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	05/19/2026

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

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and facility policy review, the facility failed to complete and document care conferences after admission for two of three residents (Residents #5 and #11) and quarterly for two of three residents (Residents #3 and #5). The facility failed to document the following; the planning of care should include and assessment of the resident's current condition, needs that the resident requires, and updates which should be shared and communicated to the resident and or resident representative. A copy of the care plan should also be available to the resident, and or resident representative for review which the facility failed to do. The facility reported a census of 25 residents. Findings include:2. The modified Minimum Data Set (MDS) Assessment tool with reference date 8/20/26 revealed Resident #5 admitted to the facility on [DATE] with diagnoses that included hyponatremia (low sodium level), non-Alzheimer's dementia, traumatic brain injury (TBI), anxiety, bipolar disorder, schizophrenia and asthma, scored 9 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment that indicated moderate cognitive impairment, with symptoms of delirium present. The resident's clinical record revealed the resident had a Court Appointed Guardian that was her decision maker, and the first care conference documented on 11/26/25, over 3 months after the resident's admission to the facility. The resident's Court Appointed Guardian stated in an interview on 5/5/26 at 2:03 p.m. the resident had been in 3 different long-term care facilities in a little over a year and familiar with some of the procedures. The Guardian stated the facility had not had a care conference with him until November, and had made changes to her psychiatric medications that were not communicated to him within the first month that she was there, because if he had been notified he would have directed that her psychiatric medications were to be managed by her psychiatrists at the psychiatric hospital and not the facility's Nurse Practitioner or other providers not familiar with her history and care requirements. The Minimum Data Set (MDS) dated [DATE] identified Resident #3 as severely cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 03 and had the following diagnoses: Heart Failure, Diabetes Mellitus and Non-Alzheimer's Dementia. The MDS also identified Resident #3 was totally dependent on staff for assistance with eating, toileting, showers, lower body dressing and putting on and removing footwear and repositioning. The MDS identified Resident #3 required substantial/maximal staff assistance with upper body dressing and oral hygiene. The MDS also identified Resident #3 displayed behaviors of delusions and physical, verbal and other behaviors of behavioral symptoms directed toward others. A review of the care conference notes revealed no documentation between 10/8/25 and 3/8/26. The notes did not include documentation of a facility self report regarding a staff member who grabbed Resident #3's arm. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Minimum Data Set (MDS) dated [DATE] identified Resident #11 as severely cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 05 and had the following diagnoses: Di George's Syndrome (a genetic disorder caused by a small missing piece of chromosome 22, resulting in poor development of several body systems), Diabetes Mellitus and Schizophrenia. The MDS also identified Resident #11 required substantial/maximal staff assistance with putting on and removing footwear and required partial/moderate assistance with showers and upper body dressing. She was independent or required minimal assist with the remaining activities of daily living. A review of the Care Conference progress notes revealed only one entry dated 2/16/26. A review of a form the facility provided had the resident's name on it, admit date [DATE], however the date of the current meeting was not complete 10. The form had staff signatures of those who attended. At the bottom of the page, handwritten in resident refused to sign 10/21/25 The form did not have documentation to show what had been discussed with the resident. A review of a form the facility provided 48 Hour Care Plan Meeting with resident's name on it and date 11/4/25, signatures of staff who attended, however, no documentation of notes to show what had been discussed with the resident. In an interview on 5/12/26 at 10:29 AM, the Social Worker reported care conferences are held weekly and documented in the Multidisciplinary Care Conference and Progress Notes in the electronic medical record. When asked why Resident #3 did not have documentation of care conferences held for 5 months, she reported it could have been when she was not here on that day. She also is the Social Worker at another facility and splits her time between that facility and this one. When asked why Resident #11 did not have documentation of a care conference note within 2 weeks after her admission date, she reported this should have been completed within a week after admission and could not explain why it was not documented. In an interview on 5/13/26 at 1:36 PM, the DON reported care conferences are held weekly and would expect the first care conference to be completed at least within the first 30 days after admission. The Facility Policy titled: Comprehensive Care Plans dated as last revised March 2022, had documentation of the following: The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and facility policy review, the facility failed to notify residents' guardian/power of attorney of changes for 2 out of 4 residents reviewed (Residents #5, with medication changes) and failed to notify the physician of Resident #6's continued problem with abdominal pain and distention until 6 days later. The facility reported a census of 25 residents. Findings include:1. The modified Minimum Data Set (MDS) Assessment tool with reference date [DATE] revealed Resident #5 admitted to the facility on [DATE] with diagnoses that included hyponatremia (low sodium level), non-Alzheimer's dementia, traumatic brain injury (TBI), anxiety, bipolar disorder, schizophrenia and asthma, scored 9 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment that indicated moderate cognitive impairment, with symptoms of delirium present. The resident's clinical record revealed: The psychiatric hospital's discharge and transfer orders dated [DATE] that directed the resident's admission to the facility also directed continued follow-up care by psychiatrists familiar with the resident's care, with follow-up appointments scheduled. Psychoactive medication orders on the resident's [DATE] admission included: a). Benztropine (an anticholinergic medication used to treat involuntary muscle movements caused by antipsychotic medication) 1 milligrams (mg) administered oral twice daily b). Divalproex (an anticonvulsant and mood-stabilizing medication) Extended Release (ER) 1500 mg administered oral at hour of sleep (HS) c). Levocarnitine (an amino acid dietary supplement used to treat high ammonia levels) 990 mg administered oral 3 times daily. d). Levothyroxine 100 micrograms (mcg) administered oral daily. e). Risperidone (a strong antipsychotic medication) 1 mg administered oral twice daily. f). Trazodone (an antidepressant medication with sedative properties) 75 mg administered oral at HS (not started until [DATE]). g). Paliperidone (an atypical antipsychotic, also called a second-generation antipsychotic that works by rebalancing certain chemicals in the brain, primarily acting as a serotonin and dopamine antagonist to help improve thinking, mood, and behavior) 564 mg administered by intramuscular injection (IM) every 84 days. Within 14 days of the resident's admission to the facility, the facility sought changes in the resident's psychiatric medication regimen from their medical director and the facility's psychiatric Nurse Practitioner (NP), and did not confer with the resident's psychiatrist provider of record, or the resident's Court Appointed Guardian and decision maker. The medication changes included: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a). On [DATE] started Haloperidol (Haldol, a very strong antipsychotic medication) 0.5 milligrams (mg) administered oral every 6 hours as needed (PRN) for 14 days, for manic episodes and aggressive behaviors. b). On [DATE] started Buspirone (an anxiolytic medication) 10 mg administered oral twice daily for schizoaffective disorder (discontinued [DATE]). c). On [DATE] added Valporic Acid (prescription anticonvulsant and mood-stabilizing medication) 250 mg administered oral twice daily for schizoaffective, bipolar disorder .(discontinued [DATE]) d). On [DATE] added Haldol 0.5 mg administered oral 4 times daily for schizoaffective disorder, (discontinued on [DATE]) e). On [DATE] increased Haldol to 1 mg administered oral 4 times daily for schizoaffective disorder (discontinued[DATE]). f). On [DATE] decreased Risperidone to 1 mg administered oral daily for 5 days, then discontinue. g). On [DATE], started Ziprasidone (a strong antipsychotic medication) 20 mg administered oral twice daily (discontinued [DATE]) h). Added Lorazepam (a strong controlled anxiolytic medication) 0.5 mg administered oral every 6 hours PRN for 14 days for behaviors or agitation. The Notification of Resident Family, Legally Responsible Party policy, dated 3/2015, provided staff directives that included: 1. When any one of the following instances occurs, the resident, family or significant other, as appropriate, is notified. a. There is a change in the resident's physical, mental or psychosocial status; b. The resident is transferred to the hospital emergency room and/or admitted for care. c. In the event of an incident, accident or unusual occurrence d. A significant change of therapy, treatment, medications or care plan approaches e. Any time the resident leaves the building for a medical consultation, x-ray, etc. f. Refusal of medications, treatments, labs and diagnostic tests for three consecutive days or a pattern of refusal that may impact on resident condition 2. The nurse must document the name of the person notified, the date and time in the nurse's notes. Any pertinent comments made by this person should be documented. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's Court Appointed Guardian stated in an interview on [DATE] at 2:03 p.m. the resident had been in 3 different facilities in a little over a year, she had problems with her mental health, schizophrenia with hallucinations and sees things that aren't real. One of the greatest challenges had been her medications. They know her at the psychiatric hospital, they know what works and what doesn't. There have been problems when other doctors, usually nurse practitioners (NP's) change her medication and she usually ends up with more symptoms/aggression/behaviors and has to go back to the hospital. He is resolute that they continue to have her psychiatric medications managed by her psychiatrist for consistency. The facility didn't call him to let him know they were changing her medication, because if they had, he would have directed them that all of her psychiatric medications were to be managed by her psychiatrists at the psychiatric hospital. Staff interviews revealed: [DATE] at 6:26 a.m. Staff Q, LPN (licensed practical nurse) stated the resident's Guardian would not allow their psych NP to manage her meds, she had to go to her psychiatrist at the psychiatric hospital. [DATE] at 9:50 a.m. Staff M, LPN stated the resident's Guardian ordered that her psychiatric medications were managed by the psychiatrists at the psychiatric hospital and not the facility providers. 2.The Minimum Data Set, dated [DATE] identified Resident #6 as cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 09 and had the following diagnoses: Fractures and other multiple trauma, Coronary Artery Disease and Diabetes Mellitus. The MDS also identified Resident #6 to be dependent on staff for assistance with oral hygiene, toileting, dressing, putting on and removing footwear and personal hygiene. The Nurse's admission assessment dated [DATE] had documentation that the resident did not have any gastro-intestinal issues, last bowel movement (BM) was [DATE]. The pain assessment was not completed to indicate which facial grimace of pain Resident #6 had. The Nurse's Progress Notes had documentation of the following: a. [DATE] 7:27 PM Abdomen is firm round and distended, as report received from the hospital nurse. b. [DATE] 3:41 AM Resident is new admit, alert and oriented x3, pivot transfer, earlier on this shift, she c/o nausea and vomiting and pain, was given as needed (PRN) Zofran and pain medication and she has been sleeping most of the night. Assessments documented over the next 3 days did not include documentation of a reassessment of the round, distended abdomen or presence of bowel sounds. c. [DATE] 6:22 AM After eating fresh fruit that had been out all day, Resident #6 had stomach pain and vomited out the undigested fruit. Bowel sounds active to all quadrants. dXXX[DATE] 9:22 AM Resident vomited this morning before breakfast. (No documentation of an assessment of her abdomen or bowel sounds) e. [DATE] 12:06 PM abdomen is bloated and she had vomited small amounts of brown emesis. Kept (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	trying to eat more while her stomach is bloated. fXXX[DATE] 5:15 PM Abdominal Evaluation/Bowels/Continence: Nausea, vomiting, diarrhea, constipation, complaint of abdominal pain and gas. PRN Gas-X given on 1st shift per report. Resident has had a daily suppository and has requested an enema (not on facility bowel protocol). g. [DATE] 5:56 PM Resident has had problems with constipation since she arrived at facility. She is receiving oxycodone for pain, which is new to the resident. She has had a suppository everyday since the 12th. Minimal results, some diarrhea, one reported medium BM. Today she started vomiting. Given Zofran, this nurse thought it was resolved, and reported it as such. Then she started vomiting again after eating supper. Emesis is dark, not coffee ground emesis, but close in color. Abdomen is distended. Bowel sounds are present in all 4 quadrants. VS: 97.2, 100/40, 79, 16, 95% RA. She continues to complain of abdominal pain. Call to Provider. Received order to transport to emergency room (ER) via ambulance for possible bowel blockage, with request for abdominal CT. h. [DATE] 6:43 PM Transported to the hospital per ambulance. i. [DATE] 12:30 PM Resident family just arrived at the facility with the news that resident had deceased early this morning. A review of the [DATE] Medication Administration Records reviewed revealed Injections received – Humalog sliding scale with meals, Novolog three times daily and Lantus once daily. Ondansetron HCl Oral Tablet 4 mg one tablet every 6 hours as needed for nausea. Doses signed out were on [DATE] at 5:57 AM and at 3:56 PM and [DATE] at 2:18 PM Bisacodyl Rectal Suppository 10 mg one suppository rectally one daily needed for constipation. Doses signed out [DATE] at 8:18 PM and [DATE] at 00:16 AM On [DATE], the Care Plan identified Resident #6 with the problem of an alteration in gastrointestinal status and directed staff to administer medications as ordered. Observe for/document side effects and effectiveness. A review of the BM records from [DATE] to 15, 2026 revealed the only BMs documented were a large one on [DATE] at 8:15 PM, constipated, large puffy like, on [DATE] at 2:36 AM large, loose diarrhea and [DATE] at 8:13 PM small and formed A review of the hospital admission history and physical notes dated [DATE] had documentation that the chief complaint: Abdominal pain, ileus versus partial small bowel obstruction (SBO) s/p NG tube placement. (small bowel obstruction status post nasogastric tube placement) Transferred to intensive care unit ICU for shock and respiratory failure on 1/19. Cardiovascular: Shock, likely septic from suspected bowel perforation Her daughters reported not being entirely sure which medications she was being given at the rehab facility and haven't been told anything about when her last bowel movement was. Patient and daughters report she has had low appetite since the surgery, but was able to tolerate some diet. For (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the last two days however, she has not had much oral intake at all due to increasingly worse abdominal distention and pain accompanied by nausea and vomiting. The vomit has had coffee ground like material and dark bilious contents. Primary Cause of Death: Cardiac arrest Conditions Directly Contributing to Death: Septic shock and bowel perforation. At approximately 2:45 AM on [DATE], the patient was pronounced dead. In an interview on [DATE] at 10:14 AM, Staff Q, LPN reported he could not recall very much about the resident and was unable to recall his assessment of her abdomen while she was here. Staff Q did report if he assessed a resident's abdomen that was firm and distended, that he would listen to bowel sounds, check the bowel record, they probably need a laxative to help them go. Normally, we give milk of magnesia (MOM) on 3rd with no BM and if no results, give Dulcolax suppository. He should reassess her at least once a shift. After she has a BM, we should chart the amount, consistency, this should be on the bowel record under tasks. In an interview on [DATE] at 10:13 AM, Staff M, LPN recalled Resident #6 had complained of pain to her hip, abdomen and back. She reported her abdomen was soft for the most part, she could not recall charting that her abdomen was bloated and vomited. If someone had a firm, distended abdomen, she would check to see what kind of bowel movements she had, check per shift, check for bowel movements, bowel sounds, if she needs a laxative. If a resident did not have a BM for 3 days, give MOM (Milk of Magnesia), if MOM is ineffective, then we should give a suppository. Then we should notify the doctor. She could not recall if any of the above had been given to Resident #6. In an interview on [DATE] at 1:15 PM, Staff P, LPN reported the following: she admitted her. She didn't speak English and Staff P spoke Spanish and she translated for her. She was in pain, she had been admitted to the facility for Physical Therapy after she broke a hip. She complained about pain, her abdomen was very distended and complained of constipation. The hospital told Staff P that she had a BM there. She recalled charting her abdomen was distended. Her bowel sounds were active to all quadrants. But she did complain that she needed to have a bowel movement and she couldn't. She did not complain of nausea, no vomiting. She did want something to eat, we gave her a sandwich and gave her something to drink. At that time, she did not have orders for a laxative. I asked if she needed one right away, she said no. Staff P reported if she assessed a resident's abdomen and noticed it's firm and distended, she should document an assessment every shift. The facility had a protocol that if the resident did not have a BM for 3 days, we give MOM (Milk of Magnesia), if MOM is ineffective, give Dulcolax suppository, if that doesn't work within a day, call the doctor for an order, he may order an enema. If enema is effective, call the doctor. In an interview on [DATE] at 2:33 PM, Staff I, RN reported she found out from Resident #6's family member that she had a resected bowel which was not in the medical records sent to this facility. She had only complained of abdominal pain for Staff I only on the day she was sent out to the hospital. Staff I also reported if a nurse assessed the resident's abdomen and noticed it was firm and distended, she should listen for bowel sounds with a stethoscope. If hypoactive – the nurse would need to notify the doctor. Check the medication administration record (MAR), if no BM for 3 days, give MOM (Milk of Magnesia), if no results, give Dulcolax suppository, if that doesn't work, call the doctor. If a nurse gave a suppository, she/he would need to chart the results, size of the BM, consistency and presence of bowel sounds. She recalled Resident #6's abdomen was distended before she was sent to the hospital. If the nurses had been told she had a resected bowel, they should (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have sent her out to the hospital earlier than they did. In an interview on [DATE] at 1:36 PM, the DON (Director of Nursing) reported if a resident was admitted with complaints of abdominal pain and firm and distended abdomen, she would expect the nurse to get a set of vitals, listen to bowel sounds, do an overall head to toe assessment then call the doctor right away. She would expect the nurses to assess the abdomen at least every shift for the next 48 to 72 Hours. She would expect them to document bowel sounds, any non-behavioral observations to indicate pain, when the last BM was, what medications were given, vital signs. If no BM after 3 days give MOM, if no results, give Dulcolax suppository, if no