STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165217	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring Acres Nursing and Rehab Center	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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the record review, resident family interview, staff interview and policy review the facility failed to provide ready access to personal funds managed by the facility. The facility provided a document with 14 of 22 residents with resident trust funds at the facility. The facility reported a census of 22 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #2 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment.On 6/3/26 at 10:52 AM Resident #2 stated she could only get money if the Administrator was at the building. 2. The MDS dated [DATE] documented Resident #5 had a BIMS of 15 indicating no cognitive impairment.On 6/4/26 at 9:52 AM Resident #5 stated she did not know how much she had in her account at the facility currently. Resident #5 said she would like to buy things at the facility like pop if she had money. Resident #5 stated she did not know if she had money or who to get the money from. 3. The MDS dated [DATE] documented Resident #6 had a BIMS of 15 indicating no cognitive impairment. On 6/4/26 at 9:38 AM Resident #6 stated he did keep money in the resident trust at the facility. Resident #6 stated the facility goes shopping twice a month and got him whatever he needed. Resident #6 said it did bother him because he did not know how much was in his resident trust because he used the money to buy cigarettes. Resident #6 said he was not sure if he could get money on the weekends or in the evening. 4. The MDS dated [DATE] documented Resident #7 had a BIMS of 5 indicating severe cognitive impairment. On 6/4/26 at 10:41 AM Resident #7's family member explained Resident #7 could only get the money when the Administrator was at the facility. On 6/1/26 at 11:57 AM the Administrator stated she covered the business office manager position at the facility. The Administrator stated she was the staff that took care of resident funds with the help of the Chief Financial Officer (CFO). The Administrator stated she does have residents that want money from the trust. The Administrator stated Resident #8 frequently asked for money from the trust. The Administrator stated they keep petty cash at the facility for the residents in a lock box in the administrators office. The Administrator stated she was the only staff member that had access to the lock box. The Administrator stated there is a cash bag in the nurse medication cart in the narcotics drawer. The Administrator explained she does not know how much money was in there. The Administrator stated the nurses were aware the money was in the narcotics drawer and there was a log. The Administrator stated she was not sure if the nurses were oriented on the money available for the residents. The Administrator stated she would have to talk to the Director of Nursing (DON). The Administrator stated she had not heard any resident voice any concerns about getting money when they wanted it. On 6/1/26 at 12:26 PM Staff H, Licensed Practical Nurse (LPN) stated the residents are supposed to have money in the narcotics drawer. Staff H opened the narcotics drawer in the medication cart. Staff H stated there was no money available in the drawer for the residents. Staff H stated there were 2 residents with wallets in the drawer but the money in one wallet was money but it was that resident's money. An observation on 6/1/26 at 12:30 PM revealed Resident #8's wallet with a social security card and identification card on the inside of the wallet. A second wallet with Resident #7's identification card (ID) on the outside with her social security card on the inside with $18.00.On 6/3/26 at 2:50 PM Staff B, Certified Nurse Assistant (CNA) stated had worked at the (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility for about 2 months. Staff B explained she has heard residents request money from the resident trust and be told they could not have it. Staff B said she has heard residents complain about not being able to get money from their funds. On 6/2/26 at 8:44 AM Staff I, Previous Business Office Manager (BOM) stated Resident #6 and Resident #8 requested money from the resident trust frequently. Staff I stated the residents had requested money and they were unable to get it. Staff I stated she was unable to withdraw the money because she balanced the funds. Staff I stated the Administrator also could not withdraw funds. Staff I stated there used to be money on the medication cart for the residents with a previous administration that was stopped. Staff I stated there was an Administrator that brought money in for the medication cart. Staff I stated the money on the medication cart was not put in place before she was terminated. On 6/1/26 at 12:32 PM the Administrator asked if Staff H knew where the money for the residents to use was in the narcotics drawer. The Administrator explained Staff H stated no there was no money in the narcotic drawer for the residents to use only 2 resident wallets. The Administrator asked Staff H if there was any other money in the whole medication cart and she said no. The Administrator stated there are only 2 resident wallets with their ID and