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	08/26/2025

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 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. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews and facility policy review, the facility failed to maintain a safe, clean and comfortable environment, free of possible hazards. The facility reported a census of 79 residents. Findings include:On 08/07/23 at 11:00 AM observation of room [ROOM NUMBER] noted carpet flooring throughout an entire room. The dark beige carpet was excessively stained with dark and pink color spills. The bathroom had a walk-in shower that was not used for bathing. The shower had multiple clear plastic trash bags filled with empty pop cans. The personal hygiene items were stored on the floor (disposable incontinence products). 1. Dining room observation on 8/25/25 at 10:25 am revealed the following:a. Peeling paint in several areas on the ceiling. 2 areas measuring about 1ftx1ft each had eroded from a water leak to the point the drywall was visible and the plaster had fallen off, with the peeled and dried paint hanging down from the ceiling about 5-10 inches in the air. 1 of these areas had a dining table right underneath. b. A large vent located in the center of the dining room had a buildup of fuzzy, dust-like particles around it. c. In the adjacent dining room several areas were noted with brown color circular stains in the ceiling tiles. d. Large glass windows to the exterior were noted to be stained and extensive residue of translucent film as from old tape marks were observed throughout the windows and doors. e. Sink next to the ice machine had visible corrosion from water around the base of the cabinet and the wall. The tile underneath the ice machine and the sink was saturated with water from the water line that was actively dripping. f. Nurses station located in the center of 4 residential hallways displayed a carpeted floor. Throughout most of the floor, large dark stains were noted in the carpet. g. On one of the four residential hallways, a skylight between rooms #308 and #309 several ceiling tiles stained with brown circular spots. One of the ceiling tiles surrounding the skylight had a spot with brown and black discoloration that had powder-like particles falling out of it accumulating on the carpeted floor. h. The entertainment area where residents were noted to spend time watching TV had a large ceiling vent. The grey filter in the vent had a buildup of fuzzy and black colored substance accumulated throughout the base. i. The carpeted floor in the main area of the facility, between the dining room and the TV noted to be soiled with varies shapes and colors.In an interview on 8/25/25 at 3:00 pm with the Maintenance Director who has been in the position for about 2 weeks, he revealed that he was new to the facility and confirmed the mentioned above areas of the facility needed improvement. He reported that the carpet cleaning machine was out of service at the moment but the replacement parts were ordered. He further stated that meanwhile a smaller carpet shampooing unit was in use to spot clean areas but it wasn't large enough to deep clean large carpeted areas such as by the nursing desk or by the main dining room area. 2. Record Review of Resident #8 Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) of 14 indicating intact cognition. The MDS reflected Resident #8 utilized a wheelchair for mobility. The MDS further documented Resident #8 required substantial/maximal assistance total from staff for performing activities of daily living but he was able to independently use the wheelchair. In an interview with Resident #8 on 8/24/25 at 10:30 am it was noted the wheelchair was visible soiled and a buildup of debris around the structural parts. The cushion seat had multiple cigarette burns extending from the center towards the edge of the seat. The lock on the left side of the wheel was not functional. Resident #8 stated the lock did not work properly for a long time and he wanted his wheelchair to look clean and the brakes fixed.In an interview with the Director of Nursing (DON) on 8/26/25 at 10:30 am she stated that the facility staff were to clean residents' wheelchairs at a minimal weekly and on as needed basis. She further stated that the carpet in room [ROOM NUMBER] had been shampooed multiple times but the stains were not lifted successfully. The DON further stated that her expectations were for the wheelchairs to be clean and the carpets to be stain-free to promote a homelike environment for the residents. The facility provided policy titled Safe and Homelike Environment revised 1/2025 documented: Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, staff interview, and policy review the facility failed to provide appropriate incontinence care for one (#11) of three residents reviewed. The facility reported a census of 79 residents. Findings include:The Minimum Data Set (MDS) assessment for Resident #11, dated 5/22/25, included diagnoses of stroke, Non-Alzheimer's Dementia, and hemiplegia (paralysis of one side of the body). The MDS identified the resident was dependent on staff for toilet hygiene and was always incontinent of urine and frequently incontinent of bowel. The MDS indicated the resident had a Brief Interview for Mental Status score of 9, indicating moderate cognitive impairment. Observation on 8/20/25 at 8 AM, Staff A, Certified Nursing Assistant (CNA) and Staff C, CNA entered Resident 11's room and washed hands and donned gloves. With the resident lying in bed, Staff A removed the resident's visibly wet brief, cleansed above the penis, the penis, and the scrotum, without cleansing the inner thighs. The resident was turned to his side and Staff A cleansed between the resident's buttocks and inner buttocks, didn't cleanse the outer buttocks and hips. Facility policy Perineal Care, revised 08/2025, documented cleanse buttocks and anus.Interview on 8/26/25 at 11:10 AM, the Director of Nursing stated expectation to cleanse all areas of buttocks and hips when completing incontinence care.