results, call the doctor with an update. After the resident has a BM, would need to document that interventions were tried. Document size, consistency of the BM, any presence of blood, any straining, if complaining of pain while they're having a BM. She could not explain what happened before Resident #6 was sent to the hospital or why the physician was not notified until 6 days later. In an interview on [DATE] at 12:06 PM AM, Resident #6's primary care physician and facility Medical Director reported the following: she could not recall when the facility first notified her of Resident #6's problems with abdominal pain since admission. She was not sure if the facility had a BM protocol. She reported if the facility had notified her earlier of the resident's condition, she would have given orders to check vital signs, check labs and to have the nurses to check for bowel sounds and palpate. A review of the Facility Policy titled: Notification of Resident Family, Legally Responsible Party dated as last reviewed [DATE] had documentation of the following: When any one of the following instances occurs, the resident, family or significant other, as appropriate, is notified. a. There is a change in the resident's physical, mental or psychosocial status; b. The resident is transferred to the hospital emergency room and/or admitted for care. c. There is a need to alter the resident's room assignment or roommate. d. In the event of an incident, accident or unusual occurrence e. A restraint is recommended. f. There has been a significant change in the resident's skin integrity. g. A significant change of therapy, treatment, medications or care plan approaches h. Any time the resident leaves the building for a medical consultation, x-ray, etc. i. Refusal of medications, treatments, labs and diagnostic tests for three consecutive days or a pattern of refusal that may impact on resident condition j. The resident is discharges without medical authority k. A decision has been made to discharge the resident from the facility 2. The nurse must document the name of the person notified, the date and time in the nurse's notes. Any pertinent comments made by this person should be documented. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, and staff and resident responsible party interviews, the facility failed to implement an effective discharge planning process for 1 of 4 records reviewed for discharge plan, (Resident #4) that focused on the resident's discharge goals, prepared the resident to effectively transition to post-discharge care, and resulted in the resident's homelessness within 7 days of discharge, and the resident's return to substance abuse and hospitalization in critical condition from a drug overdose. The facility reported a census of 25 residents. Findings include:Resident #4 was admitted to facility on 10/2/25, transferred there from a sister facility due to the resident's exit-seeking behavior, where she'd been admitted from the hospital on 9/29/25. The MDS Assessment tool with reference date 10/9/25 revealed the resident scored 12 out of 15 points possible on the BIMS cognitive assessment that indicated mild cognitive impairment, without symptoms of delirium present, and had a Level II PASRR for serious mental illness. Her diagnoses included hypertension (high blood pressure), renal insufficiency, diabetes, arthritis, anxiety, depression (other than bipolar disorder), major depressive disorder, attention-deficit hyperactivity disorder (ADHD), insomnia, chronic pain, spinal stenosis (narrowing of spinal canal inside vertebrae) of cervical region and low back pain. The assessment revealed the resident was independent for all activities of daily living, including ambulation of 150 feet on even surfaces, with exception of shower/bathe self not assessed, and transfer into shower/tub not assessed. A level II PASRR (Pre-admission Screening and Resident Review, an in-depth, person-centered evaluation triggered when there is a suspected or confirmed mental illness, intellectual disability, or related condition. It ensures individuals are placed in the most integrated, appropriate setting and receive necessary specialized services) dated 9/24/25 was a short term,180-day approval for services that ended 3/23/26 and revealed the following information: 1. Met PASRR criteria for serious mental illness for the diagnoses of schizophrenia which has led to significant symptoms that impact daily functioning and have required intensive supports in the past.2. Medical provider noted that the resident was unable to care for herself Independently due to difficulty with basic cognitive tasks and impaired judgement, noted to be confused with impairment in long and short term memory.3. A Court Appointed Guardian had been established for decision making.4. The resident had an open criminal case for charges of Assault Causing Bodily Injury and Domestic Abuse, Assault-Injury of Mental Illness with a competency evaluation scheduled for 10/08/2025.5. The resident's Guardian stated she will need to live in a supportive setting such as a nursing home or assisted living facility because the resident is unable to care for herself at home.6. Medical records note there may be an open assessment with HHS (Iowa Health and Human Services) relating to possible dependent adult abuse or self-denial of critical care.7. History of methamphetamine use with most recent use occurring just prior to 8/2/25 hospital admission. It does not appear that the resident has ever attended substance abuse treatment.8. A Modlfied Short Blessed Cognitive Test (SBT), a screening test to measure cognitive ability resulted in a score of 12. Scores of 0-4 represent cognitive functioning to be intact, scores of 5-9 indicate possible impairment and may suggest a need for evaluation of early dementing disorder, and scores of 10 or more indicate impairments that are consistent with dementia.9. The MoCA (Montreal Cognitive Assessment), a cognitive screening test designed to assist health professionals to detect mild cognitive impairment and Alzheimer's disease resulted in a score of 7. Scores of 26 and higher represent normal cognition, scores of 18-25 indicate mild cognitive impairment, scores of 10-17 indicate moderate cognitive impairment, and scores of less than 10 indicate severe cognitive impairment. The score of 7 indicates the resident would have trouble remembering, learning new things, concentrating, and making decisions that affect everyday life. The receiving facility was required to provide:1. Ongoing psychiatric medication management by a psychiatrist or a psychiatric (continued on next page)

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	165355	A. Building B. Wing	05/19/2026

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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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ARNP (to evaluate response and effectiveness of psychotropic medications on target symptoms, modify medication orders, and to evaluate ongoing need for additional behavioral health services) Individual therapy by a licensed behavioral health professional.2. Initial substance use evaluation to determine diagnosis and develop a plan of care Referral and make access possible for participation in a support group for recovery from substance abuse (AA, NA, etc.)3. Services to assist the individual in preparing to pursue supported community living.4. Language Therapy - the resident will benefit from ongoing speech therapy to improve ability to swallow and cognitive, problem solving, and reasoning skills.5. Facilitate family involvement in the individual's care and care planning, including inviting family for regular visitation, and participation in care conferences.6. Supportive counseling from nursing facility staff.7. Due to the serious history of substance use and apparent challenges it has created the resident willbenefit from a referral for evaluation of need for substance use treatment. If it is determined the resident needs substance use treatment in an inpatient setting following nursing facility care, then plansshould be made to enter treatment in whatever manner will be most beneficial for the resident.8. Obtain archived psychiatric/behavioral health treatment records to clarify history and then make those past records available to all medical and behavioral health service providers9. Because the resident has ongoing medical and mental health conditions and requires assistance from others, the resident will need to live in a supported living setting, such as supported independent living, a group home, residential care facility, assisted living, or other supported setting where help from staff is available with consistent supervision for safety and well-being. Staff at the receiving nursing facility are encouraged to reach out for immediate collaboration with MCO case managers, and any other community providers that may be involved with the resident, to find and arrange for any services the resident is eligible to receive before discharge.10. The resident will benefit from a referral to a support group for recovery from substance use and a recovery group for people with serious mental health issues to help the resident get and stay sober and to support recovery in both mental health and substance use. Additional PASRR requirements include: The admitting nursing facility must incorporate PASRR findings as part of the individual's plan of care. Maximus must be notified of all PASRR admissions and discharges viaPath Tracker within AssessmentPro If for any reason the resident chooses to discharge prematurely or without adequate services and supports in place, we strongly encourage any concerned providers or others to take all necessary steps to keep the resident safe, including requesting court orders if needed, and to contact the Iowa HHS Abuse Hotline at [PHONE NUMBER], to report the resident's high potential for dependent adult abuse and/or self-denial of critical care. The resident's Nursing Care Plan did not address any of the PASRR requirements. On 10/20/25, the resident requested to be discharged , and the resident was discharged with a friend on that date. The facility's Admission, Transfer and discharge policy, with effective date March, 2015, directed staff, in part:No resident shall be discharged without a written order from the attending physician or through other legal processes and timely notification of the legally responsible party or authorized representative.The facility may not transfer or discharge the resident unless:a. The transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility.b. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.The facility must notify the resident and, if known, the family member, surrogate, or representative of the transfer and the reasons for the transfer, and record the reasons in theclinical record.The facility is required to provide sufficient preparation and orientation to residents to ensure safe and orderly discharge from the facility.There shall be a centralized coordinated discharge plan to ensure that the resident has a program of needed continuing care after discharge from the facility. The plan shall bedeveloped within 7 days of admission and shall be an integral part of the resident care plan and updated at least every 90 days and as needed in social services progress notes. The facility could not provide the documentation that supported the resident no longer had a Court Appointed Guardian. Records available in Iowa Courts Online revealed (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the following: The resident's Court Appointed Guardian was revoked on 10/7/25, and a motion for temporary guardianship of the resident was filed by another individual that was denied. Documentation related to the resident's pending assault charges since 10/8/25 and through 4/1/26 revealed she was not competent to stand trial, she suffered from a mental disorder and could not assist in her legal defense and ordered to comply with treatment by a psychiatrist to the point of restoration in mental condition. During an interview on 5/6/26 at 9:04 a.m., the resident's Court Appointed Guardian (that ended on 10/7/25) stated the resident was a life-long drug addict that had severely effected and impaired her mental capacity and was not capable of taking care of herself. The facility didn't notify them that the resident was discharged . The resident was discharged with a friend, without her medications, started using methamphetamine as soon as she was discharged and was kicked out of the friend's home within 1 day, then lived with another friend for 5 or 6 days until she was kicked out of there as well. Then the resident stayed with various acquaintances until she was homeless and lived in a park in a large city. The resident was currently hospitalized in ICU on a ventilator from a drug overdose and from what they've heard she was not expected to survive. The Hospital medical records revealed the resident hospitalized in critical condition in the intensive Care Unit with conditions related to a drug overdose on 4/12/26. The resident remained hospitalized as of the time of survey exit.During an interview on 5/14/26 at 2:10 p.m. the facility Administrator stated the resident was discharged within 2 hours of her request for discharge, and the facility did not have time to make or coordinate any referrals for substance abuse counselling or support groups.On 5/19/26, the facility Administrator stated their medical provider sent the resident's prescriptions to the pharmacy requested by the resident on 10/20/25 (Pharmacy A). During an interview on 5/19/26 at 12:02 p.m., pharmacy staff at Pharmacy A stated they had a profile for the resident (had her information in their database) but did not receive any prescriptions from any provider on or around 10/20/25, and had not dispensed any medication to the resident.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and facility policy review, the facility failed to address PASRR recommendations on the Care Plans for two of three residents reviewed with Level 2 PASRR evaluations. (Residents #4 and #5) and failed to include interventions identified in an interdisciplinary meeting after incident involving one resident entering another resident's room causing Resident #7 to fear Resident #8). The facility reported a census of 25 residents.Findings include:1. The modified Minimum Data Set (MDS) Assessment tool with reference date [DATE] revealed Resident #5 admitted to the facility on [DATE] with diagnoses that included hyponatremia (low sodium level), non-Alzheimer's dementia, traumatic brain injury (TBI), anxiety, bipolar disorder, schizophrenia and asthma, scored 9 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment that indicated moderate cognitive impairment, with symptoms of delirium present. The resident's Level II PASRR (Pre-admission Screening and Resident Review, an in-depth, person-centered evaluation triggered when there is a suspected or confirmed mental illness, intellectual disability, or related condition. It ensures individuals are placed in the most integrated, appropriate setting and receive necessary specialized services) dated [DATE] was a short-term,180-day approval for services that ended [DATE], and revealed the following information: 1. Met PASRR criteria for serious mental illness for the diagnoses of schizoaffective disorder, bipolar type, which led to significant symptoms that impact daily functioning and have required intensive supports in the past. 2. The resident had multiple inpatient psychiatric hospitalizations between 2019 and 2025 for treatment of schizoaffective disorder, bipolar type. 3. At the time of the assessment the resident was hospitalized on an inpatient psychiatric unit by court order, for treatment of schizoaffective disorder, bipolar type, and neurocognitive disorder (conditions that cause a decline in mental functions such as memory, attention, problem-solving, and language) related to TBI. 4. The resident had a history of behaviors that included refusal of medication and care when not doing well, yelled at others, and threw and broke things when upset. 5. The resident required placement in a locked facility for safety. The receiving facility was required to provide: 1. Ongoing psychiatric medication management by a psychiatrist or a psychiatric ARNP (to evaluate response and effectiveness of psychotropic medications on target symptoms, modify medication orders, and to evaluate ongoing need for additional behavioral health services) 2. Individual therapy by a licensed behavioral health professional 3. Occupational Therapˆ (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Physical Therapy 5. Routine and/or special Dental Services to address care of teeth or dentures and oral health 5. Socialization/leisure/recreation activities appropriate to current skills or adapted to facilitate optimal participation 6. Facilitate family involvement in the individual's care and care planning, including inviting family for regular visitation, and participation in care conferences 7. Supportive counseling from nursing facility staff. The resident's Nursing Care plan did not address the PASRR requirements until [DATE]. The facility submitted a PASRR review as required before the [DATE] expiration of the PASRR that was dated [DATE]. A conditional short-term 60-day Level II PASRR dated [DATE] included the following information: 1. A ServiceMatters (company contracted for management of PASRR care coordination) review dated [DATE] was started to see if all PASRR identified services and supports noted in the most recent completed PASRR report ([DATE]) were being care planned and delivered. The ServiceMatters review was not completed because the admitting nursing facility was not compliant and did not submit the requested information needed to complete the review. 2. A ServiceMatters review dated [DATE] was completed to see if all PASRR identified services and supports noted in the most recent completed PASRR were being care plan and delivered. The ServiceMatters review found the nursing facility was not compliant. The [DATE] PASRR directed the continuation of: 1. Ongoing psychiatric medication management by a psychiatrist or a psychiatric ARNP (to evaluate response and effectiveness of psychotropic medications on target symptoms, modify medication orders, and to evaluate ongoing need for additional behavioral health services) 2. Socialization/leisure/recreation activities appropriate to current skills or adapted to facilitate optimal participation 3. Supportive counseling from nursing facility staff The resident's clinical record revealed: 1. Resident sent to a hospital emergency room (ER) for a psychiatric evaluation and treatment of (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aggressive behaviors on [DATE]. 2. Resident sent to a hospital ER for a psychiatric evaluation and treatment of aggressive behaviors on [DATE]. 3. Resident sent to the psychiatric hospital ER for psychiatric evaluation and treatment of aggressive behaviors on [DATE]. The resident hospitalized on the inpatient psychiatric unit until [DATE] for treatment of schizoaffective disorder. 4. Resident sent to the psychiatric hospital ER for psychiatric evaluation and treatment of aggressive behaviors on [DATE]. The resident hospitalized on the inpatient psychiatric unit until [DATE] for treatment of schizoaffective disorder. 5. Resident sent to the psychiatric hospital ER for psychiatric evaluation and treatment of aggressive behaviors on [DATE]. The resident hospitalized and had not returned to the facility. 6. Resident #4 was admitted to facility on [DATE], transferred there from a sister facility due to the resident's exit-seeking behavior, where she'd been admitted from the hospital on [DATE]. The MDS Assessment tool with reference date [DATE] revealed the resident scored 12 out of 15 points possible on the BIMS cognitive assessment that indicated mild cognitive impairment, without symptoms of delirium present, and had a Level II PASRR for serious mental illness. Her diagnoses included hypertension (high blood pressure), renal insufficiency, diabetes, arthritis, anxiety, depression (other than bipolar disorder), major depressive disorder, attention-deficit hyperactivity disorder (ADHD), insomnia, chronic pain, spinal stenosis (narrowing of spinal canal inside vertebrae) of cervical region and low back pain. A level II PASRR dated [DATE] was a short-term,180-day approval for services that ended [DATE] and revealed the following information: 1. Met PASRR criteria for serious mental illness for the diagnoses of schizophrenia which has led to significant symptoms that impact daily functioning and have required intensive supports in the past. 2. Medical provider noted that the resident was unable to care for herself Independently due to difficulty with basic cognitive tasks and impaired judgement, noted to be confused with impairment in long and short term memory. 3. A Court Appointed Guardian has been established for decision making. 