Social Security card present. The Administrator acknowledged after looking through the medication cart there was no money available for residents when she was not at the facility. On 6/4/26 at 2:07 PM the Administrator stated she had recognized that funds were not available to the residents 24 hours a day but now there is a cash box in the narcotics drawer in the medication cart. The Administrator acknowledged they had noticed there was a way to improve that process as well. The Administrator said there was an education on the cash box being available for all the nurses. Review of an undated facility provided policy titled, Resident Trust Fund Policy documented withdrawals may be requested by the resident or authorized representative during normal business office hours. After hours withdrawal requests should be done through nursing staff.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the record review, resident family interview, staff interview and policy the facility failed to provide an individual financial record to the resident and/or power of attorney (POA) in the form of quarterly statements and upon request. The facility provided a document with 14 of 22 residents with resident trust funds at the facility. The facility reported a census of 22 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #2 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment.On 6/3/26 at 10:52 AM Resident #2 stated the facility had not given her a quarterly statement on her resident trust account to let her know how much money she had in the trust. 2. The MDS dated [DATE] documented Resident #5 had a BIMS of 15 indicating no cognitive impairment.On 6/4/26 at 9:52 AM Resident #5 stated she had not been given a statement reflecting the amount she had in her resident trust account in a while. Resident #5 explained it had been longer than 4 or 5 months since she had received the statement. Resident #5 said she could only remember getting one statement in the last 2 years. Resident #5 said she would like to buy things at the facility like pop if she had money. 3. The MDS dated [DATE] documented Resident #6 had a BIMS of 15 indicating no cognitive impairment. On 6/4/26 at 9:38 AM Resident #6 stated he did keep money in the resident trust at the facility. Resident #6 stated the facility goes shopping twice a month and got him whatever he needed. Resident #6 stated the facility staff told him yesterday how much he had in the resident trust. Resident #6 explained it had been more than 3 months since the facility had delivered a statement with the amount in the resident trust. Resident #6 stated the facility told him they did not know how much he had in his resident trust since the new company took over in March. Resident #6 explained that since the new company took over they had not been able to tell him until yesterday how much he had in his resident trust. Resident #6 said it did bother him because he did not know how much was in his resident trust because he used the money to buy cigarettes. 4. The MDS dated [DATE] documented Resident #7 had a BIMS of 5 indicating severe cognitive impairment. On 6/4/26 at 10:41 AM Resident #7's family member stated Resident #7 did have money in the resident trust for her. Resident #7's family member stated he did not receive a statement with the amount of money in the resident trust.On 6/1/26 at 11:57 AM the Administrator stated she covered the business office manager position at the facility. The Administrator stated she was the staff that took care of resident funds with the help of the Chief Financial Officer (CFO). The Administrator stated the CFO was Staff G, CFO. The Administrator stated a statement was sent quarterly to the residents and the facility used a local bank. The Administrator stated she was not sure if she was in charge of sending out the statement quarterly. The Administrator called Staff G and put her on speaker phone at that time. The Administrator stated she does have residents that want money from the trust. The Administrator stated Resident #8 frequently asked for money from the trust. The Administrator stated they keep petty cash at the facility for the residents in a lock box in the administrators office. The Administrator stated she was the only staff member that had access to the lock box. The Administrator stated there is a cash bag in the nurse medication cart in the narcotics drawer. The Administrator explained she does not know how much money was in there. The Administrator stated the nurses were aware the money was in the narcotics drawer and there was a log. The Administrator stated she was not sure if the nurses were oriented on the money available for the residents. The Administrator stated she would have to talk to the Director of Nursing (DON). The Administrator stated the resident trust is managed in the Electronic Health Records (EHR) system and that was how the statements are generated. The Administrator stated if Staff G had a new process then she needed to tell her about the process. The Administrator stated she was not familiar with the previous process for resident trust statements either. The Administrator stated that residents had asked for money and how much was in their account. The Administrator stated she told the residents (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she did