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on record review, resident interviews, observations, staff interviews, and policy review the facility failed to provide nursing staff to assure resident safety by not responding to call lights in a timely manner to 5 of 5 residents reviewed (Resident #8, #12, #17 , and #5). The facility reported a census of 79 residents. Findings include:1.The Minimum Data Set (MDS) assessment for Resident #16, dated 7/20/25, included diagnoses of morbid obesity and heart failure. The MDS identified the resident was dependent on staff for all cares except eating. The MDS indicated the resident had a Brief Interview for Mental Status score of 13, indicating mild cognitive impairment. Interview on 8/28/25 at 4:00 PM, Resident #16 stated the staff don’t answer the call lights timely, that it takes way over 15 minutes, and the afternoon shift is the worst and the facility is always understaffed. The resident stated the other day it was over 2 hours before they answered his call light as he had timed it on his phone. 2.The MDS assessment for Resident #17, dated 7/22/25, included diagnoses of morbid obesity and heart failure. The MDS identified the resident required substantial/maximal assistance of staff for transfers and toileting and is frequently incontinent of bladder and always incontinent of bowel. The MDS indicated the resident had a Brief Interview for Mental Status score of 15, indicating no cognitive impairment. Interviews on 8/28/25 at 4:10 PM and 8/26/25 at 7:40 AM, Resident #17 stated he wished the staff would answer call lights quicker as earlier today it was 1 hour and 40 minutes before the staff answered his light. The resident stated he was wet, needed to be changed, and does have sores on his bottom and the staff are treating the sores but the sores are not getting better with not getting changed quicker. The resident stated frequently staff come in and shut off his call light, then state they will go get help and don’t return. The resident stated he will wait 15 minutes and then will turn on the call light again, as he times it on his phone. The resident stated he had asked for 2 liners placed in his brief as staff are not able to change him frequently enough and he is tired of wetting through his clothes. The resident stated he usually voids all at one time about every 1.5 hours, the brief will hold if he voids 1 time but if he voids 2 or more times then he wets thru to his clothes. The resident stated it takes 2 staff to provide cares and change him, he needed the stand lift which requires 2 staff, and frequently don’t have 2 staff available to change him that often. Additionally, the resident stated he frequently waits 1 hour to get cares completed after he asks. 3.The MDS assessment for Resident #11, dated 5/22/25, included diagnoses of stroke, Non-Alzheimer’s Dementia, and hemiplegia (paralysis of one side of the body). The MDS identified the resident was dependent on staff for transfers, dressing, and toileting. The MDS indicated the resident had a Brief Interview for Mental Status score of 9, indicating moderate cognitive impairment. Interview on 8/19/25 at 11:43 AM, Resident #11 stated staff turn off his call light and say they will be back, not come back for an hour, and this happens frequently in the morning when the resident wants to get up. The resident stated it also happens throughout the day. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The MDS assessment for Resident #8, dated 7/10/25, included diagnoses of stroke and hemiplegia (paralysis of one side of the body). The MDS identified the resident required substantial/maximal assistance of staff for transfers, toileting, and dressing. The MDS indicated the resident had a Brief Interview for Mental Status score of 14, indicating mild cognitive impairment. Interview on 8/19/25 at 12:25 PM, Resident #8 stated it takes about 1 hour for staff to answer his call light frequently and that can be anytime of the day. The resident stated the staff will come in and turn off the light, say they will be back, and don’t come right back. 5. The MDS assessment for Resident #12, dated 7/1/25, included diagnoses of stroke and hemiplegia (paralysis of one side of the body). The MDS identified the resident was dependent on staff for all cares except eating, was wheelchair dependent, and not able to propel self in wheelchair. The MDS indicated the resident had a Brief Interview for Mental Status score of 15, indicating no cognitive impairment. Observation on 8/19/25 at 11:30AM, Resident #11 in his room, reclined in a wheelchair approximately 5 feet from the bed with the call light down between the resident’s bed and wall, not within reach of the resident. Observation on 8/26/25 at 7:50AM, Resident #11 in his wheelchair approximately 4 feet from his bed, with the call light cord draped over the resident’s bed foot board, with the call button down between the mattress and footboard, not within reach of the resident. Resident asked where the call light was and confirmed he was not able to reach the call light. Facility Policy Call Lights: Accessibility and Timely Response revised 10/202 documented staff will ensure the call light is within reach of resident and secured, as needed Interview on 8/26/25 at 11:10 AM, the Director of Nursing stated the facility policy did not address the timeliness of answering a call light but her expectation was for call lights to be answered within 15 minutes and for call lights to be within reach of the residents. 