4. The resident's Guardian stated she will need to live in a supportive setting such as a nursing home or assisted living facility because the resident is unable to care for herself at home. 5. History of methamphetamine use with most recent use occurring just prior to [DATE] hospital Admission. It does not appear that the resident has ever attended substance abuse treatment. The receiving facility was required to provide: 1. Ongoing psychiatric medication management by a psychiatrist or a psychiatric ARNP (to evaluate (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	response and effectiveness of psychotropic medications on target symptoms, modify medication orders, and to evaluate ongoing need for additional behavioral health services) Individual therapy by a licensed behavioral health professional. 2. Initial substance use evaluation to determine diagnosis and develop a plan of care Referral and make access possible for participation in a support group for recovery from substance abuse (AA, NA, etc.) 3. Services to assist the individual in preparing to pursue supported community living. 4. Language Therapy – the resident will benefit from ongoing speech therapy to improve ability to swallow and cognitive, problem solving, and reasoning skills. 5. Facilitate family involvement in the individual's care and care planning, including inviting family for regular visitation, and participation in care conferences. 6. Supportive counseling from nursing facility staff. 7. Due to the serious history of substance use and apparent challenges it has created the resident will benefit from a referral for evaluation of need for substance use treatment. If it is determined the resident needs substance use treatment in an inpatient setting following nursing facility care, then plans should be made to enter treatment in whatever manner will be most beneficial for the resident. 8. Obtain archived psychiatric/behavioral health treatment records to clarify history and then make those past records available to all medical and behavioral health service providers 9. Because the resident has ongoing medical and mental health conditions and requires assistance from others, the resident will need to live in a supported living setting, such as supported independent living, a group home, residential care facility, assisted living, or other supported setting where help from staff is available with consistent supervision for safety and well-being. Staff at the receiving nursing facility are encouraged to reach out for immediate collaboration with MCO case managers, and any other community providers that may be involved with the resident, to find and arrange for any services the resident is eligible to receive before discharge. 10. The resident will benefit from a referral to a support group for recovery from substance use and a recovery group for people with serious mental health issues to help the resident get and stay sober and to support recovery in both mental health and substance use. Additional PASRR requirements include: a. The admitting nursing facility must incorporate PASRR findings as part of the individual's plan of care. Maximus(company that manages PASRR's) must be notified of all PASRR admissions and discharges via Path Tracker within AssessmentPro. b. If for any reason the resident chooses to discharge prematurely or without adequate services and supports in place, we strongly encourage any concerned providers or others to take all necessary steps to keep the resident safe, including requesting court orders if needed, and to contact the Iowa HHS Abuse Hotline at [PHONE NUMBER], to report the resident's high potential for dependent adult abuse and/or self-denial of critical care. The resident's Nursing Care Plan did not address any of the required PASRR interventions, or indicate the resident had a Level II PASRR. The resident was (continued on next page)

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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	discharged from the facility on [DATE] per her own request. 2. The Minimum Data Set (MDS) dated [DATE] identified Resident #7 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15 and had the following diagnoses: COPD (Chronic Obstructive Pulmonary Disease), Diabetes Mellitus and Respiratory Failure. The MDS also identified Resident #7 to be totally dependent on staff for assistance with toileting, showers, putting on and removing footwear and required substantial/maximal assistance with dressing. Observations of Resident #7 could not be completed as she expired prior to the initiation of the investigation survey. The Nurse's Progress Notes revealed the following: [DATE] 12:05 PM Hospice social worker here to visit. Resident did inform the hospice staff that she had an incident with another resident coming into her room last night and expressed concerns regarding personal safety while in room and feeling anxious from the incident. Social worker discussed with this writer that resident stated, I would like to have a safety plan in place. [DATE] 10:31PM Resident #7's family member reported Resident #7 stated Resident #8 put his hand on her shoulder and put his fist near her face. However, multiple staff interviewed Resident #7 who denied Resident #8 actually touched her. A review of the Facility Incident Report revealed the following: [DATE] at 1:00 PM Resident #7 reported Resident #8 came in to her room and raised his arm, but did not touch her. The hospice nurse reported there were different versions of the story being reported by the resident's family member and the resident. Care plan updated to show previous concerns with attention seeking behavior from this resident. The Care Plan was not updated after the above incident occurred. 3. The Minimum Data Set (MDS) dated [DATE] identified Resident #8 as severely cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 06 and had the following diagnoses: Non-Traumatic Brain Dysfunction, Unspecified Dementia and Non-Alzheimer's Dementia. The MDS also identified Resident #8 required substantial/maximal staff assistance with all activities of daily living except eating, walking and repositioning. The MDS did not identify him with any indicators of possible psychosis or any behaviors directed towards others. A review of the Progress Notes revealed the following: [DATE] 9:40 PM Resident #7 reported that Resident #8 entered her room, shut the door meddled with her things then came over to her recliner. He then made a fist 2 to 3 inches from her face. He said, How about I give you five? She reports that she was screaming, she had put her light on when he came into the room. He said, They can't hear you. Resident #7 said there was no physical contact with this resident. Observations of Resident #8 revealed the following interactions: [DATE] at 9:54 AM resident arguing with another female resident who kept telling him to shut up. Staff S, RN approached this resident and asked him if he wanted a cookie. Resident #8 walked away from the female resident and stood in front of the nurse's station where Staff S gave him something (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to read. [DATE] at 10:10 AM resident now arguing with another female resident sitting in a recliner by the nurse's station who kept telling him to shut up then resident sat next to this resident and began arguing with her again. No staff member sitting nearby. He did not attempt to get up and hit her. [DATE] at 10:57 AM standing at the nurse's station , arguing with Staff S, RN, who tried to re-direct him to the main dining room, he started yelling No, I do not want to hold your hand! and followed her in to the dining room and he sat down in the dining room chair. In an interview on [DATE] at 9:26 AM, the MDS Coordinator reported usually the MDS Coordinator or the DON (Director of Nursing) is responsible for making changes to the resident's care plan. When asked when a resident has a level 2 PASRR evaluation, the PASRR recommendation would need to be added to the Care Plan, she reported she did not know. She thought Social Services was responsible, however, was not sure if it was part of her job yet. She works between two buildings and may not always be aware when changes may occur. When asked why the recommendations were not added for Resident #4's Care Plan, she reported she was not working at the facility at that time. When asked why recommendations were not added to Resident #5's Care Plan, she reported she had only been working here a few weeks before she was admitted . Regarding the incident that took place between Resident #7 and Resident #8 was not added to their Care Plans as she was working at the other facility as a staff nurse. In an interview on [DATE] at 1:36 PM, the DON reported usually the MDS Coordinator and the DON is responsible for updating the care plans. When there is a level 2 PASRR evaluation completed, those recommendations be added to the resident's care plan within the first 5 days. Regarding the incident that occurred between Resident #7 and Resident #8, she would have expected that to be added to the Care Plan within a few days. A review of the Facility Policy titled: Cared Plans, Comprehensive Person dated as last reviews [DATE] failed to address the need to update Care Plans where there is a change in medication or the need to address PASRR recommendations.