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	12/19/2024

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 50500 Based on employee file review, staff interview, and policy review, the facility failed to complete a criminal record check and dependent adult/child abuse registry check prior to an employee's rehire date for 1 of 5 employee files reviewed. The facility reported a census of 61. Findings include: Employee record review of Staff E, Registered Nurse, showed a rehire date of 9/9/24. Staff E's updated Single Contact License and Background Check was initiated on 9/4/24 at 3:57 PM. The Criminal History Background Check indicated further research required and to await Division of Criminal Investigation's (DCI) final response. Staff E's employee record did not show that any further follow-up completed prior to working with residents. The facility initiated another Single Contact License and Background Check on 11/11/24 at 3:57 PM. The background check process was completed on this date. However Staff E had been working with residents from 9/9/24-11/11/24. During an interview on 12/5/24 at 10:45 AM, the Provisional Administrator acknowledged that the criminal and dependent adult/child abuse registry check was not completed prior to Staff E's re-hire date of 9/9/24. This oversight was identified during the facility's employee record audit the Administrator completed on 11/11/24. The facility policy titled Background Investigations revised 11/2024 stated The Human Resource department will conduct all applicable background investigation(s) on each individual making application for employment with this company and on any current employee if such background investigation is appropriate for position for which the individual has applied.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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	12/19/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35434 Based on clinical record review, policy review, and staff interview, the facility failed to ensure the Care Plan addressed high risk medications such as insulin and antidepressants for 1 of 5 residents reviewed for medications(Resident #29). The facility also failed to follow the Care Plan with regard to smoking materials for 1 of 4 residents reviewed for smoking (Resident #57). The facility reported a census of 61 residents. Findings include: 1. The Admission Minimum Data Set(MDS) assessment tool, dated 10/19/24, listed diagnoses for Resident #29 which included diabetes, anxiety, and depression. The MDS stated the resident received insulin (a medication used to lower blood sugar), antianxiety medications, and antidepressant medications and listed her Brief Interview for Mental Status(BIMS) score as 15 out of 15, which indicated intact cognition. The December 2024 Medication Administration Record(MAR) listed the following: a. an 11/29/24 order for Lispro insulin(a type of fast-acting insulin) per sliding scale b. an 11/30/24 order for Duloxetine(an antidepressant) 30 milligrams(mg) daily The resident's Care Plan, as of 12/4/24, did not address the resident's antidepressant or insulin and lacked information for staff regarding side effects to monitor for. On 12/5/24 at 11:21 a.m., the Director of Nursing(DON) stated care plans should address high risk medications such as insulin and antidepressants. 47079 2. On 12/02/24 at 11:21 AM, Resident #57 stated he smoked and was observed with his cigarettes and lighter in his shirt pocket. He stated he keeps his cigarettes with him because the facility would not replace lost cigarettes. The Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #57 revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated completely intact cognition. It included diagnoses of depression, hypertension (HTN), Parkinsons (brain conditions that cause slowed movements, stiffness, and tremors), right upper limb cellulitis, hypothyroidism, and malignant neoplasm (cancerous tumor) of the thyroid gland. It indicated he was independent with eating and applying/removing footwear, required setup assistance with oral hygiene and upper body dressing, and required maximum assistance with all other Activities of Daily Living (ADLs). It also revealed he did not ambulate, required setup and supervision with toilet transfer and shower transfer; respectively, and was independent with all other aspects of mobility. (continued on next page)

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	12/19/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Electronic Health Record (EHR) included a Safe Smoking Assessment Form that indicated the resident was safe to smoke without supervision but his cigarettes and lighter would be kept at the nurses' station. The Care Plan included potential for injury because the resident liked to smoke. It directed staff to ensure that there was no lighter/cigarettes at bedside and staff would provide such during smoking time in the smoking room. On 12/05/24 at 12:36 PM, the Director of Nursing (DON) stated staff should follow the Care Plan or document noncompliance. A policy titled Comprehensive Care Plan revised 11/2024 indicated the Care Plan would include resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. It also indicated the facility would develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.

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	12/19/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49698 Based on observation, clinical record review, staff interviews, and facility policy review the facility failed to fully review and revise the comprehensive Care Plans when a resident had a change in advance directives and smoking status for 6 of 24 residents reviewed (Residents #10, #21, #26, #34, #45, and #61). The facility reported a census of 61 residents. Findings include: 1. Review of Resident #10's Iowa Physician Orders for Scope of Treatment (IPOST), dated [DATE], revealed Resident #10 indicated in the event she had no pulse and was not breathing, Do Not Attempt Resuscitation (DNR). Review of Resident #10's Care Plan dated [DATE], indicated Resident #10 requested Full Code status, indicating providing emergency measures as appropriate, including CPR (Cardiopulmonary Resuscitation). 2. Review of Resident #34's IPOST, dated [DATE], indicated DNR code status. Review of Resident #34's Care plan dated [DATE], revealed Full Code status. 3. Review of Resident #45's IPOST, dated [DATE], indicated Full Code/CPR to attempt resuscitation. Review of Resident #45's Care Plan dated [DATE], failed to indicate Resident's code status. During an interview on [DATE] at 11:56 AM, Staff H, Social Worker stated, on admission residents fill out an IPOST indicating their wishes for code status. The IPOST is then signed by the facility Physician on admission or the next day. IPOST and code status is also reviewed or updated with the resident and their representative during the resident's Quarterly Care Conferences. Staff H stated, once the IPOST is completed (on admission or Care Conference) she scans these to the resident's EHR (Electronic Health Record) and updates the resident's Care Plan. If IPOST changes are completed by nursing staff, Staff H, is notified of change during morning meetings or by the nursing staff and updates the resident's Care Plan. During an interview on [DATE] at 1:00 PM, the Director of Nursing (DON) stated, nurses complete a resident's IPOST on admission and obtain the Physician's signature, then Staff H, Social Worker, will scan the IPOST to the resident's EHR and update their Care Plan. IPOST and code status are reviewed by Staff H during resident's Care Conferences and updated in the resident's Care Plan if any changes. Review of facility provided, Residents' Rights Regarding Treatment and Advance Directives Policy, revision date ,d+[DATE], revealed the following: 1. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. (continued on next page)

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	12/19/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff. 3. During the care planning process, the facility will identify, clarify, and review with the resident or legal representative whether they desire to make any changes related to any advance directives. 4. Decisions regarding advance directives and treatment will be periodically reviewed as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions. 5. Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care. 4. Review of Resident #21's Smoking Assessment, dated [DATE], indicated for safety Resident #21's smoking materials (cigarettes and lighter) will be kept at the nurses' station and Resident #21 is to wear a smoking apron. Review of Resident #21's Care Plan, dated [DATE], identified Resident as a smoker and not at risk for smoker related injury. Resident #21 may smoke independently per facility assessment. Interventions included, instructing Resident about the facility policy on smoking: locations, times and safety concerns. Resident #21's Care Plan failed to indicate resident is to wear a smoking apron while smoking. 5. Review of Resident #26's Smoking Assessment, dated [DATE], revealed Resident #26 had past accidents/incidents with smoking materials, visible burn marks on Resident's clothing/coat and need for a smoking apron. IDCT (Interdisciplinary Care Team) decision of Smoking Assessment indicated, Resident #26 refused to wear the smoking apron and is not safe smoking cigarettes. Resident had been approved to use a Vape, but not approved to smoke cigarettes. Review of Resident #26's Care Plan, dated [DATE], revealed Resident #26 needing supervision and to wear an apron while smoking. Resident #26's Care Plan failed to indicate Resident's approval for Vape and no approval to smoke cigarettes due to safety concerns. 6. On [DATE] at 2:59 PM, Resident #61, was observed smoking a cigarette, supervised by staff, and not wearing a smoking apron. On [DATE] at 3:04 PM, Resident #61, was observed smoking a cigarette, supervised by staff, and wearing a smoking apron. Review of Resident #61's EHR, failed to indicate a completed Smoking Assessment. Review of Resident #61's Care Plan, dated [DATE], failed to indicate Resident #61 is a smoker and identify any interventions. (continued on next page)

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	12/19/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 12:20 PM, Facility Administrator stated, Smoking Assessments are completed on admission, if resident voices interest in smoking, and/or any changes in condition. On completion of the Smoking Assessment, the nurse administering the assessment will then update the resident's Care Plan. During an interview on [DATE] at 1:00 PM, DON stated, nurses complete the Smoking Assessment for residents that want to smoke, the Smoking Assessment is then reviewed by IDCT to determine safety interventions for the resident while smoking. Once IDCT determination is made, the resident's Care Plan is updated. During an interview on [DATE] 11:07 AM, Staff M, MDS Coordinator stated, she receives notification during morning meeting of any changes that need to be made to a resident's Care Plan. If it is a drastic change, like Hospice care, the Care Plan will be updated right away. All changes in resident's conditions/status should be relayed to the MDS Coordinator to be added/updated in the resident's Care Plan. Staff M stated, she tries to have the update completed within 24 hours. Review of facility provided, Resident Smoking Policy revision date ,d+[DATE] stated the following: 1. Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas (weather permitting), at designated times, and in accordance with his/her care plan 2. If resident who smokes experiences any decline in condition or cognition, he/she will be reassessed for ability to smoke independently and/or to evaluate whether any additional safety measures are indicated 3. All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident's care plan Review of facility provided, Care Plan Revisions Upon Status Change Policy, revised ,d+[DATE] stated the following: The Comprehensive Care Plan will be reviewed and revised as necessary, when a resident experiences a status change. Procedure for reviewing and revising the Care Plan when a resident experiences a status change: a. Upon identification of a change in status, the nurse will notify the MDS Coordinator, the physician, and the resident representative, if applicable. b. The MDS Coordinator and the Interdisciplinary Team will discuss the residents condition and collaborate on intervention options. c. The team meeting discussion will be documented in the nursing progress notes. d. The care plan will be updated with the new or modified interventions. (continued on next page)

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	12/19/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. Staff involved in the care of the resident will report resident's response to new or modified interventions. f. Care plans will be modified as needed by the MDS Coordinator or other designated staff member. g. The Unit Manager or other designated staff member will communicate care plan interventions to all staff involved in the resident ' s care. h. The Unit Manager or other designated staff member will conduct an audit on all residents experiencing a change in status, at the time the change in status is identified, to ensure care plans have been updated to reflect current resident needs.

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	12/19/2024

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49698 Based on clinical record review, staff interviews, and facility policy review the facility failed to provide physician orders related to code status and accurately document in clinical records so that staff know immediately what action to take or not take when an emergency arises for 2 of 24 residents reviewed (Residents #10 and #34). The facility reported a census of 61 residents. Findings include: 1. Review of Resident #10's Iowa Physician Orders for Scope of Treatment (IPOST), dated [DATE], revealed Resident #10 indicated in the event she had no pulse and was not breathing, Do Not Attempt Resuscitation (DNR). Review of Resident #10's Care Plan dated [DATE], indicated Resident #10 requested Full code status, indicating providing emergency measures as appropriate, including CPR (Cardiopulmonary Resuscitation). Review of Resident #10's Electronic Health Record (EHR) indicated on the page header, Resident's code status as Full code/CPR Review of Resident #10's Physicians order dated [DATE] indicated Resident #10's code status of CPR. Review of a Care Conference Attendance Record for Resident #10, dated [DATE], indicated Resident #10's code status as DNR. 2. Review of Resident #45's IPOST, dated [DATE], indicated Full Code/CPR to attempt resuscitation. Review of Resident #45's Care Plan dated [DATE], failed to indicate Resident's code status. Review of Resident #34's EHR, indicated on the page header, Resident's code status as Full Code/CPR Review of Resident #34's Physicians order dated [DATE] indicated Resident #10's code status of CPR. During an interview on [DATE] at 12:20 PM, Staff I, CMA, said she would look at the resident's EHR page header to identify a resident's code status. During an interview on [DATE] at 12:24 PM, Staff J, LPN, stated she looks at the header in resident's EHR to find their code status. (continued on next page)

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	12/19/2024

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:56 AM, Staff H, Social Worker stated, on admission residents fill out an IPOST indicating their wishes for code status. The IPOST is then signed by the Physician on admission or the next day. IPOST and code status is also reviewed or updated with the resident and their representative during the resident's Quarterly Care Conferences. Staff H stated, once the IPOST is completed (on admission or Care Conference) she scans them to the resident's EHR and updates the resident's Care Plan. If IPOST changes are completed by nursing staff, Staff H, is notified of change during morning meetings or by the nursing staff and updates resident's Care Plan. During an interview on [DATE] at 1:00 PM, the Director of Nursing (DON) stated, nurses complete a resident's IPOST on admission and obtain the Physician's signature. Then Staff H, Social Worker, will scan the IPOST to the resident's EHR and update their Care Plan. IPOST and code status are reviewed by Staff H during resident's Care Conferences and updates resident's Care Plan with any changes. The nurse will initiate a new order indicating the resident's code status preference and send it to the Physician. Once the order is signed by the Physician, the nurse will process the order in the resident's EHR and this will trigger the code status header. Review of facility provided, Communication of Code Status Policy, revised ,d+[DATE] stated the following: 1. The facility will follow facility policy regarding a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an Advance Directive. 2. When an order is written pertaining to a resident's presence or absence of an Advance Directive, the directions will be clearly documented in designated sections of the medical record. Examples of directions to be documented include, but are not limited to: a. Full Code b. Do Not Resuscitate c. Do Not Intubate d. Do not Hospitalize 3. The nurse who notates the physician order is responsible for documenting the directions in all relevant sections of the medical record. 4. The designated sections of the medical record PCC; Profile; code status. 5. Additional means of communication of code status include: IPOST,MOST, POLST forms depending on the state. 6. In the absence of an Advance Directive or further direction from the physician, the default direction will be Full Code. 7. The presence of an Advance Directive or any physician directives related to the absence or presence of an Advance Directive shall be communicated to Social Services. (continued on next page)

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	12/19/2024

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. The Social Services Director shall maintain a list of residents who have an Advance Directive on file. 9. The resident's code status will be reviewed at least quarterly and documented in the medical record.

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	12/19/2024

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 0687 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate foot care. 35434 Based on clinical record review, policy review, and resident and staff interviews, the facility failed to ensure Resident#32 received diabetic shoes as ordered by the physician on 7/10/24 to maintain good foot health and to prevent complications for a resident with a known history of bilateral foot diabetic ulcers. The failure continued throughout July and an encounter note on 7/26/24 recorded the resident required diabetic shoes due to a history of type 2 diabetes mellitus with foot ulcer and neuropathy (nerve damage). the facility failed to follow up with a shoe vendor to ensure the shoes ordered. On 8/26/24 the resident expressed a desire for the diabetic shoes and on 8/30/24, the facility identified the resident had developed a foot ulcer. The survey team found concerns with 1 of 1 residents reviewed with a history of diabetic wounds(Resident #32). The facility reported a census of 61 residents. The IJ was determined on 12/16/24 at 3:00 PM. The IJ began on 7/26/24. The IJ immediacy was removed on 12/18/24 at 11:55 AM. The facility staff removed the Immediate Jeopardy on 12/19/24 through the following actions: The DON and designee(s) conducted a full-house audit on diabetic residents to determine at-risk diabetics and ensure proper preventative foot care. An audit was conducted to ensure all treatments, supplies, and equipment were readily available for order by the physician and were being followed to ensure residents received the proper preventative foot care. DON or designee(s) reviewed the medical records of diabetic residents to ensure that weekly skin assessments were completed and treatment recommendations/orders were in place. The DON or designee conducted a care plan audit to ensure that treatment recommendations/orders were included in the care plan and that they were being followed All facility policies and procedures related to podiatry services, skin integrity foot care, and physician orders reviewed and revised as needed. Education provided to regional Clinical Manager at Curana to ensure that all practitioners that come to Pine Acres will be collaborating with the IDT team to ensure referrals are made timely and appropriately An audit of orders, interventions, and devices regarding foot care and foot services was conducted by the Nursing Supervisor(s) to ensure proper use. The DON/Corporate Nurse/Consultant educated all licensed nurses on facility policies and procedures related to diabetes, foot care, and appropriate wound treatment measures. This included ensuring residents had necessary support surfaces and pressure-relieving devices and that staff followed the manufacturer's recommended use. (continued on next page)

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	12/19/2024

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 0687 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The DON/Corporate Nurse/Consultant educated all licensed nurses on appropriate documentation, which included transcription and entering treatment orders on the physician's order sheet in the EHR and the resident's TAR. DON/Corporate Nurse/Consultant educated all nurse aides on preventative diabetic foot care. DON/Corporate Nurse/Consultant conducted daily treatment record and nursing documentation audits to ensure accurate and complete documentation of diabetic foot care and preventative measures. For residents returning from the hospital, treatment recommendations/orders and wound care appointments will be transcribed and overseen by the DON and Corporate Nurse DON/Corporate Nurse/Consultant Monitoring will continue to monitor/audit the following: o Observation of treatments for diabetic foot care prevention and orders o Weekly physician orders o Weekly diabetic skin treatment orders related to diabetics. o Treatment recommendations and orders are being added and processed into the EHR and TAR A QAPI PIP has been initiated to report on the above monitoring and auditing procedures. All findings from the PIP will be presented at the monthly QAA meeting. Monitoring/auditing and reporting will continue for a minimum of three months. The scope lowered from J to G at the time of the survey after ensuring the facility implemented education and their policy and procedure. Findings include: The Quarterly Minimum Data Set(MDS) assessment tool, dated 8/11/24, listed diagnoses for Resident #32 which included diabetes, muscle weakness, and repeated falls. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition. Care Plan entries, dated 5/24/23, stated the resident was at risk for diabetic ulcers of the left and right feet and would have no complications related to the ulcer through the review date. The entries directed staff as follows; - ensure the application of appropriate protective devices to the affected areas. -inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness. -monitor, document, and report as needed signs and symptoms of infection to any open areas to include; redness, pain, heat swelling or pus formation (continued on next page)

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	12/19/2024

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 0687 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A 7/10/24 shoe vendor Diabetic Footwear Prescription Form listed the diagnoses of polyneuropathy (a disease that affected multiple nerves throughout the body, causing weakness, numbness, and pain) and a history of callus (a thickened area of skin that formed on the body as a result of repeated friction, pressure, or irritation) and listed the covered procedures as depth shoes and diabetic inserts. The top of the form stated the prescription must be accompanied by a signed statement of certifying physician. A 7/26/24 00:00 provider Encounter Note stated the resident had a history of Type 2 diabetes with foot ulcers and required diabetic shoes. Encounter Note dated 8/16/24 00:00 listed medication Sulfamethoxazole/Trimethoprim (antibiotic) DS (double strength) take twice daily for ten days, indicated use: left foot and heel infection. An 8/21/24 00:00 provider Encounter Note stated the resident requested diabetic shoes and (facility staff) placed the order. An 8/30/24 4:27 PM Nursing Note stated the resident had a wound to his left heel which measured 5 inches x 3 inches across the entire heel. The facility obtained a treatment order and an order for boots, including no shoe to left foot until healed. The facility lacked further documentation regarding the provision of the resident's diabetic shoes. The facility lacked documentation of communication or follow-up with the shoe vendor between 7/10/24 and 8/30/24 when the resident developed the heel wound. A 9/3/24 provider Encounter Note stated the resident had wounds to his left foot and the resident was not aware of how he sustained the wounds. A diabetic shoe order was completed on 7/26/24 and staff waited to hear back from the shoe vendor regarding the shoes. A 9/11/24 Skin/Wound note stated the wounds deteriorated and the resident had an order for an antibiotic, labs, and an x-ray. A 9/17/24 provider Encounter Note stated the left heel was not improving. The resident would likely need debridement(a procedure which involved removing dead or infected tissue from a wound). A 9/25/24 Nursing Note stated the resident underwent debridement. A 10/1/24 provider Encounter Note stated the resident's heel was not improving. A 10/7/24 Order Note stated facility staff informed the shoe vendor his diabetic shoe order was on hold due to his foot ulcer. The facility documentation lacked action of the facility to reach out, and follow up with getting the resident diabetic shoes, to help protect the residents other foot. A 10/14/24 Nursing Note stated the resident's wound would not heal. 10/15/24 Nursing Notes stated the resident's heel had redness around the wound with an odor. The notes documented a new treatment order and the resident received an order for vascular testing(a test to determine blood flow). (continued on next page)

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	12/19/2024

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 0687 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A 10/24/24 Nursing Note stated the facility received a call from the foot clinic and the resident's wound worsened. The clinic wished to send the resident to a surgeon for evaluation. A 10/25/24 Nursing Note stated the resident admitted to the hospital. A hospital Progress Note, dated 10/31/24, stated the resident had an X-ray of the left foot on 10/24/24 which showed acute osteomyelitis(inflammation of the bone) and a wound culture which showed pseudomonas(a bacteria). The resident underwent a left foot amputation on 10/26/24. An 11/2/24 Nursing Note stated the resident had an above the ankle amputation on 10/31/24. An 11/13/24 provider Encounter Note stated the resident had a left foot amputation on 10/26/24 and a left below the knee amputation on 10/31/24. The facility policy Wound Treatment Management, revised 11/2024, stated in order to promote wound healing the facility would provide evidence-based treatments in accordance with current standards of practice and physician orders. On 12/2/24 at 11:59 a.m., Resident #32 stated he had to have his leg amputated and he was upset about it. He stated he did not know how this happened. On 12/5/24 at 8:37 a.m., via phone Staff G shoe vendor Office Manager stated they requested additional paperwork from the facility in order to carry out the shoe order but they did not receive it. She stated she called the facility and informed them of this but they continued to send the same paperwork. On 12/5/24 at 8:55 a.m., via phone, Staff F Medical Doctor(MD) stated he could not say for certain if the shoes would have prevented the resident's ulcers but stated the shoes would help reduce ulcers. He stated if there was an order for diabetic shoes, he would want this carried out as soon as possible. He stated the facility would follow-up with the paperwork to make sure they obtained them. On 12/5/24 at 9:58 a.m., the Director of Nursing(DON) stated if they faxed an order for shoes, they would follow up within 24-48 hours and absolutely would follow up within 2 weeks. She stated staff should keep checking on this until it was resolved. On 12/5/24 at 2:59 p.m., the Administrator stated she had no additional documentation related to communication between the facility and the shoe vendor.

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	12/19/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on observation, resident and staff interview, record and policy review, the facility failed to provide services to protect the resident from accidents or hazards by transferring a resident in a wheelchair without foot pedals (#20), not providing supervision or apron during resident smoking breaks for 3 of 3 residents (#21, #26, and #61), and not retrieving smoking materials from 3 of 3 residents (#21, #26, and #57). The facility reported a census of 61. Findings include: 1) On 12/02/24 at 11:21 AM, Resident #57 stated he smoked and was observed with his cigarettes and lighter in his shirt pocket. He stated he keeps his cigarettes with him because the facility would not replace lost cigarettes. The Minimum Data Set (MDS) dated [DATE] for Resident #57 revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated completely intact cognition. It included diagnoses of depression, hypertension (HTN), Parkinsons (brain conditions that cause slowed movements, stiffness, and tremors), right upper limb cellulitis, hypothyroidism, and malignant neoplasm (cancerous tumor) of the thyroid gland. It indicated he was independent with eating and applying/removing footwear, required setup assistance with oral hygiene and upper body dressing, and required maximum assistance with all other Activities of Daily Living (ADLs). It also revealed he did not ambulate, required setup and supervision with toilet transfer and shower transfer; respectively, and was independent with all other aspects of mobility. The Electronic Health Record (EHR) included a Safe Smoking Assessment Form that indicated the resident was safe to smoke without supervision but his cigarettes and lighter would be kept at the nurses' station. The Care Plan included potential for injury because the resident liked to smoke. It directed staff to ensure that there was no lighter/cigarettes at bedside and staff would provide such during smoking time in the smoking room. A policy titled Resident Smoking revised 6/2024 indicated if a resident or family does not abide by the smoking policy or care plan (e.g. smoking materials are provided directly to the resident, smoking in non-smoking areas, does not wear protective gear), the plan of care may be revised to include additional safety measures. It also indicated any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas (weather permitting), at designated times, and in accordance with his/her care plan. On 12/05/24 at 12:36 PM, the Director of Nursing (DON) stated staff should collect the cigarettes and lighter from the resident and secure them in the lockbox otherwise document resident refusals. 49698 (continued on next page)

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	12/19/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #21's MDS, dated [DATE], identified the resident had a Brief Interview for Mental Status (BIMS) of 13, which indicated intact cognition. The MDS documented Resident #21's current tobacco use, having no impairment of upper or lower extremities, and independent with use of walker or wheelchair for mobility. Review of Resident #21's Care Plan, dated 11/15/24, identified Resident as a smoker and not at risk for smoker related injury. Resident #21 may smoke independently per facility assessment. Interventions included instructing Resident about the facility policy on smoking: locations, times and safety concerns. Review of Resident #21's Smoking Assessment, dated 3/16/24, documented Resident #21's need for adaptive equipment including use of a smoking apron, all smoking materials (cigarettes and lighter) will be kept at the nurses' station, and safe to smoke without supervision. Progress Note dated 8/26/24, Facility Administrator, documented speaking to Resident #21 about smoking policy, made Resident aware of smoking aprons, and Resident gave Facility Administrator a lighter and smoking material to lock at nurses' station. Progress Note dated 10/2/24, Staff H, Social Services, documented finding a lighter in Resident #21's room. Staff H, documented removing the lighter from Resident's room and placed with smoking items at the nurses' station. Observation on 12/2/24 at 2:59 PM, revealed Staff K, CMA, supervising smokers outside in the smoking area. Resident #21 was observed sitting in his wheelchair with a lit cigarette in his hand and not wearing a smoking apron. Observation on 12/3/24 at 10:56 AM, revealed three unsupervised residents outside in the smoking area, Resident #21 observed in his wheelchair with a lit cigarette in hand and not wearing a smoking apron. At 11:00 AM, Staff D, CNA, was observed exiting the building to the smoking area, saying to the three residents What are you doing? It's not smoke time. Where did you get the cigarettes and lighter? Stuff D, CNA, supervised the three residents until completing their cigarettes and did not provide smoking aprons. 3. Review of Resident #26's MDS, dated [DATE], identified the resident had a BIMS of 15, indicating intact cognition. The MDS documented Resident #26 having no current tobacco use, having no impairment of upper or lower extremities, needing moderate to maximal assistance with transfers and cares, and use of wheelchair for mobility. Resident #26's MDS indicated diagnoses of hemiplegia affecting the right side and major depressive disorder. Review of Resident #26's Care Plan, dated 8/8/24, identified Resident #26 is a supervised smoker and cannot safely get in and out of the smoking doors, to the outside. Care plan indicated to assess Resident #26's ability to smoke independently and safely, Resident #26 utilizes a smoking apron for safety and requires close monitoring while smoking in the smoking area. Staff are to ensure there is no lighter and cigarettes at bedside: staff will provide items during smoking time in the smoking room and observe clothing and skin for signs of cigarette burns. (continued on next page)

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	12/19/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #26's Smoking Assessment, dated 9/13/24, revealed Resident #26 had past accidents/incidents with smoking materials, visible burn marks on Resident's clothing/coat, all smoking materials (cigarettes, lighter and electronic smoking device) will be kept at the nurses' station and resident needs to wear a smoking apron. IDCT (Interdisciplinary Care Team) decision of Smoking Assessment indicated Resident #26 refused to wear the smoking apron and is not safe smoking cigarettes. Resident #26 requires supervision and had been approved to use a Vape, but not approved to smoke cigarettes. Progress note dated 9/17/24, Former Director of Nursing (DON), documented Resident #26 is upset that he was told he can no longer smoke. He is not following the smoking policy and has been instructed several times regarding the smoking policy. Resident refuses to wear smoking apron and does not have his own smoking materials. The DON and Administrator compromised with Resident #26 and will allow resident to vape. Smoking assessment 9/13/24 and revised 9/17/24, Resident #26 is not safe to smoke, he had several burn holes in his clothes. Progress note dated 9/24/24, Staff L, RN, documented confiscating a pack of cigarettes from Resident #26 ' s room as Resident was outside smoking without supervision, Resident had failed smoking assessment prior to this. Progress note dated 10/9/24, Staff H, Social Worker, documented Resident #26 has agreed to follow smoking policy and has not been abiding to the agreement. Resident has been keeping smoking materials at the nurses' station and also storing additional materials in his room. Resident has been smoking outside of designated smoking times, according to smoking assessment Resident #26 must comply with wearing a smoking apron. Progress note dated 11/20/24, Staff H, Social Worker, documented Resident #26 agreed to follow the smoking policy, Resident does have to be reminded to wear a smoking apron and will wear one upon reminder. Observation on 12/2/24 at 2:59 PM, revealed Staff K, CMA, supervising smokers outside in the smoking area. Resident #26 was observed sitting in his wheelchair with a lit cigarette in his hand and not wearing a smoking apron. Observation on 12/3/24 at 10:56 AM, revealed three unsupervised residents outside in the smoking area, Resident #26 observed in his wheelchair with a lit cigarette in hand and not wearing a smoking apron. At 11:00 AM, Staff D, CNA, was observed exiting the building to the smoking area, saying to the three residents What are you doing? It's not smoke time. Where did you get the cigarettes and lighter? Stuff D, CNA, supervised the three residents until completing their cigarettes and did not provide smoking aprons. Observation on 12/4/24 at 2:54 PM, revealed Resident #26 attempting to exit the door to go to the designated smoking area, setting off the door alarm. Staff C, CNA, quickly responded to the door alarm and stopped Resident #26 from exiting the building. Staff C, CNA reminded Resident #26 smoking is at 3:00 PM and Resident cannot go outside without someone to supervise. Staff C asked Resident #26 to give her a few more minutes to finish what she was working on, then she would take Resident outside to smoke. Resident observed in his wheelchair with a blanket draped over his lap holding a cigarette in one hand and lighter in the other. (continued on next page)

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	12/19/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/4/24 at 2:54 PM, Staff C, CNA stated the protective aprons are available by the door to go outside and acknowledged Resident #26 is to wear one when smoking. Staff C also revealed, she was not aware of any residents using a vape or an electronic cigarette. Observation on 12/4/25 at 3:04 PM, revealed Staff C, CNA supervising the four residents smoking, all were wearing smoking aprons and Resident #26 was smoking a cigarette and had a lighter in his other hand. 4. Review of Resident #61's MDS, dated [DATE], identified the resident had a BIMS of 13, indicating intact cognition. The MDS documented Resident #61 having no impairment of upper or lower extremities, and independent with cares and mobility. Resident #61's MDS indicated a diagnosis of Schizophrenia and history of nicotine dependence. Review of Resident #61's Admission MDS, dated [DATE], documented Resident #61 having no current tobacco use. Review of Resident #61's Care Plan, dated 8/29/24, failed to indicate Resident #61 as a smoker and identify any interventions. Review of Resident #61's EHR, failed to indicate a completed Smoking Assessment. On 12/2/24 at 2:56 PM, observation of Staff K, CMA, taking residents outside to smoke. Staff K was getting smoking materials at the nurses' station and stated there's no lighter Resident #61 approached the nurses' station, Staff K asked Resident #61 if he had a lighter. Resident #61 acknowledged Staff K, saying he had one and pulled it out of his jacket pocket. Observation on 12/2/24 at 2:59 PM, revealed Staff K, CMA, supervising smokers outside in the smoking area. Resident #61 was observed standing, smoking a cigarette and not wearing a smoking apron. During an interview on 12/5/24 at 12:20 PM, Facility Administrator stated Smoking Assessments are completed on admission, if resident voices interest in smoking, and/or any changes in condition. On completion of the Smoking Assessment, the nurse administering the assessment will then update the resident's Care Plan. The Administrator stated all Resident's smoking materials are locked at the nurses station and the staff members supervising smokers are notified by the resident's nurse of any changes. During an interview on 12/5/24 at 1:00 PM, DON stated, nurses complete the Smoking Assessment for residents that want to smoke, the Smoking Assessment is then reviewed by IDCT to determine safety interventions for the resident while smoking. Once IDCT determination is made, the resident's Care Plan is updated. DON revealed, there's a Smoking Book at the nurses' station that includes the facility's Smoking Policy, a list of residents that smoke with their listed restrictions and provisions. DON also indicated the storage of resident's smoking materials is dependent on the level of independence of each resident. There is a lock box at the nurses' station to hold the smoking materials. Review of facility provided Resident Smoking Policy revision date 6/24 stated the following: 1. Smoking is prohibited in all areas except the designated smoking area. (continued on next page)

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	12/19/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. All residents will be asked about tobacco use during the admission process, and during each quarterly or comprehensive MDS assessment process. 3. Residents who smoke will be further assessed, using the Resident Safe Smoking Assessment, to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all. 4. Electronic cigarettes (e-cigarettes/vapes/vapor pen) can catch on fire and/or explode if not handled and stored safely. Safety measure for the us of electronic cigarettes by residents will include, but are not limited to: a. A safe smoking assessment will be completed on all residents using e-cigarettes. b. Staff supervision of resident use if indicated. c. Encourage residents to use e-cigarette devices with safety features such as firing button locks, vent holes, and protection again overcharging. Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas (weather permitting), at designated times, and in accordance with his/her care plan. If resident who smokes experiences any decline in condition or cognition, he/she will be reassessed for ability to smoke independently and/or to evaluate whether any additional safety measures are indicated. All safe smoking measures will be documented on each resident ' s care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident ' s care plan. If resident or family does not abide by this policy or the resident ' s plan of care will not be permitted to supervise resident ' s smoking Smoking materials of residents requiring supervision with smoking will be maintained by nursing staff. The interdisciplinary team, with guidance from the physician, will help to support the resident ' s right to make an informed decision regarding smoking by: a. Including the resident, family, and/or resident representative in discussion regarding the risks associated with smoking. b. Developing a safe smoking plan, or an individualized plan to quit smoking. Documentation to support decision making will be included in the medical record, including but not limited to: a. Resident ' s wishes, or those of the resident ' s representative. (continued on next page)

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	12/19/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Assessment of relevant functional and cognitive factors affecting ability to smoke safely. c. Response to smoking cessation interventions. d. Compliance with smoking policy. 35434 5. The Minimum Data Set(MDS) assessment tool, dated 11/5/24, listed diagnoses for Resident #20 which included difficulty walking, heart failure, and diabetes and stated the resident was independent with propelling wheelchair. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 14 out of 15, indicating intact cognition. A 6/29/22 Care Plan entry stated the resident had altered cardiovascular status and was at risk for pain, numbness, and weakness in the extremities. On 12/2/24, Staff C Certified Nursing Assistant(CNA) pushed Resident #20 in his wheelchair from the 200 Hall to the scale located near the nursing station. The resident held his feet up but they dangled very close to the floor during the transport. The facility policy Safe Resident Handling/Transfers, reviewed 11/2024, stated staff members should maintain compliance with safe transfer practices. The policy did not specifically address foot pedals. On 12/5/24 at 11:21 a.m., the Director of Nursing(DON) stated resident's feet should sit on foot pedals while staff pushed them in a wheelchair.

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	12/19/2024

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on observation, resident and staff interviews, record review, and policy review, the facility failed to consistently perform required pre-dialysis and post-dialysis assessments for 1 of 1 resident (#35). The facility reported a census of 61. Findings include: On 12/02/24 at 2:34 PM, Resident #35 stated staff had not routinely performed assessments before or after her hemodialysis treatments. The Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated completely intact cognition. It included diagnoses of anemia, hypertension, End-Stage Renal Disease (ESRD), Diabetes Mellitus (DM), epilepsy, psychotic disorder, and Non-Alzheimer's dementia. It also revealed the resident required maximum assistance with eating and oral hygiene, and was dependent with all other Activities of Daily Living (ADLs). It indicated the resident received dialysis within previous 14 days. The Care Plan dated 7/10/22 included a dialysis focus and directed staff to perform pre/post dialysis assessments. The Electronic Health Record (EHR) included a physician's order to complete a pre and post dialysis assessment on dialysis days every Monday, Wednesday, and Friday for dialysis chair time of 7:45 AM. The EHR Progress Notes lacked pre-dialysis assessment documentation for 11/11/24 and included post-dialysis assessment documentation only for 11/08/24, 11/13/24, 11/25/24, and 11/29/24. There were no documented post-dialysis assessments located for the other eight (8) dialysis treatments Resident #35 received during November 2024. On 12/05/24 at 7:41 AM, Staff A, Registered Nurse (RN), stated a pre-dialysis and post-dialysis assessment should be completed for dialysis residents and documented in the EHR. On 12/05/24 at 8:10 AM, the Director of Nursing (DON) stated nurses should complete the specific user-defined assessments (UDA) in the EHR. A policy titled Hemodialysis revised 11/2024 indicated the nurse will ensure that the dialysis access site (e.g. AV shunt or graft) is checked before and after dialysis treatments and every shift for patency by auscultating for a bruit and palpating for a thrill. If absent, the nurse will immediately notify the attending physician, dialysis facility and/or nephrologist.

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	12/19/2024

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 0725 Level of Harm - Minimal harm or potential for actual harm 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. 35434 Based on observation, clinical record review, policy review, and staff interviews, the facility failed to provide resident care needs for 1 of 1 residents reviewed for staffing(Resident #51). The facility reported a census of 61 residents. Findings include: The Minimum Data Set(MDS) assessment tool, dated 11/5/24, listed diagnoses for Resident #51 which included hemiplegia(one-sided weakness), anxiety, and diabetes, and stated the resident was dependent on staff for toilet transfers and toileting hygiene. The MDS stated the resident was occasionally incontinent of urine and listed his Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition. The facility policy Call Lights: Accessibility and Timely Response, reviewed 11/2024, stated all staff members who saw or heard an activated call light was responsible for responding and stated if the staff member could not provide what the resident desired, the appropriate personnel should be notified. Care Plan entries, dated 12/12/22, stated the resident had the potential for impaired skin integrity related to frequent episodes of incontinence of bowel and bladder. A Care Plan entry, dated 3/23/23, stated the resident required the assistance of 1 staff member for personal hygiene. Observations on 12/3/24 revealed the following: At 8:35 a.m., Resident #51 sat in the hall and wore black shorts. The resident stated his shorts were wet and he needed changed. At 8:39 p.m., the resident entered his room and alerted his call light. At 8:41 am. a staff member walked by, but did not enter the room. The resident yelled help. At 9:00 a.m., the resident's call light remained on and a staff member walked by his room but did not enter. The resident's call light remained on until 9:06 a.m. and the resident intermittently yelled help At 9:07 a.m., Staff D Certified Nursing Assistant(CNA) entered the resident's room. While she was in the room, the resident's call light went off. Staff D exited the resident's room at 9:08 a.m. At 9:09 a.m., the resident remained in his room and wore black shorts. He stated they had to hurry and come on. (continued on next page)

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	12/19/2024

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No staff entered the resident's room from 9:07 a.m. until 9:17 a.m. and the resident continued to intermittently yell come on. At 9:18 a.m., the State Agency informed the Administrator the resident needed assistance. At 9:19 a.m., Staff D entered the resident's room. On 12/5/24 at 11:21 a.m., the Director of Nursing(DON) stated ideally staff should respond to the call light within 5 minutes. Staff should leave the light on and find the appropriate staff(to care for the resident).

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	12/19/2024

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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 50500 Based on observations, record review, staff interview, and policy review, the facility failed to ensure food prepared and maintained at the appropriate temperature as well as dishes and utensils cleaned in a sanitary manner related to incomplete food and dishwasher logs. The facility reported a census of 61. Findings include: 1. The Food Temperate Record logs reviewed for the months of September, October, and November. From 9/1/25 thru 10/5/24, 24 meals were incomplete or did not have any food temperatures recorded out of 105 meals. From 10/6/24 thru 11/2/24, 24 meals were incomplete or did not have any food temperatures recorded out of 84 meals. From 11/3/24 thru 11/30/24, 13 meals were incomplete or did not have any food temperatures recorded out of 84 meals. A food thermometer and alcohol wipes were observed in the food prep area for staff use. 2. The Dishmachine Quality Assurance Forms reviewed for the months of October and November. From 10/7/24 thru 11/3/24, 8 out of 84 meals did not have verification that the dischmachine chemical sanitizer reached 50 ppm or greater. From 11/4/24 thru 12/1/24, 16 out of 84 meals did not have verification that the dishmachine chemical sanitizer reached 50 parts per million (ppm) or greater. During an interview on 12/2/24 at 11:00 AM, the Certified Dietary Manager (CDM) acknowledged the gaps in both the food temperature and dishmachine logs. Cooks are expected to record food temperatures (hot and cold items) just prior to meal service. This is done for each meal, 3 meals per day. The washer is expected to check the chemical sanitizer level of the dishmachine 3 times per day, correlating with meals. Test strips were observed in a plastic folder along with the Dishmachine Quality Assurance Form. The policy Food Safety Requirements reviewed/revised on 11/2024 states food shall be prepared as directed until recommended temperature for the specific foods are reached. The policy further stated all equipment used in handling of food shall be cleaned and sanitized and handled in a manner to prevent contamination. The policy Sanitation Inspection reviewed/revised 11/2024, states food service staff shall inspect . dishwasher temperatures daily.

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	12/19/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50500 Based on observations, policy review, and staff interview, the facility failed to ensure food is stored in a sanitary manner to prevent contamination and foodborne illness. The facility reported a census of 61. Findings include: Initial kitchen tour completed on 12/2/24 at 10:00 AM revealed the following: a. Walk-in freezer floor with excess debris (food crumbs, several small food items, packing tape from delivery boxes) b. Fryer, which was not in use, full of oil with no cover c. Plastic cereal containers with no label or dates During an interview on 12/2/24 at 11:00 AM, the Certified Dietary Manger (CDM) reported there are no required daily or weekly cleaning checklists which staff completed. A general checklist of cleaning needs is located on the whiteboard as staff enters the kitchen. Walk-in cooler and freezer floors are swept out as needed. When not in use, the fryer should have a sheet pan over the oil to protect from contamination. The CDM acknowledged the lack of labels for the cereal containers since the cereals are not stored in their original packaging. The policy Food Safety Requirements reviewed/revised on 11/2024 states Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms. The policy also notes equipment used in the handling of food shall be cleaned and sanitized and handled in a manner to prevent contamination. The policy Sanitation Inspection reviewed/revised 11/2024 states food service staff shall inspect refrigerators/coolers, freezers . daily. The policy also directs the dietary manager to complete weekly inspections of the food service area weekly to ensure areas are clean and comply with sanitation and food service regulations. This includes the food preparation area, main production area, and the refrigerator/freezer.

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	12/19/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47079 Based on observation, resident and staff interview, record review, and policy review, the facility failed to implement infection control practices to prevent urinary tract infection (UTI) for 1 of 1 resident (#28). The facility reported a census of 61. Findings include: On 12/02/24 at 2:07 PM, the urine in the resident's indwelling catheter was noted to be opaque and cloudy. The Minimum Data Set (MDS) revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of obstructive uropathy (urine unable to drain normally), acute renal failure, and anemia. It indicated the resident required moderate assistance with personal hygiene and was dependent with toileting hygiene. It also revealed the resident had developed a urinary tract infection (UTI) while a resident. The Care Plan dated 7/05/24 included an indwelling catheter focus and directed staff to position the catheter bag and tubing below the level of the bladder and away from entrance room door. The Electronic Health Record (EHR) Progress Notes indicated the resident was hospitalized for a UTI on 6/22/24. It also indicated the resident received Cefepime for a UTI per a progress note dated 10/09/24. The Treatment Administration Record (TAR) dated October 2024 revealed the resident received Cefepime antibiotic from 10/01/24 to 10/08/24. On 12/05/24 at 10:15 AM, a continuous indwelling catheter care observation revealed Staff B, Certified Nurse Aide (CNA) grabbed the resident's wheelchair and moved it with gloved hands. She turned to the bedside table, opened an alcohol pad package and placed it on paper towel on the bedside table. She lifted the resident's urine catheter bag above the resident while the resident lied in bed. Urine was observed flowing back into the resident. She positioned the urine drainage bag over the measuring cylinder, opened the drain bag spigot, and emptied the urine into the cylinder. She grabbed the alcohol swab with the same left gloved hand, wiped the drain spigot, clamped it, and placed it back in the holder. On 12/05/24 at 10:30 AM, Staff B stated she should've performed hand hygiene and changed gloves before wiping the drain spigot. She also stated her training was to not lift the urine bag above the resident's bladder. On 12/05/24 at 12:50 PM, the Director of Nursing (DON) stated staff should follow the policy, appropriately perform hand hygiene, and not lift the bag above the bladder. (continued on next page)

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	12/19/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy titled Catheter Care revised 11/2024 directed staff to ensure drainage bag is located below the level of the bladder to discourage backflow of urine.

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	12/19/2024

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500 Based on electronic health record (EHR) review, staff interview, and policy review, the facility failed to ensure 1 of 5 residents reviewed for immunizations was provided up to date pneumococcal vaccinations (Resident #45). The facility reported a census of 61 residents. Findings include: Resident #45's Face Sheet listed her age as [AGE] years old. The original admitted listed as 12/6/22. The Immunization Record for Resident #45 lacked documentation on the resident's pneumococcal vaccination status. On 7/25/23, Resident #45 signed the Pneumococcal Vaccine Consent Form and Wavier, which indicated an interest in receiving the vaccine. The EHR lacked documentation if the vaccine had been administered as requested. During an interview on 12/5/24 at 2:00 PM , the Provisional Administrator acknowledged the lack of documentation for Resident #45's pneumococcal vaccination status and if the vaccine was administered in 2023. The Infection Prevention and Control Program document reviewed/revised on 7/2024 states residents will be offered the pneumococcal vaccines recommended by the Centers for Disease Control upon admission, unless contraindicated or received the vaccines elsewhere. The General Immunization/Vaccination policy reviewed/revised on 11/2024 states The resident ' s medical record or staff/volunteer's medical file will include documentation .that the resident received or did not receive the immunization(s) due to medical contraindication or refusal.

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	12/19/2024

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500 Based on electronic health record (EHR) review, staff interview, and policy review, the facility failed to ensure 2 of 5 residents reviewed for immunizations were provided up to date Covid vaccinations (Resident #2 and Resident #45). The facility reported a census of 61 residents. Findings include: 1. Resident #2's Face Sheet listed her age as [AGE] years old. The original admitted listed as 9/27/14. The Immunization Record for Resident #2 documented the last Covid vaccination was administered on 11/29/22. The EHR lacked documentation if an updated Covid vaccine was offered or administered in 2023. 2. Resident #45's Face Sheet listed her age as [AGE] years old. The original admitted listed as 12/6/22. The Immunization Record for Resident #45 documented the last Covid vaccination was administered on 12/21/2021. The EHR lacked documentation if an updated Covid vaccine was offered or administered in 2022 or 2023 During an interview on 12/5/24 at 2:00 PM , the the Provisional Administrator acknowledged the lack of documentation for Resident #2 and Resident #45's Covid vaccination status. The Infection Prevention and Control Program document reviewed/revised on 7/2024 states residents will be offered the COVID-19 vaccine when vaccine supplies are available to the facility. The General Immunization/Vaccination policy reviewed/revised on 11/2024 states The resident's medical record or staff/volunteer's medical file will include documentation .that the resident received or did not receive the immunization(s) due to medical contraindication or refusal.