not know it was all in the EHR system until this weekend. The Administrator stated she was trying to figure out how to know how much money the residents had and one of the residents was worried about being over resources. The Administrator explained that the resident asked if the facility had been deducting money from the trust and he was comfortable with that. The Administrator stated that resident was Resident #6. The Administrator stated she had not heard any resident voice any concerns about getting money when they wanted it. On 6/1/26 at 12:00 PM Staff G stated she did get everything up to date in the system since she came on in April for the resident trust. Staff G stated there was an external billing company and the Business Office Manager (BOM) was let go prior to her coming on. Staff G stated the residents should be getting quarterly statements that were facility generated. Staff G stated she truly did not know what the previous system was in place. Staff G stated the previous BOM was let go in the middle of March around the 15th. Staff G stated statements were generated March 31st and since she was not at the facility then she did not know how they were distributed. Staff G stated it would be a new process for this quarter for statement delivery and would be given out by whoever the Administrator decided at the facility. Staff G stated she was not familiar with the previous process for resident trust statements either. On 6/4/26 at 2:07 PM the Administrator stated she could not determine that the resident received the trust statement on March 31st of this year for the residents that had a trust with the facility. The Administrator stated she ensured the residents understood what having a trust with the facility meant yesterday. The Administrator stated she expected the statements were handed out quarterly and could not have occurred last time it should have. Review of an undated facility provided policy titled, Resident Trust Fund Policy documented residents or authorized representatives may request an accounting of trust fund activity at any time during normal business hours. The facility shall provide a written statement of resident trust fund activity at least quarterly.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, family interviews and Electronic Health Record review (EHR) the facility failed to ensure the safekeeping and confidentiality of sensitive resident records including the resident's Social Security card and Driver's License identification card for 2 of 2 residents (Resident #7 and #8). The facility reported a census of 22 residents. Findings include:1.The Minimum Data Set (MDS) dated [DATE] documented Resident #7 had a Brief Interview for Mental Status (BIMS) of 5 that indicated severe cognitive impairment.On 6/4/26 at 10:41 AM Resident #7's family stated he felt Resident #7's wallet should be locked up. Stated he does not know where the social security card or her ID is but would want that in a safe area so it did not come up missing. 2. The MDS dated [DATE] documented Resident #8 had a BIMs score of 15 that indicated no cognitive impairment.Observation on 6/1/26 at 12:26 PM revealed Staff H, Licensed Practical Nurse (LPN) opened the narcotic medication drawer on medication cart revealing Resident #7 and Resident #8's wallet with social security cards, insurance cards and drivers license identification cards present in each wallet. Observation on 6/1/26 at 12:32 PM of the Administrator revealed her removing the 2 wallets from the narcotic box on the medication cart and taking the wallets to her office. On 6/1/26 at 12:32 PM the Administrator stated none of the residents social security cards should be kept in the narcotic drawer on the medication cart.On 6/4/26 at 2:07 PM the Administrator revealed she did not think the wallet with Resident #7's and Resident #8's information was appropriately placed when in the narcotics medication drawer. The Administrator stated she notified Resident #7 and Resident #8 that their wallets were in the safe in her office. The Administrator explained the information was being protected as much as the narcotics were. The Administrator said she could not think of a reason the nurse would need access to the social security cards information. On 6/4/26 at 2:00 PM the Administrator revealed the facility lacked a formal policy on protection and safekeeping of confidential and sensitive resident records.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, resident interviews, resident family interviews, Electronic Record review (EHR), and policy review the facility failed to provide a clean and homelike environment when the floors in all areas of the buildings that had carpets had large stains. The facility also had an area of the wall in a resident's room that had black furry areas and flaking debris near a pipe with areas of the wall missing. The facility reported a census of 22 residents. Findings include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #9 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. On 6/4/26 at 10:07 AM Resident #9 stated the hallways have large stains. Resident #9 stated he frequently had his family over and would like the facility to look better. Resident #9 explained his brother came to the facility frequently and would like the building to be in better care. Resident #9 stated the doorway strip between his room and the hallway was coming up off the floor. Resident #9 explained the strip prevented the hoyer from being able to be pushed into his room so they tore the strip up. Resident #9 stated when the strip was coming up it was not difficult for him to get in was just a giant bump to get into his room and an eye sore.Observation on 6/3/26 at 11:55 AM in room [ROOM NUMBER] revealed a large area in the closet with dry, cracked and flaking debris. This area was also missing a large area of the wall with depth and texture of gray material missing from the inside of the wall. The same closet in room [ROOM NUMBER] had a soft ball size area of black fuzzy discoloration with a slightly larger area of spotted raised black fussy discoloration in an area to the left inside the same closet. This closet also had both closet doors propped on top of each other lying on the side of the doors stacked.Observations on 6/3/26 from 12:00 PM through 12:10 PM revealed several large stains on all hallways, in front of the nurses station and on all carpets at the facility. Several stains and discoloration on the carpet larger than 2 or 3 feet. Observations also revealed several doorway termination plates missing between the hallway carpet and resident's room flooring.On 6/2/26 at 8:44 AM Staff I, Previous Business Office Manager (BOM) stated there were missing areas of the wall in room [ROOM NUMBER] and the mold was growing in the closet. On 6/3/26 at 2:50 PM Staff B, Certified Nursing Assistant (CNA) stated had worked at the facility for about 2 months. Staff B stated family and residents complain all the time about the stains on the carpets at the facility. On 6/3/26 at 3:19 PM Staff J, Maintenance Director stated has worked at the facility for 3 weeks. Staff J stated there was a plan to pull all the carpet in the facility. Staff J stated the facility had not obtained prices yet. Staff J stated had not seen any black fuzzy areas or water damage in any resident rooms at the facility. Staff J acknowledged there were several resident doorways missing the termination plate because of wheelchairs pulling them up. Staff J explained he still needed to get the order together but repairs required time and money. Staff J explained the areas in the closet in room [ROOM NUMBER] were a concern to him because that was mildew. Staff J stated in room [ROOM NUMBER] the doors laying down and not being hung was completely unacceptable. Staff J explained he had just seen all of that today and the closet doors would be hung back up by tomorrow. Staff J stated the area on the wall in the closet in room [ROOM NUMBER] needed to be repaired but he needed to repair the shower next door to the room first. Staff J explained that the damage to the wall in the closet was from the shower leaking next door. Staff J stated the black fuzzy areas on the wall were mildew not mold. On 6/4/26 at 12:45 PM Staff A, Registered Nurse stated she had noticed the carpets at the facility. Staff A explained there were several stains on the carpets.On 6/3/26 at 3:39 PM the Administrator stated the company just hired a director of business development last week and had talked to the CEO about it. The Administrator stated staff had brought the issue with the wall and closet in 302 to her attention. The Administrator stated she had asked housekeeping to fix the issue. The Administrator stated the closet doors laying on the ground in front of the closet was unacceptable and (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	embarrassing. The director of business development had discussed carpet repairs but had not developed a plan to repair.On 6/4/26 at 2:00 PM the Administrator stated she did not have a policy for a clean, comfortable and homelike environment or maintenance of the facility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Record (EHR) review, observations, staff interviews, and policy review the facility failed to provide appropriate incontinence care when a resident was not taken to the toilet every 2 hours to prevent stool incontinence to 1 of 3 residents reviewed (Resident #3). The facility reported a census of 22 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #3 had a Brief Interview for Mental Status (BIMS) of 3 indicating severe cognitive impairment. The MDS documented Resident #3 was dependent (staff completed all of the effort or assistance of 2 or more is required) for toilet hygiene. The MDS further documented Resident #3 was always incontinent of bowel.Review of Resident #3's EHR titled Care plan documented an intervention initiated on 10/10/19 that Resident #3 was to be toileted every 2 hours to prevent stool incontinence. Observation on 6/3/26 at 9:59 AM of Resident #3's toilet routine revealed Staff A, Registered Nurse (RN), Staff C, Certified Nurse Assistant (CNA) and Staff B, CNA brought Resident #3 to her bedroom, transferred Resident #3 to bed, removed Resident #3's brief, completed personal cares, applied a new brief, covered Resident #3 up with a sheet and covered Resident #3 up with a blanket. Staff did not offer to take Resident #3 to the toilet.On 6/3/26 at 10:05 AM Staff B stated she had help with Resident #3 getting up that morning. Staff B stated Resident #3 was at the dining room table at 7:30 AM to eat breakfast that morning. Observation