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and staff interviews, the facility failed to ensure their staff had basic competencies and skills sets that met the behavioral health needs for residents the facility has assessed and developed care plans for, in accordance with their Facility Assessment. The facility failed to provide the education, as specified in the Facility Assessment, to promote the staff's competency, and failed to document staff competency for behavioral health management as required. The facility reported a census of 25 residents. Findings include: The Facility's assessment dated 5/2025 revealed:The facility had an average daily census of 27 resident, with age range of 43 to [AGE] years old. Seven of the residents had Level II PASRR's (Pre-admission Screening and Resident Review, an in-depth, person-centered evaluation triggered when there is a suspected or confirmed mental illness, intellectual disability, or related condition. It ensures individuals are placed in the most integrated, appropriate setting and receive necessary specialized services), and 4 residents were identified with intellectual disabilities. The facility identified they provided assistance with behavioral symptoms for 28 residents. Their staff included 8 to 10 Certified Nursing Assistants (CNA's), 6 Certified Medication Assistants (CMA's, that are also CNA's), 2 Registered Nurses (RN's), 5 Licensed Practical Nurses (LPN's), and no mental health professionals. Psychiatrists and Psychologists were available through telehealth technology. The Assessment reported the average CNA to resident ratio was 1 to 9, and the average nurse to resident ratio was 1 to 24. The Assessment described their staffing is adequate for caring for residents with dementia, mental health conditions, or history of trauma as evidenced by: 1 part time social worker and in service training and competencies for all staff. Specialized training: All staff are trained in the care on monthly and yearly trainings. The Staff Training/Education and Competencies described in the Assessment revealed: Our facility's training program includes an orientation process and ongoing training for all new and existing staff including managers, nursing and other direct care staff, individuals providing services under contractual arrangement, and volunteers consistent with their expected roles. We complete an educational needs assessment and develop a curriculum and training plan based on staff need and resident characteristics. The content at a minimum includes: Effective communicationResident rights and facility responsibilitiesAbuse, neglect, and exploitationInfection controlCulture change/person-centered careDementia management and abuse preventionSpecial needs of residentsCaring for residents who are cognitively impairedIdentification of resident changes in conditionCultural competency/trauma informed careQAPI Compliance and ethicsEmergency preparednessWorkplace hazards On [DATE] at 11:12 p.m. the Administrator provided a list of 9 current residents that had Level II PASRR's. On [DATE], the Surveyors requested copies or access to copies of their Staff Competency Assessments. As of the time of survey exit, the facility had not provided the required Competency Assessments. The facility provided a copy of their 2026 Education Calendar that revealed the following planned education programs: January - QAPI, Regulatory Prep, & Improvement Plan, Abuse and Mandatory Reporter, Fall Prevention, CPR - knowing code status and proper response, Disaster Preparedness, Safety. February - QAPI, Regulatory Prep, & Improvement Plan Review, Abuse and Mandatory Reporter, Code of Conduct Review: Customer Service Pledge, Disaster Preparedness: Elopement Procedure and Process, Safety. March - QAPI, Regulatory Prep, & Improvement Plan Review, Abuse and Mandatory Reporter, Dementia and Behavior Management, Resident Rights, Disaster Preparedness: Tornado/Strong Winds/Severe Thunderstorms, Safety. April - QAPI, Regulatory Prep, & Improvement Plan, Abuse and Mandatory Reporter, Dietary Awareness, Diabetic, & Dental, Restorative Program, Disaster Preparedness: Workplace Violence (Active Shooter), Safety. May - QAPI, Regulatory Prep, & Improvement Plan, Abuse and Mandatory Reporter, Identifying Change of Condition, Staff Burnout/Coping with StressDisaster Preparedness: Utility Failure, Safety. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	June - QAPI, Regulatory Prep, & Improvement Plan, Abuse and Mandatory Reporter, Activity Involvement as a part of daily life, Disaster Preparedness: Extreme Weather - Heat, Safety. July - QAPI, Regulatory Prep, & Improvement Plan, Abuse and Mandatory Reporter, Communication (residents, peers, supervisors, families, vendors), Compliance and Ethics, Disaster Preparedness: Hazardous Material/Waste Spill, Safety. August - QAPI, Regulatory Prep, & Improvement Plan, Abuse and Mandatory Reporter, Infection Control & Bloodborne Pathogens, Caring for Residents with Mental/Psychosocial Disorders, Disaster Preparedness: Infectious Disease & Homeland Security Threats, Safety. September - QAPI, Regulatory Prep, & Improvement Plan, Abuse and Mandatory Reporter, Wheelchair Cleaning Process, Antibiotic Stewardship & Activities of Daily Living, Disaster Preparedness: Shelter in Place, Safety. October - QAPI, Regulatory Prep, & Improvement Plan, Abuse and Mandatory Reporter, Person Centered Care, Survey Prep, Disaster Preparedness: Fire Safety, Safety: Oxygen safety and awareness. November - QAPI, Regulatory Prep, & Improvement Plan, Abuse and Mandatory Reporter, Hospice, Disaster Preparedness: Winter storm/Extreme Weather, Safety. December - QAPI, Regulatory Prep, & Improvement Plan, Abuse and Mandatory Reporter, Dementia and Behavior Management, Disaster Preparedness: Bioterrorism, Safety. On [DATE], Surveyors requested a copy of the facility's 2025 Education Calendar, a copy of staff attendees at the March, 2026 education program, the Staff Competency Assessment policy, an outline of the material presented and credentials of the March, 2026 monthly education speaker. As of the time of survey exit, the facility did not provide the 2025 Education Calendar, the staff attendance at the March, 2026 education program or a Staff Competency Assessment policy. The facility provided the outline for the presentation of Resident Rights that was provided by their Long-Term Care Ombudsman in March, 2026, and did not provide any documentation about the Dementia and Behavior Management education that was scheduled for the March, 2026 education program. The facility also provided a Documentation Training Sign-In Sheet, dated [DATE], that stated Training Topic: Documentation & Charting, and signed by 19 staff members, of unknown disciplines, for a program that started at 1:30 p.m., and without a time that the program ended. The facility provided an undated 7-page LTC Staff Training Handout: Schizophrenia and Bipolar Disorders outline with the [DATE] staff sign-in document, however there was no validation of the date the information was provided, or who provided the education if it was provided. The outline included a post-education quiz that staff would have completed, and the facility did not provide copies of the tests completed by staff members after the presentation that would have verified the delivery of the education. Staff interviews revealed: [DATE] at 6:26 a.m., Staff Q, LPN stated they had several residents with behaviors and staff had to be reactive and flexible to keep everyone safe. Management says this is how it is, younger residents with psych illnesses are in the mix and that it's normal across all long-term care. He knew/has learned from practice what usually worked and what usually doesn't, but each situation is individual. You had to try to keep all the resident's safe. They have staff meetings, sometimes they talk about resident behaviors but they could do that at every meeting and it might be more helpful. [DATE] at 9:50 a.m. Staff M, LPN stated there were several residents here with aggressive behaviors, most were younger but not all, but they are different than their older frail residents with normal dementia. They really didn't educate staff with specifics for managing resident behaviors, staff had to deal with them as they arose. The only option they really had was to send the resident to the hospital emergency room (ER) for assessment when their behaviors were aggressive and threatening. [DATE] at 1:03 p.m., Staff T, RN, stated they were getting more and more of the younger psych residents with behaviors. Staff weren't really educated to manage those complex conditions, there might be some information in the breakroom, a couple sheets of paper, if you call that education, otherwise there wasn't a plan to make sure that staff had the knowledge they needed to manage complex resident conditions and aggressive resident behaviors. [DATE] at 11:16 a.m. Staff L, CNA, stated she thought they did some education on resident conditions at staff meetings, she wasn't sure if they covered what to do about resident behaviors or psychiatric problems, she couldn't remember if they did. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] at 2:21 p.m. Staff E, CNA and Staff U, CNA stated they had training when they first started, couldn't say if they have had education about behaviors or what to do with resident's that were aggressive when they had staff meetings but thought they probably did. When asked if they could remember what to do if a resident was being difficult, they said to try to approach the resident with a different staff member, otherwise they couldn't offer any other examples of education they had received. [DATE] at 2:49 p.m. Staff I, RN stated they used to have an all dementia facility, and behaviors were a little easier to manage due to the similarities between the residents. Now their population was so diverse, the residents with psychiatric problems are younger, more mobile, stronger and agile, and staff try to do the best they can with what they have. The had monthly staff meetings and they had some quizzes to fill out for education on resident conditions, and they could never have too much of that.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and staff and resident responsible party interviews, the facility failed to incorporate care requirements into resident comprehensive care plans as directed for 2 of 5 residents reviewed with Level II PASRR's (Pre-admission Screening and Resident Review, an in-depth, person-centered evaluation triggered when there is a suspected or confirmed mental illness, intellectual disability, or related condition. It ensures individuals are placed in the most integrated, appropriate setting and receive necessary specialized services), and failed to ensure the 2 resident's attained or maintained the highest practicable mental and psychosocial well-being, evidenced by 1 of the resident's repeated inpatient psychiatric hospitalizations (Resident #5), and the other resident's inappropriate discharge that lead to homelessness and later demise (Resident #4). The facility reported a census of 25 residents. Findings include: 1. The modified Minimum Data Set (MDS) Assessment tool with reference date 8/20/26 revealed Resident #5 admitted to the facility on [DATE] with diagnoses that included hyponatremia (low sodium level), non-Alzheimer's dementia, traumatic brain injury (TBI), anxiety, bipolar disorder, schizophrenia and asthma, scored 9 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment that indicated moderate cognitive impairment, with symptoms of delirium present, the resident always able to make herself understood and always able to understand others, and the resident did not have behaviors in the 6 days that preceded the assessment. The assessment revealed other related conditions documented in the PASRR section, and did not indicate the resident had a serious