6. The MDS for Resident #5 dated 7/24/25 documented BIMS of 15 indicating no cognitive impairment. The MDS further documented Resident #5 had diagnoses of anxiety, depression and diabetes type 2 with daily insulin injections. In an Interview on 8/25/25 at 12:00 pm Resident #5 revealed call light is not answered for up to 1 hour sometimes. Resident #5 further revealed she watched the clock and often had to leave the room in her wheelchair and look for staff herself to get help. The call light in her room was functioning.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, staff interviews and policy review the facility failed to maintain infection control practices for 8 of 8 residents reviewed. The facility failed to ensure use of EBP when required, failed to maintain hand hygiene with dining and failed to maintain infection control practices during catheter care. The facility reported a census of 79 residents. Findings include: 1. Observation on 8/19/25 at 12:20 PM Staff B, Certified Nursing Assistant (CNA) was sitting at a rounded table assisting 4 residents to dine. Staff B touched 1 resident’s leg with her gloved hands, then with her gloved hand picked up a 2nd resident’s bread stick and placed the bread stick in the resident’s mouth, then proceeded to touch 2 other residents’ silverware and napkins, Staff B continued to assist all 4 residents throughout the lunch meal with the same pair of gloves on and no hand hygiene performed. 2. The Minimum Data Set (MDS) assessment for Resident #9, dated 6/17/25, included diagnoses of neurogenic bladder (inability to control urination) and urinary tract infection. The MDS identified the resident had an indwelling catheter (tube into penis to bladder to drain urine) and needed partial/moderate assistance of staff for toileting hygiene. The MDS indicated the resident had a Brief Interview for Mental Status score of 11, indicating moderate cognitive impairment. Observation on 8/20/25 at 1:40 PM, Staff D, CNA and Staff F, CNA donned gown, gloves and mask and entered Resident #9’s room. Staff D placed a graduated container (container to drain and measure urine from a catheter bag) directly on the carpeted floor, without placing a barrier between the container and the floor, and proceeded to empty the catheter bag into the graduated container, touching the drain spout to the inside of the graduated container. 3.The MDS assessment for Resident #18, dated 5/15/25, included diagnoses of neurogenic bladder and stroke. The MDS identified the resident had an indwelling catheter (tube into penis to bladder to drain urine) and needed substantial/maximal assistance of staff for toileting hygiene. The MDS indicated the resident had a Brief Interview for Mental Status score of 9, indicating moderate cognitive impairment. Observation on 8/20/25 at 1:08 PM- Staff A, CNA and Staff E, CNA sanitized their hands, donned gown and gloves, and entered Resident #18’s room, that is shared with another resident. Staff E placed a barrier on the floor, with the graduated container on the barrier. Staff E removed the catheter bag from the dignity bag, cleansed the drain tube spout, drained the urine from the bag with the spout touching the inside of the graduated container while draining. Staff E cleansed the drain tube spout again and then with Staff A holding the catheter bag, the drain tube spout again touched the inside of the graduated container 2 more times. Staff E placed the spout back into the spout holder, emptied the urine, rinsed the graduated container, placed a paper towel in the container and placed on the back of the toilet, did not cover the container. Facility policy Catheter Drainage Bag Emptying Checklist, undated, documented the container placed on a flat service below bladder, open drainage spout without touching container, and allow urine to drain completely. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Observation on 8/20/25 at Staff A and Staff C, CNA provided incontinence care to Resident #11. While completing cares, Staff C placed the package of perineal wipes on the resident’s bottom bed sheet by the resident. After completing cares, Staff C moved the package of wipes to the resident’s roommate’s bedside tray table. Interview on 8/26/25 at 11:10 AM, the Director of Nursing (DON) stated expectations for the urine graduate container to be placed on a barrier and to not allow the drain spout to touch the inside of the graduated container when emptying the catheter bag. The DON further stated expectation for staff to complete hand hygiene between assisting residents and a resident’s package of wipes used for cares to not be placed on another resident’s bedside table. 5. The MDS dated [DATE] for Resident #5 documented the following diagnoses: multidrug-resistant organism (MDRO), neurogenic bladder, pressure ulcers, cellulitis of right upper limb, and yeast infection. The MDS also indicated use of an indwelling catheter and ostomy. An observation on 8/21/25 at 1:50 pm of Resident #4 revealed a staff member was in the room providing ostomy care without a personal protective gown on. In an interview with Staff G, Registered Nurse (RN) on 8/21/25 at 1:52 pm she visualized staff completing the ostomy care and confirmed the staff in Resident #4’s room should have been following enhanced barrier precautions and utilizing Personal Protective Equipment (PPE) but was not and she was told it was because there were no gown available. Staff G proceeded to look into the supply bin located outside of Resident #4’s room and there were no gowns. Staff G proceeded to walk down the hallway and opened 6 other supply bins with enhanced barrier items/PPE, but only found 1 cart had gowns in it. She stated she will restock the PPE bins and she wasn’t aware of the bins not being stocked with PPE.