

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 10/14/2025
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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on clinical record review, facility investigative file review, staff interviews and facility policy review the facility failed to timely report an allegation of abuse to the appropriate management staff member for 1 of 5 (Resident #1) residents reviewed. The facility reported a census of 31 residents. Findings include: According to the admission Minimum Data Set (MDS) assessment with a reference date of 8/25/2025, Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15. A BIMS score of 15 suggested no cognitive impairment. Resident #1 had impairments to bilateral lower and upper extremities and utilized a motorized wheelchair. Resident #1 was frequently incontinent of urine and bowel, dependent on staff for toileting hygiene and rolling from left to right. The following diagnoses were listed for Resident #1: cerebral palsy, anemia, neurogenic bladder, anxiety, depression, bipolar, post-traumatic stress disorder (PTSD), nephrotosis, and bacteremia. The Care Plan Focus Area with a revision date of 8/25/2025 documented Resident #1 had an Activities of Daily Living (ADL) self-care deficit due to disease process. The care plan documented Resident #1 was dependent on two staff for repositioning and turning in bed (frequently) and as necessary. The facility's investigative file included the following timeline of the incident:- On 10/4/2025 at approximately 8:45 PM Staff A previous Provisional Administrator was notified by Staff C Certified Nursing Assistant (CAN) witnessed Staff D Agency CNA repositioning Resident #1 too quickly and felt it was rough. On 10/4/2025 at 8:22 PM the State Agency was notified online by Staff A.- On 10/3/25 at approximately 5:45 PM Staff C witnessed a care that was being provided Resident #1. Staff C reported that Staff D had turned Resident too quickly for her to assist and she felt it was rough. Staff C reported this allegation to Staff A on 10/4/2025 at approximately 8:45p.m. The facility provided Staff C's Dependent Adult Abuse Mandatory Reporter Training certificate. The certificate had a completion date of 5/21/2025. On 10/9/2025 at 1:52 PM Staff C stated while her and Staff D assisted Resident #1 with cares. Staff C indicated Staff D was really rough, tossing her around. Staff C told her she has to be gentle and careful while assisting the resident. Resident #1 told Staff D to stop because she was hurting her and was going too fast. Staff C acknowledged she did not know what to do because she personally had never had this issue before. She stated this happened right before supper on 10/3/2025. She called Staff A on her way home from work on 10/4/2025; her shift ended at 6:00 PM. In her mind Staff C thought she had two days not two hours to report this concern. Staff A educated her their reporting requirements of 2 hours, notifying the nurse on duty and asking the staff member in question to leave the room. On 10/10/2025 at 1:03 PM the Director of Nursing (DON) stated Staff C's concerns about how Staff D was caring for Resident #1 should have been reported as soon as possible or within two hours of the incident. The DON indicated Staff A started the investigation prior to the end of her employment with them. On 10/14/2025 at 12:11 PM the Administrator stated he took over about a week ago, on 10/6/2025. He acknowledged the facility's reporting process is dependent on what the concerns. If the situation involves harm or abuse it should be reported immediately so they can report the issue within two hours to the State Agency. The facility provided a document titled Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy that was updated on 10/19/2025. The policy statement included: these procedures shall include the screening and training of employee, protection of residents and the prevention, identification, investigation, and timely reporting of abuse, neglect, mistreatment, and misappropriation of property without fear of recrimination or intimidation. All allegations of resident neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation shall be reported to the Iowa Department of Inspections, Appeals and Licensing (DIAL) no later than two hours after the allegation is made. Persons Responsible for Reporting a Crime: Everyone having knowledge of the criminal act has an independent duty to report to law enforcement and DIAL.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on the facility investigative file review, resident and staff interviews and facility policy review the facility failed to complete a thorough investigation, for 1 of 5 residents reviewed (Resident #1), when a resident reported money was missing from her room. The facility reported a census of 31 residents. Findings include: According to the admission Minimum Data Set (MDS) assessment with a reference date of 8/25/2025, Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15. A BIMS score of 15 suggested no cognitive impairment. The following diagnoses were listed for Resident #1: cerebral palsy, anemia, neurogenic bladder, anxiety, depression, bipolar, post-traumatic stress disorder (PTSD), nephrotosis, and bacteremia. On 10/10/2025 at 10:43 AM Resident #1 stated she would keep her money wrapped in two red socks in a zip lock bag located in her top right drawer of the dresser that was located to the left of her bed. When she noticed \$90 