mental illness. The assessment revealed the resident required staff supervision/touch assistance for dressing, toileting and personal hygiene, independent for ambulation of 150 feet, transfers to and from bed and toileting, and partial/moderate staff assistance for bathing. The resident's Level II PASRR dated 8/7/25 was a short-term,180-day approval for services that ended 2/3/26, and revealed the following information:1. Met PASRR criteria for serious mental illness for the diagnoses of schizoaffective disorder, bipolar type, which led to significant symptoms that impact daily functioning and have required intensive supports in the past.2. The resident had multiple inpatient psychiatric hospitalizations between 2019 and 2025 for treatment of schizoaffective disorder, bipolar type.3. At the time of the assessment the resident was hospitalized on an inpatient psychiatric unit by court order, for treatment of schizoaffective disorder, bipolar type, and neurocognitive disorder (conditions that cause a decline in mental functions such as memory, attention, problem-solving, and language) related to TBI.4. The resident had a history of behaviors that included refusal of medication and care when not doing well, yelled at others, and threw and broke things when upset.5. The resident required placement in a locked facility for safety. The receiving facility was required to provide:1. Ongoing psychiatric medication management by a psychiatrist or a psychiatric ARNP (to evaluate response and effectiveness of psychotropic medications on target symptoms, modify medication orders, and to evaluate ongoing need for additional behavioral health services)2. Individual therapy by a licensed behavioral health professional3. Occupational Therapˆ4. Physical Therapy5. Routine and/or special Dental Services to address care of teeth or dentures and oral health5. Socialization/leisure/recreation activities appropriate to current skills or adapted to facilitate optimal participation6. Facilitate family involvement in the individual's care and care planning, including inviting family for regular visitation, and participation in care conferences7. Supportive counseling from nursing facility staff The resident's clinical record revealed:1. Psychoactive medication orders on the resident's 8/14/25 admission included:a). Benztropine (an anticholinergic medication used to treat involuntary muscle movements caused by antipsychotic medication) 1 milligrams (mg) administered oral twice dailyb). Divalproex (an anticonvulsant and mood-stabilizing medication) (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Extended Release (ER) 1500 mg administered oral at hour of sleep (HS)c). Levocarnitine (an amino acid dietary supplement used to treat high ammonia levels) 990 mg administered oral 3 times daily.d). Levothyroxine 100 micrograms (mcg) administered oral daily.e). Risperidone (a strong antipsychotic medication) 1 mg administered oral twice daily.f). Trazodone (an antidepressant medication with sedative properties) 75 mg administered oral at HS (not started until 8/27/25).g). Paliperidone (an atypical antipsychotic, also called a second-generation antipsychotic that works by rebalancing certain chemicals in the brain, primarily acting as a serotonin and dopamine antagonist to help improve thinking, mood, and behavior) 564 mg administered by intramuscular injection (IM) every 84 days. 2. The PASRR directives were not addressed in the resident's comprehensive person-centered care plan until 2/16/26.3. The psychiatric hospital's discharge and transfer orders dated 8/14/25 that directed the resident's admission to the facility also directed continued follow-up care by psychiatrists familiar with the resident's care, with follow-up appointments scheduled.4. Within 14 days of the resident's admission to the facility, the facility sought changes in the resident's psychiatric medication regimen from their medical director and the facility's psychiatric nurse practitioner, and did not confer with the resident's psychiatrist provider of record, or the resident's Court Appointed Guardian and decision maker. The medication changes included:a). On 8/28/25 started Haloperidol (Haldol, a very strong antipsychotic medication) 0.5 milligrams (mg) administered oral every 6 hours as needed (PRN) for 14 days, for manic episodes and aggressive behaviors.b). On 8/28/25 started Buspirone (an anxiolytic medication) 10 mg administered oral twice daily for schizoaffective disorder (discontinued 9/23/25).c). On 8/29/25 added Valporic Acid (prescription anticonvulsant and mood-stabilizing medication) 250 mg administered oral twice daily for schizoaffective, bipolar disorder .(discontinued 9/23/25)d). On 9/4/25 added Haldol 0.5 mg administered oral 4 times daily for schizoaffective disorder, (discontinued on 9/15/25)e). On 9/15/25 increased Haldol to 1 mg administered oral 4 times daily for schizoaffective disorder (discontinued10/22/25).f). On 9/15/25 decreased Risperidone to 1 mg administered oral daily for 5 days, then discontinue.g). On 9/16/25, started Ziprasidone (a strong antipsychotic medication) 20 mg administered oral twice daily (discontinued 10/22/25)h). Added Lorazepam (a strong controlled anxiolytic medication) 0.5 mg administered oral every 6 hours PRN for 14 days for behaviors or agitation. 5. Resident sent to a hospital emergency room (ER) for a psychiatric evaluation and treatment of aggressive behaviors on 9/9/25.6. Resident sent to a hospital ER for a psychiatric evaluation and treatment of aggressive behaviors on 10/7/25.7. Resident sent to the psychiatric hospital ER for psychiatric evaluation and treatment of aggressive behaviors on 10/27/25. The resident hospitalized on the inpatient psychiatric unit until 11/6/25 for treatment of schizoaffective disorder.8. Resident sent to the psychiatric hospital ER for psychiatric evaluation and treatment of aggressive behaviors on 2/20/26. The resident hospitalized on the inpatient psychiatric unit until 3/2/26 for treatment of schizoaffective disorder.9. Resident sent to the psychiatric hospital ER for psychiatric evaluation and treatment of aggressive behaviors on 3/3/26. The resident hospitalized and had not returned to the facility. Documentation on a 9/19/25 Psychiatrist Progress Note stated, in part:Was last seen 3 weeks ago at which time the plan was to continue current medications without changes that included:Benztropine 1 mg twice dailyBuspirone 10 mg twice dailyDepakote ER 1500 mg at HSValproic acid 250 mg twice dailyHaldol 0.5 mg q 6 hours PRN mania and aggressive behaviorsRisperidone 1 mg twice dailyTrazodone 75 mg at HSInvega trinza 546 mg IM every 84 days. Current facility med list:Haldol is now 1 mg scheduled 4 times dailyDecreased Risperidone to 1 mg once daily, scheduled to discontinue (DC) on 9/21/25Started Ziprasidone 20 mg twice dailyDepakote ER 1500 mg at HSValproic acid 250 mg twice dailyBenztropine 1 mg twice dailyBuspirone 10 mg twice dailyTrazodone 75 mg at HSInvega Trinza 546 mg every 84 days IM Was accompanied to this appointment by a staff member from a different facility that could not answer this provider's basic questions about her moods/condition. Plan was to discontinue Valproic acid due to high ammonia level, continue Depakote ER, electrocardiogram was needed before they could increase Ziprasidone, (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was aggressive, that was the best she could do until the resident settled down. 2. Resident #4 was admitted to facility on 10/2/25, transferred there from a sister facility due to the resident's exit-seeking behavior, where she'd been admitted from the hospital on 9/29/25. The MDS Assessment tool with reference date 10/9/25 revealed the resident scored 12 out of 15 points possible on the BIMS cognitive assessment that indicated mild cognitive impairment, without symptoms of delirium present, aways able to make self understood and always able to understand others, no behaviors identified and had a Level II PASRR for serious mental illness. Her diagnoses included hypertension (high blood pressure), renal insufficiency, diabetes, arthritis, anxiety, depression (other than bipolar disorder), major depressive disorder, attention-deficit hyperactivity disorder (ADHD), insomnia, chronic pain, spinal stenosis (narrowing of spinal canal inside vertebrae) of cervical region and low back pain. The assessment revealed the resident was independent for all activities of daily living, including ambulation of 150 feet on even surfaces, with exception of shower/bathe self not assessed, and transfer into shower/tub not assessed.A level II PASRR dated 9/24/25 was a short term,180-day approval for services that ended 3/23/26 and revealed the following information:1. Met PASRR criteria for serious mental illness for the diagnoses of schizophrenia which has led to significant symptoms that impact daily functioning and have required intensive supports in the past.2. Medical provider noted that the resident was unable to care for herself Independently due to difficulty with basic cognitive tasks and impaired judgement, noted to be confused with impairment in long and short term memory.3. A Court Appointed Guardian has been established for decision making.4. The resident has an open criminal case for charges of Assault Causing Bodily Injury and Domestic Abuse, Assault-Injury of Mental Illness with a competency evaluation scheduled for 10/08/2025.5. The resident's Guardian stated she will need to live in a supportive setting such as a nursing home or assisted living facility because the resident is unable to care for herself at home.6. Medical records note there may be an open assessment with HHS (Iowa Health and Human Services) relating to possible dependent adult abuse or self-denial of critical care.7. History of methamphetamine use with most recent use occurring just prior to 8/2/25 hospital admission. It does not appear that the resident has ever attended substance abuse treatment.8. A Modlfied Short Blessed Cognitive Test (SBT), a screening test to measure cognitive ability resulted in a score of 12. Scores of 0-4 represent cognitive functioning to be intact, scores of 5-9 indicate possible impairment and may suggest a need for evaluation of early dementing disorder, and scores of 10 or more indicate impairments that are consistent with dementia.9. The MoCA (Montreal Cognitive Assessment), a cognitive screening test designed to assist health professionals to detect mild cognitive impairment and Alzheimer's disease resulted in a score of 7. Scores of 26 and higher represent normal cognition, scores of 18-25 indicate mild cognitive impairment, scores of 10-17 indicate moderate cognitive impairment, and scores of less than 10 indicate severe cognitive impairment. The score of 7 indicates the resident would have trouble remembering, learning new things, concentrating, and making decisions that affect everyday life.The receiving facility was required to provide:1. Ongoing psychiatric medication management by a psychiatrist or a psychiatric advanced registered nurse practitioner ARNP (to evaluate response and effectiveness of psychotropic medications on target symptoms, modify medication orders, and to evaluate ongoing need for additional behavioral health services) Individual therapy by a licensed behavioral health professional.2. Initial substance use evaluation to determine diagnosis and develop a plan of care Referral and make access possible for participation in a support group for recovery from substance abuse (AA, NA, etc.)3. Services to assist the individual in preparing to pursue supported community living.4. Language Therapy - the resident will benefit from ongoing speech therapy to improve ability to swallow and cognitive, problem solving, and reasoning skills.5. Facilitate family involvement in the individual's care and care planning, including inviting family for regular visitation, and participation in care conferences.6. Supportive counseling from nursing facility staff.7. Due to the serious history of substance use and apparent challenges it has created the resident will benefit from a referral for (continued on next page)

