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	12/11/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, Center for Medicare and Medicaid (CMS) Services Long-Term Care (LTC) Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interview, the facility failed to accurately code the use of medication on the Minimum Data Set (MDS) Assessment for 1 of 5 residents sampled (Resident #1); and failed to accurately code a determination of serious mental illness as identified on the Preadmission Screening and Resident Review (PASRR) for 1 of 1 residents sampled (Resident #18). The facility identified a census of 51 residents.Findings include:1.Resident #1's MDS dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 7 out of 15 indicating a severe cognitive impairment. The MDS documented Resident #1 received anticoagulant (medication that prevent blood from clotting) and antiplatelet (medication that makes the blood less sticky by stopping platelets from clumpting together) medications.The September and October 2025 Electronic Medication Administration Records (EMARs) documented Resident #1 received Aspirin (antiplatelet medication) 81 Milligrams (MG) by mouth daily and Ticagrelor (antiplatelet medication) 90 MG by mouth two times a day related to unspecified atrial fibrillation from 9/1/25 to 9/30/25 and 10/1/25 to 10/2/25. The EMARs lacked documentation Resident #1 received any medication classified as an anticoagulant. A 10/2/25 Physician Visit Progress Note listed the following medications orders:a. Aspirin Oral Tablet, give 81 MG by mouth one time a day for prophylactic atrial fibrillation.b. Ticagrelor Oral Tablet 90 MG, give 1 tablet by mouth two times a day for stroke prevention related to unspecified atrial fibrillation. The 10/2/25 Physician Visit Progress Note lacked documentation of current orders for an anticoagulant medication. During an interview on 12/09/25 at 2:15 PM the MDS Coordinator reported she thought the Ticagrelor medication was an anticoagulant. She discovered the aspirin and Ticagrelor are both antiplatelet medications. She voiced she utilized the RAI MDS Manual to code the MDS. Interview completed on 12/11/25 at 11:00 AM the MDS Coordinator explained she can reference medication books and the electronic medical record system they use also has the drug classification for each residents medication listed. The CMS LTC RAI User's Manual, October 2025, Version 1.20.1, Page 1-4 documents the RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20(b)(1)(xviii), (g), and (h) require the assessment accurately reflects the resident's status.The CMS RAI User Manual, Chapter 3, Page N-8 Item N0415 High-Risk Drug Classes directs to check if the resident had taken an antiplatelet medication in the last 7 days of the MDS seven day look back period. Page N-9 directs do not code antiplatelet medications such as aspirin/extended release as anticoagulants. 2. A 10/30/24 Notice of PASRR Level II Outcome documented Resident #18 met PASRR criteria for a serious mental illness for the diagnosis of bipolar disorder, major depressive disorder which led to significant symptoms that impact the resident's daily functioning. The MDS dated [DATE], Section A1500 failed to identify Resident #18 with a state level II PASRR to have a serious mental illness or a related condition. A 11/20/25 MDS showed a Brief Interview for Mental Status (BIMS) Score of 13/15 indicating intact cognition. Resident #18 was unable to recall the current day of the week and required cueing for memory recall. The MDS listed diagnoses of anxiety, depression, and bipolar disorder. The resident received antipsychotic, antidepressant and anticonvulsant medications. A 11/25/25 Provider (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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress Note documented a Chief Complaint follow up for mental health. The History of Present Illness documented Resident #18 with a past medical history of bipolar with history of psychotic symptoms and dementia. He was last hospitalized in 2024 for an extended period of time. During an interview on 12/10/25 at 2:20 PM the MDS Coordinator reviewed section A 1500 of the MDS and stated generally the resident's physician will provide a diagnosis of serious illness or she could look at the resident PASRR. She reviews the admission paperwork, but if she doesn't see a PASRR, she still has access to it in the EHR. The level II would indicate a serious mental illness or disability disorder. The CMS RAI Manual, Chapter 3, Page A 30-32 directs to answer yes in A1500 of the MDS if the PASRR Level II screening determined the resident had a serious mental illness and continue to MDS question A1510 Level II PASRR condition.

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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. Based on observation, policy review and resident and staff interviews the facility failed to follow Enhanced Barrier Precautions (EBP) for 1 of 2 residents reviewed for EBP (Resident #14). The faciltiy reported a census of 51 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #14, dated 9/9/25, documented the resident had an indwelling catheter. During an interview on 12/8/25, the resident reported he had an indwelling catheter. An observation at the same time revealed the EBP poster on the resident's door and a chest of drawers right outside his door. During an observation on 12/10/25 at 1:31 PM, Staff A, Certified Nursing Assistant (CNA), entered the room to empty the catheter drainage bag. She performed hand hygiene and donned gloves. She proceeded to empty the drainage bag. She did not don a gown as required by EBP. During an interview on 12/10/25 at 1:38 PM, the MDS Coordinator acknowledged there was an EBP poster on the resident's door, the chest of drawers outside the room contained the required PPE, including gowns, and she would expect Staff A to follow EBP. On 12/10/25 at 2:15 PM, the Infection Preventionist explained staff are to follow EBP with catheters. She further explained she would expect staff to follow EBP including to wear a gown and gloves when they emptied a catheter. Facility Policy titled Infection Prevention and Control, last revised on 7/31/24 directed staff to wear a gown and gloves during high contact resident activities as well as residents with indwelling medical devices.