STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165355	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harvest Acres Nursing and Rehab	204 North Keokuk Washington Road Keota, IA 52248

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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 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, interviews, and policy review the facility failed to develop a comprehensive care plan for 2 of 5 residents reviewed (Residents #18 and #34). The resident's care plans contained focus areas, goals, and interventions that did not include person centered information. These sections were not updated when the comprehensive care plan was due at 14 days or with additional revisions. The facility reported a census of 27 residents.FIndings include: 1. The Minimum Data Set (MDS) for Resident #18 dated 9/10/25 documented diagnoses of hypertension, urinary tract infection within the past 30 days, anxiety and depression, and restlessness and agitation. The resident's Brief Interview for Mental Status (BIMS) score of 4/15 indicated she was severely cognitively impaired. Resident #18 required partial to moderate assistance with eating, hygiene, and dressing as well as supervision or touch assistance with bed mobility, transfers, and walking. The resident's admission date was listed as 9/4/25. During observations of Resident #18 on 12/8/25 at 10:30 AM, 10:58 AM, 11:17 AM and 12/9/25 at 9:19 AM the resident was noted to walk independently from her room to the nurses station where she would find a staff to stand with, walk with, and hold their arms for attention and support. She regularly needed 1:1 attention from staff and could be difficult to redirect as evidenced by repeat reminders not to enter other resident rooms or pick up items that did not belong to her. She wore a wander guard on her left ankle.Resident #18's Care Plan (CP) with an admission date of 9/4/25 included the following incomplete focus areas: [NAME] has hypertension related to (r/t)Date Initiated: 09/18/2025, Revision on: 12/09/2025 Adjustment to facility r/tDate Initiated: 12/05/2025, Created on: 09/04/2025, Revision on: 12/05/2025 Interventions did not include adjustment related triggers, behaviors [NAME] has a history of trauma related to life experience (specify trauma and triggering events)Date Initiated: 12/05/2025, Created on: 09/04/2025, Revision on: 12/09/2025 Interventions did not include triggering events [NAME] has a behavior problem r/tDate Initiated: 12/05/2025, Created on: 09/04/2025, Revision on: 12/09/2025 Interventions did not identify concerning behaviors [NAME] uses psychotropic medications r/tDate Initiated: 12/05/2025, Created on: 09/11/2025, Revision on: 12/09/2025 Intervention directed staff to observe for/record occurrence of target behavior symptoms (Specify: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc.) and document per facility protocol. Date Initiated: 09/11/2025, Created on: 09/11/2025, Revision on: 12/05/2025 The intervention was not specific to the resident. 2. The Minimum Data Set (MDS) for Resident #34 dated 11/5/25 documented diagnoses of wedge compression fracture of the fourth lumbar vertebra, hypertension, anxiety and depression, and chronic pain. The resident's Brief Interview for Mental Status (BIMS) score of 15/15 indicated intact cognition. Resident #34 used a walker and a wheelchair, and needed partial to moderate assistance with hygiene, upper body dressing, sit to stand, bed transfers, and walking 10 feet.Resident #34's Care Plan (CP) with an admission date of 7/23/25 included the following incomplete focus areas: The resident uses psychotropic medications r/tDate Initiated: 10/29/2025, Created on: 07/24/2025, Revision on: 10/29/2025 An intervention directed staff to observe for/record occurrence of target behavior symptoms (Specify: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc.) and document per facility protocol. Date Initiated: 07/24/2025, Created on: 07/24/2025, Revision on: 10/29/2025 The intervention was not specific to the resident. The resident has a behavior problem r/tDate Initiated: 10/29/2025, Created on: 07/24/2025, Revision on: 10/29/2025 A revision 9/17/25 indicated the behavior was due to non-compliance with transfer status. That was removed with the revision on 10/29/25. Adjustment to facility r/tDate Initiated: 10/29/2025, Created on: 07/24/2025, Revision on: 10/29/2025 The resident has hypertension r/tDate Initiated: 08/06/2025, Created on: 08/06/2025 The resident has altered respiratory status Difficulty Breathing r/tDate Initiated: 08/06/2025, Created on: 08/06/2025 The resident has potential/actual impairment to skin integrity r/tDate Initiated: 08/06/2025, Created on: 08/06/2025 An intervention indicated the resident should have treatment as ordered by the medical doctor. No resident specific skin impairments or treatments were documented.Anxiety and depression were not addressed in the care planDuring an interview with the Director of Nursing (DON) on 12/9/25 at 2:08 PM she confirmed she expected care plans to be complete and person centered. She thought staff were taking good care of the residents and acknowledged it was important to have current information in the care plan.During an interview with the Administrator on 12/10/25 at 2:58 PM she stated she had spoken with the DON regarding the care plan information not being complete

