STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165350	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Acres Rehabilitation and Care Center	1501 Office Park Road West Des Moines, IA 50265

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, clinical record review, and facility policy review, the facility failed to provide assessments, obtain orders, or follow up with physician on a resident with an identified central line for 1 of 3 residents (Resident #2) reviewed for assessment and intervention. The facility reported a census of 65 residents. Findings include: The admission Minimum Data Set (MDS), dated [DATE], revealed Resident #2 admitted to the facility from an acute hospital on 3/20/25. A Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicated intact cognition. Resident #2 diagnoses included atrial fibrillation, cirrhosis of liver, End Stage Renal Disease (ESRD), viral hepatitis, Diabetes Mellitus, immunodeficiency, and dependence on renal dialysis. The admission Assessment, dated 3/20/25, revealed Resident #2 required Hemodialysis for ESRD and had an arteriovenous left sided fistula. admission Assessment lacked identification of central or intravenous lines present upon admission. The Care Plan, initiated 3/21/25, lacked identification of central line or interventions for the care or infection prevention of central line. Review of Resident #2's Nursing Progress Notes revealed the following documentation: 1. On 3/20/25 at 10:40 PM, a Note identified that Resident #2 had a central venous catheter, dialysis catheter, located on left side internal jugular vein, covered with a transparent dressing that appeared clean, dry, and intact. Note lacked request for treatment orders or daily monitoring for signs of infection of the identified central line. 2. On 3/23/25 at 3:54 AM, nursing documented that Resident #2 had an active dialysis graft to left upper arm with bruit and thrill present, and noted that Resident #2 reported dialysis graft is currently used at dialysis appointments. Note revealed Resident #2 also had a triple lumen catheter line on left neck area and was unknown why line had not been removed prior to hospital discharge. Note lacked physician notification of central line, or request for treatment orders for the identified line. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 4/10/25 at 11:23 AM, nursing documentation revealed that Resident #2 had returned from a dialysis appointment and noted to have a left supraclavicular central line with dressing dated 2/11/25, and also had hemodialysis catheter on the same (left) arm. Nursing notified physician, present at the facility, who advised to call the dialysis center for clarification. 4. On 4/14/25 at 10:16 AM. nursing reported calling the dialysis center regarding central line in left neck and had been informed this was not used for dialysis. A verbal order received from Provider to remove central line. On 4/15/25 at 4: 24 PM, Note revealed Resident #2's dressing, stabilization sutures, and central line to left neck removed without difficulty. Note revealed pressure was applied with gauze to insertion site after removal with no signs or symptoms of infection observed and catheter removed remained intact. A new border gauze dressing was applied and secured. Review of Resident #2's March 2025, and April 2025, Medication and Treatment Administration Records, lacked orders for monitoring central line, insertion site care, or dressing change frequency to prevent infection. On 4/29/25 at 10:00 AM, Resident #2 reported he had a central line to left neck for approximately 2 months. Resident #2 denied having staff change dressings to site on left neck and revealed that some staff were talking about it getting dirty. Resident #2 stated yes, when asked if he felt the dressing to the left central line was dirty. On 4/30/25 at 1:00 PM, Staff G, Registered Nurse (RN), confirmed documenting on 4/10/25 that Resident #2 had central line to left neck with dressing dated 2/11/25. Staff G stated Resident #2 told staff this site was being used by dialysis center. Staff G had physician look at site and was instructed to call dialysis center for clarification. Staff G recalled a transparent dressing had been on central line site and site appeared without infection. Staff G reported that no orders were in place for Resident #2's central line. On 4/30/25 at 1:30 PM, Staff C, RN, confirmed working on 4/15/25 and removed Resident #2's central line with 3 lumens from the left side of neck as ordered. Staff C reported she was asked to remove the line due to Resident #2 having a left arm fistula that was used for dialysis. Staff C denied complications or signs of infection when line was removed. Staff C reported the dressing had been intact and believed it was dated March, but had been hard to read. On 