STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165303	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation Centers of Independence West Campus	1610 Third Street NE Independence, IA 50644

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 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 observation, staff interview, and resident interview, the facility failed to maintain a clean, comfortable and homelike environment. The facility reported a census of 56 residents. Findings include: 1. Observation on 8/11/2025 at 9:00 A.M. included: a. A Hall - Wall paper border above hand rail partially removed, peeling in multiple areas. Hall carpet with a large amount of dark stains and blackened colored areas. b. A Hall - room [ROOM NUMBER], #5 - Room carpet with moderate amount of dark stains. c. C Hall - room [ROOM NUMBER], #27, #36 - Room carpet with moderate amount of dark stains. 2. Observation on 8/11/25 at 8:15 A.M. revealed the following: The center hall carpet that went into the service hallway and the kitchen revealed darkened, blackish discoloration on the carpet with areas of solid blackened spots that measured the width of the doors. The carpet leading to the dining room from the center hallway was darkly discolored with blackened spots that measured the width of the double doors. Observations of the dining room at this time revealed multiple areas of darkened areas throughout the dining room, with areas of dark, black spots scattered throughout the dining room carpet. On 8/11/25 at 8:07 A.M. during an interview with Resident #7 while sitting in the dining room, the resident stated, I don't like this dirty carpet in this dining room, it is worn out, dirty and needs cleaned. She stated, I wish you could help me with this, it makes me sick to sit in here and eat my meals. On 8/12/25 at 8:20 A.M. during an interview with Staff A, Maintenance Supervisor, Staff A stated he also had concerns with the carpet and the condition of it. He stated in the summer it was hard to keep clean because of the humidity and this year all the rain had had. He reported due to recent rainfall event water came into the building which had made the carpet wrinkle. Staff A stated he last cleaned the carpet around Christmas of 2024 and stated it really needed it again. Staff A stated they had a resident who peeled the wall paper off the A Hall walls and they were working on how to fix this. The resident pulled off the wall paper almost immediately after he repaired it. Interview with Staff F, Housekeeping Supervisor on 8/12/25 at 11:00 A.M. revealed she had worked in the building since 2022, moved here from [Name Redacted] next door. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The last time the carpets were cleaned was right before Mother’s Day 2025, they spot clean the carpets regularly but it did not help. The carpet was very dirty and ground in dirt and spots. The carpet had been dirty since she transferred from the sister facility down the street.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on clinical record review and staff interviews, the facility failed to follow physician orders for one of three residents reviewed (Resident #2). The facility reported a census of 56 residents. Findings include:Resident #2's MDS (Minimum Data Set) dated 7/18/2025 revealed he had no cognitive impairment, had diagnoses including diabetes, absence left toes, anemia, heart failure, renal insufficiency, hypertension and had diabetic foot ulcers. The Care Plan identified the resident had a risk for alteration in skin integrity related to type two diabetes and other circulatory complications. It directed staff to administer treatments per physician orders, encourage good nutrition and hydration in order to promote healthier skin, and observe skin with ADL's (activities of daily living). A Wound Clinic Note dated 7/31/2025 included an order to provide one serving of Prostat AWC (advanced wound care), a protein supplement, one serving daily. Protein to assist with wound healing.On 8/12/2025 at 12:50 Staff B, DON (Director of Nursing) reported a staff nurse missed the wound clinic order for Prostat. It was hidden in the note dated 7/31/2025.On 8/12/2025 at 1:10 P. M., Staff G, LPN (Licensed Practical Nurse) reported she worked at the facility for 8 years. Resident #2 had a wound clinic order dated 7/31/2025. Staff G revealed she missed the Prostat order from the wound clinic, it was considered an order, and did not know how she missed it. Staff B put the order in the resident's record and notified the physician today. The facility policy titled Physician Orders/Transcription of Orders revised 7/2023 included the following: PURPOSE: To correctly and safely receive/transcribe physician's orders so correct order can be followed/administered. To ensure that patient medications, treatments, and plan of care are in accordance with the licensed providers orders.