| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165350 | A. Building<br>B. Wing | 01/08/2026 |

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

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, resident interviews, staff interviews and policy review the facility staff failed to provide care for a resident in an environment that maintained or enhanced dignity for one of twelve residents observed and required assistance for eating (Residents #30). The facility staff also failed to respond in a timely manner to call light and assist a resident off the toilet, and failed to administer pain medication for one of twenty-five residents sampled (Resident #7), and failed to knock and wait for a response before entered a resident's room (Resident #72 & #74) . The facility reported a census of 81 residents. Findings include:<br><br>The Minimum Data Set (MDS) dated [DATE] for Resident #7 revealed the diagnoses of osteoarthritis, chronic pain and identified a fall that resulted in a fracture. Resident #7 required the assistance of 1 for toileting and transfers. Resident #7 had a Brief Interview for Mental Status (BIMS) score of 15 for an intact cognition.<br><br>The Care Plan for Resident #7 directed staff to provide the assistance of one staff for transfer, toileting and ambulated with therapy only.<br><br>The document titled Therapy for Resident #7 revealed appointments for 30 minutes a day continued therapy due to fracture of left leg, non-weight bearing to the left lower leg and pain in her left leg.<br><br>During an interview on 1/5/26 at 4:10 pm, Resident #7 stated on 1/4/25 at 6:15 pm, she was assisted by Staff S, Certified Nursing Assistant (CNA) to the toilet and left the room. Resident #7 stated she had activated the call light within 5 minutes and no staff responded to the call light to assist her back to her bed until 7 pm. Resident #7 stated Staff S was aware she was on the toilet and she asked her roommate if anyone was in the hall and was informed four staff walked by the room and did not answer the light. Resident #7 stated that the CNA who did respond at 7 pm was not assigned to her hall yet came over to help her. Resident #7 stated sitting on the toilet for 45 minutes with staff who walked by without answering the call light made her feel like no one cared about her. Resident #7 stated when she reported having pain in her left leg that required an as needed (PRN) pain medication, the staff informed her she cannot get PRN's at that time due to the inability to find Staff R, Licensed Practical Nurse (LPN). Resident #7 stated her pain level was a 7 and when Staff R responded, she intimidated her and told her she was going to take Tylenol. Resident #7 stated she took Tylenol scheduled during the day and could have a PRN narcotic for higher levels of pain. Resident #7 stated Staff R was mean and intimidating to the point that if she was working, Resident #7 would wait until the next shift nurse arrived to request the narcotic. Resident #7 stated she had sat and cried for 2 hours due to the pain and continued to have break through pain due to working hard with<br><br>(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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | therapy. Resident #7 stated she talked to the Director of Nursing (DON) about enduring a lot of pain due to Staff R not administering her the PRN that she requested, It brought me to tears because my leg was having spasms.<br><br>During an interview on 1/8/25 at 8:38 am, the DON stated her expectation for the nurses were to provide the appropriate pain control for the residents and encourage them to offer the lower medication but the resident had the right to request and receive the narcotic for pain relief.<br><br>2. During an interview on 01/5/26 at 3:30 pm with Resident #72, a staff member entered his room without knocking and interrupted the interview to check if the resident had enough ice in his cup. Resident #72 stated it happened all the time and the staff were disrespectful to him.<br><br>During an interview on 1/5/26 at 2:30 pm with Resident #74, three staff entered his room, without knocking and interrupted the interview. Resident #74 stated, I feel this has been going on for a long time and I'm fed up with the place.<br><br>During an interview on 1/8/25 at 8:38 am, the DON stated her expectation for staff was to respond within an appropriate amount of time to the call lights, knock and announce their presence. The DON stated her expectation for the nurses were to provide the appropriate pain control for the residents and encourage them to offer the lower medication but the resident had the right to request and receive the narcotic for pain relief.<br><br>During an interview on 1/8/25 at 9:32 am, Staff O, CNA stated the staff are to respond to the call lights as quickly as possible and was encouraged to knock on the door for the residents that startle easily.<br><br>During an interview on 1/8/25 at 9:50 am, Staff U, CNA stated she believed in good bedside manners and the facility had enough staff to provide the assistance. Staff U stated they have received education on abuse and how to knock, announce themselves and to be kind.