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	165355	A. Building B. Wing	05/19/2026

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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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evaluation of need for substance use treatment. If it is determined the resident needs substance use treatment in an inpatient setting following nursing facility care, then plans should be made to enter treatment in whatever manner will be most beneficial for the resident.8. Obtain archived psychiatric/behavioral health treatment records to clarify history and then make those past records available to all medical and behavioral health service providers9. Because the resident has ongoing medical and mental health conditions and requires assistance from others, the resident will need to live in a supported living setting, such as supported independent living, a group home, residential care facility, assisted living, or other supported setting where help from staff is available with consistent supervision for safety and well-being. Staff at the receiving nursing facility are encouraged to reach out for immediate collaboration with MCO case managers, and any other community providers that may be involved with the resident, to find and arrange for any services the resident is eligible to receive before discharge.10. The resident will benefit from a referral to a support group for recovery from substance use and a recovery group for people with serious mental health issues to help the resident get and stay sober and to support recovery in both mental health and substance use.Additional PASRR requirements included:The admitting nursing facility must incorporate PASRR findings as part of the individual's plan of care. Maximus must be notified of all PASRR admissions and discharges via Path Tracker within AssessmentPro.If for any reason the resident chooses to discharge prematurely or without adequate services and supports in place, we strongly encourage any concerned providers or others to take all necessary steps to keep the resident safe, including requesting court orders if needed, and to contact the Iowa HHS Abuse Hotline at [PHONE NUMBER], to report the resident's high potentlal for dependent adult abuse and/or self-denial of critical care.The resident's Nursing Care Plan did not include any of the PASRR required interventions, or indication that the resident had a Level II PASRR.The resident had psychoactive medication orders that included:Administer Tetrabenazine 12.5 milligrams (mg) oral twice daily, ordered 10/3/25. The medication is classified as a Vesicular Monoamine Transporter 2 (VMAT2) inhibitors that prevents neurotransmitters like dopamine, serotonin, norepinephrine, and histamine from being stored and released in the brain, which helps reduce involuntary, hyperkinetic movements associated with long-term use of some psychoactive medications.The resident's clinical record revealed the medication was administered as ordered when the resident was at the sister facility from 9/29/25 through 10/1/25, and the medication not administered at the facility from the time of the order on 10/3/25 through 10/11/25, both doses administered on 10/12/25, 1 dose administered on 10/13/25 then the medication order discontinued on 10/13/25. Per Google search, sudden withdrawal of Tetrabenazine medication caused rapid re-emergence of involuntary, jerky movements within 12 to 18 hours, and can also trigger increased restlessness, insomnia, anxiety and mood swings.A Pogress Note transcribed by the facility's psychiatric Nurse Practitioner on 10/13/25 stated, in part:Staff told me that the Tetrabenazine was not covered by her insurance and it was going to cost 900$ a month- and asked me to discontinue this. I can try to see if she can get on Ingrezza 40mg oral daily for this. (Ingrezza is a medication used to treat involuntary, repetitive, or sudden body movements in adults, such as tardive dyskinesia.) The clinical record revealed Ingrezza was ordered on 10/14/25, discontinued on 10/14/25 and never administered to the resident. Pre-authorization was required for the medication, and per pharmacy interview on 5/6/26 at 3:24 p.m., the facility did not complete the documentation required for prior authorization as required.During an interview on 5/5/26 at 1:03 p.m. Staff T, Registered Nurse (RN) stated when the resident was first at the facility she didn't have behaviors, they waited for her medication to be approved and delivered. She started to have behaviors that got worse after a week or so, she contacted the pharmacy and asked if it was associated to her not getting the medication and the pharmacy agreed to send an emergency supply. Interview with the facility's pharmacy (Pharmacy A) on 5/6/26 at 3:24 p.m. revealed they received a call from facility staff on 10/11/25 requesting the resident's medication, a 3 day Emergency supply of 6 tablets was dispensed at that time pending the facility's authorization and payment for the medication. The staff (continued on next page)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, the facility staff failed to change gloves after completing incontinence care (of stool) and before applying Triad cream to a pressure ulcer to the coccyx area for one of one residents reviewed with a pressure ulcer. (Resident #3). The facility reported a census of 25 residents.Findings include:The Minimum Data Set (MDS) dated [DATE] identified Resident #3 as severely cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 03 and had the following diagnoses: Heart Failure, Diabetes Mellitus and Non-Alzheimer's Dementia. The MDS also identified Resident #3 was totally dependent on staff for assistance with eating, toileting, showers, lower body dressing and putting on and removing footwear and repositioning. The MDS identified Resident #3 required substantial/maximal staff assistance with upper body dressing and oral hygiene. The MDS also identified Resident #3 displayed behaviors of delusions and physical, verbal and other behaviors of behavioral symptoms directed toward others. A review of the Progress Notes revealed the following: 2/15/26 6:26 AM Resident's buttock red, open area in center upper portion of buttocks. Measurements 10 cm (centimeters) in length x4 cm in width, open area in middle of a circular 13 cm circular red area. On 3/16/26, the Care Plan identified Resident #3 with a Stage 3 pressure ulcer to the coccyx measuring 4 cm x 2 cm x 0.3 cm requiring daily treatment. The Care Plan failed to address the need to change gloves after providing incontinence care and before applying cream to the pressure ulcer. In an observation of incontinence care on 5/6/26 at 9:14 AM, Staff K, CNA and Staff L, CNA turned resident to his left side he began to strike Staff L, Staff K held his hand to keep him from hitting Staff L. Staff K then used correct technique to cleanse stool off Resident #3's rectal crease. There was an open area noted to coccyx approximately 4 cm long and 2 cm wide, difficult to see depth. Surrounding skin appeared slightly reddened. Then Staff K applied Triad cream to Resident #3's coccyx area without changing her gloves first. Afterwards both aides changed their gloves and applied a new incontinent brief on to the resident. In an interview on 5/12/26 at 9:57 AM, Staff K, CNA reported the following: after she cleans BM (bowel movement) off a resident, she would need to change gloves before she applies a cream to the resident's coccyx afterward. She admitted she forgot to change gloves when providing incontinence cares to Resident #3 and before she applied Triad cream to his coccyx area. She also verified he did have a pressure ulcer to his coccyx area. In an interview on 5/12/26 at10:06 AM, Staff L, CNA reported after she would clean off BM off a resident, she would need to change gloves before applying any cream to the resident's coccyx afterward. She did report Staff K, CNA forgot to change her gloves during incontinence cares the surveyor observed earlier. In an interview on 5/12/26 at 10:13 AM, Staff M, LPN reported after cleaning off BM off a resident, she would change her gloves before applying any ointment to the resident afterwards. She also verified Resident #3 did have a pressure ulcer to his coccyx area. In an interview on 5/13/26 at 1:36 PM, the DON (Director of Nursing) reported after cleaning BM off a resident, she would expect the aides to change their gloves before applying ointment to the resident's pressure ulcer to the coccyx area. A review of the undated Facility Policy titled: Incontinence Care had documentation of the following:Remove the soiled briefs or pad.Immediately clean the resident's skin gently with a wipe or cloth moistened with water or pH-balanced cleaner.Remove and discard your gloves.Perform hand hygiene.Put on clean gloves.Dry the resident's skin.Apply a moisture barrier protectant, as necessary.Inspect the skin for signs of breakdown; promptly report changes in skin integrity.Put on clean briefs or pad.