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	11/25/2025

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

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(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 - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on clinical record review, hospital record review, facility policy review, family and staff interviews, the facility failed to provide timely assessment and intervention for 2 of 3 (Resident #1 and Resident #8) residents in the sample. The facility failed to respond to reports of a change in condition for Resident #1, which resulted in a hospitalization for sepsis; and failed to notify the provider of the need to evaluate and review a 30-day order for psychotropic medications for a new admission (Resident #8) prior to their expiration. The facility reported a census of 85 residents. Findings include: 1. The Minimum Data Set (MDS) of Resident #1 dated 9/18/25 identified a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. The MDS coded that the resident needed setup or clean-up assistance to eat. The MDS documented diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), heart failure, and diabetes.The Care Plan of Resident #1 identified a Focus Area of Needing Assistance with Activities of Daily Living (ADL). It documented Resident #1 as being independent with eating after staff set up. The Care Plan identified a Focus Area of Altered Cardiovascular Status. It directed staff to monitor/document and report as needed for any symptoms which included fatigue. The Care Plan identified a Focus Area of Risk of Increase in communication problems. It directed staff to allow adequate time to respond and request clarification from the resident to ensure understanding. It additionally directed staff to monitor/document for any physical/non verbal indicators of discomfort or distress and follow-up as needed and to monitor/document/report as needed any changes in ability to communicate. The Progress Note dated 10/26/25 at 4:47 pm documented Resident #1 was sent to the hospital due to altered Mental Status. The hospital records revealed an arrival time to the Emergency Department as 10/26/25 at 5:28 pm, being admitted to the Intensive Care Unit on 10/27/25 at 2:33 pm. The hospital records documented in the emergency room, the resident was hemodynamically stable (meaning her blood pressure, heart rate and circulation were steady and adequate) but she was not responding verbally. Per the note, she did follow simple instructions and the provider ordered a CT (computed tomography) scan (an imaging test to detect for injuries, internal bleeding, etc) which was unremarkable, with lab results indicating an underlying infection.Several hours later, a hospitalist physician documented that the resident had became increasingly hypoxic (not enough oxygen reaching the body's tissues or organs) and required up to 6 liters of oxygen. During the first day of hospitalization, the resident was given diagnoses which included Sepsis (a life-threatening condition that happens when a person's immune system response overreacts to an infection, which can damage body tissues and organs) with acute renal (kidney) failure; acute hypoxic respiratory failure (a life-threatening condition where the body's lungs fail to adequately provide oxygen to the bloodstream, leading to low oxygen levels) and acute metabolic encephalopathy (a rapid decline in brain function caused by a disturbance in the body's metabolism). She had not been released from the hospital at the time of the survey. On 10/30/25 at 12:28 pm, Staff A, Certified Medication Aide (CMA) stated that on Sunday, 10/26/25 she had last given Res #1 medication in the late afternoon. She stated she told the nurse at that time the resident was kind of staring off into space and not talking much. She was able to take her medication but appeared to have a hard time swallowing. She stated the resident normally could talk, although she was very soft spoken. On (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 - Actual harm Residents Affected - Few	10/30/25, Staff B, Certified Nurse Aide (CNA) stated that when she started her shift at 6:00 am on 10/26/25, she realized right away that Res #1 was not feeling well. She stated she went to the resident's room to get her up for breakfast, and Res #1 did not respond verbally and her breathing didn't seem normal. She stated she reported this to Staff C, Licensed Practical Nurse (LPN). She added that Staff C told her this had started on the prior day, 10/25/25. She said Staff C instructed her to get Res #1 up for breakfast so staff proceeded to get her up and took her to breakfast in the dining room. She described that Res #1 ate very little, and was having difficulty remaining sitting upright, as she was leaning forward in her wheelchair so she and another staff member put her back in bed. She stated they did not attempt to get the resident up for lunch. She was dressed and incontinence cares and positioning were provided throughout the rest of the shift. She stated they also pushed extra fluids as she was not eating and turned her more frequently than normal, approximately every hour. She stated she last saw her around 1:30 pm, and prior to that day, she had not worked with Res #1 for a few days. On 10/30/25 at 2:25 pm, the Advanced Registered Nurse Practitioner (ARNP) for the facility stated she had been told the resident had been sent out to the facility over the weekend due to stroke-like