<br><br>3. The Minimum Data Set (MDS) assessment dated [DATE] identified Resident #30 had diagnoses of cerebrovascular accident (CVA)(stroke), malnutrition, aphasia (disorder that impairs speaking and understanding) and dementia. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 2, indicating severely impaired cognition. The MDS recorded the resident had dependence on staff for eating.<br><br>The Care Plan revised 11/18/25 revealed Resident #30 required assistance with ADL (activities of daily living) related to CVA. The Care Plan directed staff to provide assistance of one for eating, encourage and assist the resident to utilize compensatory techniques to decrease the risk of aspiration: alternate liquids and solids, take small bites/sips, and clear the oral cavity before taking another bite or sip.<br><br>During observation of the lunch dining service on 1/6/26 at 11:48 AM, Staff C, certified nursing assistant (CNA), sat on a chair next to Resident #30 as she fed the resident. Staff C had her right arm bent up and her elbow rested on the table. Staff C rested her head on her right hand as she fed the resident. Staff C did not look at or interact with Resident #30. Staff C held a spoonful of food by the resident's mouth and then put the food into the resident's mouth. Staff C picked up a beverage cup with a straw and pushed the straw into the resident's mouth. Staff C laid the spoon on a plate, rubbed her left eye, picked up the spoon and continued to feed the resident.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 1/8/25 at 1:15 PM, the Director of Nursing reported she expected staff to be engaged with the resident and show dignity and respect as they fed a resident. She planned to provide staff education on what was expected.<br><br>The facility's Promoting/Maintaining Resident Dignity policy reviewed / revised 12/2025 revealed it is the practice of the facility to treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintained or enhanced a resident's quality of life by recognizing each resident's individuality. Staff shall not treat the resident as if the resident is not there.<br><br>The facility's policy titled Call Lights: Accessibility and Timely Response reviewed /revised 12/2025 revealed all staff members who see or hear an activated call light are responsible for responding. The policy lacked information about the amount of time call lights needed to be answered. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>Based on record review, resident interview, staff interviews, and policy review, the facility failed to include interventions for a resident who sustained a fall with an injury (#71) and antianxiety medication and target behaviors for 1 of 5 residents (#41) in the residents' Care Plans. The facility reported a census of 81 residents. Findings include:1) On 1/05/26 at 11:26 AM, Resident #71 stated he had a previous fall from his bed the previous month and was hospitalized . He stated the facility staff directed him to place his bed in the lowest position and to call staff for assistance to prevent any future fall. His bed was not in the lowest position during the interview and there were anti-skid strips on the floor beside his bed.The Minimum Data Set (MDS) assessment for Resident #71 dated 12/11/25 revealed a Brief Interview for Mental Status (BIMS) score was not established. It included diagnoses of a stroke, unsteadiness on feet, and muscle weakness. It indicated the resident was independent with oral, toileting, and personal hygiene and upper body dressing, required supervision with eating, maximum assistance with bathing, and was dependent with lower body dressing. He was also independent with rolling left-to-right and sit-to-lying repositioning, required setup assistance with bathing transfers, and required supervision with all other mobility. It further indicated the resident sustained a fall since his admission.The Progress Notes dated 12/11/25 revealed the resident fell from his bed while sleeping and was sent to the hospital. It also indicated new fall prevention interventions would be determined upon the resident's return to the facility and the Care Plan was reviewed and updated.On 1/06/26 at 4:15 PM, Resident #71 stated his bed was not in the lowest position on 1/05/26 because he was awake watching TV. He further clarified that staff directed him to keep his bed in the lowest position when he is asleep.The Care Plan revised 12/19/25 included the resident's fall on 12/11/25 and directed staff to assist the resident with mobility and maintain a clutter-free environment. It did not include the directive for the resident's bed to be in the lowest position when the resident was asleep.On 1/07/26 at 3:07 PM, Staff G, Licensed Practical Nurse (LPN) stated the Care Plan should include the resident's bed being in the lowest position when he's asleep. At 3:19 PM, she confirmed the Care Plan did not include the directive.At 3:20 PM, Staff T, Certified Nurse Aide (CNA) stated she would