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and the facility policy, the facility failed to notify the provider for blood glucose levels over 400 mg/dl (milligrams per deciliter) for 1 of 3 residents reviewed for assessment/intervention (Resident #1). The facility reported a census of 27 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 scored a 5 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated that cognition severely impaired. The MDS revealed diagnosis for Type II diabetes mellitus and the resident received insulin 4 out of 7 days. The Care plan revealed a focus area dated 11/17/25 for potential for hypo/hyperglycemia related to diabetes mellitus and resident had a Dexcom. The interventions dated 11/17/25 revealed accuchecks as ordered, and call MD (Medical Director) for accuchecks greater than 400 and less than 70.The Electronic Medical Record (EMR) revealed the following Physician Orders: a. dated 11/10/25- Blood Glucose Monitoring- four times a day for diabetes. Call MD if below 70 or above 400.The Blood Sugar Summary revealed the following dates/times Resident #1 blood sugar over 400 mg/dl and the facility lacked documentation the provider notified:a. 11/12/25 at 5:56 PM- 584 mg/dlb. 11/17/25 at 8:25 AM- 449 mg/dlc. 11/18/25 at 8:56 AM- 421 mg/dld. 11/18/25 at 12:37 PM- 411 mg/dle. 11/20/25 at 8:20 AM- 414 mg/dlf. 11/20/25 at 2:40 PM- 447 mg/dlThe Medication Administration Note dated 11/12/25 at 9:19 PM revealed Insulin Glargine Solution 100 UNIT/ML (units/milliliters)- Inject 8 unit subcutaneously one time a day for diabetes: refused x 3 attemptsThe Nursing Note dated 11/13/25 at 3:46 AM, revealed resident BS (blood sugar) was checked at 1800 by previous shift which was 584. Previous shift attempted to give the resident her insulin and the resident refused saying that she was trying to give her heroin. On my current shift I have attempted to recheck the patients blood sugar and give her insulin 3 times, the resident is still refusing. I contacted metro and the doctor asked if she was symptomatic which she is not, and stated to try and get another BS reading on the morning shift, and to call her if the resident becomes symptomatic. Will continue to monitor the resident for symptoms and have the morning shift attempt to check her again. resident is resting with her eyes closed in the common area.During an observation on 12/8/25 at 12:33 PM, Resident #7 ambulated in the hallway with her wheeled walker independently. During an interview on 12/11/25 at 9:38 AM, Staff D, Licensed Practical Nurse (LPN) stated it was standard to notify the provider for blood sugars under 70 or over 400 mg/dl. Staff D stated the nurse would call the provider to see how many units of insulin to give if over 400 and put in a progress note. Staff D queried if she ever contacted the provider for Resident #1 blood glucose checks and Staff D stated she didn't think she ever called for Resident #1 blood sugars. During an interview on 12/11/25 at 2:02 PM, the Director of Nursing (DON) queried on Resident #1 blood glucose over 400 mg/dl and no documentation indicated in the chart and the DON stated she knew the nurses called the provider and the DON guessed the nurses didn't chart it. The DON stated more education was needed for the nurses. The DON stated when blood glucose levels were over 450 mg/dl, the nurses needed to notify the provider. The Facility Change in a Resident's Condition or Status dated February 2021 revealed: a. The nurse will notify the resident's attending physician or physician on call when there has been a specific instruction to notify the physician of changes in the resident's condition.