symptoms. She stated she was only aware of the facility calling the on call service on Sunday afternoon, October 26th, and otherwise no other calls had been recorded. She provided, via email, documentation from the on call provider who took the weekend call. The triage note from the on call provider dated 10/26/25 documented the resident's nurse reported that upon starting her shift at 2:00 pm, she checked the resident's oxygen levels and noted the resident was a little bit warm and exhibited altered mental status, described as a little bit off from her baseline. The note further documented the nurse consulted with the Certified Nurse Aides (CNA), who reported the resident had been exhibiting these symptoms for approximately one day. The nurse attempted to arouse the resident but noted she did not respond well and appeared lethargic. The nurse additionally observed a little bit of left-sided facial drooping. Vital signs were recorded as a blood pressure of 97/71 (this is lower than considered normal range but consistent with the resident's baseline) and temperature of 99 degrees Fahrenheit. The note further detailed that the resident's son wished for the resident to be sent out for evaluation to the hospital and therefore the resident was being sent via emergency services to the emergency room for evaluation.Staff C, LPN stated she worked from the day shift for eight hours on Saturday, 10/25/25 and Sunday 10/26/25 with Res #1. On 10/26/25, she stayed for an additional eight hours, but moved to a different area of the facility for the second shift. She stated she did not recall anything out of the ordinary with Res #1 on Saturday. She said on Sunday morning, the CNA did come to her and report the resident to be lethargic (a state of decreased mental alertness). She stated in response to this, she assessed her vital signs and blood sugars, which had been elevated. She added that at the 2:00 pm shift exchange, she reported to the oncoming nurse to keep an eye on the resident, and that nurse (a staffing agency nurse rather than a facility employee) later became concerned about the resident and asked for assistance. She stated that Res #1 was often sleepy and she did not consider lethargy to be anything new. Review of Progress Notes failed to reveal any documentation of change of status for Res #1. On 10/26/25, two documentations of blood sugar being checked by Staff C were revealed, both timed as 12:43 pm, with no vital signs being documented by Staff C except her oxygen saturation at 8:10 am. On 11/3/25 at 11:38 am, Staff D, CNA stated she cared for Res #1 on Saturday, 10/25/25 for both the morning and afternoon/evening shifts, from 6:00 am until 10:00 pm. She recalled that she gave Res #1 a shower on Saturday morning and Res #1 was not feeling well. She did not want to go to the dining room and requested a meal tray in her room for both breakfast and lunch. She stated she reported this on Saturday morning to Staff C, LPN.On 11/3/25 at 2:40 pm, in a second interview, Staff D, CNA stated she knew the way Res #1 was acting was not normal for her. She stated she needed to feed the resident that day (the resident normally feeds herself) but she mostly took fluids for both breakfast and lunch. She stated she recalled reporting this to both Staff C, LPN as well as a second nurse, Staff E, Registered Nurse (RN), in the evening. She stated Staff E did go and assess the resident that evening after she had told him (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Res #1 reported she felt like she was having a hard time breathing. Staff E, RN was unable to be reached for an interview and did not respond to messages. On 11/4/25 at 10:46 am Staff F, RN stated she arrived at the facility for a 2:00 pm to 10:00 pm shift on 10/26/25. Staff F works for a staffing agency and is not employed by the facility. She stated she had probably last seen Resident #1 approximately two weeks earlier. She stated during shift exchange report, Staff C, LPN told her that Res #1 had been experiencing a general decline over the last two days and had been having high blood sugars which had been monitored and were slowly dropping. She stated upon her initial assessment, she noticed a mental status decline from the last time she had worked with the resident. She described when she took the resident's hand to check her blood sugar, her hand felt hot to the touch. She tried to talk to her but the resident was minimally responsive to her. She said the resident's eyes were open but she was staring off in a daze. She stated she knew she didn't look right, so she checked her blood sugar level and her vital signs at that time. She returned later in the shift for a second assessment and spoke to the CNAs on duty who reported this was not the normal presentation of the resident. She stated one of the CNAs (she could not recall the name of the CNA) told her she had reported concerns about the resident several times to the nurses but felt nothing was being done. She said the CNA also told her the resident had gotten worse since the last time she reported it. Staff F stated at that time, she went to another hall of the facility to locate another nurse to come assist her. She located Staff G, RN. She said Staff G immediately stated the resident needed to be sent to the hospital. She then notified the resident family and the on call provider and the resident was sent to the hospital. On 11/4/25 at 11:13 am, Staff G, RN stated Staff F came to her and requested assistance