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	02/20/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on observations, interviews, clinical record review, and facility policy the facility failed to provide dignity to 3 out of 16 residents (Resident #2, #1, #10). The facility failed to provide dignity to residents as demonstrated by a resident waiting over 45 minutes for toileting, not providing privacy with incontinence, and personal embarrassment of a resident due to incontinence. The facility reported a census of 25 residents. Findings Include: 1. The Minimum Data Set (MDS) for Resident #2, dated 1/5/25 identified a Brief Interview for Mental Status (BIMS) score of 13/15 indicating normal cognitive functioning. The document revealed the resident had no behaviors. The resident had diagnoses of cerebrovascular accent (CVA) with hemiplegia or hemiparesis (stroke with an affected extremity(ies)), depression, and adjustment disorder, unspecified. With toileting, transfers, and bed mobility the resident required total assistance from staff. The document revealed Resident #2 utilized a power wheelchair with independence for distances greater than 150 feet. The document revealed the resident's frequent incontinence of bowel and bladder. Resident #2's Care Plan revised 2/10/25 revealed focus areas of Moderate Risk for Falls, and Activities of Daily Living (ADLs) self performance. The focus area related to falls revealed an intervention for use of an EZ Stand (weight bearing mechanical lift) and assistance of 2 staff to the toilet only. The ADL focus identified interventions of toileting dependent upon staff with use of bed pan or toilet in shower room, transfer with mechanical lift/Hoyer (non-weight bearing lift) with the assistance of 2, use of EZ Stand to transfer to the toilet when she is standing properly, may bend knees and hang. The Progress Notes from 3/1/24 to 2/19/25 revealed three incidents of behavior including inappropriate toileting involving a Certified Nurse Assistant (CNA), accusations involving staff, and impatience regarding needing to wait for staff assistance for toileting. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A continuous observation and interview began on 2/18/25 at 9:18 AM with Resident #2 seated in her power wheelchair outside of the bathroom/shower room door. The resident stated she had been waiting since before 9:00 to use the bathroom. Resident #2 stated she told Staff A, CNA, she needed to use the toilet when she finished taking her medication, and the staff told the resident she (the staff) was not going to wait for the resident and the resident would have to wait for her. The resident stated she has had to wait up to 2 hours for toileting depending on the time of the day. Resident #2 stated she has also at times limited how much she drinks if she thinks she may have to wait to use the bathroom. Observed Staff J, Licensed Practical Nurse (LPN) walk to and from medication cart 12 feet from the resident. Observed Staff K seated in the dining room and within line of sight of Resident #2 seated outside of the bathroom/shower room. Resident # 2 moved away from the bathroom to the nurses cart and returned to outside the bathroom/shower room door. Staff B, CNA, approached Resident #2, checked the bathroom/shower room and stated she would find an assistant to assist the resident with toileting. Staff B returned and told the resident she would have to wait as the other staff were assisting another resident. Resident #2 moved from the bathroom/shower room door to the nurses cart (12 feet distance), and returned to the bathroom/shower room door. At 10:02 AM Staff A and Staff L, CNA, went to the shower/bathroom with a mechanical weight bearing lift. The staff then went with the Resident #2 to her bedroom with a mechanical non weight bearing lift. The resident stated she was going to her room to use the bedpan versus the toilet. On 2/18/25 at 1:35 PM Staff L stated the shower room was also used for toileting residents who required the use of a mechanical lift. The staff stated Resident #2 changed from a weight bearing lift to non weight bearing lift to toilet this morning, not a permanent change. On 2/18/25 at 3:00 PM the Assistant Administrator of Nursing (ADON) stated Resident #2 would use the larger shower/bathroom as she was unable to access the bathroom with a power chair. The ADON stated the resident requires use of a weight bearing lift for toileting, and a non-weight bearing lift for w/c to and from bed transfers. The ADON stated the resident will have behaviors or not assist with use of the weight bearing lift for toileting and then would require the use of non-weight bearing lift to transfer to bed for the use of a bed pan for toileting. The ADON stated the residents should not wait longer than 15 minutes for toileting needs. On 2/19/25 at 10:35 AM Staff A stated residents should not have to wait longer than 15 minutes for use of the toilet. The staff stated if the resident required 2 staff and another staff was busy then the resident would have to wait until there were 2 staff available. The staff did not state at what point assistance might be sought from nursing or administration. On 2/18/25 at 12:55 PM the Interim Administrator and Staff M, Regional Nurse Consultant, stated residents should not have to wait longer than 15 minutes for toileting. The Interim Administrator admitted to having seen Resident #2 waiting in the shower/bathroom area, but assumed the resident was waiting for medications. The Interim Administrator expected staff to seek assistance from nursing or administration staff when needing 2 staff for transfers/care rather than have residents wait for extended periods of time. 41785 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The MDS dated [DATE], showed that Resident #1 had a BIMS score of 14 (cognitively intact.) She was totally dependent on staff for hygiene, showers, dressing and toilet transfers. The resident was frequently incontinent of bowel and bladder. Her diagnoses included; heart failure, renal insufficiency, Diabetes Mellitus, anxiety disorder and Bipolar disorder. The Care Plan updated on 7/5/23, showed that Resident #1 was a high risk for falls related to weakness and mental illness and she used an EZ stand (mechanical sit to stand lift) for transfers. The resident could propel shelf with a wheel chair and required assistance of one with showers and used adult incontinent products. Resident #1 had intellectual disabilities and was childlike in her thinking and actions. Staff were directed to allow her time to process what they were going to do. On 2/17/25 at 2:01 PM, Resident #1 was in her bedroom in a wheel chair. She was able to scoot herself in the wheel chair with her feet. Resident #1 said that she could use the bathroom but she needed 2 staff members to help. She said that it took a long time for them to answer the call light and toilet her and she often soiled herself waiting for them to come. Resident #1 said that she tried as hard as she could to hold it but sometimes she just couldn't and it makes her feel embarrassed. On 2/19/25 at 7:43 AM the Administrator acknowledged that it took two people to toilet Resident #1 and it could take a long time. She thought that during the day the resident was getting to the bathroom a couple of times and she hadn't come to her with concerns of call light times. 3. The MDS dated [DATE], for Resident #10 showed that she had a BIMS score of 0 (severe cognitive impairment) She had physical and verbal behaviors towards staff such as hitting, screaming and scratching. Resident #10 required substantial assistance with toileting hygiene, showering and dressing. The Care Plan for Resident #10, showed that she had self-care performance deficit, she was independent with transfers and would ask for help if needed. The resident had impaired safety awareness and was an elopement risk. Staff were directed to inform the nurse and re-approach in a different way, if the resident refused cares. On 2/17/25 at 12:46 PM, Resident #10 was sitting by the window in the dining room. She was able to get up on her own with a walker, and started walking across the room. The dining room had 3 other residents still sitting at tables. Staff O, CNA, approached the resident and loudly said we need to go change your pants, you're wet The resident required cueing and direction and Staff O stated several times, you're wet and we need to change your pants. On 2/19/25 at 7:43 AM the Administrator acknowledged that announcing that the resident was wet in the dining room was not dignified. According to a facility policy titled: Abuse, Prevention, Prohibition, dated 12/2024, Verbal abuse defined disparaging and derogatory terms to resident or families.