on 6/3/26 at 1:29 PM of Resident #3's toilet routine revealed Staff A, Registered Nurse (RN), Staff C, Certified Nurse Assistant (CNA) and Staff B, CNA brought Resident #3 to her bedroom, transferred Resident #3 to bed, removed Resident #3's brief, completed personal cares, applied a new brief, covered Resident #3 up with a sheet and covered Resident #3 up with a blanket. Staff did not offer to take Resident #3 to the toilet.On 6/3/26 at 2:05 PM Resident #3's family member stated will leave her sitting there until lunch, they are not repositioning her every couple hours. Resident #3's family member said staff were not checking Resident #3 to see if she was incontinent. Resident #3's family member explained she expected the staff to perform 2 hours check and change and/or toilet Resident #3 every 2 hours. Resident #3's family members stated she had expressed these concerns to multiple Director of Nursing (DON)'s and requested this be performed. On 6/3/26 at 2:50 PM Staff B explained she knew how to toilet and transfer the residents because it is in their care plan and if there was a change would lean on the co-worker for any changes. Staff B stated Resident #3 has a toilet but it was a shared bathroom. Staff B explained she was told Resident #3 was incontinent. Staff B stated she has not ever toileted Resident #3 on the toilet. Staff B said she had never seen anybody toilet Resident #3 on the toilet. On 6/4/26 at 12:45 PM Staff A, Registered Nurse (RN) stated the residents should be toileted after meals. Staff A explained that residents who can not take themselves to the bathroom should be checked, provided care or taken to the toilet every 2 hours because that was the expectation. On 6/4/26 at 11:58 AM the Director of Nursing (DON) stated Resident #3's care plan indicated she should be offered the toilet or the bed pan every 2 hours because she will be incontinent and that would lead to skin breakdown. The DON stated she expected Resident #3 would have been toileted every 2 hours not any longer. Review of an undated policy provided by the facility titled, Helping a Resident with Toileting Needs documented it was the practice of the facility to assist residents with toileting needs in order to maintain the resident's dignity as well as proper hygiene.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, family interviews, document review and policy review the facility failed to follow and prepare food according to the facility's menu, which was reviewed by the dietitian. The facility reported a census of 22 residents.Findings include:1. The Minimum Date Set (MDS) 3/8/26 documented Resident #3 had a Brief Interview for Mental Status (BIMS) of 3 indicating severe cognitive impairment. On 6/3/26 at 2:05 PM Resident #3's family member stated she did not believe they were getting delivery trucks for food and the staff had to go grocery shopping. The family member explained the kitchen staff put together whatever meals they can. States there's no actual menu and they have to put food together daily. 2. The MDS dated [DATE] documented Resident #9 had a BIMS score of 15 indicating no cognitive impairment. On 6/4/26 at 10:07 AM Resident #9 stated he heard the food truck would not deliver food because the facility owed them money. Resident #9 explained the last couple of days the kitchen had been throwing things together and were not writing it on the board because they didn't know what they were having until the day of. Observation on 6/1/26 at 11:45 AM of residents eating ham and bean soup, corn bread, corn and jello with fruit for lunch.Observation on 6/2/26 at 11:53 AM revealed residents eating stuffed green peppers, mashed potatoes, mixed vegetables with lima beans and cookies for lunch.On 6/3/26 an observation of residents eating corn dogs, sweet potato puffs, green beans, and blueberry crisp for lunch. On review of the facility provided document titled, Menu dated 6/3/26, listed the weekly meal schedule as follows: Monday-country fried steak, mashed potatoes, cream gravy, honey-buttered carrots, bread/margarine, and a banana berry cup; Tuesday-summer citrus chicken, seasoned orzo, country trio vegetables, and lemon lime cake; Wednesday-[NAME] sandwich, sweet potato puffs, green beans, and blueberry crisp; and Thursday-meatloaf, potato casserole, seasonal vegetable, bread/margarine, and a pudding sundae.On 6/2/26 at 12:45 PM Staff D, [NAME] stated she cooked all the meals the last two days. Staff D expressed they did not have any of the food for any of the meals listed on this week's menu. Staff D explained she went to the freezer, pulled what they had available and made it. Staff D stated they just got a dietician at the beginning of this week on Monday. She explained they did not get their truck last week and had alternate meals that were made from what the facility still had available last week as well. Staff D expressed the meals were not reviewed by a dietitian last week or this week. Staff D further explained the food delivery company provides the menu for four weeks at a time. Staff D stated the residents have asked what was for dinner because they do not always have the evening meal on the board. Staff D stated sometimes there are complaints about not having enough for seconds. Staff D stated it was a surprise they did not get the food supply