5/01/25 at 9:15 AM, physician confirmed looking at site per RN request and instructed nursing to contact dialysis center as it appeared that dressing had not been changed in a while. Physician revealed there would be a risk for infection if central line had not received monitoring for signs and symptoms of infection, insertion site cleaning or dressing change for several weeks. On 5/01/25 at 3:00 PM, Nurse Consultant, denied seeing orders for a central line on Resident #2's admission assessment and believed this site was being managed by dialysis center but informed that facility nurses would monitor site for signs of infection. The facility policy, titled Wound Treatment Management, revised 1/2023, revealed expectation of licensed nurse to notify physician to obtain treatment orders in absence of orders for treatment.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interviews, clinical record review, staff training schedule review, and facility policy review, the facility failed to ensure the behavioral health program was effective for a resident with history of Substance Use Disorder (SUD), when direct care staff reported a lack of training for SUD, resident plan of care lacked plans to prevent substance use in the facility, or interventions for suspected or identified substance use by resident, and lacked plans for the potential of an overdose emergency, when Resident #1 displayed erratic behaviors resulting in hospitalization with positive Methamphetamines drug test for 1 of 3 residents (Resident #1) reviewed for behavioral health. The facility reported a census of 65 residents. Findings include: The Minimum Data Set (MDS) Discharge Assessment, dated 4/24/25, for Resident#1 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. The MDS revealed that Resident #1 had verbal behaviors and other non-verbal or non-physical types of behavioral symptoms for one to three days of the seven day assessment look back period. Resident #1 utilized a wheelchair for mobility and was able to self-propel at least 150 feet. Diagnoses included: Bipolar Disorder, Schizophrenia, anxiety disorder, psychoactive substance abuse with mood disorder, alcohol abuse, and orthopedic aftercare following surgical amputation. Resident #1 utilized opioid, antipsychotic, and antidepressant medications. The Care Plan, dated 1/29/25 revealed a focus area for risk of substance use (alcohol/drugs) related to a history of addition with the goal that Resident #1 would have decreased episodes of alcohol or drug seeking behaviors by the next review. Interventions included: -Monitor laboratory test results and report abnormal results to the physician. -Evaluate the need for psychiatric or behavioral health consult. -Communicate facility rules to resident, resident representative, and all visitors that use of alcohol and non-prescribed drugs are not permitted while resident is in the facility. -Offer information for substance use programs, support the referral process, if needed and accepted. -Provide an environment that is conducive to the resident's ability to get adequate sleep. -Allow time for expression of feelings; Provide empathy, encouragement, and reassurance. The Care Plan lacked risk assessment, with identified triggers, for Resident #1's potential of substance use, signs and symptoms to monitor for specific substance use, or interventions for behaviors when substance use is suspected or identified. The Care Plan lacked signs and symptoms of overdose to monitor for, or a safety plan, with instruction for staff response, related to risk of overdose from substance use. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A History and Physical Note, completed by a Hospital prior to facility admission, dated 1/03/25, revealed admission related to bilateral foot wounds and an ongoing problem list that included: Methamphetamines use, marijuana use, alcohol abuse, Schizophrenia, Bipolar Disorder, and suicide risk. Resident #1's social history included the following substances used within the past 12 months: Methamphetamines, cocaine, marijuana, and alcohol abuse. The Note identified Resident #1 had severe agitation upon hospital admission from suspected Methamphetamines use and had a history of polysubstance abuse and psychosis. Review of Resident #1's Pre admission Screening and Resident Review (PASRR), dated 1/15/25, revealed a Level 1 screen, convalescence category, for Nursing Facility short stay approval. Resident #1's current mental health diagnoses included Schizophrenia, Bipolar Disorder, anxiety disorder, and Attention Deficit Disorder with Hyperactivity (ADHD). The PASRR revealed Resident #1's substance related diagnoses included cannabis and amphetamines, and listed both substances had been used within the previous 7-14 days. Review of Resident #1's Nursing Progress notes revealed the following entries: 1. On 4/18/25 at 11:30 AM, nursing received an order for Resident #1 to have a urine drug screen. Sample collected and awaiting results. 