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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** 47673 Based on Electronic Health Records (EHR) review, observations, resident interviews and staff interview the facility failed to provide the residents with a comfortable homelike environment by not providing warm water in the residents rooms. The facility reported a census of 25 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #6 documented a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment. On 2/17/25 at 2:05 PM Resident #6 stated the water in her sink in her room was not ever hot. Resident #6 stated she wanted the water to be hot for washing her hands and the water should be hot. Resident #6 stated the staff are aware of the issue. 2. The MDS dated [DATE] for Resident #12 documented a BIMS of 15 indicating no cognitive impairment. On 2/17/25 at 12:59 PM Resident #12 stated the water in his room took a long time to get warm and then it never does actually get hot at all. Resident #12 stated the staff are aware of the problem. 3. The MDS dated [DATE] for Resident #20 documented a BIMS of 13 indicating no cognitive impairment. On 2/17/25 at 1:01 PM Resident #20 stated she would like it if the water was hotter. Resident #20 stated the water in her sink in her bedroom was never warm or hot. 4. The MDS dated [DATE] for Resident #22 documented a BIMS of 11 indicating moderate cognitive impairment. On 2/17/25 at 11:13 AM Resident #22 stated he would like the water to be warm when he washed his hands. Observation on 2/17/25 at 11:13 AM in room [ROOM NUMBER] revealed bathroom sink water turned on and water is not warm to the touch. On 2/17/25 at 11:17 AM with water continuously on, the water is still cool to the touch. Review of EHR titled, Resident Dashboard documented Resident #22 resided in room [ROOM NUMBER]. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/17/25 at 3:47 PM Staff D Maintenance Supervisor stated he had not completed temperature checks at the facility in the last 2 weeks because his thermometer was broken. Staff D stated he just received a new thermometer but it was in his jeep at home. Staff D stated he would have to obtain the water temperatures the next day. Staff D stated Hall 3 water temperatures are usually the warmest. Staff D stated if he raised the water temperature any amount hall 3 will be too hot and out of compliance. Staff D stated the water takes a while to fully cycle through the facility pipes. Staff D stated water temperature down hall one was usually 96 - 98 degrees, down hall two 100 - 102 degrees and down hall three 106 -108 degrees. Staff D stated it took about 10 - 12 minutes for water temperatures to get to 96 degrees down hall one in room [ROOM NUMBER] or 111. Staff D stated there was quite a distance for the water to get to room [ROOM NUMBER]. Staff D stated if you turn 3 or 4 other facets down the left side of the hall the water would get hotter faster. Staff D acknowledged the water in room [ROOM NUMBER] sink was not warm or hot at 3:57 pm, 3:59 pm, 4:01 pm and 4:04 PM. Observations on 2/17/25 at 3:56 PM revealed the hot water was turned on at 3:56 PM and checked every minute till 4:05 PM. The temperature of water slightly increased to touch but never was warm. Review of document titled, Temperature Logs revealed hall one revealed temperatures were above 95 degrees. A continuous observation of water temperatures from the sink facet in room [ROOM NUMBER] on 2/19/25 from 3:04 PM to 3:35 PM revealed the following: 3:04 PM 78.0 degrees 3:05 PM 83.1 degrees 3:06 PM 84.7 degrees 3:07 PM 85.1 degrees 3:08 PM 85.3 degrees 3:09 PM 84.9 degrees 3:10 PM 84.6 degrees 3:11 PM 84.4 degrees 3:12 PM 84.2 degrees 3:13 PM 84.4 degrees 3:14 PM 84.6 degrees 3:15 PM 85.5 degrees 3:16 PM 85.6 degrees (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3:17 PM 86.0 degrees 3:18 PM 86.0 degrees 3:19 PM 86.2 degrees 3:20 PM 86.2 degrees 3:21 PM 86.7 degrees 3:22 PM 86.7 degrees 3:23 PM 87.4 degrees 3:24 PM 87.6 degrees 3:25 PM 88.0 degrees 3:26 PM 88.7 degrees 3:27 PM 88.9 degrees 3:28 PM 89.2 degrees 3:29 PM 90.0 degrees 3:30 PM 90.1 degrees 3:31 PM 90.1 degrees 3:32 PM 90.1 degrees 3:33 PM 92.3 degrees 3:34 PM 93.0 degrees 3:35 PM 93.2 degrees On 2/17/25 at 4:23 PM the Interim Administrator stated there had been no complaints of temperature of water coming out of the tap. The Interim Administrator stated the facility's expectation was the water to get warm enough to wash the residents hands in three to five minutes. On 2/18/25 at 4:00 PM the Interim Administrator acknowledged concerns with water temperature at the facility. The Interim Administrator stated she had a plumber look at the water at the facility and the recirculators that pushed the hot water did not work. The Interim Administrator stated the plumber did not think that the recirculators had been working properly for a while.