with Res #1. She stated when she arrived to Resident #1's room, she noted the resident had a slight left sided facial droop and was not talking right. She stated the resident is typically quiet but was markedly different from her usual baseline during her assessment. She stated she recommended the resident be sent to the hospital. She assisted Staff F in making phone calls and preparing paperwork to be transported to the Emergency Room. On 11/4/25 at 12:17 pm, during a second interview with Staff A, CMA she stated on 10/26/25, Resident #1 to an extent was off. She stated Resident #1 was always tired but she had concerns and reported it to Staff C, LPN. She recalled Staff C had told her that Res #1 had just recently had a vaccine and that was likely why she was not feeling well. She stated at the beginning of her shift, Res #1 was still talking but as the day went on, she was not speaking at all. She stated she reported this to both Staff C and Staff F. She recalled that Staff C told her she had checked the resident's vital signs and blood sugars and they were fine. The vaccination portion of the resident's Electronic Health Record (EHR) was reviewed. Documentation revealed no vaccine had been administered to Resident #1 since January of 2025. The Medication Administration Record (MAR) for October of 2025 was reviewed. This revealed Res #1 was scheduled to receive an RSV vaccine on 10/25/25, but it was not documented as having been received. The facility policy titled Notification of Changes, revision date of 03/2025, documented the following as its policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification.The policy documented under Circumstances Requiring Notification to includePoint 2: Significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental or psychosocial status which may include life threatening conditions or clinical complications.2. The MDS of Resident #8 dated 9/16/25 identified the presence of short and long-term memory impairment. The MDS documented diagnoses which included anxiety disorder and bipolar disorder. The MDS documented the resident received antipsychotic, antianxiety and antidepressant medications during the look-back assessment period. The Care Plan of Resident #8 identified a Focus Area of risk of complications related to the use of psychotropic drugs. The Care Plan directed staff to monitor for the continued need of medication as related to behavior and mood and to monitor for side effects and to consult the physician and/or pharmacist as needed. On 11/3/25 at 10:34 am, a family member of Res #8 stated (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	she had several concerns about the care her family member received in the facility. She clarified her biggest concern was that sometime between June of 2025 when he was admitted to the facility, and August of 2025 when she accompanied him to a psychiatric medical appointment, he had completely stopped taking his psychotropic medications. She stated they had just been cut off cold turkey. She expressed that prior to admission to the facility he took depakote (an anticonvulsants or antiepileptic drug. It is often used as a mood stabilizer in patients with bipolar disorder such as Res #8), seroquel (an antipsychotic medication) and trazodone (an antidepressant medication, often given at night to promote sleep). She stated she was not notified of these medications being stopped. She stated when she found out he was no longer on the medications and brought concerns forward to the facility, they were restarted. The hospital paperwork of Res #8 revealed he was admitted to inpatient behavioral health on 4/17/25 due to bipolar disorder and being found outdoors outside of his home disrobed. Listed diagnoses included bipolar disorder, restlessness and agitation and insomnia. The paperwork indicated a discharge date of 6/3/25 from the hospital to the facility. His discharge instructions included the medications of trazodone, 50 mg at bedtime for 30 days, quetiapine (seroquel), 200 mg and bedtime for 30 days and divalproex (depakote), 2000 mg at bedtime for 30 days. Upon admission to the facility, Staff H, LPN entered the orders as written into Res #8's electronic health record. On 11/3/25 at 3:45 pm, Staff H, LPN stated whenever the facility receives a new admission, the medical provider reviews the medication list. She believed the review would include a stop date for the medication if one was provided. She stated normally, seeing psychotropic medications stopped abruptly would be a concern, but stated they always follow physician orders. On 11/3/25 at 4:00 pm, a representative from the facility's contracted pharmacy confirmed the original orders they received for Res #8 on 6/2/25 was for 200 mg of seroquel for 30 days. He stated the order was then restarted on 8/18/25. He stated the portion of the pharmacy he works in was simply to supply the medications and the medication reviews and recommendations were completed by a consulting pharmacist. He stated he would put in a request for that person to contact the State Surveyor.The Progress Note dated 7/9/25, authored by the ARNP, noted the resident was still taking depakote, seroquel, and trazodone. The Medication Administration Report for July of 2025 revealed the resident had last taken the depakote on 7/2/25, the seroquel on 7/3/25 and the trazodone on 7/3/25. All three medications were stopped without tapering (a decrease in dosing). The Progress Note dated 8/15/25 documented the resident