2. On 4/19/25 at 8:16 PM, Resident #1 noted to have erratic behaviors, pacing the hallways in wheelchair with music playing loudly from a portable speaker. Resident #1 able to be redirected at times, given a dose of as needed Hydroxyzine for anxiety. 3. On 4/19/25 at 9:25 PM, nursing described Resident #1 as having paranoid and delusional conversations with behaviors that continued to escalate and staff unable to redirect. Note indicated receiving a report from another resident that Resident #1 was threatening to burn down the place and kill, stab someone to death tonight. Note informed when Resident #1 was asked about the threats, he confirmed making statements and reported he snapped. Nursing remained with Resident #1 until transferred out of the facility to the Hospital via ambulance with assistance from the Police Department. Resident #1 reported having 2 lighters in his room, nursing found and retrieved the lighters. 4. On 4/20/25 at 4:24 AM, Note informed that Resident #1 was given antipsychotic medications at the hospital and tested negative for drug screen. Resident #1 returned to the facility at this time. 5. On 4/20/25 at 11:34 AM, Note revealed Resident #1 wheeled chair up and down the hallway, threw chairs, Kleenex, and puzzles around the lounge room, and argued with other residents in the lounge room. Resident #1 asked staff for cigarettes, lighters, and money. Nursing report Resident #1 created an unsafe environment for all residents and staff and was transferred back to the hospital for psychiatric evaluation via ambulance with assistance from the Police Department. 6. On 4/20/25 at 6:46 PM, Note revealed hospital called nursing to report Resident #1 would be admitted for agitation, Methamphetamines abuse, and insomnia. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. On 4/23/25 at 12:38 PM, Resident #1 returned to the facility via company van. At 6:16 PM, a Note informed that staff spoke with Resident #1 regarding incidents and behaviors that put himself and others at risk for injury. A behavioral contract given to Resident #1 which stated that if he again has behaviors that place others in harm, he will be issued a 30-day discharge notice. Note informed that Resident #1 voiced understanding of the contract. 8. On 4/24/25 at 6:40 AM, Note revealed that Resident #1 had manic behaviors throughout the night with increased anxiety and hallucinations. Resident #1 paced up and down hallways, wanting to go outside to smoke every 10 minutes at the nurses station and spoke of past drug abuse and alcohol consumption. Staff able to redirect with difficulty at times, attempts to educate Resident #1 on behavior expectations were ineffective, and an as needed dose of Hydroxyzine was given for anxiety. Note informed that when Resident #1 was redirected to his room, he unrolled toilet paper, emptied a box of Kleenex, urinated, and spat on the floor in his room. 9. On 4/24/25 at 12:05 PM, Note revealed that staff follow up with Resident #1 regarding continued behaviors and reviewing the resident's behavior contract. Resident #1 voiced understanding and at 12:30 PM, the resident requested to discharge immediately back to the community. A Hospital Discharge summary, dated [DATE], revealed Resident #1's diagnoses included: Agitation or violent behavior, delusional disorders/paranoia, history of Bipolar Disorder, Methamphetamines abuse, other stimulant abuse. The Laboratory Toxicology Report, dated 4/21/25, revealed Resident #1 had positive detection of amphetamines and opioids. Review of Behavioral Contract, dated 4/23/25, signed by the facility Social Service Worker and Resident #1, revealed that if any of the behaviors witnessed on 4/19/25 and 4/20/25 were to happen again, the outcome of non-compliance would be a 30-day discharge notice and additional outcome included resident's arrest. On 4/29/25 at 12:10 PM, Staff A, Registered Nurse (RN), confirmed working with Resident #1 on 4/19/25 and 4/20/25 overnight shifts. Staff A revealed that Resident #1 had manic behavior and erratic conversations which had been worsening throughout the shift. Staff A claimed Resident #1 had been pacing the hallways in his wheelchair and told other residents that he hated being at facility, wanted to burn the place down, and had friends with a gang who would come to facility and harm people. Staff A stated Certified Nursing Assistant (CNA) staff had reported that Resident #1 was scaring residents and reported when asking Resident #1 about his comments he said people should stop making me mad and people better be careful. Staff A stated at least 2 residents were genuinely scared. Staff A reported staying with Resident #1 until