look for bed positioning interventions to be in the resident's Care Plan.2) The MDS assessment for Resident #41 dated 11/26/25 revealed a Brief Interview for Mental Status (BIMS) score of 01 out of 15 which indicated severely impaired cognition. It included diagnoses of non-Alzheimer's dementia with behavioral disturbances, anxiety, and depression. It indicated the resident was independent with eating, required moderate assistance with oral hygiene and upper body dressing, maximum assistance with toileting and personal hygiene and lower body dressing, and was dependent with bathing and footwear. It also revealed the resident took antianxiety medication in the 7-day look-back period.The Electronic Health Record (EHR) included an order dated 11/26/25 for an antianxiety medication and the behaviors the resident exhibited when she became anxious.A Progress Notes dated 12/13/25 included the resident's anxiety behaviors and indicated the resident had not exhibited them.The Care Plan revised 12/20/25 included the resident's anxiety disorder but did not include the anxiety medication, the resident's anxiety behaviors for staff to monitor, or non-medication interventions for staff to attempt.On 1/07/26 at 3:07 PM, Staff G, LPN stated the resident's anti-anxiety medications, anxiety behaviors, and interventions should be in the resident's Care Plan. At 3:19 PM, she confirmed the information was not included in the resident's Care Plan.On 1/07/26 at 3:20 PM, Staff T, CNA stated she would look for the resident's anxiety behaviors in the resident's Care Plan.On 1/08/26 at 2:26 PM, the Director of Nursing (DON) stated Care Plans should be updated to accurately reflect the resident's care based on the resident's<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | orders.A policy titled Comprehensive Care Plans revised 02/2025 indicated the Care Plan would describe resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observation, clinical record review, staff interview, and policy review, the facility failed to protect a resident's (#54) heels during a mechanical lift transfer and failed to provide supervision for an at-risk resident who went to the courtyard and smoked. The facility reported a census of 81 residents.Findings include:1) The Minimum Data Set (MDS) for Resident #54 dated 12/08/25 revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated moderately impaired cognition. It included diagnoses of single nerve damage in both legs that causes muscle weakness and a stroke. It indicated he required setup assistance for eating and oral hygiene, moderate assistance with personal and toileting hygiene, and was dependent with all other Activities of Daily Living (ADLs). He also required moderate to maximal assistance with all forms of mobility.The Electronic Health Record (EHR) included a form titled Braden Scale For Predicting Pressure Sore Risk dated 8/19/24 that revealed Resident #54 was a moderate risk for developing a pressure sore.The Care Plan revised 8/25/24 indicated the resident had potential for pressure ulcer development related to immobility and directed staff to Follow facility policies/protocols for the prevention/treatment of skin breakdown.On 1/05/26 at 11:35 AM, Staff L, Occupational Therapist (OT) and Staff M, Certified Nurse Aide (CNA) transferred Resident #54 in a mechanical lift from his bed to a wheelchair. During the transfer, the resident's heels were dragged across the mattress as staff repositioned him in the mechanical lift sling. After the resident was positioned in the wheelchair, Staff L exposed the resident's heels and the right heel was red.On 1/08/26 at 1:04 PM, Staff N, Certified Nurse Aide (CNA) stated residents' feet should not contact the mattress while actively moving the resident with a mechanical lift.On 1/08/26 at 1:14 PM, Staff O, CNA stated the resident's body should not be touching the mattress when actively moving them off the bed.On 1/08/26 at 1:18 PM, Staff P, CNA stated residents' feet should be elevated off the mattress when moving them.On 1/08/26 at 1:23 PM, Staff L stated there was no reason Resident #54's heels should have dragged across the mattress but added she was focused on preventing him from falling out of the mechanical lift sling because he was leaning trying to reach for something.On 1/08/26 at 2:26 PM, the Director of Nursing stated staff should have lowered the bed or elevated the resident's heels to prevent shearing or rubbing.A policy titled Safe Resident Handling/Transfers revised 12/2025 indicated the facility policy was to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines.2) The Minimum Data Set (MDS) for Resident #72 dated 12/03/25 revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated completely intact cognition. It included diagnoses of hemiplegia, a stroke, acute respiratory failure, high blood pressure, and diabetes mellitus. It indicated the resident required setup assistance with eating, supervision with oral hygiene, moderate assistance with personal hygiene, maximal assistance with bathing and upper body dressing, and was dependent