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 41785 Based on staff interviews, personnel record reviw and policy review the facility failed to ensure background checks were completed before hire for 1 of 5 staff reviewed. The facility reported a census of 25 residents. Findings include: In a review of staff files it was discovered that Staff G, Director of Nursing (DON) was hired on 12/2/24. An Authorization for Release of Child and Dependent Adult Abuse Information signed on 11/29/24 by the Administrator at the time. The section of the document titled: Completed by the Central Abuse Registry, indicated that the person whose information was being requested was listed on the Child Abuse Registry (Staff G) as having abused a child. The file lacked documentation of any follow up inquiry into the details of why Staff G was listed on the Registry. On 2/19/25 at 12:12 PM, Staff M, Nurse Consultant, said that she traveled to several different facilities and she started coming to this facility to help with transitions in leadership, in October. She spent most of her time with education of staff and was at this facility a couple days a week. She acknowledged that Staff G was hired on 12/2/24, but her employment did not last long because she had a lot of anxiety. Staff M said that she interviewed Staff M and may have done the offer letter, but she did not do the background check or other paperwork for the hire. Staff M said that it was the responsibility of the Administrator in the building to do the new hire paperwork. She said that if she had known that there was an abuse hit on the background check she would have made sure she didn't work until they had an explanation and she was cleared to work in a healthcare setting. On 2/19/25 at 7:43 AM, the Administrator said that she called her boss about the results of the abuse check so he called the previous Administrator. She responded that she thought the check had came back clean. The Administrator sent an email to the Central Abuse Registry and they responded that they hadn't received any further requests related to this background check. According to a facility policy titled: Abuse, Prevention, Prohibition, dated 12/2024, the facility would not knowingly employ individuals who have been found guilty of abusing, neglecting or mistreating residents. All employees would have a criminal background check. The facility would make reasonable efforts to uncover information about any past criminal prosecutions.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on clinical record review, staff interviews, and policy review the facility failed to complete a Pre-Admission Screening and Resident Review (PASARR) process for 2 of 2 residents (Resident #15, Resident #21) reviewed for PASARR. The facility failed to complete a new PASARR for a resident who was diagnosed with new mental disorder diagnoses since completion of the previous PASARR and failed to coordinate assessments with the PASARR program by incorporating the recommendations into a resident's assessment and Care Plan. The facility reported a census of 26 residents. Findings include: 1. Review of Resident #15's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating intact cognition. The MDS further revealed a diagnosis of Bipolar Disorder, Alcohol Induced Acute Pancreatitis without Necrosis or Infection, and Adjustment Disorder with Anxiety. The document indicated the resident received antidepressant and hypnotic medications. The MDS failed to identify Resident #15 was taking an antipsychotic medication. Review of a facility provided document titled, The Preadmission Screening and Resident Review Level I Screen Outcome, dated 8/13/24 revealed a summary of findings indicating that Resident #15 did not show evidence of a serious mental illness or an intellectual or developmental disability (IDD) that appeared to require PASARR intervention. The document provided, indicated the resident had a diagnosis of Bipolar Disorder (current) with a substance related diagnosis of alcohol. The document revealed the resident was taking Caplyta Pill, 21 mg/day for Bipolar Disorder. The document further revealed that should there be a discrepancy in the reported information, a status change should be submitted for further evaluation. The electronic health record (EHR) revealed Resident #15 had medical diagnoses of: a.) Bipolar II Disorder date 9/11/24 b.) Adjustment Disorder with Anxiety 9/11/24 c.) Alcohol Dependence, uncomplicated 5/16/22 The EHR Clinical Physician Orders dated 2/19/25 documented the following orders: a.) Caplyta Oral Capsule 21 MG (Lumateperone Tosylate) Give 1 capsule by mouth one time a day for depression - Start Date 11/09/2024 2000 b.) Trazadone HCl Oral Tablet 100 mg/day at bedtime for depression - start date 9/11/24 and discontinued 2/11/25. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan dated 2/10/25 revealed a focus area related to depression with Trazadone and Caplyta medications indicated. The Care Plan interventions included side effects for antidepressant medications. The Care Plan failed to have a focus area related to antipsychotic medications with goal(s) and intervention(s). On 2/19/25 at 3:15 PM GoodRx identified Caplyta (Lumateperone) as an atypical antipsychotic medication used to treat the symptoms of depression for individuals with a diagnosis of Bipolar Disorder. On 2/18/25 at 3:07 PM the Assistant Director of Nursing (ADON) acknowledged the Physician Orders reflected Caplypta was prescribed for depression and the resident did not have a diagnosis of depression. The ADON stated the Caplyta is an antipsychotic medication and it should be reflected as such on the MDS. On 2/18/25 at 3:45 PM the Interim Administrator stated Resident #15 had been admitted prior to her coming to the facility. The Interim Administrator acknowledged the PASARR dated 8/13/24 and the admission psychiatric diagnoses dated 9/11/24 should be the same, and if they were not a new PASARR should have been completed. 2. Review of Resident #21's MDS dated [DATE] revealed a BIMS score of 15/15 indicating intact cognition. The MDS further revealed a diagnosis of Schizophrenia. The document indicated the resident did not take medications related to mental illness. The facility failed to identify the resident as currently considered by the state level II PASRR process to have a serious illness. Review of a facility provided document titled, Notice of PASRR Level II Outcome, dated 6/21/23 revealed the resident required services in a nursing facility and specialized services for behavioral health and/or developmental conditions were required. The document revealed a summary of findings indicated Resident #21 had a diagnosis of Schizophrenic Disorder. The document recommended the resident have supportive services including on-going medication management by a psychiatrist, supportive counseling, delegation of a power of attorney (POA). The document revealed the resident did not require medications at the time of the assessment. The EHR revealed Resident #21 had a medical diagnosis of Other Schizophrenia. The EHR Clinical Physician Orders dated 2/19/25 documented the resident did not receive psychotropic medications. The document identified target behaviors. The Care Plan dated 2/10/25 revealed no focus areas related to the PASARR. The facility failed to incorporate the recommendations of the PASRR Level II Outcome into the resident's Care Plan. On 2/18/25 at 3:45 PM the Interim Administrator stated Resident #21 was not considered a complete new admission as the resident was a transfer from a sister facility, and therefore a new PASSAR was not completed. The Interim Administrator acknowledged she was not aware of the supports that were required from the Resident's PASARR II. The facility revealed it did not have a policy related to PASARR.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observations, resident interviews, staff interviews, clinical record review and policy review the facility failed to ensure that staff followed physicians' orders for 4 of 16 residents reviewed. Resident #18 had several pressure ulcers with treatment orders to be completed twice daily. Staff failed to complete the treatments as ordered. Staff failed to observe medication administration for Residents #14 and #20, and Staff J was alerted by a resident that she was about to give the medication for Resident #26 to the wrong person. The facility reported a census of 25 residents. Findings include: 1. According to the Minimum Data Set (MDS) dated [DATE], Resident #18 had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact) The Care Plan initiated on 12/12/24, showed that Resident #18 had self-care deficits related to trauma. He was totally dependent on staff for repositioning and had pressure ulcers. Staff were directed to administer treatment as ordered and monitor for effectiveness. According to the Wound Care Assessment Notes dated 12/4/24, Resident #18 was admitted to the facility on [DATE] from the hospital where he had been treated for urosepsis (urinary tract infection.) The resident had an accident in 2020 that resulted in paraplegia. He was hit by a vehicle in August of 2024 and participated in intensive rehabilitation. Resident #18 had extensive skin breakdown on his legs and coccyx, and at the time of the exam, the provider wrote an order to transfer him to the hospital for suspected gangrene to the Right Lower Extremity (RLE) and suspected osteomyelitis (bone infection) of coccyx wound. The Progress Notes dated 12/11/24 at 1:03 PM showed that the resident was readmitted to the facility from the hospital on 12/11/24. The following orders and treatment documentation was found in the Treatment Administration Record (TAR) for December, 2024 and January 2025: a. Treatment to the right medial heel twice a day. The treatments were not completed and the chart lacked nursing explanation on: December 19th, 21st, 22nd, 23rd, 24th and 25th and January 1st, 3rd, 4th and 5th. On the 29th and 30th nursing notes showed that they did not have the supplies to complete the treatments. b. Treatment to the right lateral leg/ankle, twice a day. The treatments were not completed and the chart lacked explanation on December 19th, 21st, 22nd, 23rd, 24th and 25th and January 1st 3rd, 4th and 5th. c. Treatment to the coccyx twice a day. Treatments were not completed as ordered, and the chart lacked explanation on December 19th, 21st, 22nd, 23rd, 24th and 25th and January 3rd, 4th and 5th. d. Treatment to bilateral ischium. Treatments were not completed as ordered and the chart lacked explanation on December 19th, 21st, 22nd, 23rd, 24th, 25th and 30th and January 1st 3rd 4th and 5th. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. Treatment to the left posterior thigh every 3 days. The treatments were not completed as ordered and without explanation on December 21st and 30th. f. Treatment to the left lateral ankle every 3 days. Treatments were not completed as ordered and without explanation on December 21st and 30th. g. Treatment to the right lateral foot daily. The treatment was not completed as ordered and without explanation on December 21st and 23rd. On 2/19/25 at 9:26 AM, Staff P, Licensed Practical Nurse (LPN) said that she worked at the facility in December on the night shift and she remembered Resident #18. She said that the resident had significant wounds but they didn't always have the supplies needed to complete the treatments as ordered. She said that she had left several notes for the Director of Nursing (DON.) Staff P said that she knew the treatments were not getting done as ordered because she would date and initial the wrapping and be gone for a couple of days and it would still be her wrapping on the ulcers. On 2/20/25 at 7:06 AM, Assistant Director of Nursing (ADON) said that she was here for a short period of time when Resident #18 was at the facility. She said that he would like to stay in his wheel chair through the day and he would go out to smoke. The nurses would say that the wound changes would take up to 2 hours and if it wasn't done in the timeframe he wanted, he would refuse. She said she would expect that nurses would put a note in the chart to indicate the refusals and call the doctor. The Facility assessment dated [DATE], showed that staff would manage pressure injury prevention and care, skin care, and wound care (surgical, other skin wounds) The DON/designee in conjunction with Skin and Would Nurse Consultants would work on the prevention of medically avoidable skin issues. Pressure Injury Assessment and Treatment policy dated 1/2025 showed that if a resident resisted treatments, staff would document the reason for the refusal, and the resident's response to the explanation of the risks of refusing the procedure the benefits of accepting the available alternative. Staff would document physician and family notification of refusal and notification of supervisor if resident refuses procedure or interventions. 47673 2. The MDS dated [DATE] for Resident #14 documented a Brief Interview of Mental Status (BIMS) score of 15 indicating severe cognitive impairment. The MDS documented a diagnosis of gastro-esophageal reflux disease without esophagitis. The Medication Administration Record (MAR) for February 2025 documented a physician's order for gas-x 80 mg give 1.5 tablets by mouth three times a day for indigestion. On 2/18/25 at 8:55 AM Staff J, Licensed Practical Nurse (LPN) completed hand hygiene. Staff J took medications (with 80 mg simethicone) to Resident #14 at the breakfast table. Resident #14 self administered medication with sips of water to wash the medications down. On 2/18/25 at 8:55 AM Staff J acknowledged one 80 mg simethicone tablet was present in the medication cup prior to taking to Resident #14. (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	02/20/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/18/25 at 9:21 AM the ADON/LPN stated she would expect the nurse to hold the medication if unable to split the medication for a half tablet or if a half tablet was unavailable then notify the physician. The ADON stated the facility can notify the pharmacy to send a half tab. The ADON acknowledged Resident #14 had a physician's order for gas-x 80 mg give 1.5 tablets. The ADON acknowledged that simethicone was not scored and should not be split. The ADON stated she would send the doctor a request for a new order for 2 simethicone tablets. 3. The MDS dated [DATE] for Resident #20 documented a BIMS score of 13 indicating no cognitive impairment. The MDS documented a diagnosis of schizoaffective disorder. The MAR dated February 2025 documented a physician's order for depakote 125 mg 1 tablet to be given at 8:00 AM, 12:00 PM, and 5:00 PM. Observation on 2/17/25 at 12:58 PM of a red oblong pill dropped off with water to Resident #20 and Staff J, Licensed Practical Nurse (LPN) left the room. On 2/17/25 at 12:58 PM Resident #20 stated the nurse dropped off the medications to her and left the room before she takes the medication frequently. On 2/17/25 at 1:00 PM Resident #20 stated she thought the pill in her hand that the nurse had dropped off was her Ativan. Review of Resident #20's medications revealed the red oblong tablet was depakote 125 mg. On 2/17/25 at 4:17 PM the Interim Director of Nursing (DON) stated she had worked at the facility for the last 2 weeks. The Interim DON acknowledged Resident #20 should have taken the medication prior to the nurse leaving the room. The Interim DON stated her expectation was the nurse would have observed Resident #20 swallow the medication before leaving the room. On 2/17/25 at 4:23 PM the Interim Administrator stated she would have expected the nurse to give the medication as ordered or hold if the medication was unavailable in that dose and obtained clarification for the order. The Interim Administrator stated she would have expected the nurse to make an observation of the medication being swallowed prior to leaving the residents room. The Interim Administrator stated the facility had no policy/procedure for medication administration. 49628 4. Review of Resident #26's MDS dated [DATE] revealed a BIMS score of 8/15 indicating moderate cognitive impairment. The document revealed a diagnosis of Non-Alzheimer's Dementia. The document revealed the resident took antipsychotic medications. Resident #26's Care Plan dated 2/10/25 revealed a focus areas related to psychotropic medications, activity involvement, diet, and self care. (continued on next page)