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, review of computerized call light response times, and facility policy review the facility failed to answer resident call lights in a timely manner for two of three residents reviewed (Resident #1, #6). The facility failed to have the call light within reach for one of seven residents reviewed (Resident #5). The facility reported a census of 56 residents. Findings include:1.The MDS (Minimum Data Set) dated 7/2/2025 reported Resident #5 had severe cognitive impairment and had diagnoses including diabetes, history of falls and fracture of the left humerus. The MDS indicated the resident had a fall with no injury since the previous assessment. The resident's Care Plan directed staff to assist the resident with transfers and ambulation with the use of a gait belt, and ensure the call light is within reach. Observation on 8/11/2025 at 9:10 a.m. revealed Resident #5 seated in her room in a recliner with a bedside table at her right side. The call light sat on the bed against the wall. The resident stated she had to go to the bathroom and attempted to lower the footrest. The surveyor summoned staff and Staff E, Certified Nursing Assistant (CNA) entered the room, applied the gait belt, and assisted the resident to the bathroom. Staff E observed the call light on the bed and stated, someone forgot to put the call light on her chair. 2. The MDS dated [DATE] revealed Resident #6 had no cognitive impairment, and the Care Plan indicated the resident had a fall risk. During an interview on 8/11/2025 at 9:20 a.m., the resident revealed staff failed to answer his call light in a timely manner. Staff , at times took up to 30 minutes to respond when he put his call light on. The resident also reported staff would enter his room, turn the call light off and state they would be right back, but failed to do so. The facility Call Light Policy revised 9/2023 included the following purpose: To ensure that there is a prompt response to the resident’s call for assistance. The facility also ensures that the call system is in proper working order. Procedures:1. Facility shall answer call lights in a timely manner2. Orient new residents as appropriate to the call light at bedside as well as the call light in the bathroom and in shower/tub rooms3. Answer call lights in a prompt and courteous manner, knocking before entering and introducing self4. When answering a call light, respond to the request. If immediate assistance cannot be provided and there is not an emergent need, call light may be turned off and resident informed that a staff member will be back to assist them shortly5. If a call light is not functional, evaluate and provide another means in order for the resident to call for assistance (i.e. bell) until the call light is fixed. Notify the administrator/maintenance director immediately for repair6. Call lights are to be placed within reach of residents for those residents who can use it. Frequent rounds and interventions per care plan must be followed for supervision of those patients who are physically and/or cognitively unable to utilize call light. (Soft touch call lights can be utilized if needed)7. Be sure that when a call light is triggered, it will either alert the staff visually, audibly, or both. 3. Review of Resident #1's MDS dated [DATE] revealed the resident had intact cognitive ability. The resident had diagnoses which included surgical repair of right and left femur, Parkinson's and congestive heart failure. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident reported the staff failed to answer her call light timely and reported incontinence episodes as a result. The resident stated she had kept records of the call lights but only recently started the log. During an interview on 8/12/25 at 10:10 am, the resident revealed that last evening at 6:00 pm she put on her call light and the staff failed to answer her call light until 6:50 pm. Interview and review of the computerized Call Light Wait time logs on 8/12/25 at 10:30 am with Staff C-Quality Assurance/Certified Medication Aide revealed the following extended call light response times for Resident #1: a. On 8/5/25 the resident activated her call light at 10:16 am, the staff failed to answer the call light for 28 minutes and 48 seconds. b. On 8/6/25 the resident activated her call light at 8:44 am, the staff failed to answer the call light for 31 minutes and 34 seconds. At 6:21 pm the resident activated her call light, the staff failed to answer the call light for 20 minutes and 24 seconds. c. On 8/7/25 the resident activated her call light at 5:09 am, the staff failed to answer the call light for 25 minutes and 25 seconds. At 12:04 pm the resident activated her call light, the staff failed to answer the call light for 40 minutes and 10 seconds. d. On 8/9/25 the resident activated her call light at 6:36 am, the staff failed to answer the call light for 33 minutes and 6 seconds. At 1:00 pm the resident activated her call light, the staff failed to answer the call light for 19 minutes and 6 seconds. e. On 8/10/25 at 6:16 am the resident activated her call light, the staff failed to answer her call light for 19 minutes and 9 seconds. At 6:18 pm the resident activated her call light, the staff failed to answer her call light for 23 minutes and 45 seconds. e. On 8/11/25 at 8:03 am the resident activated her call light, the staff failed to answer the call light for 22 minutes and 9 seconds. At 12:36 pm the resident activated her call light, the staff failed to answer her call light for 22 minutes and 4 seconds. At 1:55 pm the resident activated the call light, the staff failed to answer her call light for 17 minutes and 2 seconds. At 6:10 pm the resident activated her call light, the staff failed to answer her light for 42 minutes and 14 seconds.