for last week. On 6/2/26 at 1:44 PM Staff E, Dietary Manager (DM) stated the facility lacked a weekly menu. Staff E expressed she was worried if she had enough food for the residents. She explained the food delivery company suspended service on 4/29/26 due to an unpaid balance. Staff E stated the CEO flew in and bought food from the grocery store one time. Staff E explained she had also bought food with her own money for the residents. Staff E stated the Administrator would go to the grocery store during this time but that she did not buy enough food. Staff E stated that the facility failed to make required prepayments to the food delivery company, resulting in a missed delivery the previous week. Staff E stated after today she did not think there was going to be much unless the food delivery was made this week. Staff E reported the facility lacked a dietitian to review daily menus since April and she prepared meals based on available inventory without planning. Staff E noted that residents frequently inquired about the daily menu because she could not provide information in advance.On 6/2/26 at 2:25 PM the Director of Nursing (DON) stated that the kitchen is expected to follow the weekly menu provided by the food delivery company. She explained that due to outstanding debts incurred by previous owners, the food delivery company requires the facility to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165217	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring Acres Nursing and Rehab Center	1000 Hillcrest Drive Anita, IA 50020

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	prepay for all food orders. To address supply shortages caused by these payment constraints, the DON reported that staff must occasionally purchase groceries from external sources. She noted that while the facility has been prepaying for recent deliveries, they are actively seeking a new food provider.On 6/2/26 at 3:37 PM the Administrator stated the facility currently has a food delivery company they are working with though the facility is required to pay for the delivery before the company will deliver the food. She stated the food delivery company is who she believed generated the menus for the facility. The Administrator stated the dietitian for the facility started Monday 6/1/26. The Administrator confirmed there are times that staff has to go to the grocery store for food items needed that herself and the CEO of the facility has also had to go grocery shopping. The Administrator explained that the reason the food delivery company had not been making deliveries was because of a past due balance. She expressed her concerns with the menus not being followed and her expectations would be for them to follow the menu provided by the food delivery company. The Administrator explained her frustration with the current food delivery company's request of the facility to pay the balance in advance before the delivery would be made. She stated she is currently trying to find another food delivery company to work with. On 6/4/26 at 8:30 AM Staff F, Account Manager for the Food Delivery Service stated that an outstanding balance originated under previous ownership who currently owned the facility. He explained that after legal review, it was determined the facility owed the outstanding balance because they hired the management team but remained the same owners of the facility. Staff F explained this debt accumulated to approximately $14,000, prompting the supplier to cease shipments and threaten the removal of facility equipment, such as dishwashers and coffee machines. Staff F stated that the facility missed three to four deliveries, including the previous week. Currently, the facility has paid the balance in full; however, they are required to prepay for all future food orders.Observation on 6/3/26 revealed food truck delivery had been completed at the facility with food required for the future week.On 6/4/26 at 2:00 PM the Administrator revealed the facility lacked a formal policy for following menus reviewed by a Dietitian.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, Electronic Health Record (EHR) review, and policy review, the facility failed to complete appropriate hand hygiene for 2 of 2 residents observed (Resident #3 and #4). The facility further failed to apply appropriate Personal Protective Equipment (PPE) when catheter care was completed on a resident (Resident #3) with Enhanced Barrier Precautions (EBP). The facility reported a census of 22 residents. Findings Include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #3 had a Brief Interview for Mental Status (BIMS) score of 3 indicating severe cognitive impairment. The MDS further documented Resident #3's dependent functional abilities for toileting hygiene and personal hygiene. The MDS documented Resident #3 required an indwelling catheter and had bowel/bladder incontinence and was dependent on staff for toilet care. Observation on 6/3/26 at 9:59 AM revealed Staff A, Registered Nurse (RN), Staff B, Certified Nurse Assistant (CNA) and Staff C, CNA performed hand hygiene and applied gloves, no gowns applied prior to assisting Resident #3 with incontinence care. Staff B removed Resident #3's wheelchair foot pedals and placed a gait belt around the resident's waist. Staff A and Staff B completed a two-person