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	165217	A. Building B. Wing	02/20/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Continuous observation on 2/17/25 at 10:57 AM revealed Staff J, Licensed Practical Nurse (LPN) enter the double occupancy room of Resident #26. Staff J attempted to give Resident #26 medications which the resident refused. The resident argued with Staff J with statements of having taken my 5 medications at breakfast. The resident further stated she was not taking any other medications as she was not supposed to, and her roommate was supposed to get her medication. Staff J left the room, and then returned to the double occupancy room and went to Resident #23 to provide her medications. On 2/17/25 at 11:02 AM Staff J stated the medications provided were for Resident #23 not Resident #26 as she initially thought. On 2/17/25 at 11:05 AM Resident #26 stated Staff J had tried to give her the wrong medications, but she knew she had already taken her medications and those were not hers. On 2/17/25 at 1:45 PM Resident #23 stated Staff J had provided her morning medications at approximately 11:00 AM this morning. Review of Resident #23's MAR for 2/25 revealed the resident took morning medications for hyperlipidemia, depression, antiplatelet, anxiety, and pain. On 2/19/25 at 1:45 PM the Interim Administrator and Staff M, Regional Nurse Consultant, stated a nurse providing medication should follow the Rights of Medication Administration. The Regional Nurse Consultant stated the administration was aware of concerns with the nurse passing medications. The facility revealed there was not a policy related to medication administration.