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, interviews, and policy review the facility failed to maintain a medication administration error rate under 5% related to unprofessional standards and principles during the survey process. Of 31 medications observed 3 were not administered according to provider orders or medication inserts, and a missing medicated patch that was to be removed from a resident was not located. (Residents #1, 7,12, and 13) The facility reported a census of 27 residents.Findings include:1. The Minimum Data Set (MDS) for Resident #1 dated 11/10/25 documented diagnoses of pneumonia, thyroid disorder, and schizophrenia. The Brief Interview for Mental Status (BIMS) documented a score of 5/15 which indicated severely impaired cognition.At 7:47 AM on 12/9/24 Resident #1 was observed seated in a recliner in the common area after eating breakfast.During a medication administration observation on 12/9/25 at 8:02 AM Staff B, Licensed Practical Nurse (LPN) administered Levothyroxine Sodium Oral Tablet 88 mcg to Resident #1 with 11 other medications. The LPN stated she knew it was late but it would be okay.The progress notes do not indicate the provider was notified of the late medication.The Medication Administration Record (MAR) indicated that as of 11/14/25 Levothyroxine Sodium Oral Tablet 88 mcg was ordered by mouth one time a day related to hypothyroidism unspecified at 6:00 AM.A document provided by the facility titled [NAME]-T tablets for oral use, revised December 2017, section Indications and Usage revealed the medication should be administered once daily, preferably on an empty stomach one half to one hour before breakfast. and at least 4 hours before or after drugs that are known to interfere with absorption. The need for dose adjustments should be evaluated when regularly administering within one hour of foods that may affect absorption.During an interview with the Director of Nursing (DON) on 12/9/25 at 2:08 PM she stated that some of the nurses have been confused with the medication administration times. They were changing from scheduled windows of administration to scheduled times. They were working on it because they knew administration times had been an issue.2. The Minimum Data Set (MDS) for Resident #7 dated 12/1/25 documented diagnoses of non-Alzheimer's dementia and delirium due to known physiological condition. MDS Section C documented a Brief Interview for Mental Status (BIMS) of 3/15 indicating severe cognitive impairment.During a medication administration observation on 12/8/25 at 3:59 PM the Director of Nursing (DON) came in to the medication room to ask Staff A, Registered Nurse (RN) if Resident #7 had an as needed (PRN) medication for anxiety. Staff A reviewed the resident's clinical record and determined he did not. The RN administered PRN melatonin and the resident's evening medications. Neither the DON nor Staff A contacted the resident's provider about the resident's increased anxiety or behaviors.The Medication Administration Record (MAR) documented that beginning 11/29/25 Resident #7 could have a PRN melatonin oral tablet, 5 mg, by mouth as needed for trouble sleeping at bedtime. On 12/8/25 it was administered at 4:01 PM by Staff A. Staff A stated that giving the melatonin before the ordered bedtime administration time was 'close enough' because the resident was 'probably tired' and needed to sleep. The resident was observed taking the medication. He did not go to bed, he went by wheelchair out of his room for dinner.A Progress Note dated 12/8/25 at 4:01 PM titled eMar Medication Administration Note documented that the melatonin oral tablet 5 mg, give 5 mg by mouth as needed for trouble sleeping at bedtime, was administered for agitation/needs sleep. The progress notes did not include follow up with the provider or a responsible party regarding behavior or a PRN medication for agitation or anxiety.During an interview with the DON on 12/9/25 at 2:08 PM the DON recognized the melatonin was given too early and that it was not prescribed for agitation or anxiety. She did not think the nurse called the provider to follow up.A policy titled Liberalized Medication Pass documented 6 rights when passing medication: right drug, right dose, right route, right resident, right time, and right documentation. The guidelines for administration included HS (night time between 7:00 PM and 10:00 PM). It also included bedtime if different than above times.3. The Minimum Data Set (MDS) for Resident #12 dated 11/5/25 documented diagnoses of diabetes mellitus, schizophrenia, and muscle weakness and other lack of coordination. MDS Section C documented a Brief Interview for Mental Status (BIMS) of 13/15 indicating intact cognition.During medication administration observation on 12/9/25 at 11:09 AM Staff B, Licensed Practical Nurse (LPN) took insulin to Resident #12's room. She primed the 3 ML insulin lispro 100 Unit/ml pen injector with 2 units. After cleaning the resident's left bicep, she injected 23 units of insulin per doctor's orders. She held the pen for a count of one one thousand, Two one thousand and removed the needle.On 12/9/25 at 11:11 AM, when asked how long she was supposed to hold the pen in