with lower body dressing and toileting hygiene. He also required maximal assistance with sit-to-lying, lying-to-sitting, and bed repositioning. He was dependent with all other forms of mobility.A Progress Note dated 10/01/25 indicated Resident #72 was not an independent smoker and must be supervised.A Safe Smoking Assessment Form dated 9/24/25 indicated the resident lacked spatial and self-awareness and required supervision for smoking.The Care Plan revised 9/24/25 revealed the resident continued to smoke and would need to be supervised for smoking based on his smoking assessment. It directed staff to provide supervision to ensure the cigarette is fully extinguished to prevent the resident from burning himself and to Please show me where the designated smoking area is and assist me with getting to and from the<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | smoking area during smoking times if I need help, if not I will assist myself.On 1/06/26 at 5:35 AM, Resident #72 wheeled himself through an exit door into the enclosed smoking courtyard. The resident pressed a red alarm-cancel button then pressed the automatic door-open button prior to exiting. There was no staff present and no audible alarm was heard.At 8:41 AM, Resident #72 attempted to wheel himself to the courtyard to smoke. Staff K, Director of Rehabilitation (DOR) stopped him, took his cigarette, put a vest on him, left and returned with another resident, placed a smoking apron on both residents, and took them out to the courtyard. She stated both residents required supervision and an apron to smoke.On 1/07/26 at 4:15 AM, Resident #72 opened the courtyard door and triggered the alarm. The Director of Nursing (DON) responded immediately and informed the resident he needed staff present to smoke.On 1/08/26 at 2:26 PM, the DON stated staff should closely monitor Resident #72 when he is self-moving in his wheelchair.A policy titled Resident Smoking revised 01/2025 indicated Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas (weather permitting), in accordance with his/her care plan. It also indicated Supervision will be provided as indicated on each resident's care plan. |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observations, resident and staff interviews, facility document review and clinical record review, the facility staff did not consistently answer call lights within a reasonable amount of time. Family members and residents reported having to wait thirty to forty-five minutes for the call light to be answered numerous times during the evening and night time. Residents reported during evening cares and shift change the wait is longer. The facility reported a census of 81 residents. Findings include:During an interview on 1/05/26 at 4:10 pm, Resident #7, that had a Brief Interview for Mental Status (BIMS 15) that suggested an intact cognition, stated on 1/4/25 at 6:15 pm, she was assisted by Staff S, Certified Nursing Assistant (CNA) to the toilet and then the aide left the room. Resident #7 stated she had activated the call light within 5 minutes and no staff responded to the call light to assist her back to her bed until 7 pm. During an interview on 1/5/26 at 4:15 pm, Resident #30, that had a BIMS of 15, stated on 1/4/26 at 9 pm she turned her call light on as she needed assistance on the toilet and waited approximately 30-45 minutes and no one responded. Resident #30 stated she went to bed without getting cleaned properly. During an interview on 1/5/25 at 2:30 pm, Resident #74 stated he felt he waited extended periods of times for his call light to be answered and that had been going on for a long time in the evenings and overnight shifts. Resident #74 stated one night he choked on mucous and needed immediate assistance and no one responded for fifteen minutes and he had fear that he was choking to the point of death before he could clear it, then the staff came to his room. Resident #74 felt there was not enough staff here that do care.Resident Council meeting minutes for November 2025 listed staff (unable to identify due to not wearing their name badges) were turning off the call light, wearing ear buds during care and there were long wait times for the call lights to be answered.During an interview on 1/8/25 at 8:38 am, the DON stated her expectation for staff was to respond within an appropriate amount of time to the call lights.During an interview on 1/8/25 at 9:32 am, Staff O, CNA stated the staff are to respond to the call lights as quickly as possible and was encouraged to knock on the door for the residents that startle easily.During an interview on 1/8/25 at 9:50 am, Staff U, CNA stated she believed in good bedside manners and the facility had enough staff to provide the assistance. Policy titled Call light dated 12/2025 revealed a directive for all staff who see or hear an activated call light to respond and notify the appropriate personnel of the resident's need. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>Based on clinical record review, hospital record review, resident and staff interviews, and policy review, the facility failed to administer accurate medications to 1 of 13 residents (#38) resulting in a fall and hospitalization due to low pulse and blood pressure. The facility reported a census of 81 residents. Findings include:The Minimum Data Set (MDS) assessment for Resident #38 dated 11/29/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of chronic kidney disease, peripheral vascular disease, high blood pressure, and diabetes mellitus. It indicated she required setup with eating and oral hygiene, required moderate assistance with upper body dressing, maximal assistance with toileting hygiene, bathing, and lower body dressing, and was dependent for personal hygiene. It also indicated she required supervision with ambulating and maximal assistance with all other mobility.On 1/05/26 at 11:54 AM, Resident #38 stated she was given the wrong medications when she was first admitted to the facility. She said the medications belonged to her roommate at the time. She stated she informed the staff member that the medications were not hers but the staff member informed her they were. She stated she took the medications because she thought the doctor had ordered different medications upon admission to the facility but was not able to recall the medications. She stated shortly after she took the medications, she blacked out and fell off of her scooter. She stated she did not have any pain associated with the fall.The Medication Administration Record (MAR) did not reveal what medications the resident was given.The Electronic Health Record included a Progress Note dated 11/24/25 that revealed the resident fell as a result of a medication error. The Progress Note indicated the resident's blood pressure was low and the nurse contacted the Nurse Practitioner (NP) who ordered the staff to transfer the resident to the hospital for further evaluation and treatment.The Hospital ICU (intensive care unit) Patient Transfer Note with admission date of 11/24/25 revealed the resident was admitted for accidental drug ingestion of a muscle relaxer, an anticonvulsant, an anti-anxiety, and a blood pressure medication. She was followed for persistent bradycardia and hypotension. The acute care facility administered medications and oxygen (intermittent vasopressor support) to treat the low blood pressure and pulse. The Note documented the risk for readmission or mortality was 36% (considered high). On 1/08/26 at 12:21 PM, Staff V, Registered Nurse (RN) stated she was working on a resident hall and Staff W, Certified Medication Aide (CMA) was on another resident hall training Staff X, CMA. She stated Staff W gave the medication cart keys to Staff X and went on her break. She stated the resident whose medications were given to another resident confirmed she had not received her own medications. Staff V confirmed one of the medications Resident #38 incorrectly received was 0.2 mg of clonidine, a blood pressure medication. Staff V stated the process for administering medications includes asking the resident their name, verifying the resident by their picture in the EHR, and using the nursing five (5) rights of medication administration (patient, medication, dose, route, time).On 1/08/26 at 12:56 PM, Staff W stated Staff X, CMA had been certified a long time but was new to the facility. Staff W stated she removed the medications from the cart, gave them to Staff X, directed her to administer them to <Resident #38 name and bed location> and went on her break. She said when she returned from her break, she was informed of the medication error. She repeated the details and confirmed the scenario.On 1/08/26 at 2:26 PM, the Director of Nursing (DON) stated staff should have used the five (5) rights of medication administration, the trainee should not have administered the medications alone, and should have stopped medication administration when the resident stated the medications were not hers.A policy titled Medication Administration revised 01/2025 directed staff to identify the resident by the photo in the MAR and to ensure the six (6) rights of medication administration are<br><br>(continued on next page) |

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| Pine Acres Rehabilitation and Care Center | 1501 Office Park Road<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | followed:Right residentRight drugRight dosageRight routeRight timeRight documentationOn 1/13/26 at 9:42 AM, Staff X, CMA stated Staff W pulled the medications for three (3) residents, put them in medication cups on top of the med cart, and told her to finish administering them. Staff X stated she took the pills to the resident's room thinking it was the resident Staff W named. She stated she was not aware there was a new resident in the same room. She verbalized the process for medication administration was to ask the resident's name, date of birth , and compare the resident's picture to the MAR. She admitted the new resident did not have a picture in the EHR yet so she had no way of facial comparison. She further admitted that she did not use the 6 rights of medication administration. |