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	165217	A. Building B. Wing	02/20/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observations, staff interviews clinical record review and policy review the facility failed to implement interventions to prevent accidents and hazards for 4 of 16 residents reviewed. Residents #10 and #25 were identified as elopement risk and had Wander Guard alarm bracelets. Staff failed to ensure that the alarms were working by conducting daily checks. Staff also failed to provide safe transfer techniques with Resident #1 and #17. The facility reported a census of 25 residents. Findings include: 1. According to the Minimum Data Set (MDS) dated [DATE], Resident #17 was admitted to the facility on [DATE]. She had a Brief Interview for Mental Status (BIMS) score of 4 (severe cognitive impairment). The resident required substantial assistance with shower/bath, dressing hygiene, sit to stand and toileting transfer. Her diagnoses include cancer, anemia, non-Alzheimer's dementia, The Care Plan updated on [DATE], showed that Resident #17 had a terminal prognosis and chose Hospice care. She was dependent on staff with a wheelchair for ambulation. Resident #17 became agitated at times, and staff were to intervene before agitation escalated. On [DATE] at 1:24 PM, Resident #17 was sitting in a wheel chair near the nurses station when Staff I, Certified Nurse Aide (CNA) asked her if she needed to use the restroom. Staff I pushed the wheel chair into the shower room, and Staff O came into the room to assist. The two CNA's donned gloves, then with one on each side, they tucked their arms under the resident's arm pits and lifted her up to a standing position. The resident was uneasy and had some difficulty standing. The CNA's quickly pulled her pants down with the other hand, checked her brief and said that she was dry so they put her back into the wheel chair. 2. The MDS dated [DATE], showed that Resident #1 had a BIMS score of 14 (cognitively intact.) She was totally dependent on staff for hygiene, showers, dressing and toilet transfers. The resident was frequently incontinent of bowel and bladder. Her diagnoses included; heart failure, renal insufficiency, Diabetes Mellitus, anxiety disorder and Bipolar disorder. The Care Plan updated on [DATE], showed that Resident #1 was a high risk for falls related to weakness and mental illness and she used an EZ stand (mechanical sit to stand lift) for transfers. The resident could propel shelf with a wheel chair and required assistance of one with showers and used adult incontinent products. Resident #1 had intellectual disabilities and was childlike in her thinking and actions. Staff were directed to allow her time to process what they were going to do. (continued on next page)

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	165217	A. Building B. Wing	02/20/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1:15 PM, Resident #1 was in her wheel chair in the hallway next to the shower room. She said that she was waiting to get assistance with toileting and that they use the shower room because her bathroom is not big enough for the lift. The resident said I've been trying to hold it the best I can. Staff I, CNA and Staff O, CNA wheeled her into the room and positioned the EZ Stand, mechanical lift in front of her and directed her to put her feet on the platform. They hooked up the sling that was around her torso and buckled the belt at the front. The staff failed to attach the leg belt. Once the resident was lifted to the standing position, the staff failed to tighten the belt. The resident's arms are parallel to the floor and the sling up in her armpits. On [DATE] at 7:43 AM, the Administrator was not sure if it was required to tighten the sling belt once the resident was standing on the EZ Stand but they would follow the manufacturers recommendations. She said that staff were expected to use a gait belt with Resident #17. Page 6 of the Operator's Instructions for the EZ Stand indicated that as the patient was being raised, staff were to simultaneously tighten the safety strap buckled around the torso. The facility policy titled: Safe Lifting and Movement of Residents updated on ,d+[DATE] showed that manual lifting of residents would be eliminated when feasible. Staff responsible for direct resident care would be trained in the use of manual (gait/transfer belts, slide boards) and mechanical lifting devices. 47673 3. The MDS dated [DATE] for Resident #10 documented a BIMS of 00 indicating severe cognitive impairment. The MDS documented a diagnosis of unspecified dementia, moderate, with other behavioral disturbance. The Elopement assessment dated [DATE] documented Resident #10 was cognitively impaired and independently mobile, with wandering activity, a diagnosis of Alzheimer's or dementia and was at risk for elopement. The Elopement Assessment further documented application of electronic monitoring bracelet (Wanderguard) intervention in place. The Care Plan documented that Resident #10 was an elopement risk and had a Wanderguard placed on the right ankle. The Medication Administration Records-Treatment Administration Records (MAR-TAR) dated February 2025 documented orders to check Wanderguard every shift for placement and function two times a day for elopement risk. 4. The MDS dated [DATE] for Resident #25 documented a BIMS score of 3 indicating severe cognitive impairment. The MDS documented a diagnosis of alcohol dependence with alcohol-induced persisting dementia. (continued on next page)

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	165217	A. Building B. Wing	02/20/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Wandering and Elopement Evaluation dated [DATE] documented Resident #25 was not alert or oriented x 4, with wandering activity, a diagnosis of dementia, anxiety disorder, depression, and bi-polar. The Wandering and Elopement Evaluation further documented application of electronic monitoring bracelet (Wanderguard) intervention in place. The Wandering and Elopement Evaluation documented Resident #25 wandered the facility going up and down all the halls and in and out of all the resident rooms. The Care Plan documented that Resident #25 was an elopement risk and had a Wanderguard placed on the left ankle. The MAR-TAR dated February 2025 documented orders to check Wanderguard every shift two times a day. On [DATE] at 12:49 PM Staff D, Maintenance Director stated he completed Wanderguard functioning checks once a week on the front door. On [DATE] at 12:56 PM the Assistant Director of Nursing (ADON) stated she would assume the nurses check to ensure the Wanderguard was in place, functioning and not expired. The ADON stated there was a device that a nurse can hold up to the Wanderguard and it will tell you if the battery is expired or not, but could not say where the device was exactly at that time. The ADON stated her expectation was the nurses would know how to operate the device that checks the wander guards. On [DATE] at 1:09 PM Staff J LPN stated she had not checked the Wanderguards to ensure functioning ever since employed at the facility. Staff J acknowledged she does not know how to check Wanderguards at that facility. On [DATE] at 1:13 PM the DON stated she would look in the medication cart and acknowledged the device was not present in the medication cart. Observation on [DATE] at 1:15 PM revealed Staff M, Regional Nurse Consultant opened the medication cart drawer, removed the Wanderguard check device and explained how to use the Wanderguard check device to both Staff J and the DON. On [DATE] at 1:20 PM the Administrator stated the Wanderguard check should be on the residents MAR-TAR. The Administrator stated she expected the nurses that worked at the facility would know how to check the Wanderguards and would check the Wanderguards as ordered. The Administrator stated the facility had no policy on Wanderguard checks or following physician orders.

