STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165286	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Hill Care Center	909 6th Street Traer, IA 50675

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on personnel record review, policy review, and staff interview, the facility failed to implement their abuse policy when the facility failed to complete the required Abuse and Criminal History check within the required 30 days of hire date for 1 of 5 staff reviewed (Staff A, Dietary). The facility reported a census of 53 residents. Findings include: Staff A's personnel record review listed a hire date of 4/14/25. The record review included the Single Contact License and Background Check (SING) with a completion date of 1/31/25. The facility policy titled, Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy, reviewed 4/2024 revealed the following per the Employee Screening section: The facility shall screen all potential employees for a history of abuse, neglect, exploitation, misappropriation of property, or mistreatment of Residents. The policy further instructed the facility to conduct an Iowa criminal record check and dependent adult/child abuse registry check on all prospective employees and other individuals engaged to provide services to residents, prior to hire, in the manner prescribed under 481 Iowa Administrative Code 58.11(3).During an interview 12/2/25 at 2:44 PM, Staff B, Manager, acknowledged Staff A began employment more than 30 days after the facility had completed their background check.

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