transfer. Staff A removed Resident #3's gait belt. Staff A lifted Resident #3's legs into the bed while Staff B guided the resident's shoulders. Staff A removed Resident #3's pants and Staff B unclasped the brief, noting urine incontinence. Staff A removed gloves, performed hand hygiene, and moved the soiled brief down between the resident's legs. Staff C completed incontinence care on the front side and assisted Resident #3 in turning to her left side. Resident #3 voided during repositioning with an indwelling catheter in place. Staff A applied gloves and completed incontinence care for the buttocks, rectum, and anus, noting bowel incontinence while cleaning the anus. Staff C applied a new brief and assisted Resident #3 in turning back to the supine position with failure to perform hand hygiene or apply new gloves. Staff A and Staff B repositioned Resident #3 to remove the soiled brief and unfold a new brief. Staff A removed gloves, performed hand hygiene, and stated she was leaving the room to retrieve catheter items as she believed the catheter was leaking. Staff B removed gloves, failed to perform hand hygiene, and left Resident #3's room. Staff A returned to Resident #3's room, performed hand hygiene, and applied gloves. Staff A removed 8cc normal saline from the catheter balloon, advanced the catheter, and inserted 10cc normal saline back into the balloon. Staff A removed gloves, completed hand hygiene, and raised bilateral bedrails. Staff C gathered trash, removed the trash bag, replaced the trash bag, removed gloves, and completed hand hygiene.Observation 6/3/26 at 1:29 PM revealed Staff B, Staff C, and Staff A, transfer Resident #3 from her wheelchair into bed for incontinence care. Staff A, B, and C performed hand hygiene and applied gloves and failed to apply a gown. Staff B removed the wheelchair foot pedals and applied a gait belt to Resident #3. Staff A and B assisted Resident #3 from the wheelchair into the bed completing a two-person transfer. Staff C assisted with repositioning Resident #3 to her left side. Staff C used one wipe to perform incontinence care to Resident #3's left groin, right groin, and down the middle of her labia. Staff B assisted Staff C in repositioning Resident #3 to her right side. Staff C cleansed Resident #3's buttocks with a new wipe and applied a new brief with failure to change gloves or perform hand hygiene. Staff C positioned and fastened the brief between Resident #3's legs. Staff C repositioned Resident #3's pillows and covered Resident #3 with blankets, with failure to change gloves or perform hand hygiene. Staff B and Staff C removed their gloves. Staff C lowered the bed to the floor and left the room with failure to perform hand hygiene. Staff B left the room with failure to perform hand hygiene.2. The MDS dated [DATE] documented Resident #4 had a BIMS score of 1 indicating severe cognitive impairment. The MDS further documented Resident #4 was dependent on toileting hygiene and personal hygiene requiring staff to complete the task. The MDS revealed Resident #4 had bowel/bladder incontinence. On 6/3/26 at 11:44 PM an observation revealed Staff B and Staff C performed hand hygiene, applied gloves and assisted Resident #4 with incontinence care. Staff C, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cleansed the peri area with wipes and repositioned Resident #4 to the right side. Staff B, cleansed the buttocks with wipes, applied a new brief with failure to perform hand hygiene or change gloves. Staff B repositioned Resident #4 multiple times and fastened the brief. Staff C, applied Resident #4's pants and positioned mechanical lift sling under resident with assistance from Staff B with current gloves in place. Staff B removed gloves, Staff C removed gloves with failure to perform hand hygiene. Staff B and C removed trash, replaced trash bag, applied hand sanitizer, repositioned full body mechanical lift and applied lift sling loops correctly, Staff C operated lift and transferred resident to wheelchair. Staff B positioned the wheelchair under the Resident #4 and Staff C lowered Resident #4 into the wheelchair. On 6/4/26 at 11:58 AM the Director of Nursing (DON) stated staff must complete hand hygiene and a glove change after personal care and before applying a new, clean brief. The DON further stated staff must perform hand hygiene before leaving a resident's room. The DON confirmed her expectation that all three staff members wear a gown when providing care, specifically when a resident's catheter is leaking.Review of a facility provided policy titled, Hand Hygiene dated 2025 documented the facility required all staff to perform hand hygiene in all facility locations to prevent the spread of infection. Staff must perform hand hygiene when hands are visibly dirty or soiled with blood or body fluids, between resident contacts, after handling contaminated objects, and before applying or after removing personal protective equipment (PPE). Additionally, staff must perform hand hygiene before and after handling clean or soiled dressings and linens, and after contact with items potentially contaminated with blood, body fluids, secretions, or excretions.Review of facility provided policy titled, Enhanced Barrier Precautions dated 2025 documented an order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO.