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	01/08/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, staff interviews, and policy review, the facility failed to properly secure medications from unauthorized access by failing to lock 2 of 2 medication carts observed. The facility reported a census of 81 residents. Findings include: On 01/06/26 at 4:56 AM, a medication cart was observed unlocked in a resident hall in front of the nurse's documentation room. The cart contained an antidepressant (duloxetine) and a muscle relaxant (Baclofen). Staff I, Licensed Vocational Nurse (LVN) was observed sitting in the documentation room while the cart drawer was opened for one (1) full minute before she approached the cart. She stated the carts should not be left unlocked but added she was about to access the cart. There were no residents in the hall.On 1/07/26 at 3:05 am, a medication cart and supply cart were discovered unlocked in a resident hall in front of the nurse's documentation room. There were no staff members or residents visible in the unit hallway. The cart contained antidepressants (duloxetine and trazadone), a blood thinner (Eliquis), and a muscle relaxant (Baclofen). After three (3) minutes, Staff J, Registered Nurse (RN) approached the cart and stated the medication and supply carts should be locked when left unattended.A policy titled Medication Storage revised 01/2025 indicated:a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls.b. Only authorized personnel will have access to the keys to locked compartments.c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.On 1/08/26 at 2:26 PM, the Director of Nursing (DON) stated staff should lock the medication carts when stepping away from the computer.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, resident and staff interview, and facility policy review the facility failed to prepare and serve food that was palatable for one of four hallways observed. The facility reported a census of 81 residents. Findings include: Observation of the lunch meal service on 1/7/26 revealed the following:a. On 1/7/26 at 11:21 AM, Staff E, dietary cook, removed a large pan containing ham and cheese sandwiches from the oven. Staff D, dietary cook, checked the temperature of the entree and reported they planned to serve the sandwiches during the lunch meal service. Staff D reported the ham and cheese sandwich temperature at 130 degrees Fahrenheit. Staff E stated the cheese was melted (on the sandwiches) and that was what the residents liked. At that time the buns appeared soft. Staff E then placed another large pan of buns with ham and cheese (inside the bun) with a piece of foil over the top of the sandwiches into the oven. b. On 1/7/26 at 11:29 AM, Staff D and Staff E wheeled the warming table with the pan of hot ham and cheese sandwiches to the dining room serving area. c. On 1/7/26 at 11:37 AM, Staff E used tongs and placed a ham and cheese sandwich onto plates for several residents served in the dining room. d. On 1/7/26 at 11:58 AM, Staff E reported all of the residents had been served in the dining room. e. On 1/7/26 at 12:01 PM, Staff D and Staff E unplugged the warming cart and wheeled the cart back into the kitchen. Staff E washed her hands, then pulled the large pan of ham and cheese sandwiches (that had been placed into the over earlier) from the oven. Staff checked the temperature of the sandwiches and reported the temperature at 147 degrees F.f. On 1/7/26 at 12:12 PM, Staff D and Staff E plated food including a ham and cheese sandwich for room trays on the 100 hall. When the last room tray had been placed onto the cart, the surveyor requested an additional tray placed on the cart before the cart left the kitchen and taken to the 100 hall. Staff D plated the additional tray and the tray was placed onto the cart. g. On 1/7/26 at 12:25 PM, Staff E reported all of room trays for each hall had been plated. h. On 1/7/26 at 12:50 PM, a test tray was obtained from the 100 hall cart. All but one resident room tray had been passed at this time. The test tray revealed the following: the ham and cheese sandwich was hard to cut. The bun was very hard and dry around the edges. Only the middle section of the bun with ham and cheese was edible.Random resident interviews of residents residing on the 100 Hall on 1/8/25 at 10:30 AM to 11:20 AM revealed three of four interviewable residents reported they received a room tray for the lunch meal service on 1/7/25. The residents reported the bun on the sandwich was hard and difficult to eat. One resident reported the food was not good. Three of the four residents reported they could not eat the bread the facility served because it did not taste good. A female resident reported the hot ham and cheese sandwich that was served for lunch on 1/7/25 was gross. The bottom of the bun was hard and she could not eat it. She only ate half of the sandwich. The food that was served was always gross. The resident reported she got lunch in her room on 1/7/25. Another female resident reported she could only eat the meat from the sandwich that was served for lunch on 1/7/25. A resident that ate lunch in the dining room stated he heard staff telling the residents that required assistance how good the food was but the staff had no idea what the food was like because he believed the staff had not even ate the food the facility served the residents. During an interview on 1/8/26 at 1:45 PM, the Dietary Supervisor reported the bread came frozen from the vendor. She noticed the buns looked kind of hard when the cook removed them from the oven for the lunch meal that was served on 1/7/25 (after the cooks served residents in the dining room). The surveyor pointed out that this pan of sandwiches had been placed in the oven prior to Staff D and Staff E starting to serve residents in the dining room that day, and the sandwiches had been in the oven for 40-45 minutes. The Dietary Supervisor stated she had not looked to see what the oven temperature was set at but thought the length of time the sandwiches had been in the oven maybe caused the buns to dry out. A Food Preparations Guidelines policy reviewed/revised 12/2025 revealed food shall be prepared by methods that conserve nutritive value, flavor and appearance, and food palatable and appeared attractive.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observations, staff interviews, and policy review, the facility failed to properly protect resident information from unauthorized access by leaving 11 residents' information accessible when staff walked away from the Electronic Health Record (EHR) laptop. The facility reported a census of 81 residents. Findings include: On 1/06/26 at 5:05 AM, a laptop was observed in a resident hall with 11 residents' (301, 304, 305, 306 A, 307, & 308) Electronic Health Record (EHR) information visible.At 5:09 AM, Staff H, Registered Nurse (RN) stated laptops are not to be left open when staff are not present and also stated he didn't know it was open.On 1/08/26 at 2:26 PM, the Director of Nursing (DON) stated the laptop screen should be locked when staff walk away.A policy titled HIPAA Security Measures revised 02/2025 indicated physical safeguards will be implemented that limit physical access to its electronic information systems and the facility or facilities in which they are housed, while ensuring that properly authorized access is allowed.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **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: 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. The Care Plan for Resident #7 directed staff to provide the assistance of one staff for transfer, toileting and ambulated with therapy only. 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. 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 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. 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. 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. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #72 stated it happened all the time and the staff were disrespectful to him. 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. 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. 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. Staff U stated they have received education on abuse and how to knock, announce themselves and to be kind. 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. 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. 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. 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. 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. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. 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 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and policy review the facility failed to follow the physician's orders for 1 of 3 residents reviewed for change in condition (Resident #83). The facility reported a census of 81 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #83 admitted to the facility on [DATE] from the hospital. The resident had diagnoses of anxiety disorder, depression and toxic encephalopathy. The MDS revealed the resident had a Brief Interview for Mental Status score of 10, indicating moderately impaired cognition. The MDS indicated the resident had no behaviors but had little interest in doing things and felt down/depressed 2 to 6 days during the 14 day look-back period. The MDS indicated the resident took an antipsychotic, antianxiety, and an antidepressant medication.The MDS assessment dated [DATE] revealed the resident had an unplanned discharge to the hospital on [DATE]. The Care Plan initiated 12/17/25 revealed the resident had a diagnosis of depression and had a history of suicide attempt. The Care Plan also revealed the resident had episodes of behaviors. The resident had grabbed a fire extinguisher and sprayed it inside/outside for attention on 12/13/25 and took scissors and destroyed her roommate's pillow on 12/17/25. She refused to take medications, was resistant and refused cares, and had attention seeking behaviors. The Care Plan directed staff to administer medications as ordered (added 12/17/25), perform a medication review for behavior management (initiated 12/17/25), obtain a psychiatric consult (initiated 12/17/25), and observe and document behaviors (added 12/17/25). The admission medication orders dated 11/6/25 revealed quetiapine 25 milligrams (mg) by mouth (PO) every night, and 25 mg twice a day (BID) as needed (PRN). The Medication Administration Record (MAR) dated 11/1/25 to 11/30/25 revealed the following: a. Quetiapine 25 mg PO BID PRN for anxiety had a start date 11/14/25 and discontinued on 11/26/25. b. Quetiapine 25 mg PO every morning PRN for major depressive disorder had a start date 11/26/25.c. Quetiapine 50 mg PO at bedtime PRN had a start date 11/26/25. The MAR revealed the resident received quetiapine PRN only on 11/18/25, 11/19/25, 11/24/25 x 2, 11/25/25, 11/26/25, and 11/29/25. The MAR dated 12/1/25 to 12/31/25 revealed quetiapine only given on 12/17/25. The MAR indicated the resident in the hospital 12/18/25 to 12/27/25. A Change in Condition follow up dated 12/13/25 revealed an adverse event related to a change in condition-behavior. The resident grabbed a fire extinguisher by the back door, took it outside, sprayed it on the ground and then dropped it on the ground. The CNA (certified nursing assistant) saw this and got the nurse. When the nurse asked the resident why she did this, the resident stated she was desperate for attention. A Psychiatric assessment dated [DATE] revealed the resident had psychosis. Seroquel (quetiapine) ordered 25mg daily and Seroquel 50mg at bedtime PRN.The Progress Notes revealed: a. On 12/16/25 at 4:17 PM, during morning medication pass, resident noted to show increased anxiety with a blank stare and shaking. Nurse was able to sit with the resident and offered her a drink of water. Resident began to calm down and voiced a thank you for helping her. No further anxiety noted.b. On 12/17/25 at 10:55 AM, at approximately 10:50 AM it was reported that there was a pillow shredded near the bed of the resident's roommate. Nurse attempted to speak with the resident and asked if she saw or knew who shredded the pillow. Resident did not answer and closed her eyes. Lying in bed and refused to speak to the nurse. The resident refused to talk to the psychiatric provider yesterday.c. On 12/17/25 at 5:05 PM, a medication review by the IDT (interdisciplinary team) noted that the resident's Quetiapine 25 mg scheduled dose was not transferred to the orders on admission. d. On 12/17/25 at 5:17 PM, resident sent to the hospital for altered mental status and unsafe behaviors.A Significant Change in Condition dated 12/17/25 revealed the resident oriented to person but had delirium. She had disorganized thinking and difficulty focusing. She had psycho-motor retardation as evidenced by staying in one position and moving very slowly. She also had behaviors of being resistive to care and withdrawn. A Transfer / Discharge Form dated 12/17/25 at 5:21 PM revealed the resident was transferred to the Emergency (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Department for altered level of consciousness. The resident had behaviors over the weekend, she grabbed a fire extinguisher and sprayed it everywhere. On 12/17/25, she destroyed her roommate's pillow with scissors and now she sat on the bed rocking back and forward stating she is scared. She isolated herself in her room and recently refused medications.In an interview on 1/8/26 at 11:45 AM, Staff G, Licensed Practical Nurse (LPN) reported medication orders faxed to pharmacy to enter into the computer. The nurse then checked and confirmed the orders. All medication orders were entered by pharmacy.In an interview on 1/8/25 at 1:15 PM, the Director of Nursing (DON) reported the nurses entered some orders. If an order was for a medication, the staff faxed the order to pharmacy, pharmacy entered the order in the computer, and then the nurse confirmed the medication or treatment orders. The nurse also notified the resident or representative of the medication order, and entered a progress note. The DON checked Resident #83's electronic health record and reported orders received upon admission included for the resident to have quetiapine 25 mg BID, then the order was changed to 25 mg in the morning and 50 mg every evening which she thought were scheduled medications. The quetiapine was entered for 25 mg BID PRN initially. In an interview on 1/8/25 at 1:45 PM, the Administrator reported Resident #83 came to the facility after hospitalization. During her stay, she got a hold of a fire extinguisher and discharged the fire extinguisher outdoors. She then cut up a pillow with a pair of scissors. The resident was currently back in the hospital.A Physician Orders Policy revised 4/2024 revealed to follow facility procedures for verbal or telephone orders included calling the attending physician to verify an order, noting the order, submitting the order to the pharmacy, and transcribing the order to the medication administration record. Document the verification of the order by entering the time, date, name and title of the physician/practitioner verifying the order, and the signature and title of the person receiving the verification order.

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Pine Acres Rehabilitation and Care Center	1501 Office Park Road West Des Moines, IA 50265

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 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 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 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. 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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 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 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 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interview, record review, and policy review, the facility failed to implement infection control practices to prevent urinary tract infections (UTI) by lifting an indwelling catheter drainage bag above the resident's bladder during perineal care for 1 of 1 resident (#16). The facility reported a census of 81.Findings include:The Minimum Data Set (MDS) for Residents #16 dated 11/12/25 revealed a Brief Interview for Mental Status (BIMS) score of 09 out of 15 which indicated moderately impaired cognition. It included diagnoses of quadriplegia, a stroke, a multidrug-resistant organism infection, abnormal bladder function, and obstructive uropathy (urine unable to drain normally). It indicated the resident required setup assistance with eating, maximal assistance with oral hygiene and was dependent with all other Activities of Daily Living (ADLs) and all forms of mobility.The Care Plan revised 4/11/23 indicated the resident was at high risk for developing a UTI (urinary tract infection) due to suprapubic catheter (urinary catheter surgically placed directly into the bladder) use and directed staff to provide catheter care per protocol.The Electronic Health Record (EHR) Progress Notes indicated the resident received medication for UTI prevention.On 1/07/26 at 8:18 AM, Staff A, Certified Nurse Aide (CNA) and Staff B, CNA provided perineal care on Resident #16 while he was lying in bed. At the end of the procedure, Staff A lifted the resident's urinary bag above the resident's bladder as she put on his shorts. The urine in the drainage tubing, which contained a white, mucoid substance, flowed back into the resident's bladder.On 01/07/26 at 8:36 AM, Staff A stated she received infection prevention (IC) training, which included catheter care, upon hire. She also stated the drainage bag and tubing should not be higher than the resident and she should have not lifted the drainage bag above the resident's bladder to put on his pants.On 1/08/26 at 2:26 PM, the Director of Nursing (DON) stated staff should have not raised the drainage bag over the level of the resident's bladder.A policy titled Catheter Care revised 03/2025 directed staff to ensure drainage bag is located below the level of the bladder to discourage backflow of urine.

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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** Based on clinical record review, facility policy review, Centers for Disease Control and Prevention (CDC) guidelines, and staff interview, the facility failed to provide the pneumococcal vaccine to 1 of 5 sampled residents reviewed for immunizations (Resident #12). The facility reported a census of 81 residents.Findings include: The Minimum Data Set (MDS) assessment, dated 10/2/25 identified an admission date of 9/25/25, the resident was over age [AGE], and had diagnoses that included cancer, sepsis and respiratory failure. The MDS indicated the resident's pneumococcal immunization not up-to-date. The MDS indicated the pneumococcal vaccine not received due to the vaccine not offered.Review of the Iowa Registry Immunization System (IRIS) document scanned into the electronic health record (EHR) revealed Resident #12 had not received a pneumococcal vaccine. The pneumococcal vaccine was recommended and listed as past due. A Pneumococcal Vaccine Consent Form for Resident #12 signed by the resident's representative on 9/26/25 revealed a consent to receive the pneumococcal vaccine.Review of Resident #12 EHR Clinical Immunization list revealed the status for Prevnar 20 (pneumococcal) vaccine was pending immunization. The immunization status revealed a lack of documentation on whether Resident #12 had ever received the Pneumovax (PPSV23) vaccine, or any of the pneumococcal conjugate vaccines, Prevnar 20 (PVC20), Prevnar 21 (PVC21), or Vaxneuvance (PVC15) per the CDC guidelines.The Progress Notes dated 9/25/25 to 12/22/25 revealed the resident had a history of pneumonia. The Progress Notes lacked documentation of a pneumococcal vaccine administered. In an interview on 1/7/26 at 2:15 PM, Staff F, Assistant Director of Nursing (ADON) and Infection Preventionist, reported she had worked at the facility since 6/2025, and worked in the Infection Preventionist role since 10/2025. Staff F reported she referenced the CDC guidelines for vaccine recommendations. The facility offered the flu and pneumonia vaccine to residents. Whenever a resident admitted to the facility, she checked IRIS for the immunizations the resident had received. The facility had standing orders for immunizations. Staff offered the resident the immunization upon admission to the facility, got consent from the resident/representative to receive or decline the vaccine, and obtain the vaccine from the pharmacy. On 1/8/26 at 8:28 AM, Staff F reported she was not employed at the time Resident #12 admitted to the facility. She saw the resident had given consent and requested to get the pneumonia vaccine but the vaccine was not given. The order had been entered into the EHR but was not marked yes. It was on the MAR but not given. Staff F reported she planned to do a PIP (performance improvement plan) and work on a process to review how things were done and what they needed to do in the future to ensure residents got the vaccine.Review of the facility's policy, titled Pneumococcal Vaccine implemented 4/2019 and reviewed/revised 12/2025 revealed that residents would be assessed for eligibility per CDC guidelines and offered the pneumococcal vaccine. A consent form needed signed prior to the administration of the vaccine and filed in the individual's medical record.Review of CDC guidelines (https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/index.html) dated 10/2024, revealed administer PVC20, PVC21, or PVC15 for all adults 50 years or older who have never received any pneumococcal conjugate vaccine, or whose previous vaccination history is unknown.

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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** Based on clinical record review, staff interviews, facility policy review and Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to administer the COVID-19 vaccine to 1 of 5 sampled residents reviewed for immunizations (Resident #20). The facility reported a census of 81 residents.Findings include: The Minimum Data Set (MDS) assessment for Resident #20 dated 12/22/25 identified an admission date of 4/28/25. The MDS revealed the resident had diagnoses of sepsis and non-Alzheimer's dementia.A COVID-19 Vaccine Consent Form dated 4/28/25 revealed Resident #20 gave consent to receive the COVID vaccine.The electronic health record (EHR) under the Clinical Immunizations tab revealed a COVID-19 booster last administered on 8/26/22.On 1/7/25 at 10:36 AM, review of the clinical record for Resident #20's immunization status revealed a lack of documentation on whether Resident #20 had ever received the requested COVID vaccine. In an interview on 1/7/26 at 2:15 PM, Staff F, Assistant Director of Nursing and Infection Preventionist reported she had worked at the facility since 6/2025, and worked in the Infection Preventionist role since 10/2025. Staff F reported she referenced the CDC guidelines for COVID and vaccine recommendations. The facility offered the flu and pneumonia vaccine to residents but they had not gotten to COVID immunizations. Whenever a resident admitted to the facility, she checked IRIS (Immunization Registry Information System) for the immunizations the resident had received or needed. The facility had standing orders for immunizations. Staff offered the resident the immunization upon admission to the facility, got consent from the resident/representative to receive or decline the vaccine, and obtained the vaccine from the pharmacy. On 1/8/26 at 8:28 AM, Staff F reported she was not employed at the time Resident #20 admitted to the facility. She saw the resident had given consent and requested to get the COVID vaccine but the vaccine was not given. Staff F reported she planned to do a PIP (performance improvement plan) and work on a process to review how things were done and what they needed to do in the future to ensure residents got the vaccine. The facility's COVID-19 Vaccination policy implemented 4/2019 and reviewed/revised 12/2025 revealed COVID-19 vaccination is recommended for the prevention of COVID-19 disease and its complications for adults age [AGE] years and older. COVID-19 vaccinations will be offered to residents as per CDC and/or FDA (Food and Drug Administration) guidelines unless such immunization is medically contraindicated or the individual had already been immunized during this time period. The CDC website (https://www.cdc.gov/covid/vaccines/stay-up-to-date.html) updated 11/19/25 revealed the CDC recommends a 2025-2026 COVID-19 vaccine for people ages 6 months and older based on individual-based decision-making to helps protect you from severe illness, hospitalization, and death. It is especially important to get your 2025-2026 COVID-19 vaccine if you are ages 65 and older, are at high risk for severe COVID-19, living in a long-term care facility, or have never received a COVID-19 vaccine.