come out and help with residents that required 2 staff assistance. On 11/26/24 at 1:00 PM, the Director of Nursing (DON) said that they did not have a policy on call light response time and they follow the regulations. The Facility assessment dated [DATE], documented the facility would have resources needed to provide competent support and care for resident population every day and during emergencies. They would provide a Registered Nurse (RN) or LPN one for each shift. Staffing plan for direct care staff (CNA); based on resident need with a goal of 3.00 PPD (Hours Per Patient Day, using the number of residents, 24 x 3.0 = number of hours used in a 24 hour period. Equaling 72 CNA hours per day.) (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/26/24 at 11:30 AM, the Regional Nurse Consultant said that the Facility Assessment needed to be updated and the PPD for direct care staff calculated out to be 3 CNA's on for 24 hours a day and that was not a realistic goal.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on facility document review, and staff interviews the facility failed to ensure that a Registered Nurse (RN) was at the facility for 8 consecutive hours every day. In a 30-day timeframe, 4 days with no RN coverage. The facility reported a census of 24 residents. Findings include: In a review of the nursing schedule for the month of November 2024, it was discovered that there were no RN's scheduled on the 9th, 10th, 17th and 23rd. On 11/26/24 at 11:38 AM, the Director of Nursing (DON) said that she was a Registered Nurse and at the facility through the week and occasionally, on the weekends. She acknowledged that there was no RN coverage on November 9, 10, 17, or 23rd. She said that she would be talking to the Administrator on how they would handle RN coverage going forward. On 11/26/24 at 12:55 PM, Staff F, Nurse Scheduler, said that it had been very difficult to ensure they had RN coverage when they didn't have any on call staff and needed to rely on agency nurses. On 11/26/24 at 1:00 PM, the DON said that they did not have policy on RN coverage. According to the Facility assessment dated [DATE], the facility would have resources needed to provide competent support and care for resident population every day and during emergencies with RN or LPN one for each shift.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, resident interview, staff interviews and clinical record review the facility failed to ensure they had the proper equipment and services to meet the needs of residents before admission for 1 of 1 residents reviewed. Resident #1 sustained a knee injury that required therapy services and the facility agreed to accept the resident before considering his bariatric equipment needs. The facility reported a census of 24 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 was admitted to the facility on [DATE] from the hospital. A Brief Interview for Mental Status (BIMS) assessment, dated 10/30/24 at 8:41 AM, showed that Resident #1 had a score of 15 (cognitively intact). The following documentation was found in the Progress Notes: 1) On 10/29/24 at 3:29 PM, the resident arrived via ambulance with a knee injury. He had bilateral lower extremity swelling and he was able to stand with a walker and transfer to bed. 2) On 10/30/24 at 4:45 PM, the resident required 2 staff assist with pivot transfers. 3) On 10/31/24 at 8:57 PM, Resident #1 was in bed, on the computer and had asked about equipment. The staff was unable to answer his questions. A document titled: Functional Abilities and Goals, dated 11/5/24 at 8:31 AM, showed that Resident #1 had lower extremity impairment on both sides. He was totally dependent on staff for toileting hygiene, lower body dressing, and showering. He required substantial assistance with rolling over and sit to lying. Sit to stand, bed to chair transfers, toilet transfers and walking were not attempted in the 3 day look back period due to medical conditions and safety concerns. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/25/24 at 9:52 AM, Resident #1 was lying in a bariatric bed. There was a bariatric chair, wheel chair, commode and walker in the room. Resident #1 expressed that he was upset about the lack of planning related to his admission to the facility. He said that he came from the hospital after his knee gave out and he was transferred to the facility for rehabilitation, with a goal of going back home. When he arrived, the staff were unaware of his equipment needs. The bed was too small for him, they didn't have a large enough commode, walker or chair, and he was delayed in getting Physical Therapy (PT) so he had lost ground on the progress he had made in the hospital. The resident looked through his phone and referenced detailed notes that he had taken. He said that on November 7th the Director of Nursing (DON) talked to him about the lack of equipment, and said they had a payment issue with suppliers and needed credit approval. On November 13th he finally got the 4 items, but From October 29th through November 13th, he was mostly bed-ridden. Staff were giving him bed baths and he was using a bed pan that was too small for him and would often spill over into the bed. The hospital had a difficult time finding him a skilled nursing