attended outpatient therapy at the community hospital and returned to the facility, documenting he had a psychiatric appointment scheduled for 8/18/25. The Progress Note dated 8/17/25 documented the resident reported to his family he was not sleeping well at night. The note documented a family member stated the resident had previously been on depakote, trazodone and risperidone (a different antipsychotic medication). Staff E, RN authored this note, which also included he had reviewed the prior hospital records and it was unclear why the resident was no longer on the medications. The Progress Note dated 8/18/25, authored by Staff I, RN (former staff member, was the Director of Nursing [DON] at the time of the note) documented Res #8 had orders in place at admission to take Trazodone, Seroquel, and Depakote for 30 days and the medications ended on 7/4/25. The note further documented the resident would be attending a psychiatric appointment that day at the community hospital. The August 2025 MAR of Resident #8 revealed new orders for Trazodone, Depakote, and Seroquel were all started between 8/18/25 and 8/20/25. On 11/3/25 at 2:22 pm, Staff I, RN, former DON, stated she had been speaking to Res #8's family about his psychiatric meds in August of 2025. She stated at times, the hospitals will make an autostop date of 30 days on psychotropic medications due to Centers for Medicaid and Medicare Services (CMS) regulations regarding psychiatric diagnoses. She stated that was likely what happened with Res #8 on admission. She stated the resident's family member had came to her and asked her to look at the resident's medications. She said it was then they realized the discharging hospital had placed the orders for only 30 days. His family member stated the community hospital had always managed Res #8's psychotropic medications and requested he get an appointment there to get them restarted. She (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	added the facility did request a pharmacy review as well and the Medical Director for the facility did wish for the community hospital to continue to handle the psychotropic medications for Res #8. She added that if she had been the admitting nurse who entered the orders into the EHR, she would have questioned the 30 day stop. On 11/4/25 at 10:00 am, the ARNP stated that to her memory, the facility had never notified her of Resident #8's orders having a stop date for 30 days upon admission. She stated she would never recommend hard stopping psychotropic medications without first tapering the doses down. She recalled a family member speaking to her recently, prior to the resident's death, about how upset she was about the medications having been stopped the way they were. The ARNP stated she had no idea how it happened. She described that for all new admissions, she is provided with a list of medications the resident is on but she was unable to state if stop dates were included on these lists. She also added she had written an order for Res #8 to receive services from the consulting behavioral health services who see residents in the facility. She clarified they also may not have been aware of the 30 day stop date of the medications. On 11/4/25 at 10:57 am, a second representative from the consulting pharmacy stated she had paperwork documenting the pharmacy had questioned the 30 day stop date and she would forward those documents. An email was received from the second pharmacy representative on 11/4/25 at 11:08 am. She included two documents on separate dates showing the pharmacy did bring up the 30 day stop date to the facility. She stated one of the documents was signed and acknowledged by the medical provider but did not address the 30 day stop date.The admission Medication Review for Resident #8, dated 6/3/25 included under the section of incomplete or vague directions needing clarification: Please clarify if orders sent for 30 day supply should be continued. This document was signed at the bottom by the ARNP and dated 6/5/25 with no clarification included as per the request. The Medication Regimen Review for the facility, dated 6/1/25 - 6/18/25, included, for Res #8, under Findings/Recommendation: Please follow-up with the prescriber to clarify the 30 day stop dates on Res #8's psychotropic meds. Each of them appear to be maintenance meds that would likely be necessary to continue ongoing. On 11/4/25 at 2:11 pm, the Regional Director of Operations stated if a resident has a decline of condition, her expectation is for the medical provider to be notified. She additionally stated if the pharmacy makes a medication recommendation, her expectation is for those recommendations to be followed up on.