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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, clinical record review, interviews, and policy review the facility failed to administer medications in a sanitary manner during medication administration. A nurse was observed putting pills in her hand before putting them in medication cups, applying a medicated patch without washing her hands afterward, and touching personal items between medication passes without washing her hands. The facility reported a census of 27 residents.Findings include:During a medication administration observation on 12/9/25 at 7:35 AM Staff B, Licensed Practical Nurse (LPN) unlocked the medication cart to administer medication. The Electronic Health Record (EHR) showed the resident was scheduled for a controlled medication located in a second locked area of the cart. Staff B took out the resident's medication card for Trazodone, matched the card to the EHR, and popped the pill into her left hand, and placed it in the pill cup. After administering the medication she washed her hands and moved on to another resident. During a medication administration observation on 12/9/25 at 7:49 AM Staff B unlocked the medication cart to administer medication to another resident. She reviewed the EHR and determined the resident was supposed to have Eliquis. She was unable to find the resident's medication card and touched the computer mouse, 3 sections of the medication cart, 2 cabinet doors, two rows of resident medication cards, the marker to date the medication patch, a second medication cart, and the door of the medication room without washing her hands. One of the items she prepared was a medicated Scopolamine transdermal patch that was administered behind the resident's right ear. The LPN touched the resident's ear, hair, and right shoulder then looked for the old patch behind the left ear before she moved away. The exterior of the package indicated the nurse should wash her hands after applying the patch. When the nurse was asked what the Scopolamine was for, she stated it helped dry her out and prevented nausea. She thought the resident had improved. She held the package that included the directions to wash her hands, and looked at it when she opened it. When she returned to the medication room she did not wash or sanitize her hands.The next medication administration observation was 12/9/25 at 8:02 AM. A resident in the common area was asking for her medication. One of the medications was in the locked controlled substance area of the cart. The LPN took out the resident's Lorazepam, matched it to the EHR, pushed it into her left hand, and then placed it in the medication cup. After putting the rest of the resident's medication in a cup, she took it out to the resident. The resident had been taken to the shower room. Staff B knocked on the door, entered the shower room with the medication cup and drink, and administered the medication in the shower room. When she returned she picked up her bag, took out a personal water bottle, drank from it, touched her bag again to put it away and started preparing medication for the next resident. She did not wash or sanitize her hands. Staff B prepared medication for another resident before she next washed her hands. She administered 17 medications between hand washes and did not use hand sanitizer during the observation. When asked on 12/9/25 at 8:16 AM about training for nurses in the facility Staff B confirmed that she had training for infection control. She thought she had washed her hands but confirmed that sometimes she forgot.During an interview with the Director of Nursing on 12/9/25 at 2:08 PM she stated she expected nurses to wash their hands between residents when administering medication. She stated nurses were trained when they started, they went over medication administration expectations, and nurses were not allowed on their own until they demonstrated they could be independent.A policy titled Handwashing/Hand Hygiene revised October 2023 indicated the facility considered hand hygiene the primary means to prevent the spread of healthcare associated infections. All personnel were trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare associated infections and were expected to adhere to hand hygiene policies and practices. Hand hygiene was indicated immediately before touching a resident, after contact with body fluids or contaminated surfaces, after touching a resident, after touching a resident's environment, and immediately after glove removal.