transferred to the hospital. When queried about Resident #1's substance use, Staff A denied seeing Resident #1 using any substance or with any drug paraphernalia, but did confiscate 2 lighters from his room and claimed to hear from another resident that Resident #1 had shown him a smoking pipe that he had in possession. Staff A claimed to notify the facility's staff scheduler about allegation that Resident #1 had a smoking pipe but did not know how to proceed with it when no pipe had been seen. On 4/30/25 at 1:00 PM, Staff B, RN claimed to have seen Resident #1 with erratic behaviors and had been upset claiming that someone took 20 dollars from him. Staff B denied seeing any substances or paraphernalia in the facility but stated other staff have said they smelled it. Staff B denied having SUD training provided by the facility. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/25 at 1:20 PM, Staff C, RN, confirmed working on 4/24/25 and reported Resident #1 had a lot of yelling and screaming, and was seen wheeling self all over the place. Staff C informed that Resident #1 did not have any assigned one on one supervision with staff but had been very visible. Staff C denied having received training on SUD. On 4/30/25 at 4:52 PM, Staff D, Certified Nursing Assistant (CNA) confirmed working overnight shift when Resident #1 returned from the hospital and recalled being told by staff from the previous shift to watch out for Resident #1 as he could hurt you. Staff D denied receiving any training or education on how to care for SUD behaviors. Staff D informed that Resident #1 had not been one on one supervision with staff but was kept within sight on the days she worked. On 5/01/25 at 8:25 AM, Staff E, CNA stated when Resident #1 came back from the hospital he had been off the wall, up all night and having erratic conversations. Staff E recalled keeping an eye on Resident #1 to make sure he was not going in to any other resident's rooms. Staff E stated that she had been trained to take care of the elderly and believed facility staff needed some kind of training specific to SUD. Staff E reported hearing from other staff that Resident #1 was using a substance while residing at the facility but had not personally seen this. On 5/01/25 at 12:30 PM, Staff F, Minimum Data Set (MDS) Coordinator, revealed sharing concern with facility Administration that Resident #1 remained in room with roommate upon return from hospital as there had been verbal altercations between the two men. Resident #1 had moved to another room. Staff F recalled hearing rumors about Resident #1 using substance while at facility but denied seeing it. On 5/01/25 at 3:00 PM, Nurse Consultant reported Resident #1 had some questionable behaviors the week before hospitalization and the facility ordered a urine drug screen which had first tested negative but the 3rd screen done at hospital was found to be positive for Methamphetamines Nurse Consultant recalled Resident #1 had behaviors such as tissue throwing, requesting a cigarette every 10 minutes, and being very disruptive. Regional Nurse Consultant revealed that she had been informed that Resident #1 had drugs but questioned every staff member about this allegation and reported that all denied seeing Resident #1 with substances in possession. Nurse Consultant reported that when Resident #1 returned from the hospital on 4/23/25, facility had him sign a behavior contract and moved to a single room. Regional Nurse Consultant reported the facility does not do one on one supervision but do eyes on resident to make sure they're safe. The facility provided a document, titled Monthly Education Calendar 2025, which revealed that facility was scheduled to provide behavioral health in-service education twice per year in the months of April and October. Review of 4/17/25 behavioral health training included a PowerPoint presentation with slide titled Behavioral Health and categories that included: Common mental disorders, anxiety disorder, mood disorder, depression, Bipolar Disorder, and Schizophrenia with treatment options listed as: medications, person centered care, resident goals, and interdisciplinary approach. Training lacked identification of SUD education provided to staff. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled, Behavioral Health Services, dated 4/2025, revealed purpose of policy to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning and well being. The policy revealed expectation of all facility staff, including contracted staff and volunteers to have received education to ensure appropriate competencies and skill sets for meeting the behavioral health needs of residents and identified education to provide care specific to the individual needs of residents that are diagnosed with mental, psychosocial, or Substance Use Disorder (SUD).