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	165217	A. Building B. Wing	02/20/2025

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 41785 Based on observation, interview and record review the facility failed to ensure that competent and trained staff were providing resident care. The facility reported a census of 25 residents. Findings include: Review of the nursing schedule from 2/2/25 - 2/15/25 revealed that 5 out of the 7 nurses on the schedule were not facility staff but contracted Agency Staff (AS). On 2/18/25 at 1:09 PM, Staff J, Licensed Practical Nurse (LPN) stated she did not check wander guards and did not know how to check them at this facility. Staff J stated she did not complete an orientation checklist, she was shown the medication cart and allowed to ask questions. On 2/18/25 1:20 PM, the Administrator said that she expected the nurses to know how to check the wander guard. Stated that the facility had a checklist and she expected the facility nurses to orient them. She acknowledged That Staff J had not been at the facility since 2023 and she would have expected the nurse to complete an orientation checklist since it had been so long. On 2/19/25 at 7:43 AM, the Administrator said that they had just established an orientation checklist, a binder, and it was in a binder. It also had a code to scan that connected to the electronic charting with videos for the AS to watch. An untitled document showed a checklist of areas for nurses, Certified Medication Aides (CMA) and Certified Nurse. The facility did not have an example of Agency Staff that had completed this checklist. On 2/20/25 at 9:16 AM, Staff Q, said that she had noticed that at times, there would only be AS working and the residents get upset because their medications would be late and they were off their routine. She said that they didn't get trained and would often be asking the kitchen and housekeeping staff where to find supplied.

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	165217	A. Building B. Wing	02/20/2025

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on clinical record reviews, staff interviews, and policy review, the facility failed to identify target behaviors for psychotropic medication use for 1 of 2 residents reviewed (Resident #15). The facility reported a census of 25 residents. Findings include: Review of Resident #15's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating intact cognition. The MDS further revealed a diagnosis of bipolar disorder, alcohol induced acute pancreatitis without necrosis or infection, and adjustment disorder with anxiety. The document indicated the resident received antidepressant and hypnotic medications. The Physician Orders for Resident #15 dated 2/4/25 identified the resident was prescribed: a.) Caplyta Oral Capsule 21 MG (Lumateperone Tosylate) Give 1 capsule by mouth one time a day for depression - Start Date 11/09/2024 2000 b.) Trazadone HCl Oral Tablet 100 mg/day at bedtime for depression - start date 9/11/24 and discontinued 2/11/25. The Physician Orders failed to include target behaviors for the psychotropic medication ordered. The facility failed to correctly identify Caplyta Oral Capsule 21 mg/daily was prescribed for bipolar disorder per the Preadmission Screening and Resident Review Level I Screen Outcome, dated 8/13/24. The Progress Notes dated 9/11/24 - 2/18/25 identified behaviors of shouting at another resident, shouting at staff, slamming furniture, and picking on other residents/others belongings. The Care Plan dated 2/10/25 revealed a focus area related to depression with Trazadone and Caplyta medications indicated. The Care Plan interventions included side effects for antidepressant medications. On 2/18/25 at 3:07 PM the Assistant Director of Nursing (ADON) acknowledged Caplyta was ordered related to depression, but the resident did not have a diagnosis of depression. The ADON further acknowledged Caplyta was an atypical antipsychotic and should have reflected the bipolar disorder diagnosis. The ADON stated target behaviors were not identified with antipsychotic or antidepressant medications. On 2/18/25 at 3:55 PM the Interim Administrator stated diagnoses and orders for medications should coincide with each other. The Interim Administrator acknowledged she did not know target behaviors needed to be identified on the orders with the prescribed medication. (continued on next page)

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	165217	A. Building B. Wing	02/20/2025

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility did not provide a policy related to orders, medications, and target behavior identification.

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	165217	A. Building B. Wing	02/20/2025

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on facility document review and staff interview, the facility failed to submit 4 of 4 residents reviewed to the Iowa Department of Veteran Affairs (Resident #12, #18, #22, and #26). The facility reported a census of 25 residents. Findings include: A review of the admissions from 6/1/24 -2/17/25 revealed Resident #12 was admitted on [DATE] and remained in the facility. The facility failed to have the resident complete the Veteran's Questionnaire. A review of the admissions from 6/1/24 -2/17/25 revealed Resident #18 was admitted on [DATE] and discharged on [DATE]. The facility failed to have the resident complete the Veteran's Questionnaire. A review of the admissions from 6/1/24 -2/17/25 revealed Resident #22 was admitted on [DATE] and remained in the facility. The resident Questionnaire for a VA benefit Eligibility dated 2/19/25 completed by the Interim Administrator indicated he was a veteran and served in the Army. The Iowa Department of Veterans Affairs Resident Eligibility form printed on 2/19/25 revealed Resident #22 was not on the list of residents that were submitted to the web site. A review of the admissions from 6/1/24 -2/17/25 revealed Resident #26 was admitted on [DATE] and remained in the facility. The facility failed to have the resident complete the Veteran's Questionnaire. Within 30 days of a resident's admission to a health care facility receiving reimbursement through the medical assistance program under Iowa Code chapter 249 A, the facility shall ask the resident or the residents personal representative whether the resident is a veteran and shall document the response. If the facility determines that the resident is a veteran, the facility shall report the resident's name along with the names of the resident's spouse and any dependent children, as well as the name of the contact person for this information, to the Iowa department of Veteran's Affairs. Where appropriate, the facility first shall seek reimbursement from the identified payer source before seeking reimbursement from the medical assistance program established under Iowa Code chapter 249A. On 2/20/25 at 9:04 AM the Interim Administrator acknowledged residents had not been asked upon admission if they were eligible for veteran's benefits. The Administrator stated The Veteran's Questionnaire should be part of the admission process. The facility did not have a policy related to asking residents about veterans benefits.