was missing she notified staff and the facility replaced her money. Since then she puts her money in a lock box. Review of the facility's 5-day investigation revealed the following: -Resident statement, timeline of incident and plan of action. The 5-day investigation lacked staff and other resident interviews. On 10/10/2025 at 1:03 PM the Director of Nursing (DON) stated she was not working when Resident #1 reported her money was missing. She indicated Staff A completed the investigation and would need to see if the Administrator had the investigative file for this self-report. On 10/10/2025 at 2:00 PM the Administrator indicated he was unable to find the paper file that contained the investigation in to Resident #1's missing money. During a follow-up interview on 10/14/2025 at 10:59 AM the Administrator was asked to explain their investigative process: he stated they would separate the individuals, complete the initial investigation, 5-day report and education staff. He added all of this would be documented and sent to the State Agency. They would talk to all residents to ensure their safety and to report any concerns. They would also talk to all staff involved and other pertinent staff members. Once the investigation is completed the file would be placed in a binder or in a file on the computer. He prefers to have these files on the computer. He acknowledged they were unable to find the investigation that was completed by Staff A. On 10/14/2025 at 9:16 AM the State Agency's Intake Specialist indicated the facility submitted the following information for their self-report: Resident #1's care plan, facesheet and the facility's 5 day summary. The facility provided a document titled Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy that was updated on 10/19/2025. The policy statement included: these procedures shall include the screening and training of employee, protection of residents and the prevention, identification, investigation, and timely reporting of abuse, neglect, mistreatment, and misappropriation of property without fear of recrimination or intimidation. Should an incident or suspected incident of resident abuse be reported, observed, the Administrator or his/her designee will designate a member of management to investigate the alleged incident. The Administrator or designee will complete documentation of the allegation of resident abuse and collect any supporting documents relative to the alleged incident. A) Review documentation in the resident record D) Attempt to obtain witness statements (oral and/or written) from all known witnesses Following investigation, the Administrator or designated agent will be responsible for forwarding the results of the investigation to the Department of Inspections, Appeals, and Licensing (DIAL). The written report shall be forwarded to DIAL. This written report shall be forwarded to the Department within five days of the initial report.</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>Based on previous Centers of Medicare and Medicaid Services (CMS) from 2567 review, staff interviews, and facility policy review the facility failed to ensure they provided a comprehensive, effective Quality Assessment and Performance Improvement (QAPI) program. The facility reported a census of 31 residents. Findings Include: A review of the Department of Inspections, Appeals and Licensing website revealed the facility had repeated deficient practices identified during complaint investigations from 8/3/2023 to 6/19/2025. The repeat deficiencies cited include:-8/3/2023 during a complaint investigation: 609 Failure to Report-6/24/2024 during a complaint investigation: 610 Failure to Investigate-8/2/2024 during a complaint investigation: 609 Failure to Report-6/19/2025 during a complaint investigation: 609 Failure to ReportOn 10/14/2025 at 12:11 PM the Administrator stated he came started at the facility a week ago on 10/6/2025. He stated to prevent repeat deficiencies they would hold monthly all staff meetings, as well as mandatory meetings. If staff are unable to attend they have a week to meet with their supervisors to review items from the meeting. When asked what would be done to ensure the education provided has been retained, he stated they would revisit the education during their QAPI and all staff meetings. He wants to start doing stand downs every day to provide more communication opportunities with staff members.The facility provided a document titled Quality Assurance and Performance Improvement Plan (QAPI)/Quality Assessment and Assurance (QAA) with a revision date of 5/23/2023. The purpose of this document is to ensure facilities develop a plan that describes the process for conducting QAPI/QAA activities, such as identifying and correcting quality deficiencies as well as opportunities for improvement, which will lead to improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life, and resident safety. Quality Assurance and Performance Improvement is a systematic approach for improving quality of life, quality of care, and services we provide to our residents. We take a proactive approach to continually improve the way engage and care for our residents, caregivers, and other partners so that we may realize our vision to provide a homelike environment to our residents and a pleasant work environment to our team members. To do this, all employees will participate in ongoing QAPI efforts which support our mission of partners in care, family for life.</p>		