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, and staff interviews the facility failed to follow physician orders to remove a fentanyl patch prior to applying a new patch for 1 of 1 residents (Resident #2) reviewed. The facility reported a census of residents. Findings include: The Minimum Data Set (MDS) dated [DATE] revealed that Resident #3 had diagnoses of cancer, polyneuropathy due to other toxic agents, chronic obstructive pulmonary disease (COPD) and unspecified abdominal pain.The Care Plan initiated on 12/9/24 indicated that Resident #3 used Fentanyl related to pain and directed staff to administer the medication as ordered by the physician.The Physician's Order Summary Report dated 9/5/25 included an order for Fentanyl 25 mcg (micrograms) patch apply one patch topically to skin every 3 days and to remove old patch prior to the applying the new patch and to rotate sites.The Electronic Health Record (EHR) Progress Notes revealed that on 9/6/25 Resident #3 appeared to be confused and unable to answer questions. She was also looking around and was unable to voice needs. It also revealed that Staff A, Advanced Registered Nurse Practitioner (ARNP) was at the facility assessing the Resident #3 and noted that she was lethargic and confused with a history of urosepsis and hydronephrosis. Staff A, ARNP sent Resident #3 to the hospital given her current symptoms.The EHR revealed Resident #3's vital signs on 9/5/25 at approximately 11:30 AM were 98.4 temperature, 97 pulse, 107/69 blood pressure and 95% oxygen saturation.The Electronic Medication Administration Record (EMAR) dated 9/2025 indicated that Resident #3 had a 25 mcg (mcg) Fentanyl patch applied to the left arm on 9/2/25; and on 9/5/25 a patch placed on her right arm. The facility-controlled substance book confirmed a Fentanyl patch applied to Resident #3 on 9/2/25 was 25 mcg.The facility automated medication dispensing system report indicated that the Fentanyl patch removed and applied to Resident #3 on 9/5/25 was 25 mcg.The Emergency Medical Services (EMS) Patient Care Report dated 9/5/25 for Resident #3 indicated that a Fentanyl patch removed en route to the hospital. No further information regarding location, strength or date on patch included in report. The Emergency Department (ED) Physician Notes dated 9/5/25 indicated that Resident #3 had a second Fentanyl patched removed in the ED. No further information regarding the strength or location of the patch included in the report. The note listed diagnoses of sepsis, acute kidney injury, elevated liver enzymes, lactic acidosis, elevated thyroid stimulating hormone and anemia.The Physician Discharge summary dated [DATE], Hospital Course indicated, in part .On 9/7 Patient transferred to ICU (Intensive Care Unit) for fentanyl overdose with severe acute hepatic encephalopathy (a neuropsychiatric syndrome caused by diseased liver's inability to filter toxins, like ammonia, from the blood, allowing them to reach the brain) with increased ammonia levels in the 200's (normal 15 to 45; or 10.7 to 32 depending on type of test completed by the lab) .In an interview on 10/21/25 at approximately 8:50 AM Staff A, ARNP stated she was here on 9/5/25 prior to the transfer out of Resident #3 at around 11:30 AM. She was lethargic and confused. She believed she was septic as she has a history of urosepsis and she had a lower blood pressure and increased pulse. She did not look to see how many Fentanyl patches she had on but heard that she had two on.In an interview on 10/21/25 at 10:04 the consulting Pharmacist queried about how long a 72-hour Fentanyl patch would continue to put out medication, and he stated that 72 hours is based on averages so it could have been completely done or still releasing some medication. During an interview on 10/21/25 at 1:50 PM Staff C, Licensed Practical Nurse (LPN) queried about the 9/5/25 Fentanyl patch and she stated if she did place a patch from the automatic dispending system, she would need a second person as the machine required two sets of finger prints to remove a patch. She added she does not remember who signed with her that day. When told Resident #3 went to the hospital an hour after she applied the patch, she stated she did remember putting on the patch. She stated she remembered telling Staff A, ARNP that something was off about the resident. Staff C, LPN stated that she took off the old patch on the left arm as she has to before she can put on the new one. She also stated that (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she had a witness when she disposed of the previous patch and put it in the drug buster. She was unable to state where that would be documented. She does not remember who witnessed it but it would probably be the same one who helped her take the new one out. Then she added that if it was busy, it might have been someone else just so there was a witness.In interview on 10/22/25 at 8:08 AM Staff A, ARNP stated that Resident #3 had not been feeling well for a few days prior to her assessment on 9/5/25. She feels that Resident #3 had a urinary tract infection with sepsis based on her symptoms as she had presented that way the first time she met Resident #3. She does not feel that the resident was overdosed and stated that if the old patch from 3 days before had been removed, the outcome would have been the same. It was not a double dose as the old Fentanyl patch would have been basically completed. She also has a fatty liver so her liver enzymes were already elevated. Staff A stated the primary diagnosis in the ED was sepsis.In an interview on 10/22/25 at 12:59 PM the Administrator stated that the nurse who administered Resident #3's Fentanyl patch on 9/5/25 should have taken off the patch from 9/2/25. She did see in the ED notes that Resident #3 did have 2 patches on when transported to the hospital and should not have.In a policy titled Medication Administration revised 1/2025, it is indicated that medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. In a policy titled Controlled Substance Administration and Accountability revised 1/2025, it is indicated that all controlled drug patches removed from patients are disposed of in such a manner as to prevent diversion. It lacks direction of removal of old patches prior to new patch application.