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	165217	A. Building B. Wing	02/20/2025

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 41785 Based on facility document review and staff interview the facility failed to accurately submit the required Payroll Based Journal (PBJ) quarterly report. The facility reported a census of 25 residents. Findings include: The 2024, 4th quarter PBJ report indicated that the facility had low weekend staffing, low Registered Nurse (RN) coverage for 8 consecutive hours/day, concerns regarding Licensed Nurses coverage 24 hours a day and concerns regarding their 1-star staffing rating. On 2/17/25 at 2:00 PM the Administrator said that she has only been the Administrator since the beginning of January and the previous leaders told her that the reason the PBJ showed low staffing was because they failed to include the Agency staff hour in the report. She said that they were trying to figure out those hours and to fill in the blanks. On 2/20/25 at 9:00 AM the Administrator said that they did not have a policy on submission of information for quarterly PBJ reports.

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	165217	A. Building B. Wing	02/20/2025

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 47673 Based on staff interview, and policy review the facility failed to properly establish and implement written policies and procedures for the Quality Assurance and Performance Improvement (QAPI) plan. The facility reported a census of 25 residents. Findings include: Review of the facility policy updated 1/24 titled, QAPI Policy lacked a description of how the facility would identify, report, track, investigate and analyze adverse events or problem-prone concerns. The policy also lacked a description as to how the facility obtains and uses any feedback from resident representatives to identify high-risk or problem prone issues. The policy lacked a description of how the facility monitored the effectiveness of its performance improvement activities to ensure improvements are sustained. On 2/20/25 at 9:28 AM the Interim Administrator acknowledged QAPI had only been completed for the month of 4/24 and 6/24. The Interim Administrator acknowledged the QAPI policy lacked a description of how the facility would identify, report, track, investigate and analyze adverse events or problem-prone concerns. The Interim Administrator acknowledged the policy also lacked a description as to how the facility obtains and uses any feedback from resident representatives to identify high-risk or problem prone issues. The Interim Administrator acknowledged the policy lacked a description of how the facility monitored the effectiveness of its performance improvement activities to ensure improvements are sustained.

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	165217	A. Building B. Wing	02/20/2025

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 47673 Based on policy review, document review, and staff interview the facility failed to maintain records of quality assurance meetings for 3 of 4 quarters reviewed. The facility reported a census of 25 residents. Findings include: Review of a facility provided document titled, QA&A (Quality Assessment and Assurance) Committee Meeting Facility dated 4/4/24 and 6/6/24 revealed all necessary members attended these meetings from the same quarter. No further quarterly documentation was provided for the next three quarters. On 2/20/25 at 9:28 AM the Interim Administrator acknowledged the QAA committee had only been completed for the month of 4/24 and 6/24 from the same quarter. The Interim Administrator stated the facility's expectation was that the QAA committee would meet at a minimum of quarterly. Review of policy updated 1/24 titled, QAPI (Quality Assessment and Performance Improvement) Policy documented the QAPI program consisted of monthly / quarterly meetings.