facility because of his size, but this facility said that they could meet his needs, but when he got there, he found that they weren't prepared for him. Resident #1 said that when he didn't have a walker to use for therapy, his family went and bought one for him. Before that time, PT made due with a sit to stand that they rigged so he could do some exercising. The clinical record for the resident lacked a comprehensive care plan. A PT Evaluation and Plan of Treatment note dated 11/3/24, showed that the resident was unable to complete any ambulation or transfer as bariatric equipment had not been delivered. A note on 11/4/24 showed that the walker in the resident's room was rated for 500 pounds and he was over that weight. PT put a hold on functional transfers and ambulation until a walker arrived that can support his weight. On 11/5/24, the bariatric equipment had not arrived so they tried a Sara Steady walker device rated for 900 pounds for standing and he was able to transfer sit to stand. PT then used the Forward Wheeled [NAME] (FWW) rated for 500 pounds because the resident did not bear a lot of weight through the walker and he wanted to walk across the room and back. A PT note dated 11/8/24, showed that the equipment was still not at the facility, the family got upset and ordered him a walker that met size and weight requirements. A PT note dated 11/14/24 showed that the bariatric equipment had arrived on 11/13/24. The History and Physical (H&P) report from the referring hospital's emergency room (ER), dated 10/9/24 at 5:54 PM, showed that Resident #1 presented to the ER with right knee pain. He was getting into his truck when his leg became weak and he dislocated his knee. The X-ray was negative for fractures. The ER contacted multiple skilled nursing facilities for which the patient exceeded the maximum weight limit. Due to his weight, he required bariatric bed and lift system. A dietitian recommendation report dated 10/21/24 at 1:19 PM, (included with the hospital referral documents) showed that his admitting weight to the hospital on 10/8/24 was 770 lbs. On 10/21/24 it was 688.9 pounds, with a height of 70 inches. Some of the weight shifts likely related to fluid. A daily hospital report dated 10/22/24 at 10:46 AM, showed that Resident #1 had a height of 177.8 centimeters (cm) (70 inches) and his weight was 313.4 kilograms (690 pounds). On 11/25/24 at 1:43 PM, a Social Worker (SW) from the referring hospital said that the accepting facility would have gotten the hospital reports and therapy notes before they decided on accepting the patient. The SW said that the facility called to accept on 10/24/24. On the 28th they confirmed that the resident would transfer on the 29th. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/25/24 at 2:38 PM, the Maintenance Manager (MM) said that he knew before Resident #1 arrived that he was over 600 pounds and would need a special commode but he wasn't aware that the resident didn't have a wheel chair or walker. The MM talked about the many supply companies that he contacted trying to find the equipment. He stated that there were many barriers to getting approval from the facilities corporate office and eventually they decided on rentals and found a company that could provide those needs. On 11/26/24 at 8:40 AM, the Administrator said that she was involved in the decision to admit Resident #1 and she knew the hospital was having issues finding placement. She said that they were told that he could walk and once he got to the facility there were challenges with trying to get the equipment. Before accepting Resident #1 for admission, the Administrator, Assistant Director of Nursing (ADON), Director of Nursing (DON) brainstormed together if they could serve his needs and no one on the team had concerns about his size. They all knew that he was 700 pounds and very tall. The Administrator acknowledged that they did not start calling for the specialized equipment until 11/3/24. She said that should would have liked to have more more information from hospital about his equipment needs before they had accepted him. On 11/25/24 at 2:20 PM, Staff F, Assistance Director of Nursing (ADON) said that she was the first go-to for resident referrals. The decisions to accept were usually made between her and the DON. She said that she looked at insurance questions, medications and needs for skilled care. She said that she had been told the equipment for Resident #1 would have been delivered before his admission and that the Administrator and MM were taking care of those needs. 11/25/24 at 4:10 PM, the DON said that she became aware of the challenge with equipment needs for Resident #1 when he formally submitted a grievance. She said that before he was admitted , she wondered if they could meet his needs related to his large size. According to the Facility Assessment last updated on 2/29/24, the Administrator, DON and governing body would ensure appropriate care and services could be provided to the resident prior to granting admission into the facility. All potential residents were screened for appropriate placement prior to admission. In the case of bariatric's patients over 425 pounds, the staff would obtain more information before making the decision to admit to the facility.