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	165217	A. Building B. Wing	02/20/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observations, staff interviews and clinical record review the facility failed to implement adequate infection control measures to prevent the spread of pathogens. Staff failed to use hand hygiene while assisting Residents #17, #1 and #10 with toileting. Laundry staff failed to cover personal items while transferring to rooms, and frequently left full garbage bags on the floor. The facility reported a census of 25 residents. Findings include: 1. According to the Minimum Data Set (MDS) dated [DATE], Resident #17 was admitted to the facility on [DATE]. She had a Brief Interview for Mental Status (BIMS) score of 4 (severe cognitive impairment). The resident required substantial assistance with shower/bath, dressing hygiene, sit to stand and toileting transfer. Her diagnoses include cancer, anemia, and non-Alzheimer's dementia. The Care Plan updated on 2/10/25, showed that Resident #17 had terminal prognosis and chose Hospice care. She was dependent on staff with a wheelchair for ambulation. Resident #17 became agitated at times, staff were to intervene before agitation escalated. On 2/17/25 at 1:24 PM, Resident #17 was sitting in a wheel chair near the nurse's station when Staff I, Certified Nurse Aide (CNA) and Staff O, CNA assisted her to the shower room for toileting. Once in the bathroom, the CNA's donned disposable gloves and helped the resident to stand. They pulled down her pants, reached into her brief, then Staff O said that she was not wet. Without changing gloves, they pulled up her pants, adjusted her shirt, transferred her back to the wheel chair then wheeled her out of the bathroom without washing their hands. 2. The MDS dated [DATE], showed that Resident #1 had a BIMS score of 14 (cognitively intact.) She was totally dependent on staff for hygiene, showers, dressing and toilet transfers. The resident was frequently incontinent of bowel and bladder. Her diagnoses included heart failure, renal insufficiency, Diabetes Mellitus, anxiety disorder and bipolar disorder. The Care Plan updated on 7/5/23, showed that Resident #1 was a high risk for falls related to weakness and mental illness and she used an EZ stand (mechanical sit to stand lift) for transfers. The resident could propel shelf with a wheel chair and required assistance of one with showers and used adult incontinent products. Resident #1 had intellectual disabilities and was childlike in her thinking and actions. Staff were directed to allow her time to process what they were going to do. On 2/17/25 at 1:15 PM, with gloved hands, Staff I, and Staff O, transferred Resident #1 to the toilet with the use of the EZ Stand mechanical lift and waited for her to tell them that she was done. Staff O lifted her slightly off the toilet while Staff I used disposable wipes to clean her bottom. With the same gloved hands, Staff I pulled the resident's pants up, guided the resident to the wheel chair by touching her upper and lower body. She removed her gloves but failed to wash her hands before she left the room with a bag of trash and took it to the laundry room. On 2/19/25 at 7:43 AM the Administrator said that she would expect staff to change gloves when they are dirty and after toileting a resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. The MDS dated [DATE], for Resident #10 showed that she had a BIMS score of 0 (severe cognitive impairment) She had physical and verbal behaviors towards staff such as hitting, screaming and scratching. Resident #10 required substantial assistance with toileting hygiene, showering and dressing. The Care Plan for Resident #10, showed that she had self-care performance deficit, she was independent with transfers and would ask for help if needed. The resident had impaired safety awareness and was an elopement risk. Staff were directed to inform the nurse and re-approach in a different way, if the resident refused cares. On 2/17/25 at 12:46 PM, Resident #10 was sitting by the window in the dining room. She was able to get up on her own with a walker, and started walking across the room. Staff O, CNA, approached the resident and loudly said we need to go change your pants, you're wet Staff O assisted the resident to the bathroom for toileting. The chair where the resident had been sitting had a visible wet area on the seat. At 1:13 PM Staff O had completed the toileting but failed to return to the dining room to clean and disinfect the seat. On 2/19/25 at 7:43 AM the Administrator acknowledged that the seat should have been cleaned and sanitized when it was soiled. According to the facility policy titled: Hand Hygiene dated 2019; Hand hygiene continued to be the primary means of preventing the transmission of infection. Hand hygiene consistent with accepted standards of practice such as the use of ABHR instead of soap and water in all clinical situations except when after using the restroom. 47673 4. On 2/19/25 at 10:32 AM Staff D, Laundry Supervisor / Maintenance Supervisor stated laundry was not being delivered covered. Staff D stated the facility used to have a delivery cart but it was currently being utilized as a cart to hold all the items that do not have residents names on them. Staff D stated the facility did not have a way to deliver laundry covered. On 2/19/25 at 11:13 AM the Interim Administrator stated she would expect the laundry would be covered when it was delivered. She stated there is no policy or procedure for laundry delivery.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 47673 Based on facility document review, staff interviews, and facility job description review the facility failed to employ a staff with specialized training in infection prevention and control. The facility reported a census of 25 residents. Findings include: Review of a facility document dated 12/24 titled, Job Description Manual/Infection Prevention (IP) Nurse position description revealed the Infection Preventionist must possess current, specialized training and certification in Infection Control (IC) in an approved course. On 2/19/25 at 9:05 AM the Assistant Director of Nursing (ADON) stated she was certificated in infection prevention. The ADON stated that she completed the IP course but was unable to find the document at the moment. On 2/19/25 at 9:18 AM the Interim Administrator stated the facility did not have a copy of the IP nurse certification. The Interim Administrator acknowledged the facility was unable to produce the certification for the IP nurse. The Interim stated the facility would expect the IP nurse would have appropriate certification for the position. Request for certification or documentation from the Administrator for any employee who has completed specialized training in infection prevention and control revealed no documentation or certifications of qualifications.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on Electronic Health Record (EHR) review, and staff interviews the facility failed to develop and implement policies and procedures, to ensure the resident's medical record included documentation that the resident did or did not receive pneumococcal immunizations for 4 of 5 residents reviewed (Resident #6, #13, #17, and #20). The facility reported a census of 25 residents. Findings included: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #6 documented a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment. Review of Resident #6 EHR revealed no document of consent or declination for the pneumococcal immunization and no documentation the resident ever received pneumococcal immunization. 2. The MDS dated [DATE] for Resident #13 documented a BIMS of 13 indicating no cognitive impairment. Review of Resident #13 EHR revealed no document of consent or declination for the pneumococcal immunization and no documentation the resident ever received pneumococcal immunization. 3. The MDS dated [DATE] for Resident #17 documented a BIMS of 10 indicating moderate cognitive impairment. Review of Resident #17 EHR revealed no document of consent or declination for the pneumococcal immunization and no documentation the resident ever received pneumococcal immunization. 4. The MDS dated [DATE] for Resident #20 documented a BIMS of 13 indicating no cognitive impairment. Review of Resident #20 EHR revealed no document of consent or declination for the pneumococcal immunization and no documentation the resident ever received pneumococcal immunization. On 2/19/25 at 9:00 AM Staff M, Regional Nurse Consultant acknowledged Resident #6, #13, #17, and #20 did not receive pneumococcal immunizations and were not offered pneumococcal immunizations at the facility. On 2/19/25 at 9:18 AM the Interim Administrator stated the facility's expectation was that pneumococcal immunizations would have been offered to the residents at the facility per federal regulations or there would have been documentation they had received pneumococcal immunizations in the past.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on Electronic Health Record (EHR) review, policy review, and staff interviews the facility failed to develop and implement policies and procedures, to ensure the resident's medical record included documentation that the residents were offered the immunization and did or did not receive the COVID-19 immunizations for 4 of 5 residents reviewed (Resident #3, #6, #13, and #17). The facility reported a census of 25 residents. Findings included: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #3 documented a Brief Interview of Mental Status (BIMS) of 9 indicating moderate cognitive impairment. Review of Resident #3's EHR revealed no document of consent or declination for the COVID-19 immunization. 2. The MDS dated [DATE] for Resident #6 documented a BIMS of 15 indicating no cognitive impairment. Review of Resident #6's EHR revealed no document of consent or declination for the COVID-19 immunization. 3. The MDS dated [DATE] for Resident #13 documented a BIMS of 13 indicating no cognitive impairment. Review of Resident #13's EHR revealed no document of consent or declination for the COVID-19 immunization. 4. The MDS dated [DATE] for Resident #17 documented a BIMS of 10 indicating moderate cognitive impairment. Review of Resident #17's EHR revealed no document of consent or declination for the COVID-19 immunization. On 2/19/25 at 9:00 AM Staff M, Regional Nurse Consultant acknowledged Resident #3, #6, #13, and #17 did not receive Covid-19 vaccinations in 2024. On 2/19/25 at 9:18 AM the Interim Administrator stated the facility's expectation was Covid-19 immunizations would have been offered to the residents at the facility per federal regulations. Review of the policy dated 8/22/24 titled, SARS-CoV-2 Infection Policy documented COVID-19 Vaccines: HCP, residents, and visitors should be offered resources and counseled about the importance of receiving the COVID-19 vaccine. Additionally encourage everyone to remain up to date with all recommended COVID-19 vaccine doses.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 41785 Based on personnel file review, and staff interviews the facility failed to ensure that all Certified Nurse Aides (CNA's) had completed the required 12 hours of continuing education annually for 2 of 5 files reviewed. The facility reported a census of 25 residents. Findings include: A review of the personal files for CNA's revealed that two charts lacked evidence that they had completed 12 hours of annual training; Staff E, CNA, hired on 1/2/23, and Staff A, CNA hired on 12/27/23. On 2/19/25 at 7:43 AM the Administrator said that they have established an Inservice schedule with each session lasting an hour. She said that in the last month they had reviewed with the staff, the expectations of attending monthly in-services. On 2/20/25 at 8:28 AM the Administrator said they did not have a policy on CNA annual training requirements. According to the Facility Assessment updated on 2/2025, CNA's would have ongoing training, monitoring and supervision done by the charge nurse or nurse administration staff. An Annual In-Service Calendar showed the plan for monthly education that would provide for the required 12 hours per year training for direct care staff.